

Requested by Representative NOSSE

**PROPOSED AMENDMENTS TO  
A-ENGROSSED HOUSE BILL 3046**

1 On page 1 of the printed A-engrossed bill, delete lines 19 and 20 and insert  
2 “in the mental disorders section of the current edition of the:

3 “(A) International Classification of Disease; or

4 “(B) Diag”.

5 On page 2, line 1, delete “International Classi-” and delete line 2 and in-  
6 sert “:

7 “(A) International Classification of Disease; or

8 “(B)”.

9 On page 3, delete lines 31 and 32 and insert “in the mental disorders  
10 section of the current edition of the:

11 “(A) International Classification of Disease; or

12 “(B) Diag”.

13 In line 39, delete “International” and delete line 40.

14 In line 41, delete “of the” and insert “:

15 “(A) International Classification of Disease; or

16 “(B)”.

17 Delete line 42.

18 In line 43, delete “the Oregon Health Authority” and insert:

19 “(2) No later than March 1 of each calendar year, the Oregon Health  
20 Authority shall prescribe the form and manner for each coordinated care  
21 organization to report to the authority, on or before June 1 of the calendar

1 year,”.

2 On page 4, delete lines 26 through 45.

3 On page 5, delete lines 1 through 8 and insert:

4 “(4) Each calendar year the authority, in collaboration with individuals  
5 representing behavioral health treatment providers, community mental  
6 health programs, coordinated care organizations, the Consumer Advisory  
7 Council established in ORS 430.073 and consumers of mental health or sub-  
8 stance use disorder treatment, shall, based on the information reported under  
9 subsection (2) of this section, identify and assess:

10 “(a) Coordinated care organizations’ compliance with the requirements for  
11 parity between the behavioral health coverage and the coverage of medical  
12 and surgical treatment in the medical assistance program; and

13 “(b) The authority’s compliance with the requirements for parity between  
14 the behavioral health coverage and the coverage of medical and surgical  
15 treatment in the medical assistance program for individuals who are not  
16 enrolled in a coordinated care organization.

17 “(5) No later than December 31 of each calendar year, the authority shall  
18 submit a report to the interim committees of the Legislative Assembly re-  
19 lated to mental or behavioral health, in the manner provided in ORS 192.245,  
20 that includes:

21 “(a) The authority’s findings under subsection (4) of this section on com-  
22 pliance with rules regarding mental health parity, including a comparison  
23 of coverage for members of coordinated care organizations to coverage for  
24 medical assistance recipients who are not enrolled in coordinated care or-  
25 ganizations as applicable; and:

26 “(b) An assessment of:

27 “(A) The adequacy of the provider network as prescribed by the authority  
28 by rule.

29 “(B) The timeliness of access to mental health and substance use disorder  
30 treatment and services, as prescribed by the authority by rule.

1 “(C) The criteria used by each coordinated care organization to determine  
2 medical necessity and behavioral health coverage, including each coordinated  
3 care organization’s payment protocols and procedures.

4 “(D) Data on services that are requested but that coordinated care or-  
5 ganizations are not required to provide.

6 “(E) The consistency of credentialing requirements for behavioral health  
7 treatment providers with the credentialing of medical and surgical treatment  
8 providers.

9 “(F) The utilization review, as defined by the authority by rule, applied  
10 to behavioral health coverage compared to coverage of medical and surgical  
11 treatments.

12 “(G) The specific findings and conclusions reached by the authority with  
13 respect to the coverage of mental health and substance use disorder treat-  
14 ment and the authority’s analysis that indicates that the coverage is or is  
15 not in compliance with this section.

16 “(H) The specific findings and conclusions of the authority demonstrating  
17 a coordinated care organization’s compliance with this section and with the  
18 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Eq-  
19 uity Act of 2008 (P.L. 110-343) and rules adopted thereunder.

20 “(6) Except as provided in subsection (5)(b)(D) of this section, this section  
21 does not require coordinated care organizations to report data on services  
22 that are not funded on the prioritized list of health services compiled by the  
23 Health Evidence Review Commission under ORS 414.690.”

