House Bill 2359

Sponsored by Representatives SALINAS, RUIZ, Senator FREDERICK (Presession filed.)

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.**

Requires health care providers to work with health care interpreters from health care interpreter registry operated by Oregon Health Authority to provide interpretation services. Requires authority to adopt rules to enforce requirement. Provides exceptions.

Requires interpretation service companies to register with authority. Requires companies to only employ or contract with health care interpreters listed on health care registry, subject to exceptions. Requires Commissioner of Bureau of Labor and Industries to enforce requirement to only employ or contract with health care interpreters listed on registry.

Requires Oregon Council on Health Care Interpreters to adopt code of ethics for health care interpreters and procedures to evaluation quality of health interpretation services.

Requires authority to train and certify or qualify health care interpreters, maintain central registry of certified or qualified health care interpreters from which patients or health care providers can schedule appointments with health care interpreters and publish specified guidance to health care interpreters.

Requires coordinated care organizations to use health care interpreters listed on health care interpreter registry.

Makes certain health care interpreters subject workers for purposes of workers' compensation benefits.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health care interpreters; creating new provisions; amending ORS 192.630, 413.550, 413.552, 413.556, 413.558, 414.572 and 656.027; repealing ORS 657.048; and declaring an emergency.

Whereas current law contains a loophole for health care providers and interpretation service companies to justify working with untrained health care interpreters despite the availability of health care interpreters who are qualified or certified by the Oregon Health Authority; and

Whereas current law does not hold accountable health care providers and interpretation service companies for failing to work with qualified or certified interpreters or for failing to work with best practices in providing health care interpretation services; and

Whereas there is currently no complaint process for health care interpreters who experience wage or other labor violations; and

Whereas there is a growing demand for health care interpreters in rural communities in this state, especially for interpreters capable of interpreting languages of limited diffusion in those areas; and

Whereas health care interpreters suffer from the inequitable business practices of interpretation service companies; and

Whereas due to the low payment rates and the rising cost of training and testing, current and potential health care interpreters are reluctant to invest in training, testing, qualification or certification because of the low return on their investment; and

Whereas there is a lack of uniformity statewide in the quality of health care interpretation services; and

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.

Whereas there is a lack of a uniform training curriculum statewide; now, therefore,

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

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

(a) "Health care interpreter" has the meaning given that term in ORS 413.550.

(b) "Health care interpreter registry" has the meaning given that term in ORS 413.550.

(2) Except as provided in subsection (3) of this section, a health care provider who does not have or does not have on-site staff who have a demonstrated proficiency in the language preferred by a patient of the provider shall work with a health care interpreter from the health care interpreter registry administered by the Oregon Health Authority under ORS 413.558 when communicating with the patient.

(3) A health care provider may work with a health care interpreter who is not listed on the health care interpreter registry only if the provider:

(a) Verifies, in the manner prescribed by the authority by rule, that the provider has taken all steps necessary to obtain a health care interpreter from the health care interpreter registry in accordance with rules adopted by the authority under ORS 413.558; or

(b)(A) Has offered the patient the services of a health care interpreter from the health care interpreter registry and the patient declined the offer and chose a different interpreter;

(B) Has documented the offer and the patient's decline of the offer; and

(C) Determines that the interpreter chosen by the patient meets National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care as issued by the United States Department of Health and Human Services and guidance issued by the United States Department of Justice under Title VI of the Civil Rights Act of 1964.

(4) A health care provider shall maintain records of each patient encounter in which the provider worked with a health care interpreter from the health care interpreter registry. The records must include:

(a) The name of the health care interpreter; and

(b) The health care interpreter's registry number.

(5) If a health care provider or the provider's staff knows that a patient has an infectious disease, the provider or staff shall inform any health care interpreter who will be working with the patient in person. If a health care provider or the provider's staff learns that a patient who worked with a health care interpreter has an infectious disease, within 24 hours, the provider or staff shall notify the authority of the name of the health care interpreter who worked with the patient.

(6) A health care provider shall ensure that a health care interpreter who works with the provider and a patient in person has received all vaccines and testing recommended by the Centers for Disease Control and Prevention for health care workers. The provider shall administer any vaccines or provide the testing that a health care interpreter lacks at no cost to the health care interpreter.

(7) A health care provider shall give personal protective equipment recommended by the authority to health care interpreters providing services on-site at no cost to the health care interpreter and may not suggest to the health care interpreter that the health care interpreter should procure the health care interpreter's own personal protective equipment as a condition for working with the health care provider.

(8) The authority shall adopt rules to carry out the provisions of this section.

SECTION 2. (1) With the advice of the Oregon Council on Health Care Interpreters, the

Oregon Health Authority shall implement by rule policies and processes to hold accountable:

(a) Health care interpreters for the quality of interpretation services provided and for adhering to safety standards established by the authority;

(b) Health care providers for:

(A) Working only with certified health care interpreters listed on the health care registry described in ORS 413.558 in accordance with ORS 414.572 (2)(e) and section 1 of this 2021 Act; and

(B) Providing language access services required by federal and state law including, but not limited to, 42 U.S.C. 18116, Title VI of the Civil Rights Act, Title VI Guidance issued by the United States Department of Justice and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care as issued by the United States Department of Health and Human Services; and

(c) Health care interpreter trainers and health care interpreter training programs for the quality of training provided.

(2) The policies and processes must include, at a minimum, investigating and resolving complaints, including anonymous complaints and complaints in languages other than English, about:

(a) The failure of a health care provider to comply with ORS 414.572 (2)(e) or section 1 of this 2021 Act.

(b) A health care provider requesting that a bilingual staff member or a friend or family member of a patient provide interpretation services instead of working with a health care interpreter listed on the health care registry described in ORS 413.558.

(c) A health care provider using a third party to give appointment reminder calls to patients instead of initiating a three-way call involving the provider or provider's staff, the interpreter and the patient to give the appointment reminder.

(d) The failure of a health care interpreter listed on the health care registry to comply with standards adopted by the Oregon Council on Health Care Interpreters under ORS 413.556.

(3) If the authority finds that a complaint is well-founded, the authority may:

(a) Issue a written warning with a corrective action plan.

