March 3, 2022
To: Brooke Hall, Health Care Policy Analyst, DCBS
Fr: NAMI Oregon & Coalition Partners
Re: Implementing Section 8 in HB 3046

NAMI Oregon and its Coalition Partners offer the following comments regarding draft Oregon Administrative Rules implementing parity requirements in HB 3046. Our comments focus on **Section 8 Paragraph 5** and subparagraphs as listed within our comments.

It is this section of the legislation that includes key parity requirements in HB 3046. Specifically, the section mandates the use of particular level of placement instruments for utilization review, which is designed to ensure that individuals and families receive the care they need for the duration necessary to treat their underlying conditions. It also requires that utilization review be consistent with generally accepted standards of care as defined in Section 5 Paragraph 1(e).

Section 8 Paragraph 5: Level of Placement

It is essential that the Division's regulations ensure absolute clarity that a group health insurer or an issuer of an individual health benefit plan must use *solely* the most recent version of the levels of care placement criteria developed by the nonprofit professional association for the relevant clinical association, as the clear language of 5(a)(B) requires. The Division should make unambiguous that insurers and issuers cannot apply different, additional, conflicting, or more restrictive utilization review criteria with respect to level of care placement, continued stay, and transfer or discharge. The Division should also make clear that "level of care placement decisions" include not only initial placement but also continued stay and transfer or discharge decisions, which are inextricably linked with the appropriate level of care for an enrollee.

To ensure proper use of level of care placement criteria, the Division should require use of the relevant nonprofit professional association criteria from the relevant clinical specialty in a manner established or approved by the association, with appropriate licenses obtained from the association or its approved vendor(s). For electronic usage of the criteria, insurers and issuers must be required to utilize the criteria using association-approved algorithms. Such requirements are critical to prevent misuse of the criteria and to implement the statutory text.

The exclusive use of these criteria, unmodified, is essential to ensuring that plan members receive care at the appropriate levels of placement and for the duration necessary to meet their specific needs consistent with generally accepted standards of care.

Prohibiting Conflicting Criteria for Level of Placement

We strongly urge the Division to affirmatively state that other criteria for utilization review not involving level of placement permitted in 5(a)(C) cannot be used to water down treatments available within specific levels of placement mandated in 5(a)(B) or be used to determine or alter duration of treatment in conflict with 5(a)(B).

For example, a major for-profit company provides criteria that bundles level of placement and treatment into a single criteria that is sometimes at odds with instruments such as ASAM, LOCUS, and CALOCUS-CASII in terms of both level of placement and treatment duration. Such criteria could be used to deny treatments commonly available within a level of placement, undermining the level of placement determination. This is inconsistent with the statutory requirements of HB 3046. The law, which does grant some flexibility for utilization review outside of level of placement decisions, does not permit the layering of other criteria or guidelines in relation to level of placement, accompanying treatments, and treatment duration.

Specify Compliant Level of Placement Criteria

NAMI strongly urges the Division to specify in rule the level of placements criteria that meet the requirement in 5(a)(B). For consideration, we offer the following language:

> *For purposes of utilization review determinations concerning level of placement, continued stay, and transfer or discharge, the following instruments shall be considered compliant with 5(a)(B):*
>
> - *For a primary substance use disorder diagnosis in adolescents and adults, the ASAM Criteria by the American Society of Addiction Medicine.*
> - *For a primary mental health diagnosis in adults nineteen (19) years of age and older, Level of Care Utilization System (LOCUS) by the American Association for Community Psychiatry.*
> - *For a primary mental health diagnosis in children six (6) to eighteen (18) years of age, Child and Adolescent Level of Care/Service Intensity Utilization System (merged CALOCUS-CASII) by the American Association for Community Psychiatry and the American Academy of Child and Adolescent Psychiatry.*
> - *For a primary mental health diagnosis in children five (5) years of age and younger, Early Child Service Intensity Instrument (ECSII) by the American Academy of Child and Adolescent Psychiatry.*

There are currently no other level of care criteria from a nonprofit professional association for the relevant clinical specialty besides these criteria. Furthermore, because these level of care criteria cover the full scope of level of care placement decisions, the Division should make clear that for level of care placement, continued stay, and transfer or discharge decisions that none of the exceptions from 5(b) apply.

Level of Placement Criteria Reporting

As part of annual reporting, we urge that insurers and issuers report to the Division how they have incorporated the applicable nonprofit professional association criteria/guidelines in a manner that demonstrates that a plan has adopted and

implemented the criteria as required, including having the appropriate licensing agreements in place with each association. We further recommend that the Division consult with the California Department of Managed Health Care and the California Department of Insurance, which are implementing similar requirements and required specific reporting from plans on their compliance actions. For example, reporting could require a plan to "disclose the criteria being utilized and the specific procedures by which the plan uses the criteria to identify the appropriate level of placement."

Disclosure of Criteria Outside of Level of Placement

HB 3046 also requires that "such other criteria and guidelines" (meaning not those from nonprofit professional association for the relevant clinical specialties) utilized by insurers and issuers be made available publicly and to insureds upon request "to the extent permitted by copyright laws." We urge the Division to ensure these other criteria/guidelines are made publicly available and to insureds upon request to the maximum extent possible and not to allow insurers and issuers to hide behind spurious copyright claims. Insureds have a right to know what criteria/guidelines are being used by insurers and issuers to make decisions relating to behavioral health coverage.