24 On page 5, delete line 42 and insert “, to the extent permitted by the  
25 federal Health Insurance Portability and Accountability Act privacy regu-  
26 lations, 45 C.F.R. parts 160 and 164, ORS 192.553 to 192.581 or other state  
27 or federal laws limiting the disclosure of health information.”

28 On page 7, line 28, delete the boldfaced material.

29 On page 8, line 42, delete “no less frequently than” and insert “in a  
30 manner equivalent to the manner in which”.

1 On page 10, line 16, after “shall” insert “provide, at no cost” and delete  
2 lines 17 through 24 and insert:

3 “(a) A formal education program, presented by nonprofit clinical specialty  
4 associations or other entities authorized by the department, to educate the  
5 insurer’s or the issuer’s staff and any individuals described in subsection  
6 (2)(k) of this section who conduct reviews.

7 “(b) To stakeholders, including participating providers and insureds, the  
8 medical necessity, utilization or other clinical review criteria and any edu-  
9 cation or training materials or resources regarding medical necessity, utili-  
10 zation or other clinical review criteria, to the extent permitted by copyright  
11 laws.”.

12 On page 13, delete lines 23 through 45 and delete pages 14 through 20.

13 On page 21, delete lines 1 through 27 and insert:

14 **“SECTION 7.** Section 2 of this 2021 Act is amended to read:

15 **“Sec. 2.** (1) As used in this section:

16 “(a) ‘Behavioral health benefits’ means insurance coverage of mental  
17 health treatment and services and substance use disorder treatment and  
18 services.

19 “(b) ‘Carrier’ has the meaning given that term in ORS 743B.005.

20 “(c) ‘Geographic region’ means the geographic area of the state estab-  
21 lished by the Department of Consumer and Business Services for the purpose  
22 of determining geographic average rates, as defined in ORS 743B.005.

23 “(d) ‘Health benefit plan’ has the meaning given that term in ORS  
24 743B.005.

25 “(e) ‘Median maximum allowable reimbursement rate’ means the median  
26 of all maximum allowable reimbursement rates, minus incentive payments,  
27 paid for each billing code for each provider type during a calendar year.

28 “(f) ‘Mental health treatment and services’ means the treatment of or  
29 services provided to address any condition or disorder that falls under any  
30 of the diagnostic categories listed in the mental disorders section of the

1 current edition of the:

2 “(A) International Classification of Disease; or

3 “(B) Diagnostic and Statistical Manual of Mental Disorders.

4 “(g) ‘Nonquantitative treatment limitation’ means a limitation that is not  
5 expressed numerically but otherwise limits the scope or duration of behav-  
6 ioral health benefits.

7 “(h) ‘Substance use disorder treatment and services’ means the treatment  
8 of or services provided to address any condition or disorder that falls under  
9 any of the diagnostic categories listed in the substance use section of the  
10 current edition of the:

11 “(A) International Classification of Disease; or

12 “(B) Diagnostic and Statistical Manual of Mental Disorders.

13 “(2) Each carrier that offers an individual or group health benefit plan  
14 in this state that provides behavioral health benefits shall conduct an annual  
15 analysis of whether the processes, strategies, specific evidentiary standards  
16 or other factors the carrier used to design, determine applicability of and  
17 apply each nonquantitative treatment limitation to behavioral health bene-  
18 fits within each classification of benefits are comparable to, and are applied  
19 no more stringently than, the processes, strategies, specific evidentiary  
20 standards or other factors the carrier used to design, determine applicability  
21 of and apply each nonquantitative treatment limitation to medical and sur-  
22 gical benefits within the corresponding classification of benefits.

23 “(3) On or before March 1 of each year, all carriers that offer individual  
24 or group health benefit plans in this state that provide behavioral health  
25 benefits shall report to the Department of Consumer and Business Services,  
26 in the form and manner prescribed by the department, the following infor-  
27 mation:

28 “(a) The specific plan or coverage terms or other relevant terms regarding  
29 the nonquantitative treatment limitations and a description of all mental  
30 health or substance use disorder and medical or surgical benefits to which

1 each such term applies in each respective benefits classification.

2 “(b) The factors used to determine that the nonquantitative treatment  
3 limitations will apply to mental health or substance use disorder benefits and  
4 medical or surgical benefits.

