

# A-Engrossed House Bill 3126

Ordered by the House April 3  
Including House Amendments dated April 3

Sponsored by Representatives SANCHEZ, PHAM H; Representative NELSON (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.

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.

**Sunsets pilot program January 2, 2030.**

*[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.

## A BILL FOR AN ACT

Relating to behavioral health treatment; creating new provisions; and amending ORS 743A.168.

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

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

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

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

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

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

**(A) An emergency evaluation area where children can be stabilized, connected with outpatient treatment and discharged the same day;**

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

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

**(D) A behavioral health clinician, as defined in ORS 414.025, on staff and available to**

**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.

1 consult internally and with other regional hospitals within 24 hours if needed;

2 (E) Peer and family support specialist services; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

36 **SECTION 2.** (1) The Oregon Health Authority shall first implement the Emergency Be-  
37 havioral Health Services for Children program established in section 1 of this 2023 Act as a  
38 pilot program for up to three Regional Child Psychiatric Centers in hospitals in three sepa-  
39 rate regional trauma areas. The authority shall provide funding for a Child Psychiatric  
40 Emergency unit that a Regional Child Psychiatric Center elects to operate. The System of  
41 Care Advisory Council established in ORS 418.978 shall oversee the planning process for the  
42 pilot regions.

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

45 (3) No later than September 15, 2025, the authority, in coordination with participants in

1 **the program in each participating regional trauma area, shall report, in the manner provided**  
2 **in ORS 192.245, to the interim committees of the Legislative Assembly related to health, the**  
3 **authority's evaluation and assessment of the program and recommendations, if any, for leg-**  
4 **islative actions needed to improve the program.**

5 **SECTION 3.** ORS 743A.168, as amended by section 8, chapter 629, Oregon Laws 2021, is  
6 amended to read:

7 743A.168. (1) As used in this section:

8 (a) "Behavioral health assessment" means an evaluation by a provider, in person or using tele-  
9 medicine, to determine a patient's need for behavioral health treatment.

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

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

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

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

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

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

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

23 (B) Products and services that:

24 (i) Address the specific needs of a patient for the purpose of screening for, preventing, diagnos-  
25 ing, managing or treating an illness, injury or condition or symptoms of an illness, injury or condi-  
26 tion;

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

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

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

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

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

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

38 (j) "Provider" means:

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

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

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

45 (D) A day or partial hospitalization program;

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

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

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

5 (A) Psychiatry;

6 (B) Psychology;

7 (C) Clinical sociology;

8 (D) Addiction medicine and counseling; and

9 (E) Behavioral health treatment.

10 (L) "Standards of care and clinical practice guidelines" includes but is not limited to:

11 (A) Patient placement criteria;

12 (B) Recommendations of agencies of the federal government; and

13 (C) Drug labeling approved by the United States Food and Drug Administration.

14 (m) "Utilization review" has the meaning given that term in ORS 743B.001.

15 (n) "Valid, evidence-based sources" includes but is not limited to:

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

17 (B) Recommendations of nonprofit health care provider professional associations; and

18 (C) Specialty societies.

19 (2) A group health insurance policy or an individual health benefit plan that is not a grandfa-  
20 thered health plan providing coverage for hospital or medical expenses, other than limited benefit  
21 coverage, shall provide coverage for expenses arising from the diagnosis of behavioral health con-  
22 ditions and medically necessary behavioral health treatment at the same level as, and subject to  
23 limitations no more restrictive than, those imposed on coverage or reimbursement of expenses aris-  
24 ing from treatment for other medical conditions. The following apply to coverage for behavioral  
25 health treatment:

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

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

39 **(B) Notwithstanding subparagraph (A) of this paragraph, and consistent with ORS**  
40 **743A.012, the coverage of behavioral health treatment for a patient presenting to a Regional**  
41 **Child Psychiatric Center with a behavioral health crisis may not be subject to prior author-**  
42 **ization or require that the professional providing the treatment be credentialed by the**  
43 **insurer offering the policy or plan.**

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

45 (A) A behavioral health assessment;

1 (B) No less than the level of services determined to be medically necessary in a behavioral  
2 health assessment of the specific needs of a patient or in a patient's care plan:

3 (i) To effectively treat the patient's underlying behavioral health condition rather than the mere  
4 amelioration of current symptoms such as suicidal ideation or psychosis; and

5 (ii) For care following a behavioral health crisis, to transition the patient to a lower level of  
6 care;

7 (C) Treatment of co-occurring behavioral health conditions or medical conditions in a coordi-  
8 nated manner;

9 (D) Treatment at the least intensive and least restrictive level of care that is safe and most ef-  
10 fective and meets the needs of the insured's condition;

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

13 (F) Treatment to maintain functioning or prevent deterioration;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 (k)(A) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to phy-  
11 sicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists, ORS 40.250  
12 and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed profes-  
13 sional counselors and licensed marriage and family therapists, a group health insurer or issuer of  
14 an individual health benefit plan may provide for review for level of treatment of admissions and  
15 continued stays for treatment in health facilities, residential facilities, day or partial hospitalization  
16 programs and outpatient services by either staff of a group health insurer or issuer of an individual  
17 health benefit plan or personnel under contract to the group health insurer or issuer of an individual  
18 health benefit plan that is not a grandfathered health plan, or by a utilization review contractor,  
19 who shall have the authority to certify for or deny level of payment.

