Enrolled
House Bill 4070

Introduced and printed pursuant to House Rule 12.00. Presession filed (at the request of House Interim Committee on Behavioral Health for Representative Hai Pham)

CHAPTER .....

AN ACT

Relating to health care; creating new provisions; amending ORS 137.227, 137.228, 414.025, 414.595, 414.723, 414.780, 430.010, 430.021, 430.215, 430.256, 430.265, 430.306, 430.342, 430.345, 430.350, 430.359, 430.362, 430.364, 430.366, 430.380, 430.381, 430.401, 430.560, 430.610, 430.627, 430.630, 430.637, 430.640, 430.644, 430.646, 430.695, 430.705, 430.709, 430.905, 471.810, 675.523, 743A.012 and 743A.168; repealing ORS 430.315, 430.368, 430.565 and 430.634; and prescribing an effective date.

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

SECTION 1. ORS 414.780 is amended to read:

414.780. (1) As used in this section:

(a) "Behavioral health coverage" means mental health treatment and services and substance use disorder treatment or services reimbursed by a coordinated care organization.

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

(c) "Mental health treatment and services" means the treatment of or services provided to address any condition or disorder that falls under any of the diagnostic categories listed in the mental disorders section of the current edition of the:

(A) International Classification of Disease; or

(B) Diagnostic and Statistical Manual of Mental Disorders.

(d) "Nonquantitative treatment limitation" means a limitation that is not expressed numerically but otherwise limits the scope or duration of behavioral health coverage, such as medical necessity criteria or other utilization review.

(e) "Substance use disorder treatment and services" means the treatment of and any services provided to address any condition or disorder that falls under any of the diagnostic categories listed in the substance use section of the current edition of the:

(A) International Classification of Disease; or

(B) Diagnostic and Statistical Manual of Mental Disorders.

(2) The Oregon Health Authority and coordinated care organizations shall ensure that:

(a) Access to mental health treatment and services and substance use disorder treatment and services is comparable to access to medical and surgical treatment and services; and

(b) Limitations are applied to mental health treatment and services and substance use disorder treatment and services no more stringently than to medical and surgical treatment and services.

[*(2)*] **(3)** No later than March 1 of each calendar year, the Oregon Health Authority shall prescribe the form and manner for each coordinated care organization to report to the authority, on

or before June 1 of the calendar year, information about the coordinated care organization's compliance with mental health parity requirements **under this section and 42 C.F.R. part 438, subpart K**, including but not limited to the following:

(a) The specific plan or coverage terms or other relevant terms regarding the nonquantitative treatment limitations and a description of all mental health or substance use disorder benefits and medical or surgical benefits to which each such term applies in each respective benefits classification.

(b) The factors used to determine that the nonquantitative treatment limitations will apply to mental health or substance use disorder benefits and medical or surgical benefits.

(c) The evidentiary standards used for the factors identified in paragraph (b) of this subsection, when applicable, provided that every factor is defined, and any other source or evidence relied upon to design and apply the nonquantitative treatment limitations to mental health or substance use disorder benefits and medical or surgical benefits.

(d) The number of denials of coverage of mental health treatment and services, substance use disorder treatment and services and medical and surgical treatment and services, the percentage of denials that were appealed, the percentage of appeals that upheld the denial and the percentage of appeals that overturned the denial.

(e) The percentage of claims for behavioral health coverage and for coverage of medical and surgical treatments that were paid to in-network providers and the percentage of such claims that were paid to out-of-network providers.

(f) The limitations imposed for entry into services for mental health treatment and services, substance use disorder treatment and services and medical and surgical treatment and services.

[*(f)*] **(g)** Other data or information the authority deems necessary to assess a coordinated care organization's compliance with mental health parity requirements.

[*(3)*] **(4)** Coordinated care organizations must demonstrate in the documentation submitted under subsection [*(2)*] **(3)** of this section, that the processes, strategies, evidentiary standards and other factors used to apply nonquantitative treatment limitation to mental health or substance use disorder treatment, as written and in operation, are comparable to and are applied no more stringently that the processes, strategies, evidentiary standards and other factors used to apply nonquantitative treatment limitations to medical or surgical treatments in the same classification.

[*(4)*] **(5)** Each calendar year the authority, in collaboration with individuals representing behavioral health treatment providers, community mental health programs, coordinated care organizations, the Consumer Advisory Council established in ORS 430.073 and consumers of mental health or substance use disorder treatment, shall, based on the information reported under subsection [*(2)*] **(3)** of this section, identify and assess:

(a) Coordinated care organizations' compliance with the requirements for parity between the behavioral health coverage and the coverage of medical and surgical treatment in the medical assistance program; and

(b) The authority's compliance with the requirements for parity between the behavioral health coverage and the coverage of medical and surgical treatment in the medical assistance program for individuals who are not enrolled in a coordinated care organization.

[*(5)*] **(6)** No later than December 31 of each calendar year, the authority shall submit a report to the interim committees of the Legislative Assembly related to mental or behavioral health, in the manner provided in ORS 192.245, that includes:

(a) The authority's findings under subsection [*(4)*] **(5)** of this section on compliance with rules regarding mental health parity, including a comparison of coverage for members of coordinated care organizations to coverage for medical assistance recipients who are not enrolled in coordinated care organizations as applicable; and

(b) An assessment of:

(A) The adequacy of the provider network as prescribed by the authority by rule.

(B) The timeliness of access to mental health and substance use disorder treatment and services, as prescribed by the authority by rule.

(C) The criteria used by each coordinated care organization to determine medical necessity and behavioral health coverage, including each coordinated care organization's payment protocols and procedures.

(D) Data on services that are requested but that coordinated care organizations are not required to provide.

(E) The consistency of credentialing requirements for behavioral health treatment providers with the credentialing of medical and surgical treatment providers.

(F) The utilization review, as defined by the authority by rule, applied to behavioral health coverage compared to coverage of medical and surgical treatments.

(G) The specific findings and conclusions reached by the authority with respect to the coverage of mental health and substance use disorder treatment and the authority's analysis that indicates that the coverage is or is not in compliance with this section.

(H) The specific findings and conclusions of the authority demonstrating a coordinated care organization's compliance with this section and with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343) and rules adopted thereunder.

[*(6)*] **(7)** Except as provided in subsection [*(5)(b)(D)*] **(6)(b)(D)** of this section, this section does not require coordinated care organizations to report data on services that are not funded on the prioritized list of health services compiled by the Health Evidence Review Commission under ORS 414.690.

SECTION 2. ORS 414.595 is amended to read:

414.595. (1) As used in this section:

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

(b) "Subcontractor" means an entity that contracts with a coordinated care organization to provide health care, dental care, behavioral health care or other services to medical assistance recipients enrolled in the coordinated care organization.

(2) The Oregon Health Authority shall conduct one external quality review of each coordinated care organization annually. The authority may contract with an external quality review organization to conduct the review.

(3) The authority shall compile a standard list of documents that the authority or contracted review organization collects from coordinated care organizations and subcontractors. When requesting information from a coordinated care organization about its subcontractors, the authority or contracted review organization shall inform the coordinated care organization of the documents on the standard list that have been collected from the coordinated care organization's subcontractors in the preceding 12-month period.

(4) The authority or a contracted review organization may not**:**

(a) Request information from a coordinated care organization that is duplicative of or redundant with information previously provided by the coordinated care organization or a subcontractor if the information was provided within the preceding 12-month period and the relevant content of the information has not changed.

(b) Make a negative finding about or impose a penalty on a coordinated care organization based on documents or templates that were created by the authority for use by coordinated care organizations unless the coordinated care organization has entered information into the document or template that materially deviates from the compliance standard.

(5) The authority shall provide a contracted review organization with all information about a coordinated care organization in the authority's possession as necessary for the contracted review organization to conduct the external quality review. A contracted review organization may not seek information from a coordinated care organization before first requesting the information from the authority.

(6) This section does not apply to documents requested, submitted or collected in connection with an audit for or an investigation of fraud, waste or abuse and does not:

(a) Prohibit a coordinated care organization from requesting from a subcontractor information required by law or contract;

(b) Require the authority or a contracted review organization to disclose to a coordinated care organization any information described in this section collected from a coordinated care organization or a subcontractor; or

(c) Permit the authority or a contracted review organization to disclose to a coordinated care organization confidential or proprietary information reported to the authority or contracted review organization by another coordinated care organization or a subcontractor.

SECTION 3. ORS 430.610 is amended to read:

430.610. It is declared to be the policy and intent of the Legislative Assembly that:

(1) Subject to the availability of funds **appropriated or otherwise made available by the Legislative Assembly**, services should be available to all persons with [*mental or emotional disturbances, developmental disabilities, alcoholism or drug dependence, and persons who are alcohol or drug abusers,*] **mental health or substance use disorders or intellectual or developmental disabilities,** regardless of age, county of residence or ability to pay;

(2) The Department of Human Services, the Oregon Health Authority and other state agencies shall conduct their activities in the least costly and most efficient manner so that delivery of services to persons with [*mental or emotional disturbances, developmental disabilities, alcoholism or drug dependence, and persons who are alcohol or drug abusers,*] **mental health or substance use disorders or intellectual or developmental disabilities** shall be effective and coordinated;

(3) To the greatest extent possible, mental health **and substance use disorder treatment** and developmental disabilities services shall be delivered in the community where the person lives in order to achieve maximum coordination of services and minimum disruption in the life of the person; and

(4) The State of Oregon shall [*encourage*] **collaborate with**, aid and financially assist [*its*] **tribal and** county governments [*in the establishment and development of*] **to establish and develop** community mental health programs or community developmental disabilities programs[*, including but not limited to, treatment and rehabilitation services for persons with mental or emotional disturbances, developmental disabilities, alcoholism or drug dependence, and persons who are alcohol or drug abusers, and prevention of these problems through county administered community mental health programs or community developmental disabilities programs*] **to provide services for persons with mental health or substance use disorders or intellectual or developmental disabilities**. **The collaboration required under this section shall include outreach to each of the federally recognized Indian tribes in Oregon.**

SECTION 4. ORS 430.646 is amended to read:

430.646. In allocating funds for community mental health programs affecting persons with mental [*or emotional disturbances*] **health or substance use disorders**, the Oregon Health Authority shall observe the following priorities:

(1) To ensure the establishment and operation of community mental health programs for persons with mental [*or emotional disturbances*] **health or substance use disorders** in every geographic area of the state to provide some services in each category of services described in ORS 430.630 (3) unless a waiver has been granted;

(2) To ensure survival of services that address the needs of persons within the priority of services under ORS 430.644 and that meet authority standards;

(3) To develop the interest and capacity of community mental health programs to provide new or expanded services to meet the needs for services under ORS 430.644 and to promote the equal availability of such services throughout the state; and

(4) To encourage and assist in the development of model projects to test new **evidence-based** services and innovative methods of service delivery.

SECTION 5. ORS 430.010 is amended to read:

430.010. As used in this chapter:

(1) "Outpatient service" means:

(a) A program or service providing treatment by appointment and by:

(A) Physicians licensed under ORS 677.100 to 677.228;

(B) Psychologists licensed by the Oregon Board of Psychology under ORS 675.010 to 675.150;

(C) Nurse practitioners licensed by the Oregon State Board of Nursing under ORS 678.010 to 678.415;

(D) Regulated social workers authorized to practice regulated social work by the State Board of Licensed Social Workers under ORS 675.510 to 675.600;

(E) Professional counselors or marriage and family therapists licensed by the Oregon Board of Licensed Professional Counselors and Therapists under ORS 675.715 to 675.835; or

(F) Naturopathic physicians licensed by the Oregon Board of Naturopathic Medicine under ORS chapter 685; or

(b) A program or service providing treatment by appointment that is licensed, approved, established, maintained, contracted with or operated by the authority under:

(A) ORS 430.265 to 430.380 and 430.610 to 430.880 for alcoholism;

(B) ORS 430.265 to 430.380, 430.405 to 430.565 and 430.610 to 430.880 for drug addiction; or

(C) ORS 430.610 to 430.880 for mental [*or emotional disturbances*] **health or substance use disorders**.

