82nd OREGON LEGISLATIVE ASSEMBLY--2023 Regular Session

House Bill 3126

Sponsored by Representative SANCHEZ (at the request of Providence Health and Services)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Establishes Emergency Behavioral Health Services for Children program in Oregon Health Authority to promote timely delivery of behavioral health services to children who present to hospital emergency departments in behavioral health crises. Directs authority to implement up to three pilot programs in three regions with one hospital per region willing to be Regional Child Psychiatric Center. Allows center to also open Child Psychiatric Emergency unit within pilot region with funding provided by authority.

Adds to State Trauma Advisory Board and area trauma advisory boards representation from designated regions that participate in Emergency Behavioral Health Services for Children program.

Prohibits insurance policies or certificates that reimburse costs of medical care from requiring prior authorization of treatment provided to individual presenting to Regional Child Psychiatric Center with behavioral health crisis or from denying coverage because health professional providing treatment is not credentialed with insurer offering policy or certificate.

1 **A BILL FOR AN ACT**

2 Relating to behavioral health treatment; creating new provisions; and amending ORS 431A.055,
3 431A.070, 431A.075, 431A.085, 431A.095 and 743A.168.

4 **Be It Enacted by the People of the State of Oregon:**

5 **SECTION 1. Section 2 of this 2023 Act is added to and made a part of ORS 431A.085 to**
6 **431A.105.**

7 **SECTION 2. (1) As used in this section:**

8 **(a) "Behavioral health" includes mental health and substance use disorders.**

9 **(b) "Child" means an individual under 18 years of age.**

10 **(2) The Emergency Behavioral Health Services for Children program is established in the**
11 **Oregon Health Authority. The program shall operate in cooperation with the Emergency**
12 **Medical Services for Children Program established under ORS 431A.105 and the Emergency**
13 **Medical Services and Trauma Systems Program created in ORS 431A.085 to promote the**
14 **timely delivery of behavioral health services to children who present to hospital emergency**
15 **departments in behavioral health crises.**

16 **(3)(a) The authority shall establish by rule criteria for designating hospitals within a ge-**
17 **ographic region as Regional Child Psychiatric Centers. At a minimum, hospitals designated**
18 **as Regional Child Psychiatric Centers must have available on site children's comprehensive**
19 **psychiatric emergency services that include:**

20 **(A) An emergency evaluation area where children can be stabilized, connected with out-**
21 **patient treatment and discharged the same day;**

22 **(B) Services to facilitate the child transitioning to the next level of care;**

23 **(C) A child psychiatrist on staff available for consultation within 24 hours if needed;**

24 **(D) A behavioral health clinician, as defined in ORS 414.025, on staff and available to**
25 **consult internally and with other regional hospitals within 24 hours if needed;**

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

(E) Peer and family support specialist services; and

(F) Connections to local resources for post-hospital follow up.

(b) A hospital designated as a Regional Child Psychiatric Center may have a Child Psychiatric Emergency unit staffed 24 hours per day, seven days a week that:

(A) Offers outpatient observation services or inpatient beds, 24 hours per day and seven days per week, meeting criteria adopted by the authority by rule; and

(B) Provides services, including medication management, that bridge the transition of patients from the unit to outpatient services.

(4) All other hospitals within the region of a Regional Child Psychiatric Center must have a memorandum of understanding with a Regional Child Psychiatric Center that meets criteria prescribed by the authority by rule, including but not limited to terms that:

(a) Ensure the ability of the hospital to consult with and connect to the child psychiatry unit and a social worker at the Regional Child Psychiatric Center by interactive video; and

(b) Facilitate the coordination with local resources for post-hospital follow up.