20 (B) Review shall be made according to criteria made available to providers in advance upon  
21 request.

22 (C) Review shall be performed by or under the direction of a physician licensed under ORS  
23 677.100 to 677.228, a psychologist licensed by the Oregon Board of Psychology, a clinical social  
24 worker licensed by the State Board of Licensed Social Workers or a professional counselor or mar-  
25 riage and family therapist licensed by the Oregon Board of Licensed Professional Counselors and  
26 Therapists, in accordance with standards of the National Committee for Quality Assurance or  
27 Medicare review standards of the Centers for Medicare and Medicaid Services.

28 (D) Review may involve prior approval, concurrent review of the continuation of treatment,  
29 post-treatment review or any combination of these. However, if prior approval is required, provision  
30 shall be made to allow for payment of urgent or emergency admissions, subject to subsequent re-  
31 view. If prior approval is not required, group health insurers and issuers of individual health benefit  
32 plans that are not grandfathered health plans shall permit providers, policyholders or persons acting  
33 on their behalf to make advance inquiries regarding the appropriateness of a particular admission  
34 to a treatment program. Group health insurers and issuers of individual health benefit plans that  
35 are not grandfathered health plans shall provide a timely response to such inquiries. Noncontracting  
36 providers must cooperate with these procedures to the same extent as contracting providers to be  
37 eligible for reimbursement.

38 (L) Health maintenance organizations may limit the receipt of covered services by enrollees to  
39 services provided by or upon referral by providers contracting with the health maintenance organ-  
40 ization. Health maintenance organizations and health care service contractors may create substan-  
41 tive plan benefit and reimbursement differentials at the same level as, and subject to limitations no  
42 more restrictive than, those imposed on coverage or reimbursement of expenses arising out of other  
43 medical conditions and apply them to contracting and noncontracting providers.

44 (3) This section does not prohibit a group health insurer or issuer of an individual health benefit  
45 plan that is not a grandfathered health plan from managing the provision of benefits through com-

1 mon methods, including but not limited to selectively contracted panels, health plan benefit differ-  
2 ential designs, preadmission screening, prior authorization of services, utilization review or other  
3 mechanisms designed to limit eligible expenses to those described in subsection (2)(b) of this section  
4 provided such methods comply with the requirements of this section.

5 (4) The Legislative Assembly finds that health care cost containment is necessary and intends  
6 to encourage health insurance plans designed to achieve cost containment by ensuring that re-  
7 imbursement is limited to appropriate utilization under criteria incorporated into the insurance, ei-  
8 ther directly or by reference, in accordance with this section.

9 (5)(a) Any medical necessity, utilization or other clinical review conducted for the diagnosis,  
10 prevention or treatment of behavioral health conditions or relating to service intensity, level of care  
11 placement, continued stay or discharge must be based solely on the following:

12 (A) The current generally accepted standards of care.

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

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

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

24 (A) Are outside the scope of criteria and guidelines described in paragraph (a)(B) of this sub-  
25 section, if the guidelines were developed in accordance with the current generally accepted stan-  
26 dards of care; or

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

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

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

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

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

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

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

8 (b) An insurer or health care service contractor shall, subject to subsection (2) of this section,  
9 pay benefits toward the covered charges of noncontracting providers of services for behavioral  
10 health treatment. The insured shall, subject to subsection (2) of this section, have the right to use  
11 the services of a noncontracting provider of behavioral health treatment, whether or not the be-  
12 havioral health treatment is provided by contracting or noncontracting providers.

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

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

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

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

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

21 (E) Support groups.

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

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

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

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

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

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

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

44 (13) The Director of the Department of Consumer and Business Services and the Oregon Health  
45 Authority, after notice and hearing, may adopt reasonable rules not inconsistent with this section



1 that are considered necessary for the proper administration of this section. The director shall adopt  
2 rules making it a violation of this section for a group health insurer or issuer of an individual health  
3 benefit plan other than a grandfathered health plan to require providers to bill using a specific  
4 billing code or to restrict the reimbursement paid for particular billing codes other than on the basis  
5 of medical necessity.

6 (14) This section does not:

7 (a) Prohibit an insured from receiving behavioral health treatment from an out-of-network pro-  
8 vider or prevent an out-of-network behavioral health provider from billing the insured for any un-  
9 reimbursed cost of treatment.

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

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

14 **SECTION 4. Section 2 of this 2023 Act is repealed on January 2, 2030.**

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