(2) "Residential facility" means a program or facility [*providing*] **that provides** an organized full-day or part-day program of treatment[. *Such a program or facility shall be*] **and that is** licensed, approved, established, maintained, contracted with or operated by the authority under:

(a) ORS 430.265 to 430.380 and 430.610 to 430.880 for [*alcoholism*] **alcohol use disorder**;

(b) ORS 430.265 to 430.380, 430.405 to 430.565 and 430.610 to 430.880 for [*drug addiction*] **substance use disorder**; or

(c) ORS 430.610 to 430.880 for mental [*or emotional disturbances*] **health or substance use disorders**.

SECTION 6. ORS 430.021 is amended to read:

430.021. Subject to ORS 417.300 and 417.305:

(1) The Department of Human Services shall directly or through contracts with private entities, counties under ORS 430.620 or other public entities:

(a) Direct, promote, correlate and coordinate all the activities, duties and direct services for persons with developmental disabilities.

(b) Promote, correlate and coordinate the developmental disabilities activities of all governmental organizations throughout the state in which there is any direct contact with developmental disabilities programs.

(c) Establish, coordinate, assist and direct a community developmental disabilities program in cooperation with local government units and integrate such a program with the state developmental disabilities program.

(d) Promote public education in this state concerning developmental disabilities and act as the liaison center for work with all interested public and private groups and agencies in the field of developmental disabilities services.

(2) The Oregon Health Authority shall directly or by contract with private or public entities:

(a) Direct, promote, correlate and coordinate all the activities, duties and direct services for persons with mental [*or emotional disturbances, alcoholism or drug dependence*] **health or substance use disorders**.

(b) Promote, correlate and coordinate the mental health **and substance use disorder** activities of all governmental organizations throughout the state in which there is any direct contact with mental health **or substance use disorder** programs.

(c) Establish, coordinate, assist and direct a community mental health program in cooperation with local government units and integrate such a program with the state mental health program.

(d) Promote public education in this state concerning mental health **and substance use disorders** and act as the liaison center for work with all interested public and private groups and agencies in the field of mental health **and substance use disorder** services.

(3) The department and the authority shall develop cooperative programs with interested private groups throughout the state to effect better community awareness and action in the fields of mental health**, substance use disorders** and developmental disabilities, and encourage and assist in all necessary ways community general hospitals to establish psychiatric services.

(4) To the greatest extent possible, the least costly settings for treatment, outpatient services and residential facilities shall be widely available and utilized except when contraindicated because of individual health care needs. State agencies that purchase treatment for mental [*or emotional disturbances*] **health or substance use disorders** shall develop criteria consistent with this policy. In reviewing applications for certificates of need, the Director of the Oregon Health Authority shall take this policy into account.

(5) The department and the authority shall accept the custody of persons committed to its care by the courts of this state.

(6) The authority shall adopt rules to require a facility and a nonhospital facility as those terms are defined in ORS 426.005, and a provider that employs a person described in ORS 426.415, if subject to authority rules regarding the use of restraint or seclusion during the course of mental health treatment of a child or adult, to report to the authority each calendar quarter the number of incidents involving the use of restraint or seclusion. The aggregate data shall be made available to the public.

SECTION 7. ORS 430.215 is amended to read:

430.215. (1) The Department of Human Services shall be responsible for planning, policy development, administration and delivery of services to children with developmental disabilities and their families. Services to children with developmental disabilities may include, but are not limited to, case management, family support, crisis and diversion services, intensive in-home services, and residential and foster care services. The department may deliver the services directly or through contracts with private entities, counties under ORS 430.620 or other public entities.

(2) The Oregon Health Authority shall be responsible for psychiatric residential and day treatment services for children with mental [*or emotional disturbances*] **health or substance use conditions**.

SECTION 8. ORS 430.265 is amended to read:

430.265. The Oregon Health Authority is authorized to contract with the federal government for services to [*alcohol and drug-dependent*] persons **with a substance use disorder** who are either residents or nonresidents of the State of Oregon.

SECTION 9. ORS 430.627 is amended to read:

430.627. (1) The purposes of ORS 430.626 to 430.628 are to build upon and improve the statewide coordinated crisis system in this state and to:

(a) Remove barriers to accessing quality behavioral health crisis services;

(b) Improve equity in behavioral health treatment and ensure culturally, linguistically and developmentally appropriate responses to individuals experiencing behavioral health crises, in recognition that, historically, crisis response services placed marginalized communities at disproportionate risk of poor outcomes and criminal justice involvement;

(c) Ensure that all residents of this state receive a consistent and effective level of behavioral health crisis services no matter where they live, work or travel in the state; and

(d) Provide increased access to quality community behavioral health services to prevent interactions with the criminal justice system and prevent hospitalizations.

(2) Moneys from the 9-8-8 Trust Fund established in ORS 430.624 shall be used as follows:

(a) Revenues from the 9-8-8 coordinated crisis services tax that are deposited into the fund shall be used only for:

(A) The crisis call center system and crisis hotline center described in subsections (4) and (5) of this section; and

(B) To the extent that the crisis call center system and crisis hotline center are fully funded, the expansion and ongoing funding of mobile crisis intervention teams.

(b) Moneys other than revenues from the 9-8-8 coordinated crisis services tax that are deposited into the fund shall be used for:

(A) A wide array of crisis stabilization services, including services provided by:

(i) Crisis stabilization centers;

(ii) Facilities offering short-term respite services;

(iii) Peer respite centers; and

(iv) Behavioral health urgent care walk-in centers; and

(B) Community mental health program provision of crisis stabilization services or funding to cities to establish or maintain one or more mobile crisis intervention teams under ORS 430.628.

(3) The Oregon Health Authority shall adopt by rule requirements for crisis stabilization centers that, at a minimum, require a center to:

(a) Be designed to prevent or ameliorate a behavioral health crisis or reduce acute symptoms of mental illness or substance use disorder, for individuals who do not require inpatient treatment, by providing continuous 24-hour observation and supervision;

(b) Be staffed 24 hours per day, seven days per week, 365 days per year by a multidisciplinary team capable of meeting the needs of individuals in the community experiencing all levels of crisis, that may include, but is not limited to:

(A) Psychiatrists or psychiatric nurse practitioners;

(B) Nurses;

(C) Licensed or credentialed clinicians in the region where the crisis stabilization center is located who are capable of completing assessments; and

(D) Peers with lived experiences similar to the experiences of the individuals served by the center;

(c) Have a policy prohibiting rejecting patients brought in or referred by first responders, and have the capacity, at least 90 percent of the time, to accept all referrals;

(d) Have services to address substance use crisis issues;

(e) Have the capacity to [*assess*] **screen** physical health needs and provide needed care and a procedure for transferring an individual, if necessary, to a setting that can meet the individual's physical health needs if the facility is unable to provide the level of care required;

(f) Offer walk-in and first responder drop-off options;

(g) Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated;

(h) Screen for violence risk and complete more comprehensive violence risk assessments and planning when clinically indicated; and

(i) Meet other requirements prescribed by the authority.

(4) The authority shall:

(a) Implement, maintain and improve the 9-8-8 suicide prevention and behavioral health crisis hotline and ensure the efficient and effective routing of calls, including staffing and technological infrastructure enhancements necessary to achieve operational and clinical standards and best practices set forth by the 988 Suicide and Crisis Lifeline and prescribed by the authority; and

(b) Maintain a crisis hotline center to receive calls, texts and chats from the 9-8-8 suicide prevention and behavioral health crisis hotline and to provide crisis intervention services and crisis care coordination anywhere in this state 24 hours per day, seven days per week. The crisis hotline center shall:

(A) Have an agreement to participate in the 988 Suicide and Crisis Lifeline network.

(B) Meet 988 Suicide and Crisis Lifeline requirements and best practices guidelines for operational and clinical standards and any additional clinical and operational standards prescribed by the authority.

(C) Record data, provide reports and participate in evaluations and related quality improvement activities.

(D) Establish formal agreements to collaborate with other agencies to ensure safe, integrated care for people in crisis who reach out to the 9-8-8 suicide prevention and behavioral health crisis hotline.

(E) Contact and coordinate with the local community mental health programs for rapid deployment of a local mobile crisis intervention team and follow-up services as needed.

(F) Utilize technologies, including chat and text applications, to provide a no-wrong-door approach for individuals seeking help from the crisis hotline and ensure collaboration among crisis and emergency response systems used throughout this state, such as 9-1-1 and 2-1-1, and with other centers in the 988 Suicide and Crisis Lifeline network.

(G) Establish policies and train staff on serving high-risk and specialized populations, including but not limited to lesbian, gay, bisexual, transgender and queer youth, minorities, veterans and individuals who have served in the military, firefighters and other first responders, rural residents, individuals with co-occurring disorders and other racially and ethnically diverse communities. Policies and training established under this subparagraph must include:

(i) Policies and training on transferring calls made to the 9-8-8 suicide prevention and behavioral health crisis hotline to an appropriate specialized center within or external to the 988 Suicide and Crisis Lifeline network; and

(ii) Training on providing linguistically and culturally competent care and follow-up services to individuals accessing the 9-8-8 suicide prevention and behavioral health crisis hotline consistent with guidance and policies established by the 988 Suicide and Crisis Lifeline.

(5) The staff of the crisis hotline center described in subsection (4) of this section must include individuals who possess the linguistic and cultural competency to respond to individuals within the demographics of the communities served and shall:

(a) Have access to the most recently reported information regarding available mental health and behavioral health crisis services.

(b) Track and maintain data regarding responses to calls, texts and chats to the 9-8-8 suicide prevention and behavioral health crisis hotline.

(c) Work to resolve crises with the least invasive intervention possible.

(d) Connect callers whose crisis is de-escalated or otherwise managed by hotline staff with appropriate follow-on services and undertake follow-up contact with the caller when appropriate.

(6) Crisis stabilization services provided to individuals accessing the 9-8-8 suicide prevention and behavioral health crisis hotline shall be reimbursed by the authority, coordinated care organizations or commercial insurance, depending on the individual's insurance status.

(7) The authority shall adopt rules to allow appropriate information sharing and communication across all crisis service providers as necessary to carry out the requirements of this section and shall work in concert with the 988 Suicide and Crisis Lifeline and the Veterans Crisis Line for the purposes of ensuring consistency of public messaging about 9-8-8 suicide prevention and behavioral health crisis hotline services.

SECTION 10. ORS 430.630 is amended to read:

430.630. (1) In addition to any other requirements that may be established by rule by the Oregon Health Authority, each community mental health program, subject to the availability of funds **appropriated or otherwise made available by the Legislative Assembly**, [*shall provide guidance and assistance to local Behavioral Health Resource Networks for the joint development of programs and activities to increase access to treatment and shall provide the following basic services to persons with alcoholism or drug dependence, and persons who are alcohol or drug abusers*] **shall provide or ensure the provision of the following basic services for persons with or at risk of developing mental health or substance use disorders**:

(a) Outpatient services;

(b) Aftercare for persons released from hospitals;

(c) Training, case and program consultation and education for community agencies, related professions and the public;

(d) Guidance and assistance to other human service agencies for joint development of prevention programs and activities to reduce factors causing [*alcohol abuse, alcoholism, drug abuse and drug dependence*] **substance use disorders**; and

(e) Age-appropriate treatment options for older adults.