5 “(c) The evidentiary standards used for the factors identified in paragraph  
6 (b) of this subsection, when applicable, provided that every factor is defined,  
7 and any other source or evidence relied upon to design and apply the non-  
8 quantitative treatment limitations to mental health or substance use disorder  
9 benefits and medical or surgical benefits.

10 “(d) The comparative analyses demonstrating that the processes, strate-  
11 gies, evidentiary standards and other factors used to apply the nonquantita-  
12 tive treatment limitations to mental health or substance use disorder  
13 benefits, as written and in operation, are comparable to, and are applied no  
14 more stringently than, the processes, strategies, evidentiary standards and  
15 other factors used to apply the nonquantitative treatment limitations to  
16 medical or surgical benefits in the benefits classification.

17 “(e) The specific findings and conclusions reached by the insurer with  
18 respect to the health insurance coverage, including any results of the ana-  
19 lyses described in paragraphs (a) to (d) of this subsection that indicate that  
20 the plan or coverage is or is not in compliance with this section.

21 “[*f*] *The number of denials of behavioral health benefits and medical and*  
22 *surgical benefits, the percentage of denials that were appealed, the percentage*  
23 *of appeals that upheld the denial and the percentage of appeals that overturned*  
24 *the denial.*]

25 “[*g*] *The percentage of claims for behavioral health benefits and medical*  
26 *and surgical benefits that were paid to in-network providers and the percentage*  
27 *of such claims that were paid to out-of-network providers.*]

28 “[*h*] *The median maximum allowable reimbursement rate for each time-*  
29 *based office visit billing code for each behavioral treatment provider type and*  
30 *each medical provider type.*]

1       “[(i) *The reimbursement rate in each geographic region for a time-based*  
2 *office visit and the percentage of the Medicare rate the reimbursement rate*  
3 *represents, paid to:]*

4       “[(A) *Psychiatrists.*]

5       “[(B) *Psychiatric mental health nurse practitioners.*]

6       “[(C) *Psychologists.*]

7       “[(D) *Licensed clinical social workers.*]

8       “[(E) *Licensed professional counselors.*]

9       “[(F) *Licensed marriage and family therapists.*]

10       “[(j) *The reimbursement rate in each geographic region for a time-based*  
11 *office visit and the percentage of the Medicare rate the reimbursement rate*  
12 *represents, paid to:]*

13       “[(A) *Physicians.*]

14       “[(B) *Physician assistants.*]

15       “[(C) *Licensed nurse practitioners.*]

16       “[(k) *The specific findings and conclusions of the carrier under subsection*  
17 *(2) of this section demonstrating compliance with ORS 743A.168 and the Paul*  
18 *Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act*  
19 *of 2008 (P.L. 110-343) and rules adopted thereunder.*]

20       “[(L)] (f) Other data or information the department deems necessary to  
21 assess a carrier’s compliance with mental health parity requirements.

22       “(4) No later than September 15 of each calendar year, the department  
23 shall report to the interim committees of the Legislative Assembly related  
24 to mental or behavioral health, in the manner provided in ORS 192.245, the  
25 information reported under subsection (3) of this section, including the  
26 department’s overall comparison of carriers’ coverage of mental health  
27 treatment and services and substance use disorder treatment and services to  
28 carriers’ coverage of medical or surgical treatments or services.

29       “**SECTION 8.** ORS 743A.168, as amended by section 5 of this 2021 Act,  
30 is amended to read:

1 “743A.168. (1) As used in this section:

2 “(a) ‘Behavioral health assessment’ means an evaluation by a provider, in  
3 person or using telemedicine, to determine a patient’s need for behavioral  
4 health treatment.

5 “(b) ‘Behavioral health condition’ has the meaning prescribed by rule by  
6 the Department of Consumer and Business Services.

7 “(c) ‘Behavioral health crisis’ means a disruption in an insured’s mental  
8 or emotional stability or functioning resulting in an urgent need for imme-  
9 diate outpatient treatment in an emergency department or admission to a  
10 hospital to prevent a serious deterioration in the insured’s mental or phys-  
11 ical health.