(b) Impose a civil penalty on a health care provider under section 3 of this 2021 Act.

(c) Revoke or suspend the certification or qualification of a health care interpreter under ORS 413.558 or subject the health care interpreter to probationary conditions.

(d) Require a health care interpreter to complete training and document that the training was completed.

SECTION 3. The Oregon Health Authority may impose a civil penalty, not to exceed $1,000, for each violation of section 1 of this 2021 Act or a well-founded complaint under section 2 of this 2021 Act. Penalties shall be imposed in the manner provided in ORS 183.745.

SECTION 4. (1) As used in this section, "health care interpreter registry" means the registry described in ORS 413.558.

(2) A person may not operate an interpretation service company in this state unless the company is registered with the Oregon Health Authority.

(3) A person shall apply to register a company as an interpretation service company by submitting an application and paying a fee as prescribed by the authority. The authority shall register the company if the company meets criteria established by the authority by rule.

(4) A registered interpretation service company shall:

(a) Notify a health care provider if a health care interpreter referred by the company is not listed on the health care interpreter registry and explain why the company did not refer a health care interpreter listed on the health care interpreter registry;

(b) Report to the authority, in the form and manner specified by the authority:

(A) Every case in which the company refers a health care interpreter who is not listed on the health care interpreter registry; and

(B) Annually:

(i) The company's process for developing and working with certified health care interpreters and qualified health care interpreters;

(ii) The percentage of health care interpreters referred by the company who are not listed on the health care interpreter registry; and

(iii) The number of appointments to provide interpretation services that were made for health care interpreters who were not listed on the health care interpreter registry;

(c) Provide to health care interpreters who are independent contractors and to health care providers, once per year and upon the request of a health care interpreter or provider, the contracts of the company with health care interpreters and with clients of the company;

(d) Track and make available upon request information on how many requests for health care interpretation appointments that the company was unable to fulfill;

(e) When becoming aware that a contracted health care interpreter has or had an infectious disease, within 24 hours notify all other contracted health care interpreters who were at the same location at the same time as the infected health care interpreter; and

(f) Inform each health care interpreter of the health care interpreter's right to personal protective equipment in a medical setting.

(5) A registered interpretation service may not require or suggest to a health care interpreter that the health care interpreter procure the health care interpreter's own personal protective equipment as a condition of receiving a referral.

SECTION 5. (1) As used in this section:

(a) "Health care interpreter" has the meaning given that term in ORS 413.550.

(b) "Interpretation service company" has the meaning given that term in ORS 413.550.

(2) Except as provided in subsection (3) of this section, an interpretation service company may not employ or contract with a health care interpreter who is not listed on the health care interpreter registry described in ORS 413.558.

(3) An interpretation service company may employ or contract with a health care interpreter who is not listed on the health care interpreter registry only if the company verifies that the company has taken all steps, in accordance with rules adopted by the Oregon Health Authority under ORS 413.558, to obtain a health care interpreter who is listed on the health care registry.

(4) The Commissioner of the Bureau of Labor and Industries shall establish by rule standards, policies and processes to hold accountable interpretation service companies for contracting with or employing as health care interpreters only health care interpreters listed on the health care interpreter registry in accordance with subsection (2) of this section.

(5) The standards, policies and processes established under subsection (4) of this section must include, at a minimum:

(a) A requirement for an interpretation service company to:

(A) Notify a health care provider if a health care interpreter furnished by the company is not a health care interpreter listed on the health care interpreter registry; and

(B) Report to the commissioner, in the form and manner specified by the commissioner, every case in which the company refers a health care interpreter who is not listed on the health care interpreter registry.

(b) A standard prohibiting an interpretation service company from representing to a health care provider that a contracted or employed health care interpreter referred by the company is a certified health care interpreter unless the interpreter has met the requirements for certification under ORS 413.558 and has been issued a valid certification by the authority.

(c) A process for investigating and resolving complaints in the manner provided in ORS 659A.820, including anonymous complaints and complaints in languages other than English, about:

(A) The failure of an interpretation service company to contract with or employ health care interpreters who are listed on the health care interpreter registry in accordance with subsection (2) of this section; and

(B) An interpretation service company's unfair labor or contracting practices, discrimination, violation of consumer protections, risks to the health or safety of patients, conflicts of interest or compliance with law.

(6) If the commissioner determines that a complaint is well-founded the bureau may:

(a) Issue a warning with a corrective action plan; or

(b) Impose a fine of no more than $5,000 for each violation.

(7) Subsection (5)(c)(B) of this section may not be construed to impair, extinguish or infringe on any existing rights, claims or remedies under state or federal law.

SECTION 6. ORS 413.550 is amended to read:

413.550. As used in ORS 413.550 to 413.558:

(1) "Certified health care interpreter" means an individual who has been approved and certified by the Oregon Health Authority.

(2) "Coordinated care organization" has the meaning given that term in ORS 414.025.

[*(2)*] **(3)** "Health care" means medical, surgical**, oral** or hospital care or any other remedial care recognized by state law, including physical and behavioral health care.

[*(3)*] **(4)(a)** "Health care interpreter" means an individual who is readily able to:

[*(a)*] **(A) Communicate in English and also** communicate with a person with limited English proficiency **or who communicates in signed language**;

[*(b)*] **(B)** Accurately interpret the oral statements of a person with limited English proficiency, or the statements of a person who communicates in [*sign*] **signed** language, into English;

(C) Accurately interpret oral statements in English to a person with limited English proficiency or who communicates in signed language;

[*(c)*] **(D)** Sight translate documents from a person with limited English proficiency; **and**

[*(d)*] **(E)** Interpret the oral statements of other persons into the language of the person with limited English proficiency or into [*sign*] **signed** language[*; and*]**.**

[*(e) Sight translate documents in English into the language of the person with limited English proficiency.*]

(b) "Health care interpreter" also includes an individual who can provide the services described in paragraph (a) of this subsection using relay or indirect interpretation.

(5) "Health care interpreter registry" means the registry described in ORS 413.558 that is administered by the authority.

(6) "Health care provider" means an individual, coordinated care organization, prepaid managed care health services organization or other entity licensed or certified to provide health care in this state that is reimbursed with public funds, in whole or in part.