(2) As alternatives to state hospitalization, it is the responsibility of the community mental health program to ensure that, subject to the availability of funds, the following services for [*persons with alcoholism or drug dependence, and persons who are alcohol or drug abusers,*] **alcohol and substance misuse** are available when needed and approved by the Oregon Health Authority:

(a) Emergency services on a 24-hour basis, such as telephone consultation, crisis intervention and prehospital screening examination;

(b) Care and treatment for a portion of the day or night, which may include day treatment centers, work activity centers and after-school programs;

(c) Residential care and treatment in facilities such as halfway houses, detoxification centers and other community living facilities;

(d) Continuity of care, such as that provided by service coordinators, community case development specialists and core staff of federally assisted community mental health centers;

(e) Inpatient treatment in community hospitals; and

(f) Other alternative services to state hospitalization as defined by the Oregon Health Authority.

(3) In addition to any other requirements that may be established by rule of the Oregon Health Authority, each community mental health program, subject to the availability of funds, shall provide or ensure the provision of the following services to persons with mental [*or emotional disturbances*] **health or substance use disorders**:

(a) Screening and evaluation to determine the client's service needs;

(b) Crisis stabilization to meet the needs of persons with acute mental [*or emotional disturbances*] **health or substance use disorders**, including the costs of investigations and prehearing detention in community hospitals or other facilities approved by the authority for persons involved in involuntary commitment procedures;

(c) Vocational and social services that are appropriate for the client's age, designed to improve the client's vocational, social, educational and recreational functioning;

(d) Continuity of care to link the client to housing and appropriate and available health and social service needs;

(e) Psychiatric care in state and community hospitals, subject to the provisions of subsection (4) of this section;

(f) Residential services;

(g) Medication monitoring;

(h) Individual, family and group counseling and therapy;

(i) Public education and information;

(j) Prevention of mental [*or emotional disturbances*] **health or substance use disorders** and promotion of mental health;

(k) Consultation with other community agencies;

(L) Preventive mental health services for children and adolescents, including primary prevention efforts, early identification and early intervention services. Preventive services should be patterned after service models that have demonstrated effectiveness in reducing the incidence of emotional, behavioral and cognitive disorders in children. As used in this paragraph:

(A) "Early identification" means detecting [*emotional disturbance in its*] **mental health or substance use disorders in their** initial developmental stage;

(B) "Early intervention services" for children at risk of later development of [*emotional disturbances*] **mental health or substance use disorders** means programs and activities for children and their families that promote conditions, opportunities and experiences that encourage and develop emotional stability, self-sufficiency and increased personal competence; and

(C) "Primary prevention efforts" means efforts that prevent [*emotional problems*] **mental health and substance use disorders** from occurring by addressing issues early so that [*disturbances*] **disorders** do not have an opportunity to develop; and

(m) Preventive mental health services for older adults, including primary prevention efforts, early identification and early intervention services. Preventive services should be patterned after service models that have demonstrated effectiveness in reducing the incidence of emotional and behavioral disorders and suicide attempts in older adults. As used in this paragraph:

(A) "Early identification" means detecting [*emotional disturbance in its*] **mental health or substance use disorders in their** initial developmental stage;

(B) "Early intervention services" for older adults at risk of development of [*emotional disturbances*] **mental health or substance use disorders** means programs and activities for older adults and their families that promote conditions, opportunities and experiences that encourage and maintain emotional stability, self-sufficiency and increased personal competence and that deter suicide; and

(C) "Primary prevention efforts" means efforts that prevent [*emotional problems*] **mental health and substance use disorders** from occurring by addressing issues early so that [*disturbances*] **disorders** do not have an opportunity to develop.

(4) A community mental health program shall assume responsibility for psychiatric care in state and community hospitals, as provided in subsection (3)(e) of this section, in the following circumstances:

(a) The person receiving care is a resident of the county served by the program. For purposes of this paragraph, "resident" means the resident of a county in which the person maintains a current mailing address or, if the person does not maintain a current mailing address within the state, the county in which the person is found, or the county in which a court-committed person with a mental illness has been conditionally released.

(b) The person has been hospitalized involuntarily or voluntarily, pursuant to ORS 426.130 or 426.220, or has been hospitalized as the result of a revocation of conditional release.

(c) Payment is made for the first 60 consecutive days of hospitalization.

(d) The hospital has collected all available patient payments and third-party reimbursements.

(e) In the case of a community hospital, the authority has approved the hospital for the care of persons with mental [*or emotional disturbances*] **health or substance use disorders**, the community mental health program has a contract with the hospital for the psychiatric care of residents and a representative of the program approves voluntary or involuntary admissions to the hospital prior to admission.

(5) Subject to the review and approval of the Oregon Health Authority, a community mental health program may initiate additional services after the services defined in this section are provided.

(6) Each community mental health program and the state hospital serving the program's geographic area shall enter into a written agreement concerning the policies and procedures to be followed by the program and the hospital when a patient is admitted to, and discharged from, the hospital and during the period of hospitalization.

(7)**(a)** Each community mental health program shall have a mental health advisory committee, appointed by the board of county commissioners or the county court or, if two or more counties have combined to provide mental health services, the boards or courts of the participating counties [*or, in the case of a Native American reservation, the tribal council*].

(b) Each tribal community mental health program shall have a mental health advisory committee, appointed by the tribal council.

(8) A community mental health program may request and the authority may grant a waiver regarding provision of one or more of the services described in subsection (3) of this section upon a showing by the county and a determination by the authority that persons with mental [*or emotional disturbances*] **health or substance use disorders** in that county would be better served and unnecessary institutionalization avoided.

(9)(a) As used in this subsection, "local mental health authority" means one of the following entities:

(A) The board of county commissioners of one or more counties that establishes or operates a community mental health program;

(B) The tribal council, in the case of a federally recognized **Indian** tribe [*of Native Americans*] **in Oregon** that elects to enter into an agreement to provide mental health services; or

(C) A regional local mental health authority comprising two or more boards of county commissioners.

(b) Each local mental health authority that provides mental health **and substance use disorder** services shall determine the need for local mental health **and substance use disorder** services and adopt a comprehensive local plan for the delivery of mental health **and substance use disorder** services for children, families, adults and older adults that describes the methods by which the local mental health authority shall provide those services. The purpose of the local plan is to create a blueprint to provide mental health **and substance use disorder** services that are directed by and responsive to the mental health **and substance use disorder** needs of individuals in the community served by the local plan. A local mental health authority shall coordinate its local planning with the development of the community health improvement plan under ORS 414.575 by the coordinated care organization serving the area. The Oregon Health Authority may require a local mental health authority to review and revise the local plan periodically.

(c) The local plan shall identify ways to:

(A) Coordinate and ensure accountability for all levels of care described in paragraph (e) of this subsection;

(B) Maximize resources for consumers and minimize administrative expenses;

(C) Provide supported employment and other vocational opportunities for consumers;

(D) Determine the most appropriate service provider among a range of qualified providers;

(E) Ensure that appropriate mental health **and substance use disorder** referrals are made;

(F) Address local housing needs for persons with mental health **or substance use** disorders;

(G) Develop a process for discharge from state and local psychiatric hospitals and transition planning between levels of care or components of the system of care;

(H) Provide peer support services, including but not limited to drop-in centers and paid peer support;

(I) Provide transportation supports; and

(J) Coordinate services among the criminal and juvenile justice systems, adult and juvenile corrections systems and local mental health programs to ensure that persons with mental [*illness*] **health or substance use disorders** who come into contact with the justice and corrections systems receive needed care and to ensure continuity of services for adults and juveniles leaving the corrections system.

(d) When developing a local plan, a local mental health authority shall:

(A) Coordinate with the budgetary cycles of state and local governments that provide the local mental health authority with funding for mental health **and substance use disorder** services;

(B) Involve consumers, advocates, families, service providers, schools and other interested parties in the planning process;

(C) Coordinate with the local public safety coordinating council to address the services described in paragraph (c)(J) of this subsection;

(D) Conduct a population based needs assessment to determine the types of services needed locally;

(E) Determine the ethnic, age-specific, cultural and diversity needs of the population served by the local plan;

(F) Describe the anticipated outcomes of services and the actions to be achieved in the local plan;

(G) Ensure that the local plan coordinates planning, funding and services with:

(i) The educational needs of children, adults and older adults;

(ii) Providers of social supports, including but not limited to housing, employment, transportation and education; and

(iii) Providers of physical health and medical services;

(H) Describe how funds, other than state resources, may be used to support and implement the local plan;

(I) Demonstrate ways to integrate local services and administrative functions in order to support integrated service delivery in the local plan; and

(J) Involve the local mental health advisory committees described in subsection (7) of this section.

(e) The local plan must describe how the local mental health authority will ensure the delivery of and be accountable for clinically appropriate services in a continuum of care based on consumer needs. The local plan shall include, but not be limited to, services providing the following levels of care:

(A) Twenty-four-hour crisis services;

(B) Secure and nonsecure extended psychiatric care;

(C) Secure and nonsecure acute psychiatric care;

(D) Twenty-four-hour supervised structured treatment;

(E) Psychiatric day treatment;

(F) Treatments that maximize client independence;

(G) Family and peer support and self-help services;

(H) Support services;

(I) Prevention and early intervention services;

(J) Transition assistance between levels of care;

(K) Dual diagnosis services;

(L) Access to placement in state-funded psychiatric hospital beds;

(M) Precommitment and civil commitment in accordance with ORS chapter 426; and

(N) Outreach to older adults at locations appropriate for making contact with older adults, including senior centers, long term care facilities and personal residences.

(f) In developing the part of the local plan referred to in paragraph (c)(J) of this subsection, the local mental health authority shall collaborate with the local public safety coordinating council to address the following:

(A) Training for all law enforcement officers on ways to recognize and interact with persons with mental [*illness*] **health or substance use disorders**, for the purpose of diverting them from the criminal and juvenile justice systems;

(B) Developing voluntary locked facilities for crisis treatment and follow-up as an alternative to custodial arrests;

(C) Developing a plan for sharing a daily jail and juvenile detention center custody roster and the identity of persons of concern and offering mental health **and substance use disorder** services to those in custody;

(D) Developing a voluntary diversion program to provide an alternative for persons with mental [*illness*] **health or substance use disorders** in the criminal and juvenile justice systems; and

(E) Developing mental health **and substance use disorder** services, including housing, for persons with mental [*illness*] **health or substance use disorders** prior to and upon release from custody.

(g) Services described in the local plan shall:

(A) Address the vision, values and guiding principles described in the Report to the Governor from the Mental Health Alignment Workgroup, January 2001;

(B) Be provided to children, older adults and families as close to their homes as possible;

(C) Be culturally appropriate and competent;

(D) Be, for children, older adults and adults with mental health **or substance use disorder** needs, from providers appropriate to deliver those services;

(E) Be delivered in an integrated service delivery system with integrated service sites or processes, and with the use of integrated service teams;

(F) Ensure consumer choice among a range of qualified providers in the community;

(G) Be distributed geographically;

(H) Involve consumers, families, clinicians, children and schools in treatment as appropriate;

(I) Maximize early identification and early intervention;

(J) Ensure appropriate transition planning between providers and service delivery systems, with an emphasis on transition between children and adult mental health services;

(K) Be based on the ability of a client to pay;

(L) Be delivered collaboratively;

(M) Use age-appropriate, research-based quality indicators;

(N) Use best-practice innovations; and

(O) Be delivered using a community-based, multisystem approach.

(h) A local mental health authority shall submit to the Oregon Health Authority a copy of the local plan and revisions adopted under paragraph (b) of this subsection at time intervals established by the Oregon Health Authority.