12 “(d) ‘Facility’ means a corporate or governmental entity or other provider  
13 of services for the treatment of behavioral health conditions.

14 “(e) ‘Generally accepted standards of care’ means:

15 “(A) Standards of care and clinical practice guidelines that:

16 “(i) Are generally recognized by health care providers practicing in rele-  
17 vant clinical specialties; and

18 “(ii) Are based on valid, evidence-based sources; and

19 “(B) Products and services that:

20 “(i) Address the specific needs of a patient for the purpose of screening  
21 for, preventing, diagnosing, managing or treating an illness, injury or con-  
22 dition or symptoms of an illness, injury or condition;

23 “(ii) Are clinically appropriate in terms of type, frequency, extent, site  
24 and duration; and

25 “(iii) Are not primarily for the economic benefit of an insurer or payer  
26 or for the convenience of a patient, treating physician or other health care  
27 provider.

28 “(f) ‘Group health insurer’ means an insurer, a health maintenance or-  
29 ganization or a health care service contractor.

30 “(g) ‘Median maximum allowable reimbursement rate’ means the median



1 of all maximum allowable reimbursement rates, minus incentive payments,  
2 paid for each billing code for each provider type during a calendar year.

3 “(h) ‘Prior authorization’ has the meaning given that term in ORS  
4 743B.001.

5 “(i) ‘Program’ means a particular type or level of service that is organ-  
6 izationally distinct within a facility.

7 “(j) ‘Provider’ means:

8 “(A) A behavioral health professional or medical professional licensed or  
9 certified in this state who has met the credentialing requirement of a group  
10 health insurer or an issuer of an individual health benefit plan that is not  
11 a grandfathered health plan as defined in ORS 743B.005 and is otherwise el-  
12 ible to receive reimbursement for coverage under the policy;

13 “(B) A health care facility as defined in ORS 433.060;

14 “(C) A residential facility as defined in ORS 430.010;

15 “(D) A day or partial hospitalization program;

16 “(E) An outpatient service as defined in ORS 430.010; or

17 “(F) A provider organization certified by the Oregon Health Authority  
18 under subsection [(8)] (9) of this section.

19 “(k) ‘Relevant clinical specialties’ includes but is not limited to:

20 “(A) Psychiatry;

21 “(B) Psychology;

22 “(C) Clinical sociology;

23 “(D) Addiction medicine and counseling; and

24 “(E) Behavioral health treatment.

25 “(L) ‘Standards of care and clinical practice guidelines’ includes but is  
26 not limited to:

27 “(A) Patient placement criteria;

28 “(B) Recommendations of agencies of the federal government; and

29 “(C) Drug labeling approved by the United States Food and Drug Ad-  
30 ministration.

1 “(m) ‘Utilization review’ has the meaning given that term in ORS  
2 743B.001.

3 “(n) ‘Valid, evidence-based sources’ includes but is not limited to:

4 “(A) Peer-reviewed scientific studies and medical literature;

5 “(B) Recommendations of nonprofit health care provider professional as-  
6 sociations; and

7 “(C) Specialty societies.

8 “(2) A group health insurance policy or an individual health benefit plan  
9 that is not a grandfathered health plan providing coverage for hospital or  
10 medical expenses, other than limited benefit coverage, shall provide coverage  
11 for expenses arising from the diagnosis of behavioral health conditions and  
12 medically necessary behavioral health treatment at the same level as, and  
13 subject to limitations no more restrictive than, those imposed on coverage  
14 or reimbursement of expenses arising from treatment for other medical con-  
15 ditions. The following apply to coverage for behavioral health treatment:

16 “(a) The coverage may be made subject to provisions of the policy that  
17 apply to other benefits under the policy, including but not limited to pro-  
18 visions relating to copayments, deductibles and coinsurance. Copayments,  
19 deductibles and coinsurance for treatment in health care facilities or resi-  
20 dential facilities may not be greater than those under the policy for expenses  
21 of hospitalization in the treatment of other medical conditions. Copayments,  
22 deductibles and coinsurance for outpatient treatment may not be greater  
23 than those under the policy for expenses of outpatient treatment of other  
24 medical conditions.