(5) Each regional trauma area designated under ORS 431A.060 that lies within a region of a Regional Child Psychiatric Center shall, in coordination with coordinated care organizations, the local county behavioral health authorities in the region, hospitals in the region and other community partners:

(a) Conduct a needs assessment for the region to identify funding needs and determine gaps in behavioral health services and access to behavioral health services within each county in the region;

(b) Develop a response plan based on the resources of the counties, hospitals and other service providers in the region;

(c) Establish policies and procedures to ensure that services required to be provided are provided regardless of insurance or ability to pay;

(d) Jointly decide which hospitals shall serve as the Regional Child Psychiatric Centers;

(e) Identify staffing needed within the region to develop competencies in serving children's behavioral health needs; and

(f) Identify any needed upgrades to the emergency departments or to crisis stabilization short stay units to accommodate the needs of children presenting with behavioral health crises.

(6) All hospitals within the region of a Regional Child Psychiatric Center shall have in place a memorandum of understanding with the Regional Child Psychiatric Center to allow providers from the Regional Child Psychiatric Center to treat patients at the hospitals.

SECTION 3. (1) The Oregon Health Authority shall first implement the Emergency Behavioral Health Services for Children program established in section 2 of this 2023 Act as a pilot program for up to three Regional Child Psychiatric Centers in hospitals in three separate regional trauma areas. The authority shall provide funding for a Child Psychiatric Emergency unit that a Regional Child Psychiatric Center elects to operate.

(2) The authority shall evaluate and assess the impact of the pilot program on outcomes determined by each regional trauma area and approved by the authority.

(3) No later than September 15, 2025, the authority, in coordination with participants in the program in each participating regional trauma area, shall report, in the manner provided in ORS 192.245, to the interim committees of the Legislative Assembly related to health, the authority's evaluation and assessment of the program and recommendations, if any, for leg-

1 **islative actions needed to improve the program.**
2 **SECTION 4.** ORS 431A.055 is amended to read:
3 431A.055. (1) The State Trauma Advisory Board is established within the Oregon Health Au-
4 thority. [*The board must have at least 18 members. The Director of the Oregon Health Authority shall*
5 *appoint at least 17 voting members as described in subsection (2) of this section.*] The chairperson of
6 the State Emergency Medical Service Committee established under ORS 682.039, or the
7 chairperson's designee, shall be a nonvoting member. **The Director of the Oregon Health Au-**
8 **thority shall appoint the members described in subsection (2) of this section as voting**
9 **members.**
10 (2) The director shall, subject to subsection (3) of this section, appoint members to serve on the
11 State Trauma Advisory Board, including:
12 (a) At least one member from each area trauma advisory board described in ORS 431A.070.
13 (b) At least two physicians who are trauma surgeons from each trauma center designated by the
14 authority as a Level I trauma center.
15 (c) From trauma centers designated by the authority as Level I or Level II trauma centers, at
16 least one physician who is a neurosurgeon or orthopedic surgeon.
17 (d) From trauma centers designated by the authority as Level I trauma centers **or hospitals**
18 **with a Regional Child Psychiatric Center described in section 2 of this 2023 Act**:
19 (A) At least one physician who practices emergency medicine; [*and*]
20 (B) At least one nurse who is a trauma program manager**; and**
21 **(C) At least one child psychiatrist**.
22 (e) From trauma centers designated by the authority as Level II trauma centers:
23 (A) At least one physician who is a trauma surgeon; and
24 (B) At least one nurse who is a trauma coordinator.
25 (f) From trauma centers designated by the authority as Level III trauma centers **or hospitals**
26 **with a Regional Child Psychiatric Center described in section 2 of this 2023 Act**:
27 (A) At least one physician who is a trauma surgeon or who practices emergency medicine;
28 [*and*]
29 (B) At least one nurse who is a trauma coordinator**; and**
30 **(C) At least one licensed clinical social worker or a licensed professional counselor who**
31 **works with children and youth presenting with behavioral health crises in a Regional Child**
32 **Psychiatric Center described in section 2 of this 2023 Act**.
33 (g) At least one nurse who is a trauma coordinator from a trauma center designated by the
34 authority as a Level IV trauma center.
35 (h) From a predominately urban area:
36 (A) At least one trauma hospital administration representative; and
37 (B) At least one emergency medical services provider.
38 (i) From a predominately rural area:
39 (A) At least one trauma hospital administration representative; and
40 (B) At least one emergency medical services provider.
41 (j) At least two public members.
42 (k) At least one representative from a public safety answering point.
43 (3) In appointing members under subsection (2)(j) of this section, the director may not appoint
44 a member who has an economic interest in the provision of emergency medical services or trauma
45 care.