SECTION 11. ORS 430.640 is amended to read:

430.640. (1) The Oregon Health Authority, in carrying out the legislative policy declared in ORS 430.610, subject to the availability of funds, shall:

(a) Assist Oregon counties and groups of Oregon counties in the establishment and financing of community mental health programs operated or contracted for by one or more counties.

(b) If a county declines to operate or contract for a community mental health program, contract with another public agency or private corporation to provide the program. The county must be provided with an opportunity to review and comment.

(c) In an emergency situation when no community mental health program is operating within a county or when a county is unable to provide a service essential to public health and safety, operate the program or service on a temporary basis.

(d) [*At the request of the tribal council of a federally recognized tribe of Native Americans, contract with the tribal council for the establishment and operation of a community mental health program in the same manner in which the authority contracts with a county court or board of county commissioners.*] **If one of the nine federally recognized tribes in this state decides to establish and operate a community mental health program, assist the tribe in the establishment and financing of a community mental health program in the same manner that the authority assists other community mental health programs.**

(e) If a county agrees, contract with a public agency or private corporation for all services within one or [*more*] **both** of the following program areas:

(A) Mental [*or emotional disturbances*] **health disorders**.

(B) [*Drug abuse*] **Substance use disorders**.

[*(C) Alcohol abuse and alcoholism.*]

(f) Approve or disapprove the local plan and budget information for the establishment and operation of each community mental health program. Subsequent amendments to or modifications of an approved plan or budget information involving more than 10 percent of the state funds provided for services under ORS 430.630 may not be placed in effect without prior approval of the authority. However, an amendment or modification affecting 10 percent or less of state funds for services under ORS 430.630 within the portion of the program for persons with mental [*or emotional disturbances*] **health disorders** or within the portion for persons with [*alcohol or drug dependence*] **substance use disorders** may be made without authority approval.

(g) Make all necessary and proper rules to govern the establishment and operation of community mental health programs, including adopting rules defining the range and nature of the services which shall or may be provided under ORS 430.630.

(h) Collect data and evaluate services in the state hospitals [*in accordance with the same methods prescribed for community mental health programs under ORS 430.634*].

(i) Develop guidelines that include, for the development of comprehensive local plans in consultation with local mental health authorities:

(A) The use of integrated services;

(B) The outcomes expected from services and programs provided;

(C) Incentives to reduce the use of state hospitals;

(D) Mechanisms for local sharing of risk **and savings** for state hospitalization;

(E) The provision of clinically appropriate levels of care based on an assessment of the mental health **and substance use disorder** needs of consumers;

(F) The transition of consumers between levels of care; and

(G) The development, maintenance and continuation of older adult mental health **and substance use disorder** programs with mental health **and substance use disorder** professionals trained in geriatrics.

(j) Work with local mental health authorities to provide incentives for community-based care whenever appropriate while simultaneously ensuring adequate statewide capacity.

(k) Provide technical assistance and information regarding state and federal requirements to local mental health authorities throughout the local planning process required under ORS 430.630 (9).

(L) Provide incentives for local mental health authorities to enhance or increase vocational placements for adults with mental health **or substance use disorder** needs.

(m) Develop or adopt nationally recognized system-level performance measures[*, linked to the Oregon Benchmarks,*] for state-level monitoring and reporting of mental health services for children, adults and older adults, including but not limited to quality and appropriateness of services, outcomes from services, structure and management of local plans, prevention of mental health disorders and integration of mental health services with other needed supports.

(n) Develop standardized criteria for each level of care described in ORS 430.630 (9), including protocols for implementation of local plans, strength-based mental health assessment and case planning.

(o) Develop a comprehensive long-term plan for providing appropriate and adequate mental health treatment and services to children, adults and older adults that is derived from the needs identified in local plans, is consistent with the vision, values and guiding principles in the Report to the Governor from the Mental Health Alignment Workgroup, January 2001, and addresses the need for and the role of state hospitals.

(p) Report biennially to the Governor and the Legislative Assembly on the progress of the local planning process and the implementation of the local plans adopted under ORS 430.630 (9)(b) and the state planning process described in paragraph (o) of this subsection, and on the performance measures and performance data available under paragraph (m) of this subsection.

(q) On a periodic basis, not to exceed 10 years, reevaluate the methodology used to estimate prevalence and demand for mental health services using the most current nationally recognized models and data.

(r) Encourage the development of regional local mental health authorities comprised of two or more boards of county commissioners that establish or operate a community mental health program.

(2) The Oregon Health Authority may provide technical assistance and other incentives to assist in the planning, development and implementation of regional local mental health authorities whenever the Oregon Health Authority determines that a regional approach will optimize the comprehensive local plan described under ORS 430.630 (9).

(3) The enumeration of duties and functions in subsections (1) and (2) of this section shall not be deemed exclusive nor construed as a limitation on the powers and authority vested in the authority by other provisions of law.

SECTION 12. ORS 430.644 is amended to read:

430.644. Within the limits of available funds, community mental health programs shall provide those services as defined in ORS 430.630 (3)(a) to (h) to persons in the following order of priority:

(1) Those persons who, in accordance with the assessment of professionals in the field of mental health, are at immediate risk of hospitalization for the treatment of mental [*or emotional disturbances*] **health disorders** or are in need of continuing services to avoid hospitalization or pose a hazard to the health and safety of themselves, including the potential for suicide, or others and those persons under 18 years of age who, in accordance with the assessment of professionals in the field of mental health, are at immediate risk of removal from their homes for treatment of mental [*or emotional disturbances*] **health conditions** or exhibit behavior indicating high risk of developing [*disturbances*] **conditions** of a severe or persistent nature;

(2) Those persons who, because of the nature of their mental illness, their geographic location or their family income, are least capable of obtaining assistance from the private sector; and

(3) Those persons who, in accordance with the assessment of professionals in the field of mental health, are experiencing mental [*or emotional disturbances*] **health disorders** but will not require hospitalization in the foreseeable future.

SECTION 13. ORS 430.695 is amended to read:

430.695. (1) Any program fees, third-party reimbursements, contributions or funds from any source, except client resources applied toward the cost of care in group homes for persons with developmental disabilities or mental illness and client resources and third-party payments for community psychiatric inpatient care, received by a community mental health program or a community developmental disabilities program are not an offset to the costs of the services and may not be applied to reduce the program's eligibility for state funds, providing the funds are expended for mental health or developmental disabilities services approved by the Oregon Health Authority or the Department of Human Services.

(2) Within the limits of available funds, the authority and the department may contract for specialized, statewide and regional services including but not limited to group homes for persons with **intellectual or** developmental disabilities or mental [*or emotional disturbances*] **health or substance use disorders**, day and residential treatment programs for children and adolescents with mental [*or emotional disturbances*] **health or substance use conditions** and community services for clients of the Psychiatric Security Review Board under ORS 161.315 to 161.351.

(3) Fees and third-party reimbursements, including all amounts paid pursuant to Title XIX of the Social Security Act by the Department of Human Services or the Oregon Health Authority, for mental health services or developmental disabilities services and interest earned on those fees and reimbursements shall be retained by the community mental health program or community developmental disabilities program and expended for any service that meets the standards of ORS 430.630 or 430.662.

SECTION 14. ORS 430.705 is amended to read:

430.705. Notwithstanding ORS 430.640, the State of Oregon, through the Oregon Health Authority, may establish the necessary facilities and provide comprehensive mental health services for children throughout the state. These services may include, but need not be limited to:

(1) The prevention of [*mental illness, emotional disturbances and drug dependency*] **mental health or substance use conditions** in children; and

(2) The treatment of children with mental [*illness, emotional disturbances and drug dependency*] **health or substance use conditions**.

SECTION 15. ORS 430.709 is amended to read:

430.709. (1) In accordance with ORS 430.357, and consistent with the budget priority policies adopted by the Alcohol and Drug Policy Commission, the Oregon Health Authority may fund regional centers for the treatment of adolescents with [*drug and alcohol dependencies*] **a substance use condition**.

(2) The authority shall define by rule a minimum number of inpatient beds and outpatient slots necessary for effective treatment and economic operation of any regional center funded by state funds.

(3) The areas to be served by any treatment facility shall be determined by the following:

(a) Areas that demonstrate the most need;

(b) Areas with no treatment program or an inadequate program; and

(c) Areas where there is strong, organized community support for youth treatment programs.

(4) The area need is determined by the local planning committee for [*alcohol and drug*] **substance use** prevention and treatment services under ORS 430.342 using the following information:

(a) Current area youth admissions to treatment programs;

(b) Per capita consumption of alcohol in the area;

(c) Percentage of area population between 10 and 18 years of age;

(d) Whether the area has effective, specialized outpatient and early intervention services in place;

(e) Whether the area suffers high unemployment and economic depression; and

(f) Other evidence of need.

(5) As used in this section, "regional center" means a community residential treatment facility including intensive residential and outpatient care for adolescents with [*drug and alcohol dependencies*] **a substance use condition**.

SECTION 16. ORS 430.905 is amended to read:

430.905. The Legislative Assembly declares:

[*(1) Because the growing numbers of pregnant substance users and drug- and alcohol-affected infants place a heavy financial burden on Oregon's taxpayers and those who pay for health care, it is the policy of this state to take effective action that will minimize these costs.*]

[*(2)*] **(1)** Special attention must be focused on preventive programs and services directed at women at risk of becoming pregnant [*substance users*] **individuals with substance use disorders** as well as on pregnant women who use substances or who are at risk of substance use [*or abuse*] **disorders**.

[*(3)*] **(2)** It is the policy of this state to achieve desired results such as alcohol- and drug-free pregnant women and healthy infants through a holistic approach covering the following categories of needs:

(a) Biological-physical need, including but not limited to [*detoxification*] **withdrawal management**, dietary and obstetrical.

(b) Psychological need, including but not limited to support[,] **and** treatment for [*anxiety, depression and low self-esteem*] **mental health conditions**.

(c) Instrumental need, including but not limited to child care, transportation to facilitate the receipt of services and housing.

(d) Informational and educational needs, including but not limited to prenatal and postpartum health, substance use and parenting.

SECTION 17. ORS 430.380 is amended to read:

430.380. (1) There is established in the General Fund of the State Treasury an account to be known as the Mental Health [*Alcoholism and Drug Services*] **and Substance Use** Account. Moneys deposited in the account are continuously appropriated for the purposes of ORS 430.345 to 430.380 and to provide funding for sobering facilities registered under ORS 430.262. Moneys deposited in the account may be invested in the manner prescribed in ORS 293.701 to 293.857.

(2) Forty percent of the moneys in the Mental Health [*Alcoholism and Drug Services*] **and Substance Use** Account shall be continuously appropriated to the counties on the basis of population. The counties must use the moneys for the establishment, operation and maintenance of [*alcohol and drug abuse*] **substance use** prevention, early intervention and treatment services and for local matching funds under ORS 430.345 to 430.380. The counties may use up to 10 percent of the moneys appropriated under this subsection to provide funds for sobering facilities registered under ORS 430.262.

(3) Forty percent of the moneys shall be continuously appropriated to the Oregon Health Authority to be used for state matching funds to counties for [*alcohol and drug abuse*] **substance use** prevention, early intervention and treatment services pursuant to ORS 430.345 to 430.380. The authority may use up to 10 percent of the moneys appropriated under this subsection for matching funds to counties for sobering facilities registered under ORS 430.262.