(7) "Interpretation service company" means an entity engaged in the business of arranging for health care interpreters to work with health care providers.

[*(4)*] **(8)** "Person with limited English proficiency" means a person who, by reason of place of birth or culture, [*speaks*] **communicates in** a language other than English and does not [*speak*] **communicate in** English with adequate ability to communicate effectively with a health care provider.

(9) "Prepaid managed care health services organization" has the meaning given that term in ORS 414.025.

[*(5)*] **(10)** "Qualified health care interpreter" means an individual who has [*received*] **been issued** a valid letter of qualification from the authority.

[*(6)*] **(11)** "Sight translate" means to translate a written document into spoken or [*sign*] **signed** language.

SECTION 7. ORS 413.552 is amended to read:

413.552. (1) The Legislative Assembly finds that persons with limited English proficiency, or who communicate in [*sign*] **signed** language, are often unable to interact effectively with health care providers. Because of language differences, persons with limited English proficiency, or who communicate in [*sign*] **signed** language, are often excluded from health care services, experience delays or denials of health care services or receive health care services based on inaccurate or incomplete information.

(2) The Legislative Assembly further finds that the lack of competent health care interpreters among health care providers impedes the free flow of communication between the health care provider and patient, **negatively impacting health outcomes and** preventing clear and accurate communication and the development of empathy, confidence and mutual trust that is essential for an effective relationship between health care provider and patient.

(3) It is the policy of the Legislative Assembly to require the use of certified health care interpreters or qualified health care interpreters [*whenever possible*] **to the greatest extent practicable** to ensure the accurate and adequate provision of health care to persons with limited English proficiency and to persons who communicate in [*sign*] **signed** language.

(4) It is the policy of the Legislative Assembly that health care for persons with limited English proficiency be provided according to the guidelines established under the policy statement issued August 30, 2000, by the U.S. Department of Health and Human Services, Office for Civil Rights, entitled, "Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency," and the 1978 Patient's Bill of Rights.

SECTION 8. ORS 413.556 is amended to read:

413.556. The Oregon Council on Health Care Interpreters shall work in cooperation with the Oregon Health Authority to:

(1) Develop testing, qualification and certification standards**, consistent with the International Medical Interpreters Association standards,** for health care interpreters for persons with limited English proficiency and for persons who communicate in [*sign*] **signed** language.

[*(2) Coordinate with other states, the federal government or professional organizations to develop and implement educational and testing programs for health care interpreters.*]

[*(3) Examine operational and funding issues, including but not limited to the feasibility of developing a central registry and annual subscription mechanism for health care interpreters.*]

(2) Adopt for health care interpreters on the health care interpreter registry a code of ethics based on the National Council on Interpreting in Health Care code of ethics.

(3) Adopt procedures to evaluate the quality of health care interpretation services provided by interpretation service companies and by health care interpreters listed on the health care interpreter registry.

(4) Do all other acts as shall be necessary or appropriate under the provisions of ORS 413.550 to 413.558.

SECTION 9. ORS 413.558 is amended to read:

413.558. (1) In consultation with the Oregon Council on Health Care Interpreters, the Oregon Health Authority shall by rule establish procedures for testing, qualification and certification of health care interpreters for persons with limited English proficiency or for persons who communicate in [*sign*] **signed** language, including but not limited to:

(a) Minimum standards for qualification and certification as a health care interpreter, **which may be modified as necessary,** including:

(A) Oral [*and written*] **or signed** language skills in English and in the language for which health care interpreter qualification or certification is granted; and

(B) Formal education or training in **interpretation,** medical **behavioral or oral health** terminology, anatomy and physiology[*, medical interpreting ethics and interpreting skills*];

(b) Categories of expertise of health care interpreters based on the English and non-English skills, or interpreting skills, and the medical terminology skills of the person seeking qualification or certification;

(c) Procedures for receiving applications and for examining applicants for qualification or certification;

(d) The content and administration of required examinations;

(e) The requirements and procedures for reciprocity of qualification and certification for health care interpreters qualified or certified in another state or territory of the United States or by another certifying body in the United States; and

(f) Fees for application, examination, initial issuance, renewal and reciprocal acceptance of qualification or certification as a health care interpreter if deemed necessary by the authority.

(2) Any person seeking qualification or certification as a health care interpreter must submit an application to the authority. If the applicant meets the requirements for qualification or certification established by the authority under this section, the authority shall issue a letter of qualification or a certification to the health care interpreter. **The authority shall notify a person of the authority's determination on the person's application no later than 60 days after the date the application is received by the authority.**

(3) The authority shall work with other states, the federal government or professional organizations to develop educational and testing programs and procedures for the qualification and certification of health care interpreters.

(4) In addition to the requirements for qualification established under subsection (1) of this section, a person may be qualified as a health care interpreter only if the person:

(a) Is able to fluently interpret [*the dialect,*] slang**, idioms and specialized vocabulary in**

English and the idioms, slang or specialized vocabulary of the non-English language for which qualification is sought; and

(b) Has had at least 60 hours of health care interpreter training that includes anatomy and physiology and concepts of [*medical*] **health care** interpretation.

(5) A person may not use the title of "qualified health care interpreter" in this state unless the person has met the requirements for qualification established under subsections (1) and (4) of this section and has been issued a valid letter of qualification by the authority.

(6) In addition to the requirements for certification established under subsection (1) of this section, a person may be certified as a health care interpreter only if:

(a) The person has met all the requirements established under subsection (4) of this section; and

(b) The person has passed written and oral examinations required by the authority in English, in a non-English language or [*sign*] **signed** language and in medical terminology.

(7) A person may not use the title of "certified health care interpreter" in this state unless the person has met the requirements for certification established under subsections (1) and (6) of this section and has been issued a valid certification by the authority.

(8) The authority shall:

(a) Provide health care interpreter training and continuing education in accordance with standards adopted by the Oregon Council on Health Care Interpreters under ORS 413.556 to professionalize the health care interpreter workforce in this state. The training may be provided at no cost or, if not, must be affordable; and

(b) Maintain a record of all health care interpreters who have completed an approved training program.