(4)(a) The State Trauma Advisory Board shall:

(A) Advise the authority with respect to the authority's duties and responsibilities under ORS 431A.050 to 431A.080, 431A.085, 431A.090, 431A.095, 431A.100 and 431A.105 **and section 2 of this 2023 Act**;

(B) Advise the authority with respect to the adoption of rules under ORS 431A.050 to 431A.080, 431A.085, 431A.095 and 431A.105 **and section 2 of this 2023 Act**;

(C) Analyze data related to the emergency medical services and trauma system developed pursuant to ORS 431A.050; and

(D) Suggest improvements to the emergency medical services and trauma system developed pursuant to ORS 431A.050 **and section 2 of this 2023 Act**.

(b) In fulfilling the duties, functions and powers described in this subsection, the board shall:

(A) Make evidence-based decisions that emphasize the standard of care attainable throughout this state and by individual communities located in this state; and

(B) Seek the advice and input of coordinated care organizations.

(5)(a) The State Trauma Advisory Board may establish a Quality Assurance Subcommittee for the purposes of providing peer review support to and discussing evidence-based guidelines and protocols with the members of area trauma advisory boards and [*trauma care*] providers **in trauma centers and Regional Child Psychiatric Centers** located in this state.

(b) Notwithstanding ORS 414.227, meetings of the subcommittee are not subject to ORS 192.610 to 192.690.

(c) Personally identifiable information provided by the State Trauma Advisory Board to individuals described in paragraph (a) of this subsection is not subject to ORS 192.311 to 192.478.

(6) A majority of the voting members of the board constitutes a quorum for the transaction of business.

(7) Official action taken by the board requires the approval of a majority of the voting members of the board.

(8) The board shall nominate and elect a chairperson from among its voting members.

(9) The board shall meet at the call of the chairperson or of a majority of the voting members of the board.

(10) The board may adopt rules necessary for the operation of the board.

(11) The term of office of each voting member of the board is four years, but a voting member serves at the pleasure of the director. Before the expiration of the term of a voting member, the director shall appoint a successor whose term begins January 1 next following. A voting member is eligible for reappointment. If there is a vacancy for any cause, the director shall make an appointment to become immediately effective for the unexpired term.

(12) Members of the board are not entitled to compensation, but may be reimbursed from funds available to the Oregon Health Authority, for actual and necessary travel and other expenses incurred by them in the performance of their official duties in the manner and amounts provided for in ORS 292.495.

SECTION 5. ORS 431A.070 is amended to read:

431A.070. (1)(a) Area trauma advisory boards shall meet as often as necessary to:

(A) Identify specific trauma area needs and problems; and

(B) Propose to the Oregon Health Authority area trauma system plans and changes that meet state standards and objectives.

(b) The authority, acting with the advice of the State Trauma Advisory Board established under

ORS 431A.055, has the authority to implement plans and changes proposed under paragraph (a) of this subsection.

(2) In concurrence with the Governor, the authority shall select members for each trauma area from lists submitted by local associations of emergency medical services providers, emergency nurses, emergency physicians, surgeons, hospital administrators, emergency medical services agencies and citizens at large. The members of an area trauma advisory board must be broadly representative of the trauma area as a whole. An area trauma advisory board must consist of at least [*16*] **17** members and must include:

(a) Two surgeons;

(b) Two physicians serving as emergency physicians;

(c) Two hospital administrators from different hospitals;

(d) Two nurses serving as emergency nurses;

(e) Two emergency medical services providers serving different emergency medical services;

(f) One behavioral health provider from a Regional Child Psychiatric Center designated under section 2 of this 2023 Act;

[*(f)*] **(g)** One emergency medical services medical director;

[*(g)*] **(h)** Two representatives of the public at large selected from among those submitting letters of application in response to public notice by the authority;

[*(h)*] **(i)** One representative of any bordering state that is included within the patient referral area;

[*(i)*] **(j)** One ambulance service owner or operator or both; and

[*(j)*] **(k)** One representative from a public safety answering point.