(4) Twenty percent of the moneys shall be continuously appropriated to the Oregon Health Authority to be used for [*alcohol and drug abuse*] **substance use** prevention, early intervention and treatment services for adults in custody of correctional and penal institutions and for parolees therefrom and for probationers as provided pursuant to rules of the authority. However, prior to expenditure of moneys under this subsection, the authority must present its program plans for approval to the appropriate legislative body which is either the Joint Ways and Means Committee during a session of the Legislative Assembly or the Emergency Board during the interim between sessions.

(5) Counties and state agencies:

(a) May not use moneys appropriated to counties and state agencies under subsections (1) to (4) of this section for [*alcohol and drug*] **substance use** prevention and treatment services that do not meet or exceed minimum standards established under ORS 430.357; and

(b) Shall include in all grants and contracts with providers of [*alcohol and drug*] **substance use** prevention and treatment services a contract provision that the grant or contract may be terminated by the county or state agency if the provider does not meet or exceed the minimum standards adopted by the Oregon Health Authority pursuant to ORS 430.357. A county or state agency may not be penalized and is not liable for the termination of a contract under this section.

SECTION 18. ORS 430.366 is amended to read:

430.366. (1) Every proposal for [*alcohol and drug abuse*] **substance use** prevention, early intervention and treatment services received from an applicant shall contain:

(a) A clear statement of the goals and objectives of the program for the following fiscal year, including the number of persons to be served and methods of measuring the success of services rendered;

(b) A description of services to be funded; and

(c) A statement of the minorities to be served, if a minority program.

(2) Each grant recipient and provider of [*alcohol and drug abuse*] **substance use** prevention, early intervention and treatment services funded with moneys from the Mental Health [*Alcoholism and Drug Services*] **and Substance Use** Account established by ORS 430.380 shall report to the Alcohol and Drug Policy Commission all data regarding the services in the form and manner prescribed by the commission. This subsection does not apply to sobering facilities that receive moneys under ORS 430.380.

SECTION 19. ORS 471.810 is amended to read:

471.810. (1) At the end of each month, the Oregon Liquor and Cannabis Commission shall certify the amount of moneys available for distribution in the Oregon Liquor and Cannabis Commission Account and, after withholding such moneys as it may deem necessary to pay its outstanding obligations, shall within 35 days of the month for which a distribution is made direct the State Treasurer to pay the amounts due, upon warrants drawn by the Oregon Department of Administrative Services, as follows:

(a) Fifty-six percent, or the amount remaining after the distribution under subsection (4) of this section, credited to the General Fund available for general governmental purposes wherein it shall be considered as revenue during the quarter immediately preceding receipt;

(b) Twenty percent to the cities of the state in such shares as the population of each city bears to the population of the cities of the state, as determined by Portland State University last preceding such apportionment, under ORS 190.510 to 190.610;

(c) Ten percent to counties in such shares as their respective populations bear to the total population of the state, as estimated from time to time by Portland State University; and

(d) Fourteen percent to the cities of the state to be distributed as provided in ORS 221.770 and this section.

(2) The commission shall direct the Oregon Department of Administrative Services to transfer 50 percent of the revenues from the taxes imposed by ORS 473.030 and 473.035 to the Mental Health [*Alcoholism and Drug Services*] **and Substance Use** Account in the General Fund to be paid monthly as provided in ORS 430.380.

(3) If the amount of revenues received from the taxes imposed by ORS 473.030 for the preceding month was reduced as a result of credits claimed under ORS 473.047, the commission shall compute the difference between the amounts paid or transferred as described in subsections (1)(b), (c) and (d) and (2) of this section and the amounts that would have been paid or transferred under subsections (1)(b), (c) and (d) and (2) of this section if no credits had been claimed. The commission shall direct the Oregon Department of Administrative Services to pay or transfer amounts equal to the differences computed for subsections (1)(b), (c) and (d) and (2) of this section from the General Fund to the recipients or accounts described in subsections (1)(b), (c) and (d) and (2) of this section.

(4) Notwithstanding subsection (1) of this section, no city or county shall receive for any fiscal year an amount less than the amount distributed to the city or county in accordance with ORS 471.350 (1965 Replacement Part), 473.190 and 473.210 (1965 Replacement Part) and this section during the 1966-1967 fiscal year unless the city or county had a decline in population as shown by its census. If the population declined, the per capita distribution to the city or county shall be not less than the total per capita distribution during the 1966-1967 fiscal year. Any additional funds required to maintain the level of distribution under this subsection shall be paid from funds credited under subsection (1)(a) of this section.

(5) Notwithstanding subsection (1) of this section, amounts to be distributed from the Oregon Liquor and Cannabis Commission Account that are attributable to a per bottle surcharge imposed by the Oregon Liquor and Cannabis Commission, shall be credited to the General Fund.

SECTION 20. ORS 430.560 is amended to read:

430.560. (1) The Oregon Health Authority shall adopt rules to establish requirements, in accordance with ORS 430.357, for drug treatment programs that contract with the authority and that involve:

(a) [*Detoxification*] **Withdrawal management**; **and**

(b) [*Detoxification*] **Withdrawal management** with acupuncture and counseling[*; and*]

[*(c) The supplying of synthetic opiates to such persons under close supervision and control. However, the supplying of synthetic opiates shall be used only when detoxification or detoxification with acupuncture and counseling has proven ineffective or upon a written request of a physician licensed by the Oregon Medical Board or a naturopathic physician licensed by the Oregon Board of Naturopathic Medicine showing medical need for synthetic opiates. A copy of the request must be included in the client's permanent treatment and releasing authority records*].

(2) [*Notwithstanding subsection (1) of this section, synthetic opiates*] **Medication for opioid use** may be made available to a pregnant woman with her informed consent without prior resort to the treatment programs described in subsection (1)[*(a) and (b)*] of this section.

SECTION 21. ORS 430.342 is amended to read:

430.342. (1) The governing body of each county or combination of counties in a mental health administrative area, as designated by the Alcohol and Drug Policy Commission, shall:

(a) Appoint a local planning committee for [*alcohol and drug*] **substance use** prevention and treatment services; or

(b) Designate an already existing body to act as the local planning committee for [*alcohol and drug*] **substance use** prevention and treatment services.

(2) The committee shall coordinate with local Behavioral Health Resource Networks, described in ORS 430.389, to identify needs and establish priorities for [*alcohol and drug*] **substance use** prevention and treatment services that best suit the needs and values of the community and shall report its findings to the Oregon Health Authority, the governing bodies of the counties served by the committee and the budget advisory committee of the commission.

(3) Members of the local planning committee shall be representative of the geographic area and shall be persons with interest or experience in developing [*alcohol and drug*] **substance use** prevention and treatment services. The membership of the committee shall include a number of minority members which reasonably reflects the proportion of the need for prevention, treatment and rehabilitation services of minorities in the community.

SECTION 22. ORS 430.345 is amended to read:

430.345. Upon application therefor, the Oregon Health Authority may make grants from funds specifically appropriated for the purposes of carrying out ORS 430.338 to 430.380 to any applicant for the establishment, operation and maintenance of alcohol and drug abuse prevention, early intervention and treatment services. When necessary, a portion of the appropriated funds may be designated by the authority for training and technical assistance, or additional funds may be appropriated for this purpose. Alcohol and drug abuse prevention, early intervention and treatment services shall be approved if the applicant establishes to the satisfaction of the authority:

(1)(a) The adequacy of the services to accomplish the goals of the applicant and the needs and priorities established under ORS 430.338 to 430.380; or

(b) The community need for the services as determined by the local planning committee for [*alcohol and drug*] **substance use** prevention and treatment services under ORS 430.342;

(2) That an appropriate operating agreement exists, or will exist with other community facilities able to assist in providing alcohol and drug abuse prevention, early intervention and treatment services, including nearby detoxification centers and halfway houses; and

(3) That the services comply with the rules adopted by the authority pursuant to ORS 430.357.

SECTION 23. ORS 430.350 is amended to read:

430.350. (1) Every applicant for a grant made under ORS 430.345 to 430.380 shall be assisted in the preparation and development of [*alcohol and drug abuse*] **substance use** prevention, early intervention and treatment services by the local planning committee operating in the area to which the application relates. Every application shall establish to the satisfaction of the Oregon Health Authority that the committee was actively involved in the development and preparation of such program.

(2) The authority shall require of every applicant for a grant made under ORS 430.345 to 430.380 the recommendation of the local planning committee in the area to which the application relates. The authority shall take such recommendation into consideration before making or refusing grants under ORS 430.345 to 430.380.

SECTION 24. ORS 430.359 is amended to read:

430.359. (1) Upon approval of an application, the Oregon Health Authority shall enter into a matching fund relationship with the applicant. In all cases the amount granted by the authority under the matching formula shall not exceed 50 percent of the total estimated costs, as approved by the authority, of the alcohol and drug abuse prevention, early intervention and treatment services.

(2) The authority shall distribute funds to applicants consistent with the budget priority policies adopted by the Alcohol and Drug Policy Commission, the community needs as determined by local planning committees for [*alcohol and drug*] **substance use** prevention and treatment services under ORS 430.342 and the particular needs of minority groups with a significant population of affected persons. The funds granted shall be distributed monthly.

(3) Federal funds at the disposal of an applicant for use in providing alcohol and drug abuse prevention, early intervention and treatment services may be counted toward the percentage contribution of an applicant.

(4) An applicant that is, at the time of a grant made under this section, expending funds appropriated by its governing body for the alcohol and drug abuse prevention, early intervention and treatment services shall, as a condition to the receipt of funds under this section, maintain its financial contribution to these programs at an amount not less than the preceding year. However, the financial contribution requirement may be waived in its entirety or in part in any year by the authority because of:

(a) The severe financial hardship that would be imposed to maintain the contribution in full or in part;

(b) The application of any special funds for the alcohol and drug abuse prevention, early intervention and treatment services in the prior year when such funds are not available in the current year;

(c) The application of federal funds, including but not limited to general revenue sharing, distributions from the Oregon and California land grant fund and block grant funds to the alcohol and drug abuse prevention, early intervention and treatment services in the prior year when such funds are not available for such application in the current year; or

(d) The application of fund balances resulting from fees, donations or underexpenditures in a given year of the funds appropriated to counties pursuant to ORS 430.380 to the alcohol and drug abuse prevention, early intervention and treatment services in the prior year when such funds are not available for such application in the current year.

(5) Any moneys received by an applicant from fees, contributions or other sources for alcohol and drug abuse prevention, early intervention and treatment services for service purposes, including federal funds, shall be considered a portion of an applicant's contribution for the purpose of determining the matching fund formula relationship. All moneys so received shall only be used for the purposes of carrying out ORS 430.345 to 430.380.

(6) Grants made pursuant to ORS 430.345 to 430.380 shall be paid from funds specifically appropriated therefor and shall be paid in the same manner as other claims against the state are paid.

SECTION 25. ORS 430.362 is amended to read:

430.362. (1) To receive priority consideration under ORS 430.359 (2), an applicant shall clearly set forth in its application:

(a) The number of minorities within the county with significant populations of affected persons and an estimate of the nature and extent of the need within each minority population for [*alcohol and drug abuse*] **substance use** prevention, early intervention and treatment services; and

(b) The manner in which the need within each minority population is to be addressed, including support for minority programs under the application.

(2) Minority program funding proposals included within an application must be clearly identified as minority programs and must include distinct or severable budget statements.

(3) Nothing in this section is intended to preclude any minority program from being funded by a city or county or to preclude any other program from serving the needs of minorities.