25 “(b) The coverage of behavioral health treatment may not be made subject  
26 to treatment limitations, limits on total payments for treatment, limits on  
27 duration of treatment or financial requirements unless similar limitations  
28 or requirements are imposed on coverage of other medical conditions. The  
29 coverage of eligible expenses of behavioral health treatment may be limited  
30 to treatment that is medically necessary as determined in accordance with

1 this section and no more stringently under the policy than for other medical  
2 conditions.

3 “(c) The coverage of behavioral health treatment must include:

4 “(A) A behavioral health assessment;

5 “(B) No less than the level of services determined to be medically neces-  
6 sary in a behavioral health assessment of the specific needs of a patient or  
7 in a patient’s care plan:

8 “(i) To effectively treat the patient’s underlying behavioral health condi-  
9 tion rather than the mere amelioration of current symptoms such as suicidal  
10 ideation or psychosis; and

11 “(ii) For care following a behavioral health crisis, to transition the pa-  
12 tient to a lower level of care;

13 “(C) Treatment of co-occurring behavioral health conditions or medical  
14 conditions in a coordinated manner;

15 “(D) Treatment at the least intensive and least restrictive level of care  
16 that is safe and most effective and meets the needs of the insured’s condition;

17 “(E) A lower level or less intensive care only if it is comparably as safe  
18 and effective as treatment at a higher level of service or intensity;

19 “(F) Treatment to maintain functioning or prevent deterioration;

20 “(G) Treatment for an appropriate duration based on the insured’s par-  
21 ticular needs;

22 “(H) Treatment appropriate to the unique needs of children and adoles-  
23 cents;

24 “(I) Treatment appropriate to the unique needs of older adults; and

25 “(J) Coordinated care and case management as defined by the Department  
26 of Consumer and Business Services by rule.

27 “(d) The coverage of behavioral health treatment may not limit coverage  
28 for treatment of pervasive or chronic behavioral health conditions to short-  
29 term or acute behavioral health treatment at any level of care or placement.

30 “(e) A group health insurer or an issuer of an individual health benefit

1 plan other than a grandfathered health plan shall have a network of pro-  
2 viders of behavioral health treatment sufficient to meet the standards de-  
3 scribed in ORS 743B.505. If there is no in-network provider qualified to  
4 timely deliver, as defined by rule, medically necessary behavioral treatment  
5 to an insured in a geographic area, the group health insurer or issuer of an  
6 individual health benefit plan shall provide coverage of out-of-network med-  
7 ically necessary behavioral health treatment without any additional out-of-  
8 pocket costs if provided by an available out-of-network provider that enters  
9 into an agreement with the insurer to be reimbursed at in-network rates.

10 “(f) A provider is eligible for reimbursement under this section if:

11 “(A) The provider is approved or certified by the Oregon Health Author-  
12 ity;

13 “(B) The provider is accredited for the particular level of care for which  
14 reimbursement is being requested by the Joint Commission or the Commis-  
15 sion on Accreditation of Rehabilitation Facilities;

16 “(C) The patient is staying overnight at the facility and is involved in a  
17 structured program at least eight hours per day, five days per week; or

18 “(D) The provider is providing a covered benefit under the policy.

19 “(g) A group health insurer or an issuer of an individual health benefit  
20 plan other than a grandfathered health plan must use the same methodology  
21 to set reimbursement rates paid to behavioral health treatment providers  
22 that the group health insurer or issuer of an individual health benefit plan  
23 uses to set reimbursement rates for medical and surgical treatment providers.

24 “(h) A group health insurer or an issuer of an individual health benefit  
25 plan other than a grandfathered health plan must update the methodology  
26 and rates for reimbursing behavioral health treatment providers in a manner  
27 equivalent to the manner in which the group health insurer or issuer of an  
28 individual health benefit plan updates the methodology and rates for reim-  
29 bursing medical and surgical treatment providers, unless otherwise required  
30 by federal law.

1 “(i) A group health insurer or an issuer of an individual health benefit  
2 plan other than a grandfathered health plan that reimburses out-of-network  
3 providers for medical or surgical services must reimburse out-of-network be-  
4 havioral health treatment providers on the same terms and at a rate that is  
5 in parity with the rate paid to medical or surgical treatment providers.