(3) Members of an area trauma advisory board described in subsection [*(2)(g)*] **(2)(h)** of this section may not have an economic interest in health care services provided in the trauma area for which the area trauma advisory board makes proposals under subsection (1)(a)(B) of this section.

SECTION 6. ORS 431A.075 is amended to read:

431A.075. (1) A provider may not be held liable for acting in accordance with approved trauma system plans **or plans developed in accordance with section 2 (5)(b) of this 2023 Act**.

(2) A person who in good faith provides data or other information to the Oregon Trauma Registry in accordance with ORS 431A.085 to 431A.105 is immune from any civil or criminal liability that might otherwise be incurred or imposed with respect to provision of the data.

SECTION 7. ORS 431A.085 is amended to read:

431A.085. (1) The Emergency Medical Services and Trauma Systems Program is created within the Oregon Health Authority for the following purposes:

(a) Administering and regulating ambulances;

(b) Training and licensing emergency medical services providers;

(c) Establishing and maintaining emergency medical systems, including trauma systems; and

(d) Maintaining the Oregon Trauma Registry for purposes related to trauma reimbursement, system quality assurance and cost efficiency.

(2) The duties vested in the authority under ORS 431A.050 to 431A.080 **and 431A.085 to 431A.105** and ORS chapter 682 shall be performed by the program.

(3) The program shall be administered by a director.

(4) The director of the program shall apply moneys transferred to the program under ORS 442.870 to:

(a) Developing state and regional standards of care;

(b) Developing a statewide educational curriculum to teach standards of care;
(c) Implementing quality improvement programs;
(d) Creating a statewide data system for prehospital care; and
(e) Providing ancillary services to enhance this state's emergency medical service system.
(5) The director of the program shall adopt rules for the Oregon Trauma Registry. Rules adopted under this subsection must establish:
(a) The information that must be reported by trauma centers to the program for inclusion in the Oregon Trauma Registry;
(b) The form and frequency of reporting information under paragraph (a) of this subsection; and
(c) Procedures and standards for the administration of the Oregon Trauma Registry.
(6) The director of the program may adopt rules establishing, from information maintained in the Oregon Trauma Registry, a registry of information related to brain injury trauma.

SECTION 8. ORS 431A.095 is amended to read:

431A.095. (1) Designated trauma centers and providers, **designated Regional Child Psychiatric Centers and providers,** physical rehabilitation centers, alcohol and drug rehabilitation centers and ambulances shall develop a monthly log of all unsponsored, inadequately insured [*trauma system*] patients determined by the hospital to have an injury severity score greater than or equal to 13 **or to require a transfer for acute psychiatric care**, and submit monthly to the Emergency Medical Services and Trauma Systems Program the true costs and unpaid balance for the care of these patients.
(2) No reimbursement for these patients shall occur until:
(a) All information required by the Emergency Medical Services and Trauma Systems Program rules is submitted to the Oregon Trauma Registry**, if applicable**; and
(b) The Emergency Medical Services and Trauma Systems Program confirms that the injury severity score, as defined by the Oregon Health Authority by rule, is greater than or equal to 13.
(3) The Emergency Medical Services and Trauma Systems Program shall cause providers to be reimbursed in the following decreasing order of priority:
(a) Designated trauma centers and providers **and designated Regional Child Psychiatric Centers and providers**;
(b) Physical rehabilitation centers;
(c) Alcohol and drug rehabilitation centers; and
(d) Ambulances.
(4) Subject to the availability of funds, the Emergency Medical Services and Trauma Systems Program shall cause the designated trauma centers **and designated Regional Child Psychiatric Centers** and providers to be paid first in full. Subsequent providers shall be paid from the balance remaining according to priority.
(5) Any matching funds, available pursuant to the Trauma Care Systems Planning and Development Act of 1990 (P.L. 101-590), that are available for purposes of the Emergency Medical Services and Trauma Systems Program may be used for related studies and projects and reimbursement for uncompensated care.