SECTION 26. ORS 430.364 is amended to read:

430.364. Within the limits of available funds, in giving priority consideration under ORS 430.359 (2), the Oregon Health Authority shall:

(1) Identify all applications containing funding proposals for minority programs and assess the extent to which such funding proposals address the needs of minorities as stated in ORS 430.362, adjusting such amounts as it deems justified on the basis of the facts presented for its consideration and such additional information as may be necessary to determine an appropriate level of funding for such programs, and award such funds to those applicants for the purposes stated in the application; and

(2) After making a determination of the appropriate level of funding minority programs under subsection (1) of this section, assess the remaining portions of all applications containing minority program funding proposals together with applications which do not contain funding proposals for minority programs on the basis of the remaining community need determined by the local planning committee for [*alcohol and drug*] **substance use** prevention and treatment services under ORS 430.342, adjusting such amounts as it deems justified on the basis of the facts presented for its consideration and such additional information as may be necessary to determine an appropriate level of funding such programs, and award such funds to those applicants.

SECTION 27. ORS 430.381 is amended to read:

430.381. Nothing in ORS 430.347, 430.359, 430.380, 471.805, 471.810, 473.030 or this section shall be construed as justification for a reduction in General Fund support of local [*alcohol and drug abuse*] **substance use** prevention, early intervention and treatment services.

SECTION 28. ORS 430.256 is amended to read:

430.256. (1) The Director of the Oregon Health Authority shall administer [*alcohol and drug abuse*] **substance use** programs, including but not limited to programs or components of programs described in ORS 430.397 to 430.401 and 475.225 and ORS chapters 430 and [*801 to 822*] **813**.

(2) Subject to ORS 417.300 and 417.305, the director shall:

(a) Report to the Alcohol and Drug Policy Commission on accomplishments and issues occurring during each biennium, and report on a new biennial plan describing resources, needs and priorities for all [*alcohol and drug abuse*] **substance use** programs.

(b) Develop within the Oregon Health Authority priorities for [*alcohol and drug abuse*] **substance use** programs and activities.

(c) Conduct statewide and special planning processes that provide for participation from state and local agencies, groups and individuals.

(d) Identify the needs of special populations including minorities, elderly, youth, women and individuals with disabilities.

(e) Subject to ORS chapter 183, adopt such rules as are necessary for the performance of the duties and functions specified by this section.

(3) The director may apply for, receive and administer funds, including federal funds and grants, from sources other than the state. Subject to expenditure limitation set by the Legislative Assembly, funds received under this subsection may be expended by the director:

(a) For the study, prevention or treatment of [*alcohol and drug abuse and dependence*] **substance use disorders** in this state.

(b) To provide training, both within this state and in other states, in the prevention and treatment of [*alcohol and drug abuse and dependence*] **substance use disorders**.

(4) The director shall, in consultation with state agencies and counties, establish guidelines to coordinate program review and audit activities by state agencies and counties that provide funds to [*alcohol and drug*] **substance use** prevention and treatment programs. The purpose of the guidelines is to minimize duplication of auditing and program review requirements imposed by state agencies and counties on [*alcohol and drug*] **substance use** prevention and treatment programs that receive state funds, including programs that receive beer and wine tax revenues under ORS 430.380 and 471.810.

SECTION 29. ORS 675.523 is amended to read:

675.523. A person may not practice clinical social work unless the person is a clinical social worker licensed under ORS 675.530 or a clinical social work associate certified under ORS 675.537, except if the person is:

(1) Licensed or certified by the State of Oregon to provide mental health services, provided that the person is acting within the lawful scope of practice for the person's license or certification and does not represent that the person is a regulated social worker;

(2) Certified to provide [*alcohol and drug abuse*] **substance use disorder** prevention services, intervention services and treatment in compliance with rules adopted under ORS 430.256 and 430.357, provided that the person is acting within the lawful scope of practice for the person's certification and does not represent that the person is a regulated social worker;

(3) Employed by or contracting with an entity that is certified or licensed by the State of Oregon under ORS 430.610 to 430.695 to provide mental health treatment or addiction services, provided that the person is practicing within the lawful scope of the person's employment or contract;

(4) A recognized member of the clergy, provided that the person is acting in the person's ministerial capacity and does not represent that the person is a regulated social worker; or

(5) A student in a social work graduate degree program that meets the requirements established by the State Board of Licensed Social Workers by rule.

SECTION 30. ORS 430.315, 430.368, 430.565 and 430.634 are repealed.

SECTION 31. ORS 430.306 is amended to read:

430.306. As used in ORS 430.262, [*430.315,*] 430.335, 430.342, 430.397, 430.399, 430.401, 430.402, 430.420 and 430.630, unless the context requires otherwise:

[*(1) "Alcoholic" means any person who has lost the ability to control the use of alcoholic beverages, or who uses alcoholic beverages to the extent that the health of the person or that of others is substantially impaired or endangered or the social or economic function of the person is substantially*

disrupted. An alcoholic may be physically dependent, a condition in which the body requires a continuing supply of alcohol to avoid characteristic withdrawal symptoms, or psychologically dependent, a condition characterized by an overwhelming mental desire for continued use of alcoholic beverages.]

(1) "Alcohol use disorder" means a chronic condition, varying from mild to severe, in which a person:

(a) Has an impaired ability to stop or control the drinking of alcohol despite negative social, health or occupational impacts; and

(b) May experience cravings, withdrawal or continued alcohol use despite harmful consequences.

(2) "Detoxification center" means a publicly or privately operated profit or nonprofit facility approved by the Oregon Health Authority that provides emergency care or treatment for [*alcoholics or drug-dependent persons*] **persons with substance use disorders**.

(3) "Director of the treatment facility" means the person in charge of treatment and rehabilitation programs at a treatment facility.

[*(4) "Drug-dependent person" means one who has lost the ability to control the personal use of controlled substances or other substances with abuse potential, or who uses such substances or controlled substances to the extent that the health of the person or that of others is substantially impaired or endangered or the social or economic function of the person is substantially disrupted. A drug-dependent person may be physically dependent, a condition in which the body requires a continuing supply of a drug or controlled substance to avoid characteristic withdrawal symptoms, or psychologically dependent, a condition characterized by an overwhelming mental desire for continued use of a drug or controlled substance.*]

[*(5)*] **(4)** "Halfway house" means a publicly or privately operated profit or nonprofit, residential facility approved by the authority that provides rehabilitative care and treatment for [*alcoholics or drug-dependent persons*] **persons with substance use disorders**.

[*(6)*] **(5)** "Local planning committee" means a local planning committee for [*alcohol and drug*] **substance use** prevention and treatment services appointed or designated by the county governing body under ORS 430.342.

[*(7)*] **(6)** "Police officer" means a member of a law enforcement unit who is employed on a part-time or full-time basis as a peace officer, commissioned by a city, a county or the Department of State Police and responsible for enforcing the criminal laws of this state and any person formally deputized by the law enforcement unit to take custody of a person who is intoxicated or under the influence of controlled substances.

[*(8)*] **(7)** "Sobering facility" means a facility that meets all of the following criteria:

(a) The facility operates for the purpose of providing to individuals who are acutely intoxicated a safe, clean and supervised environment until the individuals are no longer acutely intoxicated.

(b) The facility contracts with or is affiliated with a treatment program or a provider approved by the authority to provide [*addiction*] **substance use disorder** treatment, and the contract or affiliation agreement includes, but is not limited to, case consultation, training and advice and a plan for making referrals to [*addiction*] **substance use disorder** treatment.

(c) The facility, in consultation with the [*addiction*] **substance use disorder** treatment program or provider, has adopted comprehensive written policies and procedures incorporating best practices for the safety of intoxicated individuals, employees of the facility and volunteers at the facility.

(d) The facility is registered with the Oregon Health Authority under ORS 430.262.

(8) "Substance use disorder" means a chronic condition in which:

(a) Drug or alcohol use leads to significant impairment;

(b) Drug or alcohol use continues despite harmful consequences; and

(c) A person may experience intense cravings, an inability to reduce use of a substance or physical withdrawal and may spend significant time obtaining a substance or neglecting important activities.

(9) "Treatment facility" includes outpatient facilities, inpatient facilities and other facilities the authority determines suitable and that provide services that meet minimum standards established

under ORS 430.357, any of which may provide diagnosis and evaluation, medical care, [*detoxification*] **withdrawal management**, social services or [*rehabilitation for alcoholics or drug-dependent persons*] **treatment for persons with substance use disorders,** and which operate in the form of a general hospital, a state hospital, a foster home, a hostel, a clinic or other suitable form approved by the authority.

SECTION 32. ORS 430.401 is amended to read:

430.401. A police officer, person acting under the authority of a mobile crisis intervention team as defined in ORS 430.626, physician, naturopathic physician, physician associate, nurse practitioner, judge, treatment facility, treatment facility staff member or sobering facility, or the staff of the sobering facility, may not be held criminally or civilly liable for actions pursuant to ORS [*430.315,*] 430.335, 430.397 to 430.401 and 430.402 provided the actions are in good faith, on probable cause and without malice.

SECTION 33. ORS 137.227 is amended to read:

137.227. (1) After a defendant has been convicted of a crime, the court may cause the defendant to be evaluated to determine if the defendant is [*an alcoholic or a drug-dependent person*] **a person with an alcohol use disorder or substance use disorder**, as those terms are defined in ORS 430.306. The evaluation shall be conducted by an agency or organization designated under subsection (2) of this section.

(2) The court shall designate agencies or organizations to perform the evaluations required under subsection (1) of this section. The designated agencies or organizations must meet the standards set by the Oregon Health Authority to perform the evaluations for [*drug dependency*] **substance use disorders** and must be approved by the authority. Wherever possible, a court shall designate agencies or organizations to perform the evaluations that are separate from those that may be designated to carry out a program of treatment for [*alcohol or drug dependency*] **alcohol use disorder or substance use disorder**.

SECTION 34. ORS 137.228 is amended to read:

137.228. (1) When a defendant is sentenced for a crime, the court may enter a finding that the defendant is [*an alcoholic or a drug-dependent person*] **a person with an alcohol use disorder or substance use disorder**, as those terms are defined in ORS 430.306. The finding may be based upon any evidence before the court, including, but not limited to, the facts of the case, stipulations of the parties and the results of any evaluation conducted under ORS 137.227.

(2) When the court finds that the defendant is [*an alcoholic or a drug-dependent person*] **a person with an alcohol use disorder or substance use disorder**, the court, when it sentences the defendant to a term of imprisonment, shall direct the Department of Corrections to place the defendant in an appropriate alcohol or drug treatment program, to the extent that resources are available. The alcohol or drug treatment program shall meet the standards promulgated by the Oregon Health Authority pursuant to ORS 430.357.

SECTION 35. ORS 414.025 is amended to read:

414.025. As used in this chapter and ORS chapters 411 and 413, unless the context or a specially applicable statutory definition requires otherwise:

(1)(a) "Alternative payment methodology" means a payment other than a fee-for-services payment, used by coordinated care organizations as compensation for the provision of integrated and coordinated health care and services.

(b) "Alternative payment methodology" includes, but is not limited to:

(A) Shared savings arrangements;

(B) Bundled payments; and

(C) Payments based on episodes.

(2) "Behavioral health assessment" means an evaluation by a behavioral health clinician, in person or using telemedicine, to determine a patient's need for immediate crisis stabilization.

(3) "Behavioral health clinician" means:

(a) A licensed psychiatrist;

(b) A licensed psychologist;

(c) A licensed nurse practitioner with a specialty in psychiatric mental health;

(d) A licensed clinical social worker;

(e) A licensed professional counselor or licensed marriage and family therapist;

[*(f) A certified clinical social work associate;*]

[*(g)*] **(f)** An intern**, associate** or resident who is working under a board-approved supervisory contract in a clinical mental health field; or

[*(h)*] **(g)** Any other clinician **who is credentialed by the state and** whose authorized scope of practice includes mental health diagnosis and treatment.