(9) The authority shall:

(a) Establish and maintain a central registry for all health care interpreters who are qualified or certified by the authority based on standards adopted by the council, establish a four-year subscription mechanism for the registry and adopt by rule fees to cover the reasonable costs of administering the registry.

(b) Provide a website or otherwise implement a system, in collaboration with a labor union or other representative of the health care interpreter workforce, that allows a patient or health care provider to access the health care interpreter registry and schedule appointments with qualified or certified health care interpreters.

(c) Inform health care interpreters on the registry when the authority proposes or implements rules or policies that affect how health care interpreter services are paid for.

(d) Publish job-specific guidance on the use of personal protective equipment for health care interpreters and update the guidance if necessary to address new public health and safety information that includes:

(A) When to use personal protective equipment;

(B) What personal protective equipment is necessary;

(C) How to properly don, use and doff personal protective equipment to prevent self-contamination;

(D) How to properly dispose of or disinfect personal protective equipment; and

(E) The limitations of items of personal protective equipment in avoiding contact with contagions.

(10) The authority shall prescribe the steps that must be taken by an entity required to use an interpreter and the verification required to allow the entity to work with an inter-

preter who is not listed on the health care interpreter registry or otherwise certified.

(11) The authority shall adopt rules to carry out the provisions of this section.

SECTION 10. The amendments to ORS 413.558 by section 9 of this 2021 Act do not require the Oregon Health Authority or the Oregon Council on Health Care Interpreters to establish a new health care interpreter registry in addition to the health care interpreter registry in effect on the effective date of this 2021 Act.

SECTION 11. ORS 192.630 is amended to read:

192.630. (1) All meetings of the governing body of a public body shall be open to the public and all persons shall be permitted to attend any meeting except as otherwise provided by ORS 192.610 to 192.690.

(2) A quorum of a governing body may not meet in private for the purpose of deciding on or deliberating toward a decision on any matter except as otherwise provided by ORS 192.610 to 192.690.

(3) A governing body may not hold a meeting at any place where discrimination on the basis of race, color, creed, sex, sexual orientation, national origin, age**, language** or disability is practiced. However, the fact that organizations with restricted membership hold meetings at the place does not restrict its use by a public body if use of the place by a restricted membership organization is not the primary purpose of the place or its predominant use.

(4)(a) Meetings of the governing body of a public body shall be held:

(A) Within the geographic boundaries over which the public body has jurisdiction;

(B) At the administrative headquarters of the public body;

(C) At the nearest practical location; or

(D) If the public body is a state, county, city or special district entity, within Indian country of a federally recognized Oregon Indian tribe that is within the geographic boundaries of this state. For purposes of this subparagraph, "Indian country" has the meaning given that term in 18 U.S.C. 1151.

(b) Training sessions may be held outside the jurisdiction as long as no deliberations toward a decision are involved.

(c) A joint meeting of two or more governing bodies or of one or more governing bodies and the elected officials of one or more federally recognized Oregon Indian tribes shall be held within the geographic boundaries over which one of the participating public bodies or one of the Oregon Indian tribes has jurisdiction or at the nearest practical location.

(d) Meetings may be held in locations other than those described in this subsection in the event of an actual emergency necessitating immediate action.

(5)(a) It is discrimination on the basis of disability for a governing body of a public body to meet in a place inaccessible to persons with disabilities, or, upon request of a person who is deaf or hard of hearing, to fail to make a good faith effort to have an interpreter for persons who are deaf or hard of hearing provided at a regularly scheduled meeting. The sole remedy for discrimination on the basis of disability shall be as provided in ORS 192.680.

(b) The person requesting the interpreter shall give the governing body at least 48 hours' notice of the request for an interpreter, shall provide the name of the requester, [*sign*] **signed** language preference and any other relevant information the governing body may request.

[*(c) If a meeting is held upon less than 48 hours' notice, reasonable effort shall be made to have an interpreter present, but the requirement for an interpreter does not apply to emergency meetings.*]

[*(d)*] **(c)** If certification of interpreters occurs under state or federal law, the Oregon Health

Authority or other state or local agency shall [*try to*] **make a good faith effort to** refer only certified interpreters to governing bodies for purposes of this subsection.

[*(e)*] **(d)** As used in this subsection, "good faith effort" [*includes, but is not limited to, contacting the department or other state or local agency that maintains a list of qualified interpreters and arranging for the referral of one or more qualified interpreters to provide interpreter services*] **means taking the steps prescribed by the authority by rule under ORS 413.558 (10)**.

SECTION 12. ORS 414.572 is amended to read:

414.572. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and requirements for a coordinated care organization and shall integrate the criteria and requirements into each contract with a coordinated care organization. Coordinated care organizations may be local, community-based organizations or statewide organizations with community-based participation in governance or any combination of the two. Coordinated care organizations may contract with counties or with other public or private entities to provide services to members. The authority may not contract with only one statewide organization. A coordinated care organization may be a single corporate structure or a network of providers organized through contractual relationships. The criteria and requirements adopted by the authority under this section must include, but are not limited to, a requirement that the coordinated care organization:

(a) Have demonstrated experience and a capacity for managing financial risk and establishing financial reserves.

(b) Meet the following minimum financial requirements:

(A) Maintain restricted reserves of $250,000 plus an amount equal to 50 percent of the coordinated care organization's total actual or projected liabilities above $250,000.

(B) Maintain capital or surplus of not less than $2,500,000 and any additional amounts necessary to ensure the solvency of the coordinated care organization, as specified by the authority by rules that are consistent with ORS 731.554 (6), 732.225, 732.230 and 750.045.

(C) Expend a portion of the annual net income or reserves of the coordinated care organization that exceed the financial requirements specified in this paragraph on services designed to address health disparities and the social determinants of health consistent with the coordinated care organization's community health improvement plan and transformation plan and the terms and conditions of the Medicaid demonstration project under section 1115 of the Social Security Act (42 U.S.C. 1315).

(c) Operate within a fixed global budget and, by January 1, 2023, spend on primary care, as defined in section 2, chapter 575, Oregon Laws 2015, at least 12 percent of the coordinated care organization's total expenditures for physical and mental health care provided to members, except for expenditures on prescription drugs, vision care and dental care.