We also note that, regardless of HB 3046's provision relating to copyright, federal law *requires* that any guidelines/criteria used as part of an adverse benefit determination must be provided to the plan enrollee upon request, without regard for copyright. Recent FAQs from the Department of Labor and Department Health and Human Services outlines the federal requirements clearly:

> *[W]ith respect to non-grandfathered group health plans and nongrandfathered group or individual health insurance coverage, claimants (or their authorized representative) have a right upon appeal of an adverse benefit determination (or a final internal adverse benefit determination) to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits. This right includes access to documents with information on medical necessity criteria for both medical/surgical benefits and MH/SUD benefits…*[1]

The Division must reinforce this federal requirement with insurers and issuers subject to its oversight authority, regardless of any spurious claim that they might make that HB 3046's copyright provision preclude such disclosure. Without such disclosure, it becomes nearly impossible for individuals and their families to successfully challenge wrongful denials.

Related, we ask the Division to establish a pathway and processes for appeals to the Division if a carrier declines to disclose criteria under the copyright exemption. Having criteria publicly available and available to members on request (outside of any adverse benefit determination) ensures that such criteria can be examined to determine if it complies with the definition of generally accepted standards of care.

[1] See Question 6 of "FAQs About Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45," https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf.

Require Other Criteria to Demonstrate Compliance Before Being Used

The requirements of HB 3046 requiring non-level-of-care criteria/guidelines to be "based on" generally accepted standards of care and current treatment criteria or practice guidelines of nonprofit professional associations will be significantly weakened if the Division does not require plans to demonstrate *prior to usage* that these other criteria/guidelines meet the requirements of 5(a)(C) and 5(b). Nor should the Division allow insurers or issuers to claim that "based on" permits derivative criteria that are inconsistent with generally accepted standards of care and nonprofit professional association criteria. Such a claim would render meaningless the requirement of 5(b)(A) and (B) that such other criteria be "developed in accordance with current generally accepted standards of care."

Therefore, we request that the Division establish detailed requirements for how insurers and issuers must meet the requirements that other criteria be consistent with generally accepted standards of care and with nonprofit professional association criteria/guidelines. New York State regulators have done nation-leading work on ensuring that plans' mental health criteria are consistent with generally accepted standards of care (as outlined in "Guiding Principles" that New York State requires criteria to meet)[2]. New York State shows how state regulators can take action to understand the criteria and guidelines that plans are using and ensure that their content meets the requirements of the law.

Erring on the Side of Caution – A Generally Accepted Standard of Care

Based on extensive expert testimony, the federal court in *Wit v. United Behavioral Health* made detailed findings of fact regarding the standards of mental health and substance use disorder care that are generally accepted by clinicians. While we strongly encourage the Division to make itself familiar with these standards (which have not been challenged by the defendant in its appeal) given HB 3046's requirements, there is one generally accepted standard that is particularly critical. As the court described, "It is a generally accepted standard of care that when there is ambiguity as to the appropriate level of care, the practitioner should err on the side of caution by placing the patient in a higher level of care." Furthermore, the court noted that the LOCUS criteria, which the court found reflects generally accepted standards of care, direct practitioners to assign the "highest score in which it is more likely than not that [at] least one criterion has been met…."

Therefore, we ask the Division adopt language such as:

> *When an enrollee has met criteria for a score within one or more levels of care of the ASAM Criteria, LOCUS, CALOCUS-CASII, or ECSII instruments a plan shall assign the highest score in which it is more likely than not that at least one criterion has been met. When there is any ambiguity regarding the correct score, the reviewer shall assign the higher score, as directed by the criteria.*

Meeting the requirement in 5(c) will be critical to ensuring that individuals and families seeking help actually receive help that is suitable to the needs with which they are presenting.

[2] https://omh.ny.gov/omhweb/bho/omh_mnc_guiding_principles.pdf.

Paragraph 5(c) clearly also states that if a level of placement indicated by the criteria is not available, "the insurer shall authorize the next higher level of care." The phrase "not available" does not mean "not available in network." The Division should make clear that insurers and issuers have an obligation to arrange out-of-network care (with patient costs limited to in-network cost-sharing without the possibility of balance billing) when the most appropriate level of care is not available in network or locally. When the most appropriate level of care is clear, insurers or issuers should not be allowed to avoid out-of-network placement at in-network cost sharing at that appropriate level by steering insureds inappropriately to higher levels of care that are available in-network. This underscores the importance of the Division monitoring and enforcing network adequacy as described in Section 5 Paragraph 2(e).

Information in Denials

If there is a disagreement between a provider and the insurer over level of placement, an insurer or issuer is required to disclose to the "provider of the service the full details of the insurer's score or assessment using the relevant level of care placement criteria and guidelines…" We suggest the Division specify critical points of information that are required to be provided.

The written notification should at minimum include the following information in addition to the scores and/or assessment findings:

- The enrollee's MH/SUD condition(s) for which the plan or contracted entity conducted utilization management review.
- The clinical specialty at issue.
- A list of all criteria or guidelines used, including any nonprofit professional association criteria, criteria outside the scope of the nonprofit professional association criteria or criteria that relate to advancements in technology or types of care not covered in the most recent versions of the nonprofit professional association criteria.
- A summary of the reasons for deviating from the criteria listed in law and rule, if applicable.
- A summary of the plan's clinical reason(s) for its decision, including providing the full detail of the plan or contracted entity's scoring using the criteria listed in law and rule.