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

(5) "Behavioral health home" means a mental health disorder or substance use disorder treatment organization, as defined by the Oregon Health Authority by rule, that provides integrated health care to individuals whose primary diagnoses are mental health disorders or substance use disorders.

(6) "Category of aid" means assistance provided by the Oregon Supplemental Income Program, aid granted under ORS 411.877 to 411.896 and 412.001 to 412.069 or federal Supplemental Security Income payments.

(7) "Community health worker" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who:

(a) Has expertise or experience in public health;

(b) Works in an urban or rural community, either for pay or as a volunteer in association with a local health care system;

(c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community the worker serves;

(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Provides health education and information that is culturally appropriate to the individuals being served;

(f) Assists community residents in receiving the care they need;

(g) May give peer counseling and guidance on health behaviors; and

(h) May provide direct services such as first aid or blood pressure screening.

(8) "Coordinated care organization" means an organization meeting criteria adopted by the Oregon Health Authority under ORS 414.572.

(9) "Dental subcontractor" means a prepaid managed care health services organization that enters into a noncomprehensive risk contract with a coordinated care organization or the Oregon Health Authority to provide dental services to medical assistance recipients.

(10) "Doula" means a trained professional who provides continuous physical, emotional and informational support to an individual during pregnancy, labor and delivery or the postpartum period to help the individual achieve the healthiest and most satisfying experience possible.

(11) "Dually eligible for Medicare and Medicaid" means, with respect to eligibility for enrollment in a coordinated care organization, that an individual is eligible for health services funded by Title XIX of the Social Security Act and is:

(a) Eligible for or enrolled in Part A of Title XVIII of the Social Security Act; or

(b) Enrolled in Part B of Title XVIII of the Social Security Act.

(12)(a) "Family support specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who provides supportive services to and has experience parenting a child who:

(A) Is a current or former consumer of mental health or addiction treatment; or

(B) Is facing or has faced difficulties in accessing education, health and wellness services due to a mental health or behavioral health barrier.

(b) A "family support specialist" may be a peer wellness specialist or a peer support specialist.

(13) "Global budget" means a total amount established prospectively by the Oregon Health Authority to be paid to a coordinated care organization for the delivery of, management of, access to and quality of the health care delivered to members of the coordinated care organization.

(14) "Health insurance exchange" or "exchange" means an American Health Benefit Exchange described in 42 U.S.C. 18031, 18032, 18033 and 18041.

(15) "Health services" means at least so much of each of the following as are funded by the Legislative Assembly based upon the prioritized list of health services compiled by the Health Evidence Review Commission under ORS 414.690:

(a) Services required by federal law to be included in the state's medical assistance program in order for the program to qualify for federal funds;

(b) Services provided by a physician as defined in ORS 677.010, a nurse practitioner licensed under ORS 678.375, a behavioral health clinician or other licensed practitioner within the scope of the practitioner's practice as defined by state law, and ambulance services;

(c) Prescription drugs;

(d) Laboratory and X-ray services;

(e) Medical equipment and supplies;

(f) Mental health services;

(g) Chemical dependency services;

(h) Emergency dental services;

(i) Nonemergency dental services;

(j) Provider services, other than services described in paragraphs (a) to (i), (k), (L) and (m) of this subsection, defined by federal law that may be included in the state's medical assistance program;

(k) Emergency hospital services;

(L) Outpatient hospital services; and

(m) Inpatient hospital services.

(16) "Income" has the meaning given that term in ORS 411.704.

(17)(a) "Integrated health care" means care provided to individuals and their families in a patient centered primary care home or behavioral health home by licensed primary care clinicians, behavioral health clinicians and other care team members, working together to address one or more of the following:

(A) Mental illness.

(B) Substance use disorders.

(C) Health behaviors that contribute to chronic illness.

(D) Life stressors and crises.

(E) Developmental risks and conditions.

(F) Stress-related physical symptoms.

(G) Preventive care.

(H) Ineffective patterns of health care utilization.

(b) As used in this subsection, "other care team members" includes but is not limited to:

(A) Qualified mental health professionals or qualified mental health associates meeting requirements adopted by the Oregon Health Authority by rule;

(B) Peer wellness specialists;

(C) Peer support specialists;

(D) Community health workers who have completed a state-certified training program;

(E) Personal health navigators; or

(F) Other qualified individuals approved by the Oregon Health Authority.

(18) "Investments and savings" means cash, securities as defined in ORS 59.015, negotiable instruments as defined in ORS 73.0104 and such similar investments or savings as the department or the authority may establish by rule that are available to the applicant or recipient to contribute toward meeting the needs of the applicant or recipient.

(19) "Medical assistance" means so much of the medical, mental health, preventive, supportive, palliative and remedial care and services as may be prescribed by the authority according to the standards established pursuant to ORS 414.065, including premium assistance under ORS 414.115 and 414.117, payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of health services and for services described in ORS 414.710.

(20) "Medical assistance" includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. Except as provided in ORS 411.439 and 411.447, "medical assistance" does not include care or services for a resident of a nonmedical public institution.

(21) "Mental health drug" means a type of legend drug, as defined in ORS 414.325, specified by the Oregon Health Authority by rule, including but not limited to:

(a) Therapeutic class 7 ataractics-tranquilizers; and

(b) Therapeutic class 11 psychostimulants-antidepressants.

(22) "Patient centered primary care home" means a health care team or clinic that is organized in accordance with the standards established by the Oregon Health Authority under ORS 414.655 and that incorporates the following core attributes:

(a) Access to care;

(b) Accountability to consumers and to the community;

(c) Comprehensive whole person care;

(d) Continuity of care;

(e) Coordination and integration of care; and

(f) Person and family centered care.

(23) "Peer support specialist" means any of the following individuals who meet qualification criteria adopted by the authority under ORS 414.665 and who provide supportive services to a current or former consumer of mental health or addiction treatment:

(a) An individual who is a current or former consumer of mental health treatment; or

(b) An individual who is in recovery, as defined by the Oregon Health Authority by rule, from an addiction disorder.

(24) "Peer wellness specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who is responsible for assessing mental health and substance use disorder service and support needs of a member of a coordinated care organization through community outreach, assisting members with access to available services and resources, addressing barriers to services and providing education and information about available resources for individuals with mental health or substance use disorders in order to reduce stigma and discrimination toward consumers of mental health and substance use disorder services and to assist the member in creating and maintaining recovery, health and wellness.

(25) "Person centered care" means care that:

(a) Reflects the individual patient's strengths and preferences;

(b) Reflects the clinical needs of the patient as identified through an individualized assessment; and

(c) Is based upon the patient's goals and will assist the patient in achieving the goals.

(26) "Personal health navigator" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who provides information, assistance, tools and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions and desired outcomes.

(27) "Prepaid managed care health services organization" means a managed dental care, mental health or chemical dependency organization that contracts with the authority under ORS 414.654 or with a coordinated care organization on a prepaid capitated basis to provide health services to medical assistance recipients.

(28) "Quality measure" means the health outcome and quality measures and benchmarks identified by the Health Plan Quality Metrics Committee and the metrics and scoring subcommittee in accordance with ORS 413.017 (4) and 413.022 and the quality metrics developed by the Behavioral Health Committee in accordance with ORS 413.017 (5).

(29)(a) "Quality of life in general measure" means an assessment of the value, effectiveness or cost-effectiveness of a treatment that gives greater value to a year of life lived in perfect health than the value given to a year of life lived in less than perfect health.

(b) "Quality of life in general measure" does not mean an assessment of the value, effectiveness or cost-effectiveness of a treatment during a clinical trial in which a study participant is asked to rate the participant's physical function, pain, general health, vitality, social functions or other similar domains.

(30) "Resources" has the meaning given that term in ORS 411.704. For eligibility purposes, "resources" does not include charitable contributions raised by a community to assist with medical expenses.

(31) "Social determinants of health" means:

(a) Nonmedical factors that influence health outcomes;

(b) The conditions in which individuals are born, grow, work, live and age; and

(c) The forces and systems that shape the conditions of daily life, such as economic policies and systems, development agendas, social norms, social policies, racism, climate change and political systems.

(32) "Tribal traditional health worker" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who:

(a) Has expertise or experience in public health;

(b) Works in a tribal community or an urban Indian community, either for pay or as a volunteer in association with a local health care system;

(c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community the worker serves;

(d) Assists members of the community to improve their health, including physical, behavioral and oral health, and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Provides health education and information that is culturally appropriate to the individuals being served;

(f) Assists community residents in receiving the care they need;

(g) May give peer counseling and guidance on health behaviors; and

(h) May provide direct services, such as tribal-based practices.

(33)(a) "Youth support specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who, based on a similar life experience, provides supportive services to an individual who:

(A) Is not older than 30 years of age; and

(B)(i) Is a current or former consumer of mental health or addiction treatment; or

(ii) Is facing or has faced difficulties in accessing education, health and wellness services due to a mental health or behavioral health barrier.

(b) A "youth support specialist" may be a peer wellness specialist or a peer support specialist.

SECTION 36. ORS 743A.012 is amended to read:

743A.012. (1) As used in this section:

(a) "Behavioral health assessment" means an evaluation by a behavioral health clinician, in person or using telemedicine, to determine a patient's need for immediate crisis stabilization.

(b) "Behavioral health clinician" means:

(A) A licensed psychiatrist;

(B) A licensed psychologist;

(C) A licensed nurse practitioner with a specialty in psychiatric mental health;

(D) A licensed clinical social worker;

(E) A licensed professional counselor or licensed marriage and family therapist;

[*(F) A certified clinical social work associate;*]

[*(G)*] **(F)** An intern**, associate** or resident who is working under a board-approved supervisory contract in a clinical mental health field; or

[*(H)*] **(G)** Any other clinician **who is credentialed by the state and** whose authorized scope of practice includes mental health diagnosis and treatment.

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

(d) "Emergency medical condition" means a medical condition:

(A) That manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would:

(i) Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy;

(ii) Result in serious impairment to bodily functions; or

(iii) Result in serious dysfunction of any bodily organ or part;

(B) With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child; or

(C) That is a behavioral health crisis.

(e) "Emergency medical screening exam" means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

(f) "Emergency medical service provider" has the meaning given that term in ORS 682.025.

(g) "Emergency medical services transport" means an emergency medical services provider's evaluation and stabilization of an individual experiencing a medical emergency and the transportation of the individual to the nearest medical facility capable of meeting the needs of the individual.

(h) "Emergency services" means, with respect to an emergency medical condition:

(A) An emergency medical services transport;

(B) An emergency medical screening exam or behavioral health assessment that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(C) Such further medical examination and treatment as are required under 42 U.S.C. 1395dd to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital.

(i) "Grandfathered health plan" has the meaning given that term in ORS 743B.005.

(j) "Health benefit plan" has the meaning given that term in ORS 743B.005.

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

(L) "Stabilize" means to provide medical treatment as necessary to:

(A) Ensure that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur during or to result from the transfer of the patient to or from a facility; and

(B) With respect to a pregnant woman who is in active labor, to perform the delivery, including the delivery of the placenta.

(2) All insurers offering a health benefit plan shall provide coverage without prior authorization for emergency services.

(3) A health benefit plan, other than a grandfathered health plan, must provide coverage required by subsection (2) of this section:

(a) For the services of participating providers, without regard to any term or condition of coverage other than:

(A) The coordination of benefits;

(B) An affiliation period or waiting period permitted under part 7 of the Employee Retirement Income Security Act, part A of Title XXVII of the Public Health Service Act or chapter 100 of the Internal Revenue Code;

(C) An exclusion other than an exclusion of emergency services; or

(D) Applicable cost-sharing; and

(b) For the services of a nonparticipating provider:

(A) Without imposing any administrative requirement or limitation on coverage that is more restrictive than requirements or limitations that apply to participating providers;

(B) Without imposing a copayment amount or coinsurance rate that exceeds the amount or rate for participating providers;

(C) Without imposing a deductible, unless the deductible applies generally to nonparticipating providers; and

(D) Subject only to an out-of-pocket maximum that applies to all services from nonparticipating providers.