(d) Develop and implement alternative payment methodologies that are based on health care quality and improved health outcomes.

(e) Coordinate the delivery of physical health care, [*mental health and chemical dependency services*] **behavioral health care**, oral health care and covered long-term care services.

(f) Engage community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the coordinated care organization's members and in the coordinated care organization's community.

(2) In addition to the criteria and requirements specified in subsection (1) of this section, the authority must adopt by rule requirements for coordinated care organizations contracting with the

authority so that:

(a) Each member of the coordinated care organization receives integrated person centered care and services designed to provide choice, independence and dignity.

(b) Each member has a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery.

(c) The supportive and therapeutic needs of each member are addressed in a holistic fashion, using patient centered primary care homes, behavioral health homes or other models that support patient centered primary care and behavioral health care and individualized care plans to the extent feasible.

(d) Members receive comprehensive transitional care, including appropriate follow-up, when entering and leaving an acute care facility or a long term care setting.

(e) Members [*receive*] **are provided:**

(A) Assistance in navigating the health care delivery system**;**

(B) Assistance [*and*] in accessing community and social support services and statewide resources[*, including through the use of certified health care interpreters and qualified health care interpreters, as those terms are defined in ORS 413.550*]**;**

(C) Meaningful language access as required by federal and state law including, but not limited to, 42 U.S.C. 18116, Title VI of the Civil Rights Act, Title VI Guidance issued by the United States Department of Justice and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care as issued by the United States Department of Health and Human Services; and

(D) Qualified health care interpreters or certified health care interpreters listed on the health care interpreter registry, as those terms are defined in ORS 413.550.

(f) Services and supports are geographically located as close to where members reside as possible and are, if available, offered in nontraditional settings that are accessible to families, diverse communities and underserved populations.

(g) Each coordinated care organization uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable and if financially viable.

(h) Each coordinated care organization complies with the safeguards for members described in ORS 414.605.

(i) Each coordinated care organization convenes a community advisory council that meets the criteria specified in ORS 414.575.

(j) Each coordinated care organization prioritizes working with members who have high health care needs, multiple chronic conditions[*, mental illness or chemical dependency*] **or behavioral health conditions** and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services, including the services described in ORS 414.766, to reduce the use of avoidable emergency room visits and hospital admissions.

(k) Members have a choice of providers within the coordinated care organization's network and that providers participating in a coordinated care organization:

(A) Work together to develop best practices for care and service delivery to reduce waste and improve the health and well-being of members.

(B) Are educated about the integrated approach and how to access and communicate within the integrated system about a patient's treatment plan and health history.

(C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-

making and communication.

(D) Are permitted to participate in the networks of multiple coordinated care organizations.

(E) Include providers of specialty care.

(F) Are selected by coordinated care organizations using universal application and credentialing procedures and objective quality information and are removed if the providers fail to meet objective quality standards.

(G) Work together to develop best practices for culturally **and linguistically** appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.

(L) Each coordinated care organization reports on outcome and quality measures adopted under ORS 414.638 and participates in the health care data reporting system established in ORS 442.372 and 442.373.

(m) Each coordinated care organization uses best practices in the management of finances, contracts, claims processing, payment functions and provider networks.

(n) Each coordinated care organization participates in the learning collaborative described in ORS 413.259 (3).

(o) Each coordinated care organization has a governing body that complies with ORS 414.584 and that includes:

(A) At least one member representing persons that share in the financial risk of the organization;

(B) A representative of a dental care organization selected by the coordinated care organization;

(C) The major components of the health care delivery system;

(D) At least two health care providers in active practice, including:

(i) A physician licensed under ORS chapter 677 or a nurse practitioner licensed under ORS 678.375, whose area of practice is primary care; and

(ii) A [*mental health or chemical dependency treatment*] **behavioral health** provider;

(E) At least two members from the community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community; and

(F) At least two members of the community advisory council, one of whom is or was within the previous six months a recipient of medical assistance and is at least 16 years of age, or a parent, guardian or primary caregiver of an individual who is or was within the previous six months a recipient of medical assistance.

(p) Each coordinated care organization's governing body establishes standards for publicizing the activities of the coordinated care organization and the organization's community advisory councils, as necessary, to keep the community informed.

(q) Each coordinated care organization publishes on a website maintained by or on behalf of the coordinated care organization, in a manner determined by the authority, a document designed to educate members about best practices, care quality expectations, screening practices, treatment options and other support resources available for members who have mental illnesses or substance use disorders.

(r) Each coordinated care organization works with the Tribal Advisory Council established in ORS 414.581 and has a dedicated tribal liaison, selected by the council, to:

(A) Facilitate a resolution of any issues that arise between the coordinated care organization and a provider of Indian health services within the area served by the coordinated care organization;

(B) Participate in the community health assessment and the development of the health improvement plan;

(C) Communicate regularly with the Tribal Advisory Council; and

(D) Be available for training by the office within the authority that is responsible for tribal affairs, any federally recognized tribe in Oregon and the urban Indian health program that is located within the area served by the coordinated care organization and operated by an urban Indian organization pursuant to 25 U.S.C. 1651.

(3) The authority shall consider the participation of area agencies and other nonprofit agencies in the configuration of coordinated care organizations.

(4) In selecting one or more coordinated care organizations to serve a geographic area, the authority shall:

(a) For members and potential members, optimize access to care and choice of providers;

(b) For providers, optimize choice in contracting with coordinated care organizations; and

(c) Allow more than one coordinated care organization to serve the geographic area if necessary to optimize access and choice under this subsection.

(5) On or before July 1, 2014, each coordinated care organization must have a formal contractual relationship with any dental care organization that serves members of the coordinated care organization in the area where they reside.

(6) A coordinated care organization shall post to the coordinated care organization's website annually an updated list of language service providers and health care interpreters that the coordinated care organization works with.