6 “(j) Outpatient coverage of behavioral health treatment shall include  
7 follow-up in-home service or outpatient services if clinically indicated under  
8 [*any medical necessity, utilization or other clinical review conducted for the*  
9 *diagnosis, prevention or treatment of behavioral health conditions or relating*  
10 *to service intensity, level of care placement, continued stay or discharge*] **cri-**  
11 **teria and guidelines described in subsection (5) of this section.** The  
12 policy may limit coverage for in-home service to persons who are homebound  
13 under the care of a physician only if clinically indicated under [*any medical*  
14 *necessity, utilization or other clinical review conducted for the diagnosis, pre-*  
15 *vention or treatment of behavioral health conditions or relating to service in-*  
16 *tensity, level of care placement, continued stay or discharge*] **criteria and**  
17 **guidelines described in subsection (5) of this section.**

18 “(k)(A) Subject to the patient or client confidentiality provisions of ORS  
19 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS  
20 40.230 relating to psychologists, ORS 40.250 and 675.580 relating to licensed  
21 clinical social workers and ORS 40.262 relating to licensed professional  
22 counselors and licensed marriage and family therapists, a group health  
23 insurer or issuer of an individual health benefit plan may provide for review  
24 for level of treatment of admissions and continued stays for treatment in  
25 health facilities, residential facilities, day or partial hospitalization programs  
26 and outpatient services by either staff of a group health insurer or issuer  
27 of an individual health benefit plan or personnel under contract to the group  
28 health insurer or issuer of an individual health benefit plan that is not a  
29 grandfathered health plan, or by a utilization review contractor, who shall  
30 have the authority to certify for or deny level of payment.

1 “(B) Review shall be made according to criteria made available to pro-  
2 viders in advance upon request.

3 “(C) Review shall be performed by or under the direction of a physician  
4 licensed under ORS 677.100 to 677.228, a psychologist licensed by the Oregon  
5 Board of Psychology, a clinical social worker licensed by the State Board  
6 of Licensed Social Workers or a professional counselor or marriage and  
7 family therapist licensed by the Oregon Board of Licensed Professional  
8 Counselors and Therapists, in accordance with standards of the National  
9 Committee for Quality Assurance or Medicare review standards of the Cen-  
10 ters for Medicare and Medicaid Services.

11 “(D) Review may involve prior approval, concurrent review of the con-  
12 tinuation of treatment, post-treatment review or any combination of these.  
13 However, if prior approval is required, provision shall be made to allow for  
14 payment of urgent or emergency admissions, subject to subsequent review.  
15 If prior approval is not required, group health insurers and issuers of indi-  
16 vidual health benefit plans that are not grandfathered health plans shall  
17 permit providers, policyholders or persons acting on their behalf to make  
18 advance inquiries regarding the appropriateness of a particular admission to  
19 a treatment program. Group health insurers and issuers of individual health  
20 benefit plans that are not grandfathered health plans shall provide a timely  
21 response to such inquiries. Noncontracting providers must cooperate with  
22 these procedures to the same extent as contracting providers to be eligible  
23 for reimbursement.

24 “(L) Health maintenance organizations may limit the receipt of covered  
25 services by enrollees to services provided by or upon referral by providers  
26 contracting with the health maintenance organization. Health maintenance  
27 organizations and health care service contractors may create substantive  
28 plan benefit and reimbursement differentials at the same level as, and subject  
29 to limitations no more restrictive than, those imposed on coverage or re-  
30 imbursement of expenses arising out of other medical conditions and apply

1 them to contracting and noncontracting providers.

2 “(3) This section does not prohibit a group health insurer or issuer of an  
3 individual health benefit plan that is not a grandfathered health plan from  
4 managing the provision of benefits through common methods, including but  
5 not limited to selectively contracted panels, health plan benefit differential  
6 designs, preadmission screening, prior authorization of services, utilization  
7 review or other mechanisms designed to limit eligible expenses to those de-  
8 scribed in subsection (2)(b) of this section provided such methods comply  
9 with the requirements of this section.