SECTION 9. ORS 743A.168, as amended by section 8, chapter 629, Oregon Laws 2021, is amended to read:

743A.168. (1) As used in this section:
(a) "Behavioral health assessment" means an evaluation by a provider, in person or using telemedicine, to determine a patient's need for behavioral health treatment.

(b) "Behavioral health condition" has the meaning prescribed by rule by the Department of Consumer and Business Services.

(c) "Behavioral health crisis" means a disruption in an insured's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the insured's mental or physical health.

(d) "Facility" means a corporate or governmental entity or other provider of services for the treatment of behavioral health conditions.

(e) "Generally accepted standards of care" means:

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

(i) Are generally recognized by health care providers practicing in relevant clinical specialties; and

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

(B) Products and services that:

(i) Address the specific needs of a patient for the purpose of screening for, preventing, diagnosing, managing or treating an illness, injury or condition or symptoms of an illness, injury or condition;

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

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

(f) "Group health insurer" means an insurer, a health maintenance organization or a health care service contractor.

(g) "Median maximum allowable reimbursement rate" means the median of all maximum allowable reimbursement rates, minus incentive payments, paid for each billing code for each provider type during a calendar year.

(h) "Prior authorization" has the meaning given that term in ORS 743B.001.

(i) "Program" means a particular type or level of service that is organizationally distinct within a facility.

(j) "Provider" means:

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

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

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

(D) A day or partial hospitalization program;

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

(F) A provider organization certified by the Oregon Health Authority under subsection (9) of this section.

(k) "Relevant clinical specialties" includes but is not limited to:

(A) Psychiatry;

(B) Psychology;

(C) Clinical sociology;

(D) Addiction medicine and counseling; and

(E) Behavioral health treatment.

(L) "Standards of care and clinical practice guidelines" includes but is not limited to:
(A) Patient placement criteria;
(B) Recommendations of agencies of the federal government; and
(C) Drug labeling approved by the United States Food and Drug Administration.
(m) "Utilization review" has the meaning given that term in ORS 743B.001.
(n) "Valid, evidence-based sources" includes but is not limited to:
(A) Peer-reviewed scientific studies and medical literature;
(B) Recommendations of nonprofit health care provider professional associations; and
(C) Specialty societies.

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

(a) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to copayments, deductibles and coinsurance. Copayments, deductibles and coinsurance for treatment in health care facilities or residential facilities may not be greater than those under the policy for expenses of hospitalization in the treatment of other medical conditions. Copayments, deductibles and coinsurance for outpatient treatment may not be greater than those under the policy for expenses of outpatient treatment of other medical conditions.

(b)**(A)** The coverage of behavioral health treatment may not be made subject to treatment limitations, limits on total payments for treatment, limits on duration of treatment or financial requirements unless similar limitations or requirements are imposed on coverage of other medical conditions. The coverage of eligible expenses of behavioral health treatment may be limited to treatment that is medically necessary as determined in accordance with this section and no more stringently under the policy than for other medical conditions.

(B) Notwithstanding subparagraph (A) of this paragraph, and consistent with ORS 743A.012, the coverage of behavioral health treatment for a patient presenting to a Regional Child Psychiatric Center with a behavioral health crisis may not be subject to prior authorization or require that the professional providing the treatment be credentialed by the insurer offering the policy or plan.