SECTION 13. ORS 414.572, as amended by section 14, chapter 489, Oregon Laws 2017, section 4, chapter 49, Oregon Laws 2018, section 8, chapter 358, Oregon Laws 2019, section 2, chapter 364, Oregon Laws 2019, section 58, chapter 478, Oregon Laws 2019, and section 7, chapter 529, Oregon Laws 2019, is amended to read:

414.572. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and requirements for a coordinated care organization and shall integrate the criteria and requirements into each contract with a coordinated care organization. Coordinated care organizations may be local, community-based organizations or statewide organizations with community-based participation in governance or any combination of the two. Coordinated care organizations may contract with counties or with other public or private entities to provide services to members. The authority may not contract with only one statewide organization. A coordinated care organization may be a single corporate structure or a network of providers organized through contractual relationships. The criteria and requirements adopted by the authority under this section must include, but are not limited to, a requirement that the coordinated care organization:

(a) Have demonstrated experience and a capacity for managing financial risk and establishing financial reserves.

(b) Meet the following minimum financial requirements:

(A) Maintain restricted reserves of $250,000 plus an amount equal to 50 percent of the coordinated care organization's total actual or projected liabilities above $250,000.

(B) Maintain capital or surplus of not less than $2,500,000 and any additional amounts necessary to ensure the solvency of the coordinated care organization, as specified by the authority by rules that are consistent with ORS 731.554 (6), 732.225, 732.230 and 750.045.

(C) Expend a portion of the annual net income or reserves of the coordinated care organization that exceed the financial requirements specified in this paragraph on services designed to address

health disparities and the social determinants of health consistent with the coordinated care organization's community health improvement plan and transformation plan and the terms and conditions of the Medicaid demonstration project under section 1115 of the Social Security Act (42 U.S.C. 1315).

(c) Operate within a fixed global budget and spend on primary care, as defined by the authority by rule, at least 12 percent of the coordinated care organization's total expenditures for physical and mental health care provided to members, except for expenditures on prescription drugs, vision care and dental care.

(d) Develop and implement alternative payment methodologies that are based on health care quality and improved health outcomes.

(e) Coordinate the delivery of physical health care, [*mental health and chemical dependency services*] **behavioral health care**, oral health care and covered long-term care services.

(f) Engage community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the coordinated care organization's members and in the coordinated care organization's community.

(2) In addition to the criteria and requirements specified in subsection (1) of this section, the authority must adopt by rule requirements for coordinated care organizations contracting with the authority so that:

(a) Each member of the coordinated care organization receives integrated person centered care and services designed to provide choice, independence and dignity.

(b) Each member has a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery.

(c) The supportive and therapeutic needs of each member are addressed in a holistic fashion, using patient centered primary care homes, behavioral health homes or other models that support patient centered primary care and behavioral health care and individualized care plans to the extent feasible.

(d) Members receive comprehensive transitional care, including appropriate follow-up, when entering and leaving an acute care facility or a long term care setting.

(e) Members [*receive*] **are provided:**

(A) Assistance in navigating the health care delivery system**;**

(B) Assistance [*and*] in accessing community and social support services and statewide resources[*, including through the use of certified health care interpreters and qualified health care interpreters, as those terms are defined in ORS 413.550*]**;**

(C) Meaningful language access as required by federal and state law including, but not limited to, 42 U.S.C. 18116, Title VI of the Civil Rights Act, Title VI Guidance issued by the United States Department of Justice and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care as issued by the United States Department of Health and Human Services; and

(D) Qualified health care interpreters or certified health care interpreters listed on the health care interpreter registry, as those terms are defined in ORS 413.550.

(f) Services and supports are geographically located as close to where members reside as possible and are, if available, offered in nontraditional settings that are accessible to families, diverse communities and underserved populations.

(g) Each coordinated care organization uses health information technology to link services and

care providers across the continuum of care to the greatest extent practicable and if financially viable.

(h) Each coordinated care organization complies with the safeguards for members described in ORS 414.605.

(i) Each coordinated care organization convenes a community advisory council that meets the criteria specified in ORS 414.575.

(j) Each coordinated care organization prioritizes working with members who have high health care needs, multiple chronic conditions[*, mental illness or chemical dependency*] **or behavioral health conditions** and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services, including the services described in ORS 414.766, to reduce the use of avoidable emergency room visits and hospital admissions.

(k) Members have a choice of providers within the coordinated care organization's network and that providers participating in a coordinated care organization:

(A) Work together to develop best practices for care and service delivery to reduce waste and improve the health and well-being of members.

(B) Are educated about the integrated approach and how to access and communicate within the integrated system about a patient's treatment plan and health history.

(C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making and communication.

(D) Are permitted to participate in the networks of multiple coordinated care organizations.

(E) Include providers of specialty care.

(F) Are selected by coordinated care organizations using universal application and credentialing procedures and objective quality information and are removed if the providers fail to meet objective quality standards.

(G) Work together to develop best practices for culturally **and linguistically** appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.

(L) Each coordinated care organization reports on outcome and quality measures adopted under ORS 414.638 and participates in the health care data reporting system established in ORS 442.372 and 442.373.

(m) Each coordinated care organization uses best practices in the management of finances, contracts, claims processing, payment functions and provider networks.

(n) Each coordinated care organization participates in the learning collaborative described in ORS 413.259 (3).

(o) Each coordinated care organization has a governing body that complies with ORS 414.584 and that includes:

(A) At least one member representing persons that share in the financial risk of the organization;

(B) A representative of a dental care organization selected by the coordinated care organization;

(C) The major components of the health care delivery system;

(D) At least two health care providers in active practice, including:

(i) A physician licensed under ORS chapter 677 or a nurse practitioner licensed under ORS 678.375, whose area of practice is primary care; and

(ii) A [*mental health or chemical dependency treatment*] **behavioral health** provider;

(E) At least two members from the community at large, to ensure that the organization's

decision-making is consistent with the values of the members and the community; and

(F) At least two members of the community advisory council, one of whom is or was within the previous six months a recipient of medical assistance and is at least 16 years of age or a parent, guardian or primary caregiver of an individual who is or was within the previous six months a recipient of medical assistance.

(p) Each coordinated care organization's governing body establishes standards for publicizing the activities of the coordinated care organization and the organization's community advisory councils, as necessary, to keep the community informed.

