TO: Cassandra Soucy and HB 3046 Rules Advisory Committee (RAC) Members

DATE: December 3, 2021

SUBJECT: Comments on HB 3046 areas for rulemaking

Thank you for the opportunity to submit comments regarding areas of HB 3046 that should be included in the next round of rulemaking. As members of the coalition of behavioral health providers and advocates who worked to pass HB 3046 in the 2021 session, we wanted to take the opportunity to point out the specific areas of the bill we believe need to be discussed during the agency's rulemaking process.

1. *Section 5(2)(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.*

Establishing the definition for the timely delivery of service in rule is a key to the efficacy of HB 3046 in increasing access to behavioral health care for all Oregonians. We know that accessing care in a reasonable amount of time is vitally important to the treatment of behavioral health and that current practices by carriers create barriers that impact that access. Coalition members have heard from patients across the state who are unable to find a provider to see them in a reasonable amount of time due to a myriad of reasons. We request that the Division engage in a thorough rulemaking process to determine a definition for timely delivery of care, as the coalition recognize that it is a complex issue that can have different meanings depending on the behavioral health needs of the individual. As part of this process, we encourage the Division to look to other state's work, such as California, who earlier this year passed legislation

requiring all health insurers to have available access to appropriate mental health care within two weeks of the client's first request.

2. *Section 5(12): 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.*

This provision was included in the bill because coalition members repeatedly heard from behavioral health providers that carriers are engaging utilization review strategies that often result in rejected payments to providers often after the services have been rendered. These reviews are abrupt, capricious, intimidating, time consuming, and often lead to the provider paying a lot of money back to the insurer. Providers feel like they are continually coding for the accurate service duration and then receiving push back from insurers to code at a lower amount of time at a lower level of reimbursement. This practice results in providers being reimbursed incorrectly, as many providers do not have the administrative support or time to go back and forth with carriers (much of which occurs after the service has already been rendered).

We urge the Division to adopt rules that prevent carriers from continuing this practice unless medical necessity calls for it based on clear research-based evidence that the shorter time period procedure code is more effective. Additionally, the Division needs to ensure that carriers are making those medical necessity decisions based on the current generally accepted standards of care, rather than with the goal of reducing costs.

3. *Section 6(4)(a): An adequate number and geographic distribution, as prescribed by the department by rule, of licensed professional counselors, licensed marriage and family therapists, licensed clinical social workers, psychologists, and psychiatrists who are accepting new patients, based on the needs of the insureds under the policy or certificate, including but not limited to providers who can address the needs of:*
   (A)Children and adults;
   (B) Individuals with limited English proficiency or who are illiterate;
   (C) Individuals with diverse cultural or ethnic backgrounds;
   (D) Individuals with chronic or complex behavioral health conditions; and
   (E) Other groups specified by the department by rule;

It is no secret that Oregonians are struggling to find behavioral health care providers that take their insurance and have room in their schedules to accept new patients. This is even more true for Oregonians living in rural parts of the state or for those that need specialized treatment. While many of the components of HB 3046 will increase access to care, these efforts will be diminished if the Division doesn't establish clear network adequacy requirements for carriers. These requirements will need to look different based on member populations and needs and the coalition looks forward to engaging in a robust rulemaking process to determine the

adequate number and geographic distribution of providers needed to meet the behavioral health needs of Oregonians.

The appropriateness of the provider should include clinical specialties, geography, race, sexual identity/orientation, gender, ethnicity, language diversity, and hearing/vision impairment. With that in mind, we echo the comments submitted to the RAC by Basic Rights Oregon and encourage the Division to add “individuals who are who are gay, lesbian, bisexual, transgender, and any other minority gender identity or sexual orientation" to the list of groups that need providers with specific background and expertise.

4. *Section 8(5)*
   (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.

We appreciate that the Division included the requirement in the reporting rules that carriers provide a summary of the criteria and guidelines used for making level of care placement decisions. We encourage the Division to provide further requirements in rule that the information provided by carriers include the specific instruments utilized to ensure that they are “the most recent version of the levels of care placement criteria developed by the nonprofit professional association for the relevant clinical specialty.” These have been recognized through a federal ruling as the LOCUS, CALOCUS-CASII, and ASAM, as well as a few others.

For decisions not related to level of care placement decisions, the coalition requests that the Division provide clear rules for making the criteria and guidelines publicly available. This information should include how plan members can access, or request to access, these criteria to ensure members have a clear and logical pathway to obtain this information. While HB 3046 does not require the use of specific criteria, it does require that the criteria be based on current generally accepted standards of care that are valid and evidence based. By providing clear rules around the availability of that criteria to the public, members can ensure that the care coverage decisions being made by carriers are based on current generally accepted standards of care and therefore in line with the bill.