10 “(4) The Legislative Assembly finds that health care cost containment is  
11 necessary and intends to encourage health insurance plans designed to  
12 achieve cost containment by ensuring that reimbursement is limited to ap-  
13 propriate utilization under criteria incorporated into the insurance, either  
14 directly or by reference, in accordance with this section.

15 “(5)(a) **Any medical necessity, utilization or other clinical review**  
16 **conducted for the diagnosis, prevention or treatment of behavioral**  
17 **health conditions or relating to service intensity, level of care place-**  
18 **ment, continued stay or discharge must be based solely on the fol-**  
19 **lowing:**

20 “(A) **The current generally accepted standards of care.**

21 “(B) **For level of care placement decisions, the most recent version**  
22 **of the levels of care placement criteria developed by the nonprofit**  
23 **professional association for the relevant clinical specialty.**

24 “(C) **For medical necessity, utilization or other clinical review con-**  
25 **ducted for the diagnosis, prevention or treatment of behavioral health**  
26 **conditions that does not involve level of care placement decisions,**  
27 **other criteria and guidelines may be utilized if such criteria and**  
28 **guidelines are based on the current generally accepted standards of**  
29 **care including valid, evidence-based sources and current treatment**  
30 **criteria or practice guidelines developed by the nonprofit professional**

1 association for the relevant clinical specialty. Such other criteria and  
2 guidelines must be made publicly available and made available to in-  
3 sureds upon request to the extent permitted by copyright laws.

4 “(b) This subsection does not prevent a group health insurer or an  
5 issuer of an individual health benefit plan other than a grandfathered  
6 health plan from using criteria that:

7 “(A) Are outside the scope of criteria and guidelines described in  
8 paragraph (a)(B) of this subsection, if the guidelines were developed  
9 in accordance with the current generally accepted standards of care;  
10 or

11 “(B) Are based on advancements in technology of types of care that  
12 are not addressed in the most recent versions of sources specified in  
13 paragraph (a)(B) of this subsection, if the guidelines were developed  
14 in accordance with current generally accepted standards of care.

15 “(c) For all level of care placement decisions, an insurer shall au-  
16 thorize placement at the level of care consistent with the insured’s  
17 score or assessment using the relevant level of care placement criteria  
18 and guidelines as specified in paragraph (a)(B) of this subsection. If  
19 the level of care indicated by the criteria and guidelines is not avail-  
20 able, the insurer shall authorize the next higher level of care. If there  
21 is disagreement about the appropriate level of care, the insurer shall  
22 provide to the provider of the service the full details of the insurer’s  
23 scoring or assessment using the relevant level of care placement cri-  
24 teria and guidelines specified in paragraph (a)(B) of this subsection.

25 “[5] (6) To ensure the proper use of any [*medical necessity, utilization*  
26 *or other clinical review conducted for the diagnosis, prevention or treatment*  
27 *of behavioral health conditions or relating to service intensity, level of care*  
28 *placement, continued stay or discharge]* **criteria and guidelines described**  
29 **in subsection (5) of this section**, a group health insurer or an issuer of an  
30 individual health benefit plan shall provide, at no cost:



1 “(a) A formal education program, presented by nonprofit clinical specialty  
2 associations or other entities authorized by the department, to educate the  
3 insurer’s or the issuer’s staff and any individuals described in subsection  
4 (2)(k) of this section who conduct reviews.

5 “(b) To stakeholders, including participating providers and insureds, the  
6 [*medical necessity, utilization or other clinical review criteria*] **criteria and**  
7 **guidelines described in subsection (5) of this section** and any education  
8 or training materials or resources regarding [*medical necessity, utilization or*  
9 *other clinical review criteria, to the extent permitted by copyright laws*] **the**  
10 **criteria and guidelines.**

11 “[~~(6)~~] (7) This section does not prevent a group health insurer or issuer  
12 of an individual health benefit plan that is not a grandfathered health plan  
13 from contracting with providers of health care services to furnish services  
14 to policyholders or certificate holders according to ORS 743B.460 or 750.005,  
15 subject to the following conditions:

16 “(a) A group health insurer or issuer of an individual health benefit plan  
17 that is not a grandfathered health plan is not required to contract with all  
18 providers that are eligible for reimbursement under this section.