(q) Each coordinated care organization publishes on a website maintained by or on behalf of the coordinated care organization, in a manner determined by the authority, a document designed to educate members about best practices, care quality expectations, screening practices, treatment options and other support resources available for members who have mental illnesses or substance use disorders.

(r) Each coordinated care organization works with the Tribal Advisory Council established in ORS 414.581 and has a dedicated tribal liaison, selected by the council, to:

(A) Facilitate a resolution of any issues that arise between the coordinated care organization and a provider of Indian health services within the area served by the coordinated care organization;

(B) Participate in the community health assessment and the development of the health improvement plan;

(C) Communicate regularly with the Tribal Advisory Council; and

(D) Be available for training by the office within the authority that is responsible for tribal affairs, any federally recognized tribe in Oregon and the urban Indian health program that is located within the area served by the coordinated care organization and operated by an urban Indian organization pursuant to 25 U.S.C. 1651.

(3) The authority shall consider the participation of area agencies and other nonprofit agencies in the configuration of coordinated care organizations.

(4) In selecting one or more coordinated care organizations to serve a geographic area, the authority shall:

(a) For members and potential members, optimize access to care and choice of providers;

(b) For providers, optimize choice in contracting with coordinated care organizations; and

(c) Allow more than one coordinated care organization to serve the geographic area if necessary to optimize access and choice under this subsection.

(5) On or before July 1, 2014, each coordinated care organization must have a formal contractual relationship with any dental care organization that serves members of the coordinated care organization in the area where they reside.

(6) A coordinated care organization shall post to the coordinated care organization's website annually an updated list of language service providers and health care interpreters that the coordinated care organization works with.

SECTION 14. ORS 656.027 is amended to read:

656.027. All workers are subject to this chapter except those nonsubject workers described in the following subsections:

(1) A worker employed as a domestic servant in or about a private home. For the purposes of this subsection "domestic servant" means any worker engaged in household domestic service by private employment contract, including, but not limited to, home health workers.

(2) A worker employed to do gardening, maintenance, repair, remodeling or similar work in or about the private home of the person employing the worker.

(3)(a) A worker whose employment is casual and either:

(A) The employment is not in the course of the trade, business or profession of the employer; or

(B) The employment is in the course of the trade, business or profession of a nonsubject employer.

(b) For the purpose of this subsection, "casual" refers only to employments where the work in any 30-day period, without regard to the number of workers employed, involves a total labor cost of less than $500.

(4) A person for whom a rule of liability for injury or death arising out of and in the course of employment is provided by the laws of the United States.

(5) A worker engaged in the transportation in interstate commerce of goods, persons or property for hire by rail, water, aircraft or motor vehicle, and whose employer has no fixed place of business in this state.

(6) Firefighter and police employees of any city having a population of more than 200,000 that provides a disability and retirement system by ordinance or charter.

(7)(a) Sole proprietors, except those described in paragraph (b) of this subsection. When labor or services are performed under contract, the sole proprietor must qualify as an independent contractor **to be a nonsubject worker**.

(b) Sole proprietors actively licensed under ORS 671.525 or 701.021. When labor or services are performed under contract for remuneration, notwithstanding ORS 656.005 (30), the sole proprietor must qualify as an independent contractor. Any sole proprietor licensed under ORS 671.525 or 701.021 and involved in activities subject thereto is conclusively presumed to be an independent contractor.

(8) Except as provided in subsection (23) of this section, partners who are not engaged in work performed in direct connection with the construction, alteration, repair, improvement, moving or demolition of an improvement on real property or appurtenances thereto. When labor or services are performed under contract, the partnership must qualify as an independent contractor **to be a nonsubject worker**.

(9) Except as provided in subsection (25) of this section, members, including members who are managers, of limited liability companies, regardless of the nature of the work performed. However, members, including members who are managers, of limited liability companies with more than one member, while engaged in work performed in direct connection with the construction, alteration, repair, improvement, moving or demolition of an improvement on real property or appurtenances thereto, are subject workers. When labor or services are performed under contract, the limited liability company must qualify as an independent contractor **to be a nonsubject worker**.

(10) Except as provided in subsection (24) of this section, corporate officers who are directors of the corporation and who have a substantial ownership interest in the corporation, regardless of the nature of the work performed by such officers, subject to the following limitations:

(a) If the activities of the corporation are conducted on land that receives farm use tax assessment pursuant to ORS chapter 308A, corporate officer includes all individuals identified as directors in the corporate bylaws, regardless of ownership interest, and who are members of the same family, whether related by blood, marriage or adoption.

(b) If the activities of the corporation involve the commercial harvest of timber and all officers

of the corporation are members of the same family and are parents, daughters or sons, daughters-in-law or sons-in-law or grandchildren, then all such officers may elect to be nonsubject workers. For all other corporations involving the commercial harvest of timber, the maximum number of exempt corporate officers for the corporation shall be whichever is the greater of the following:

(A) Two corporate officers; or

(B) One corporate officer for each 10 corporate employees.

(c) When labor or services are performed under contract, the corporation must qualify as an independent contractor **to be a nonsubject worker**.

(11) A person performing services primarily for board and lodging received from any religious, charitable or relief organization.

(12) A newspaper carrier utilized in compliance with the provisions of ORS 656.070 and 656.075.

(13) A person who has been declared an amateur athlete under the rules of the United States Olympic Committee or the Canadian Olympic Committee and who receives no remuneration for performance of services as an athlete other than board, room, rent, housing, lodging or other reasonable incidental subsistence allowance, or any amateur sports official who is certified by a recognized Oregon or national certifying authority, which requires or provides liability and accident insurance for such officials. A roster of recognized Oregon and national certifying authorities will be maintained by the Department of Consumer and Business Services, from lists of certifying organizations submitted by the Oregon School Activities Association and the Oregon Park and Recreation Society.

(14) Volunteer personnel participating in the ACTION programs, organized under the Domestic Volunteer Service Act of 1973, P.L. 93-113, known as the Foster Grandparent Program and the Senior Companion Program, whether or not the volunteers receive a stipend or nominal reimbursement for time and travel expenses.