(c) The coverage of behavioral health treatment must include:
(A) A behavioral health assessment;
(B) No less than the level of services determined to be medically necessary in a behavioral health assessment of the specific needs of a patient or in a patient's care plan:
(i) To effectively treat the patient's underlying behavioral health condition rather than the mere amelioration of current symptoms such as suicidal ideation or psychosis; and
(ii) For care following a behavioral health crisis, to transition the patient to a lower level of care;
(C) Treatment of co-occurring behavioral health conditions or medical conditions in a coordinated manner;
(D) Treatment at the least intensive and least restrictive level of care that is safe and most ef-

fective and meets the needs of the insured's condition;

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

(F) Treatment to maintain functioning or prevent deterioration;

(G) Treatment for an appropriate duration based on the insured's particular needs;

(H) Treatment appropriate to the unique needs of children and adolescents;

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

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

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

(e) A group health insurer or an issuer of an individual health benefit plan other than a grandfathered health plan shall have a network of providers of behavioral health treatment sufficient to meet the standards described in ORS 743B.505. If there is no in-network provider qualified to timely deliver, as defined by rule, medically necessary behavioral treatment to an insured in a geographic area, the group health insurer or issuer of an individual health benefit plan shall provide coverage of out-of-network medically necessary behavioral health treatment without any additional out-of-pocket costs if provided by an available out-of-network provider that enters into an agreement with the insurer to be reimbursed at in-network rates.

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

(A) The provider is approved or certified by the Oregon Health Authority;

(B) The provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities;

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

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

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

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

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

(j) Outpatient coverage of behavioral health treatment shall include follow-up in-home service or outpatient services if clinically indicated under criteria and guidelines described in subsection (5) of this section. The policy may limit coverage for in-home service to persons who are homebound under the care of a physician only if clinically indicated under criteria and guidelines described in subsection (5) of this section.

1 (k)(A) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to phy-
2 sicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists, ORS 40.250
3 and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed profes-
4 sional counselors and licensed marriage and family therapists, a group health insurer or issuer of
5 an individual health benefit plan may provide for review for level of treatment of admissions and
6 continued stays for treatment in health facilities, residential facilities, day or partial hospitalization
7 programs and outpatient services by either staff of a group health insurer or issuer of an individual
8 health benefit plan or personnel under contract to the group health insurer or issuer of an individual
9 health benefit plan that is not a grandfathered health plan, or by a utilization review contractor,
10 who shall have the authority to certify for or deny level of payment.
11 (B) Review shall be made according to criteria made available to providers in advance upon
12 request.
13 (C) Review shall be performed by or under the direction of a physician licensed under ORS
14 677.100 to 677.228, a psychologist licensed by the Oregon Board of Psychology, a clinical social
15 worker licensed by the State Board of Licensed Social Workers or a professional counselor or mar-
16 riage and family therapist licensed by the Oregon Board of Licensed Professional Counselors and
17 Therapists, in accordance with standards of the National Committee for Quality Assurance or
18 Medicare review standards of the Centers for Medicare and Medicaid Services.
19 (D) Review may involve prior approval, concurrent review of the continuation of treatment,
20 post-treatment review or any combination of these. However, if prior approval is required, provision
21 shall be made to allow for payment of urgent or emergency admissions, subject to subsequent re-
22 view. If prior approval is not required, group health insurers and issuers of individual health benefit
23 plans that are not grandfathered health plans shall permit providers, policyholders or persons acting
24 on their behalf to make advance inquiries regarding the appropriateness of a particular admission
25 to a treatment program. Group health insurers and issuers of individual health benefit plans that
26 are not grandfathered health plans shall provide a timely response to such inquiries. Noncontracting
27 providers must cooperate with these procedures to the same extent as contracting providers to be
28 eligible for reimbursement.
29 (L) Health maintenance organizations may limit the receipt of covered services by enrollees to
30 services provided by or upon referral by providers contracting with the health maintenance organ-
31 ization. Health maintenance organizations and health care service contractors may create substan-
32 tive plan benefit and reimbursement differentials at the same level as, and subject to limitations no
33 more restrictive than, those imposed on coverage or reimbursement of expenses arising out of other
34 medical conditions and apply them to contracting and noncontracting providers.
35 (3) This section does not prohibit a group health insurer or issuer of an individual health benefit
36 plan that is not a grandfathered health plan from managing the provision of benefits through com-
37 mon methods, including but not limited to selectively contracted panels, health plan benefit differ-
38 ential designs, preadmission screening, prior authorization of services, utilization review or other
39 mechanisms designed to limit eligible expenses to those described in subsection (2)(b) of this section
40 provided such methods comply with the requirements of this section.
41 (4) The Legislative Assembly finds that health care cost containment is necessary and intends
42 to encourage health insurance plans designed to achieve cost containment by ensuring that re-
43 imbursement is limited to appropriate utilization under criteria incorporated into the insurance, ei-
44 ther directly or by reference, in accordance with this section.
45 (5)(a) Any medical necessity, utilization or other clinical review conducted for the diagnosis,