(4) All insurers offering a health benefit plan shall provide information to enrollees in plain language regarding:

(a) What constitutes an emergency medical condition;

(b) The coverage provided for emergency services;

(c) How and where to obtain emergency services; and

(d) The appropriate use of 9-1-1.

(5) An insurer offering a health benefit plan may not discourage appropriate use of 9-1-1 and may not deny coverage for emergency services when 9-1-1 is used.

(6) This section is exempt from ORS 743A.001.

SECTION 37. ORS 414.723 is amended to read:

414.723. (1) As used in this section:

(a)(A) "Audio only" means the use of audio telephone technology, permitting real-time communication between a health care provider and a patient for the purpose of diagnosis, consultation or treatment.

(B) "Audio only" does not include:

(i) The use of facsimile, electronic mail or text messages.

(ii) The delivery of health services that are customarily delivered by audio telephone technology and customarily not billed as separate services by a health care provider, such as the sharing of laboratory results.

(b) "Telemedicine" means the mode of delivering health services using information and telecommunication technologies to provide consultation and education or to facilitate diagnosis, treatment, care management or self-management of a patient's health care.

(2) To encourage the efficient use of resources and to promote cost-effective procedures in accordance with ORS 413.011 (1)(L), the Oregon Health Authority shall reimburse the cost of health services delivered **by the providers described in subsection (3) of this section** using telemedicine, including but not limited to:

(a) Health services transmitted via landlines, wireless communications, the Internet and telephone networks;

(b) Synchronous or asynchronous transmissions using audio only, video only, audio and video and transmission of data from remote monitoring devices; and

(c) Communications between providers or between one or more providers and one or more patients, family members, caregivers or guardians.

(3) The authority shall reimburse the cost of health services delivered using telemedicine by:

(a) A provider who is licensed or certified in this state;

(b) A provider who is unlicensed, practices in this state and is employed by an entity with a certificate of approval issued by the authority;

(c) A community mental health program;

(d) A hospital; or

(e) A federally qualified health center.

[*(3)(a)*] **(4)(a)** The authority shall pay the same reimbursement for a health service regardless of whether the service is provided in person or using any permissible telemedicine application or technology.

(b) Paragraph (a) of this subsection does not prohibit the use of value-based payment methods, including global budgets or capitated, bundled, risk-based or other value-based payment methods, and does not require that any value-based payment method reimburse telemedicine health services based on an equivalent fee-for-service rate.

[*(4)*] **(5)** The authority shall include the costs of telemedicine services in its rate assumptions for payments made to clinics or other providers on a prepaid capitated basis.

[*(5)*] **(6)** This section does not require the authority or a coordinated care organization to pay a provider for a service that is not included within the Healthcare Procedure Coding System or the American Medical Association's Current Procedural Terminology codes.

[*(6)*] **(7)** The authority shall adopt rules to ensure that coordinated care organizations reimburse the cost of health services delivered using telemedicine, consistent with subsections (2) [*and (3)*] **to (4)** of this section.

SECTION 38. ORS 430.637 is amended to read:

430.637. (1) As used in this section:

(a) "Assessment" means an on-site quality assessment of an organizational provider that is conducted:

(A) If the provider has not been accredited by a national organization meeting the quality standards of the Oregon Health Authority;

(B) By the Oregon Health Authority, another state agency or a contractor on behalf of the authority or another state agency; and

(C) For the purpose of issuing a certificate of approval.

(b) "Organizational provider" means an organization that provides mental health **or substance use disorder** treatment [*or chemical dependency treatment and is not a coordinated care organization*] **and that is:**

(A) Located in this state; or

(B) Licensed and located in another state and accepts residents of this state for in-person treatment.

(2) The Oregon Health Authority shall convene a committee, in accordance with ORS 183.333, to advise the authority with respect to the adoption, by rule, of criteria for an assessment. The advisory committee shall advise the authority during the development of the criteria. The advisory committee shall be reconvened as needed to advise the authority with respect to updating the criteria to conform to changes in national accreditation standards or federal requirements for health plans and to advise the authority on opportunities to improve the assessment process. The advisory committee shall include, but is not limited to:

(a) A representative of each coordinated care organization certified by the authority;

(b) Representatives of organizational providers;

(c) Representatives of insurers and health care service contractors that have been accredited by the National Committee for Quality Assurance; and

(d) Representatives of insurers that offer Medicare Advantage Plans that have been accredited by the National Committee for Quality Assurance.

(3) The advisory committee described in subsection (2) of this section shall recommend:

(a) Objective criteria for a shared assessment tool that complies with national accreditation standards and federal requirements for health plans;

(b) Procedures for conducting an assessment;

(c) Procedures to eliminate redundant reporting requirements for organizational providers; and

(d) A process for addressing concerns that arise between assessments regarding compliance with quality standards.

(4) If another state agency, or a contractor on behalf of the state agency, conducts an assessment that meets the criteria adopted by the authority under subsection (2) of this section, the authority may rely on the assessment as evidence that the organizational provider meets the assessment requirement for receiving a certificate of approval.

(5) The authority shall provide a report of an assessment to the organizational provider that was assessed and, upon request, to a coordinated care organization, insurer or health care service contractor.

(6) If an organizational provider has not been accredited by a national organization that is acceptable to a coordinated care organization, the coordinated care organization shall rely on the assessment conducted in accordance with the criteria adopted under subsection (2) of this section as evidence that the organizational provider meets the assessment requirement.

(7) This section does not:

(a) Prevent a coordinated care organization from requiring its own on-site quality assessment if the authority, another state agency or a contractor on behalf of the authority or another state agency has not conducted an assessment in the preceding 36-month period; or

(b) Require a coordinated care organization to contract with an organizational provider.

(8)(a) The authority shall adopt by rule standards for determining whether information requested by a coordinated care organization from an organizational provider is redundant with respect to the reporting requirements for an assessment or if the information is outside of the scope of the assessment criteria.

(b) A coordinated care organization may request additional information from an organizational provider, in addition to the report of the assessment, if the request:

(A) Is not redundant and is within the scope of the assessment according to standards adopted by the authority as described in this subsection; and

(B) Is necessary to resolve questions about whether an organizational provider meets the coordinated care organization's policies and procedures for credentialing.

(c) The authority shall implement a process for resolving a complaint by an organizational provider that a reporting requirement imposed by a coordinated care organization is redundant or outside of the scope of the assessment criteria.

(9)(a) The authority shall establish and maintain a database containing the documents required by coordinated care organizations for the purpose of credentialing an organizational provider.

(b) With the advice of the committee described in subsection (2) of this section, the authority shall adopt by rule the content and operational function of the database including, at a minimum:

(A) The types of organizational providers for which information is stored in the database;

(B) The types and contents of documents that are stored in the database;

(C) The frequency by which the documents the authority shall obtain updated documents;

(D) The means by which the authority will obtain the documents; and

(E) The means by which coordinated care organizations can access the documents in the database.

(c) The authority shall provide training to coordinated care organization staff who are responsible for processing credentialing requests on the use of the database.

SECTION 39. ORS 743A.168 is amended to read:

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

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

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

(c) "Behavioral health crisis" means a disruption in an insured's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency de-

partment or admission to a hospital to prevent a serious deterioration in the insured's mental or physical health.

(d) "Facility" means a [*corporate or governmental entity or other provider of services for the treatment of behavioral health conditions*] **facility located in this state that provides mental health or substance use disorder treatment**.

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

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

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

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

(B) Products and services that:

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

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

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

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

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

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

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

(j) "Provider" means:

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

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

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

(D) A day or partial hospitalization program;

(E) An outpatient service**,** as defined in ORS 430.010**, that provides treatment in this state**;

(F) A licensed outpatient facility with a certified substance use disorder program that employs certified alcohol and drug counselor level providers; or

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

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

(A) Psychiatry;

(B) Psychology;

(C) Clinical sociology;

(D) Addiction medicine and counseling; and

(E) Behavioral health treatment.

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

(A) Patient placement criteria;

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

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

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

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

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

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

(C) Specialty societies.

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

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

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

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

(A) A behavioral health assessment;

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

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

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

(C) Treatment of co-occurring behavioral health conditions or medical conditions in a coordinated manner;

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

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

(F) Treatment to maintain functioning or prevent deterioration;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(k)(A) Subject to ORS 743A.171 and to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists, ORS 40.250 and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed professional counselors and licensed marriage and family therapists, a group health insurer or issuer of an individual health benefit plan may provide for review for level of treatment of admissions and continued stays for treatment in health facilities, residential facilities, day or partial hospitalization programs and outpatient services by either staff of a group health insurer or issuer of an individual health benefit plan or personnel under contract to the group health insurer or issuer of an individual health benefit plan that is not a grandfathered health plan, or by a utilization review contractor, who shall have the authority to certify for or deny level of payment.

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

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

(D) Review may involve prior authorization, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior authorization is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent review. If prior authorization is not required, group health insurers and issuers of individual health benefit plans that are not grandfathered health plans shall permit providers, policyholders or persons acting on their behalf to make advance inquiries regarding the appropriateness of a particular admission to a treatment program. Group health insurers and issuers of individual health benefit plans that are not grandfathered health plans shall provide a timely response to such in-

quiries. Noncontracting providers must cooperate with these procedures to the same extent as contracting providers to be eligible for reimbursement.

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

(3) Except as provided in ORS 743A.171, this section does not prohibit a group health insurer or issuer of an individual health benefit plan that is not a grandfathered health plan from managing the provision of benefits through common methods, including but not limited to selectively contracted panels, health plan benefit differential designs, preadmission screening, prior authorization of services, utilization review or other mechanisms designed to limit eligible expenses to those described in subsection (2)(b) of this section provided such methods comply with the requirements of this section.

(4) The Legislative Assembly finds that health care cost containment is necessary and intends to encourage health insurance plans designed to achieve cost containment by ensuring that reimbursement is limited to appropriate utilization under criteria incorporated into the insurance, either directly or by reference, in accordance with this section.

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

(A) The current generally accepted standards of care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(E) Support groups.

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

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

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

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

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

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

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

(13) The Director of the Department of Consumer and Business Services and the Oregon Health Authority, after notice and hearing, may adopt reasonable rules not inconsistent with this section that are considered necessary for the proper administration of this section. The director shall adopt

rules making it a violation of this section for a group health insurer or issuer of an individual health benefit plan other than a grandfathered health plan to require providers to bill using a specific billing code or to restrict the reimbursement paid for particular billing codes other than on the basis of medical necessity.

(14) This section does not:

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

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

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

SECTION 40. The amendments to ORS 414.025, 414.723, 430.637, 743A.012 and 743A.168 by sections 35 to 39 of this 2026 Act become operative on January 1, 2027.

SECTION 41. This 2026 Act takes effect on the 91st day after the date on which the 2026 regular session of the Eighty-third Legislative Assembly adjourns sine die.

Passed by House February 18, 2026

Repassed by House March 4, 2026

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Julie Fahey, Speaker of House

Passed by Senate March 3, 2026

.....
Rob Wagner, President of Senate

Received by Governor:

.....M.,....., 2026

Approved:

.....M.,....., 2026

.....
Tina Kotek, Governor

Filed in Office of Secretary of State:

.....M.,....., 2026

.....
Tobias Read, Secretary of State