(15) A person who has an ownership or leasehold interest in equipment and who furnishes, maintains and operates the equipment. As used in this subsection "equipment" means:

(a) A motor vehicle used in the transportation of logs, poles or piling.

(b) A motor vehicle used in the transportation of rocks, gravel, sand, dirt or asphalt concrete.

(c) A motor vehicle used in the transportation of property by a for-hire motor carrier that is required under ORS 825.100 or 825.104 to possess a certificate or permit or to be registered.

(16) A person engaged in the transportation of the public for recreational down-river boating activities on the waters of this state pursuant to a federal permit when the person furnishes the equipment necessary for the activity. As used in this subsection, "recreational down-river boating activities" means those boating activities for the purpose of recreational fishing, swimming or sightseeing utilizing a float craft with oars or paddles as the primary source of power.

(17) A person who receives no wage other than ski passes or other noncash remuneration for performing volunteer:

(a) Ski patrol activities; or

(b) Ski area program activities sponsored by a ski area operator, as defined in ORS 30.970, or by a nonprofit corporation or organization.

(18) A person 19 years of age or older who contracts with a newspaper publishing company or independent newspaper dealer or contractor to distribute newspapers to the general public and perform or undertake any necessary or attendant functions related thereto.

(19) A person performing foster parent or adult foster care duties pursuant to [*ORS 412.001 to 412.161 and 412.991 or*] ORS chapter [*411,*] 418, 430 or 443.

(20) A person performing services on a volunteer basis for a nonprofit, religious, charitable or relief organization, whether or not such person receives meals or lodging or nominal reimbursements or vouchers for meals, lodging or expenses.

(21) A person performing services under a property tax work-off program established under ORS 310.800.

(22) A person who performs service as a caddy at a golf course in an established program for the training and supervision of caddies under the direction of a person who is an employee of the golf course.

(23)(a) Partners who are actively licensed under ORS 671.525 or 701.021 and who have a substantial ownership interest in a partnership. If all partners are members of the same family and are parents, spouses, sisters, brothers, daughters or sons, daughters-in-law or sons-in-law or grandchildren, all such partners may elect to be nonsubject workers. For all other partnerships licensed under ORS 671.510 to 671.760 or 701.021, the maximum number of exempt partners shall be whichever is the greater of the following:

(A) Two partners; or

(B) One partner for each 10 partnership employees.

(b) When labor or services are performed under contract for remuneration, notwithstanding ORS 656.005 (30), the partnership qualifies as an independent contractor. Any partnership licensed under ORS 671.525 or 701.021 and involved in activities subject thereto is conclusively presumed to be an independent contractor.

(24)(a) Corporate officers who are directors of a corporation actively licensed under ORS 671.525 or 701.021 and who have a substantial ownership interest in the corporation, regardless of the nature of the work performed. If all officers of the corporation are members of the same family and are parents, spouses, sisters, brothers, daughters or sons, daughters-in-law or sons-in-law or grandchildren, all such officers may elect to be nonsubject workers. For all other corporations licensed under ORS 671.510 to 671.760 or 701.021, the maximum number of exempt corporate officers shall be whichever is the greater of the following:

(A) Two corporate officers; or

(B) One corporate officer for each 10 corporate employees.

(b) When labor or services are performed under contract for remuneration, notwithstanding ORS 656.005 (30), the corporation qualifies as an independent contractor. Any corporation licensed under ORS 671.525 or 701.021 and involved in activities subject thereto is conclusively presumed to be an independent contractor.

(25)(a) Limited liability company members who are members of a company actively licensed under ORS 671.525 or 701.021 and who have a substantial ownership interest in the company, regardless of the nature of the work performed. If all members of the company are members of the same family and are parents, spouses, sisters, brothers, daughters or sons, daughters-in-law or sons-in-law or grandchildren, all such members may elect to be nonsubject workers. For all other companies licensed under ORS 671.510 to 671.760 or 701.021, the maximum number of exempt company members shall be whichever is the greater of the following:

(A) Two company members; or

(B) One company member for each 10 company employees.

(b) When labor or services are performed under contract for remuneration, notwithstanding ORS 656.005 (30), the company qualifies as an independent contractor. Any company licensed under ORS 671.525 or 701.021 and involved in activities subject thereto is conclusively presumed to be an in-

dependent contractor.

(26) A person serving as a referee or assistant referee in a youth or adult recreational soccer match whose services are retained on a match-by-match basis.

(27) A person performing language translator or interpreter services that are provided for others through an agent or broker **except for a certified health care interpreter and a qualified health care interpreter, as defined in ORS 430.550**.

(28) A person who operates, and who has an ownership or leasehold interest in, a passenger motor vehicle that is operated as a taxicab or for nonemergency medical transportation. As used in this subsection:

(a) "Lease" means a contract under which the lessor provides a vehicle to a lessee for consideration.

(b) "Leasehold" includes, but is not limited to, a lease for a shift or a longer period.

(c) "Passenger motor vehicle that is operated as a taxicab" means a vehicle that:

(A) Has a passenger seating capacity that does not exceed seven persons;

(B) Is transporting persons, property or both on a route that begins or ends in Oregon; and

(C)(i) Carries passengers for hire when the destination and route traveled may be controlled by a passenger and the fare is calculated on the basis of any combination of an initial fee, distance traveled or waiting time; or

(ii) Is in use under a contract to provide specific service to a third party to transport designated passengers or to provide errand services to locations selected by the third party.

(d) "Passenger motor vehicle that is operated for nonemergency medical transportation" means a vehicle that:

(A) Has a passenger seating capacity that does not exceed seven persons;

(B) Is transporting persons, property or both on a route that begins or ends in Oregon; and

(C) Provides medical transportation services under contract with or on behalf of a mass transit or transportation district.

SECTION 15. ORS 657.048 is repealed.

SECTION 16. (1) Section 4 of this 2021 Act and the amendments to ORS 413.550, 413.552 and 413.556 by sections 6 to 8 this 2021 Act become operative on September 1, 2021.

(2) Sections 1 to 3 and 5 of this 2021 Act and the amendments to ORS 414.572 by sections 12 and 13 of this 2021 Act become operative on January 1, 2022.

SECTION 17. This 2021 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2021 Act takes effect on its passage.