prevention or treatment of behavioral health conditions or relating to service intensity, level of care placement, continued stay or discharge must be based solely on the following:

(A) The current generally accepted standards of care.

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

(C) For medical necessity, utilization or other clinical review conducted for the diagnosis, prevention or treatment of behavioral health conditions that does not involve level of care placement decisions, other criteria and guidelines may be utilized if such criteria and guidelines are based on the current generally accepted standards of care including valid, evidence-based sources and current treatment criteria or practice guidelines developed by the nonprofit professional association for the relevant clinical specialty. Such other criteria and guidelines must be made publicly available and made available to insureds upon request to the extent permitted by copyright laws.

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

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

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

(c) For all level of care placement decisions, an insurer shall authorize placement at the level of care consistent with the insured's score or assessment using the relevant level of care placement criteria and guidelines as specified in paragraph (a)(B) of this subsection. If the level of care indicated by the criteria and guidelines is not available, the insurer shall authorize the next higher level of care. If there is disagreement about the appropriate level of care, the insurer shall provide to the provider of the service the full details of the insurer's scoring or assessment using the relevant level of care placement criteria and guidelines specified in paragraph (a)(B) of this subsection.

(6) To ensure the proper use of any criteria and guidelines described in subsection (5) of this section, a group health insurer or an issuer of an individual health benefit plan shall provide, at no cost:

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

(b) To stakeholders, including participating providers and insureds, the criteria and guidelines described in subsection (5) of this section and any education or training materials or resources regarding the criteria and guidelines.

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

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

(b) An insurer or health care service contractor shall, subject to subsection (2) of this section, pay benefits toward the covered charges of noncontracting providers of services for behavioral

health treatment. The insured shall, subject to subsection (2) of this section, have the right to use the services of a noncontracting provider of behavioral health treatment, whether or not the behavioral health treatment is provided by contracting or noncontracting providers.

(8)(a) This section does not require coverage for:

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

(B) A long-term residential mental health program that lasts longer than 45 days unless clinically indicated under criteria and guidelines described in subsection (5) of this section;

(C) Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present;

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

(E) Support groups.

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

(9) The Oregon Health Authority shall establish a process for the certification of an organization described in subsection (1)(j)(F) of this section that:

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

(b) Does not contract with the authority, a subcontractor of the authority or a community mental health program.

(10) The Oregon Health Authority shall adopt by rule standards for the certification provided under subsection (9) of this section to ensure that a certified provider organization offers a distinct and specialized program for the treatment of mental or nervous conditions.

(11) The Oregon Health Authority may adopt by rule an application fee or a certification fee, or both, to be imposed on any provider organization that applies for certification under subsection (9) of this section. Any fees collected shall be paid into the Oregon Health Authority Fund established in ORS 413.101 and shall be used only for carrying out the provisions of subsection (9) of this section.

(12) The intent of the Legislative Assembly in adopting this section is to reserve benefits for different types of care to encourage cost effective care and to ensure continuing access to levels of care most appropriate for the insured's condition and progress in accordance with this section. This section does not prohibit an insurer from requiring a provider organization certified by the Oregon Health Authority under subsection (9) of this section to meet the insurer's credentialing requirements as a condition of entering into a contract.

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

(14) This section does not:

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

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

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