19 “(b) An insurer or health care service contractor shall, subject to sub-  
20 section (2) of this section, pay benefits toward the covered charges of non-  
21 contracting providers of services for behavioral health treatment. The  
22 insured shall, subject to subsection (2) of this section, have the right to use  
23 the services of a noncontracting provider of behavioral health treatment,  
24 whether or not the behavioral health treatment is provided by contracting  
25 or noncontracting providers.

26 “[~~(7)(a)~~] (8)(a) This section does not require coverage for:

27 “(A) Educational or correctional services or sheltered living provided by  
28 a school or halfway house;

29 “(B) A long-term residential mental health program that lasts longer than  
30 45 days unless clinically indicated under [*any medical necessity, utilization*

1 *or other clinical review conducted by the insurer for the diagnosis, prevention*  
2 *or treatment of behavioral health conditions or relating to service intensity,*  
3 *level of care placement, continued stay or discharge] **criteria and guidelines***  
4 **described in subsection (5) of this section;**

5 “(C) Psychoanalysis or psychotherapy received as part of an educational  
6 or training program, regardless of diagnosis or symptoms that may be pres-  
7 ent;

8 “(D) A court-ordered sex offender treatment program; or

9 “(E) Support groups.

10 “(b) Notwithstanding paragraph (a)(A) of this subsection, an insured may  
11 receive covered outpatient services under the terms of the insured’s policy  
12 while the insured is living temporarily in a sheltered living situation.

13 “[8] **(9)** The Oregon Health Authority shall establish a process for the  
14 certification of an organization described in subsection (1)(j)(F) of this sec-  
15 tion that:

16 “(a) Is not otherwise subject to licensing or certification by the authority;  
17 and

18 “(b) Does not contract with the authority, a subcontractor of the author-  
19 ity or a community mental health program.

20 “[9] **(10)** The Oregon Health Authority shall adopt by rule standards for  
21 the certification provided under subsection [(8)] **(9)** of this section to ensure  
22 that a certified provider organization offers a distinct and specialized pro-  
23 gram for the treatment of mental or nervous conditions.

24 “[10] **(11)** The Oregon Health Authority may adopt by rule an applica-  
25 tion fee or a certification fee, or both, to be imposed on any provider or-  
26 ganization that applies for certification under subsection [(8)] **(9)** of this  
27 section. Any fees collected shall be paid into the Oregon Health Authority  
28 Fund established in ORS 413.101 and shall be used only for carrying out the  
29 provisions of subsection [(8)] **(9)** of this section.

30 “[11] **(12)** The intent of the Legislative Assembly in adopting this section

1 is to reserve benefits for different types of care to encourage cost effective  
2 care and to ensure continuing access to levels of care most appropriate for  
3 the insured's condition and progress in accordance with this section. This  
4 section does not prohibit an insurer from requiring a provider organization  
5 certified by the Oregon Health Authority under subsection [(8)] **(9)** of this  
6 section to meet the insurer's credentialing requirements as a condition of  
7 entering into a contract.

8 “[~~(12)~~] **(13)** The Director of the Department of Consumer and Business  
9 Services and the Oregon Health Authority, after notice and hearing, may  
10 adopt reasonable rules not inconsistent with this section that are considered  
11 necessary for the proper administration of this section. The director shall  
12 adopt rules making it a violation of this section for a group health insurer  
13 or issuer of an individual health benefit plan other than a grandfathered  
14 health plan to require providers to bill using a specific billing code or to  
15 restrict the reimbursement paid for particular billing codes other than on the  
16 basis of medical necessity.

17 “[~~(13)~~] **(14)** This section does not:

18 “(a) Prohibit an insured from receiving behavioral health treatment from  
19 an out-of-network provider or prevent an out-of-network behavioral health  
20 provider from billing the insured for any unreimbursed cost of treatment.

21 “(b) Prohibit the use of value-based payment methods, including global  
22 budgets or capitated, bundled, risk-based or other value-based payment  
23 methods.

24 “(c) Require that any value-based payment method reimburse behavioral  
25 health services based on an equivalent fee-for-service rate.”.

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