

## HOUSE AMENDMENTS TO A-ENGROSSED HOUSE BILL 2086

By JOINT COMMITTEE ON WAYS AND MEANS

June 23

1 On page 1 of the printed A-engrossed bill, line 2, after “ORS” insert “413.017, 413.032,  
2 414.025,”.

3 In line 3, delete “; repealing ORS” and insert “and”.

4 On page 2, delete lines 3 through 30 and insert:

5 **“SECTION 1. The Oregon Health Authority shall:**

6 **“(1) Establish programs that are peer and community driven that ensure access to cul-**  
7 **turelly specific and culturally responsive behavioral health services for people of color, tribal**  
8 **communities and people of lived experience.**

9 **“(2) Provide medical assistance reimbursement for tribal-based practices.**

10 **“SECTION 2. The Oregon Health Authority shall reimburse the cost of co-occurring**  
11 **mental health and substance use disorder treatment services paid for on a fee-for-service**  
12 **basis at an enhanced rate based on:**

13 **“(1) Existing reimbursement codes used for co-occurring disorder treatments;**

14 **“(2) Clinical complexity; and**

15 **“(3) The education level of the provider.**

16 **“SECTION 3. The Oregon Health Authority shall provide one-time start-up funding for**  
17 **behavioral health treatment programs that provide integrated co-occurring disorder treat-**  
18 **ment.**

19 **“SECTION 4. The Oregon Health Authority shall conduct a study of reimbursement rates**  
20 **for co-occurring disorder treatments, including treatment of a co-occurring intellectual and**  
21 **developmental disability and problem gambling disorder.”.**

22 In line 31, delete “3” and insert “5”.

23 In line 33, delete “section 2” and insert “sections 2 to 4”.

24 In line 38, delete “4” and insert “6”.

25 Delete line 45.

26 On page 3, delete lines 1 through 5 and insert:

27 **“SECTION 7. (1) The Oregon Health Authority shall conduct a study of Medicaid rates**  
28 **paid for:**

29 **“(a) Behavioral health services compared to physical health services; and**

30 **“(b) Addiction treatment services compared to mental health services to providers with**  
31 **equivalent levels of education and training.**

32 **“(2) No later than February 1, 2022, the authority shall report to the interim committees**  
33 **of the Legislative Assembly related to behavioral and mental health, in the manner provided**  
34 **in ORS 192.245, the results of the study conducted under subsection (1) of this section and**  
35 **recommendations for:**

1       “(a) Achieving a living wage for behavioral health care workers, including additional  
2 treatment providers, peers and family support specialists; and

3       “(b) Providing more equitable wages between physical health care workers and behavioral  
4 health care workers.”.

5       In line 6, delete “6” and insert “8” and delete “(1)”.

6       Delete lines 11 through 35.

7       In line 36, delete “8” and insert “9”.

8       In line 39, delete “9” and insert “10”.

9       In line 45, delete “10” and insert “11”.

10      On page 4, line 3, delete “11” and insert “12”.

11      Delete lines 24 through 45.

12      On page 5, delete lines 1 through 18 and insert:

13      “**SECTION 13.** ORS 430.717 is amended to read:

14      “430.717. (1) As used in this section:

15      “(a) ‘Children and adolescents’ means individuals 20 years old and younger.

16      “(b) ‘Coordinated care organization’ has the meaning given that term in ORS 414.025.

17      “(c) ‘Insurer’ means an insurer, as defined in ORS 731.106, that has a certificate of in-  
18 surance to transact health insurance in this state, other than disability insurance.

19      “(d) ‘Intensive behavioral health treatment provider’ means any provider licensed in this  
20 state to provide intensive psychiatric treatment, acute inpatient treatment or residential  
21 substance use disorder treatment of children and adolescents.

22      “(2) Intensive behavioral health treatment providers, coordinated care organizations and  
23 insurers shall collect and provide data to the Oregon Health Authority, or to a third party  
24 vendor that contracts with the authority, in the manner prescribed by the authority on the  
25 demand for and capacity to provide treatment of children and adolescents presenting with  
26 high acuity behavioral health needs. Intensive behavioral health treatment providers shall  
27 submit:

28      “(a) Data on bed capacity;

29      “(b) Referrals received, by provider; and

30      “(c) Other information prescribed by the authority.

31      “(3) The authority may provide funding to intensive behavioral health treatment provid-  
32 ers to collect and provide the data described in subsection (2) of this section.

33      “(4) The authority shall use the data described in subsection (2) of this section to:

34      “(a) Monitor and track the capacity of intensive behavioral health treatment providers  
35 to provide treatment of children and adolescents presenting with high acuity behavioral  
36 health needs;

37      “(b) Identify gaps in data that prevent the tracking of intensive behavioral health service  
38 capacity and develop a plan for addressing the gaps that includes providing assistance to  
39 providers and modifying required data elements that must be reported;

40      “(c) Develop benchmarks and performance measures for intensive behavioral health  
41 treatment capacity; and

42      “(d) Conduct research and evaluation of the children’s and adolescents’ continuum of  
43 care.

44      “(5) The authority shall share data and coordinate processes with the Department of  
45 Human Services to populate the Children’s System Data Dashboard described in ORS 418.981.



1           “(F) A special district.

2           “(G) Any private nonprofit organization that receives the majority of its funding from the state  
3 and requests to participate on the committee.

4           “(b) The Public Health Benefit Purchasers Committee shall:

5           “(A) Identify and make specific recommendations to achieve uniformity across all public health  
6 benefit plan designs based on the best available clinical evidence, recognized best practices for  
7 health promotion and disease management, demonstrated cost-effectiveness and shared demographics  
8 among the enrollees within the pools covered by the benefit plans.

9           “(B) Develop an action plan for ongoing collaboration to implement the benefit design alignment  
10 described in subparagraph (A) of this paragraph and shall leverage purchasing to achieve benefit  
11 uniformity if practicable.

12           “(C) Continuously review and report to the Oregon Health Policy Board on the committee’s  
13 progress in aligning benefits while minimizing the cost shift to individual purchasers of insurance  
14 without shifting costs to the private sector or the health insurance exchange.

15           “(c) The Oregon Health Policy Board shall work with the Public Health Benefit Purchasers  
16 Committee to identify uniform provisions for state and local public contracts for health benefit plans  
17 that achieve maximum quality and cost outcomes. The board shall collaborate with the committee  
18 to develop steps to implement joint contract provisions. The committee shall identify a schedule for  
19 the implementation of contract changes. The process for implementation of joint contract provisions  
20 must include a review process to protect against unintended cost shifts to enrollees or agencies.

21           “(3)(a) The Health Care Workforce Committee shall include individuals who have the collective  
22 expertise, knowledge and experience in a broad range of health professions, health care education  
23 and health care workforce development initiatives.

24           “(b) The Health Care Workforce Committee shall coordinate efforts to recruit and educate  
25 health care professionals and retain a quality workforce to meet the demand that will be created  
26 by the expansion in health care coverage, system transformations and an increasingly diverse pop-  
27 ulation.

28           “(c) The Health Care Workforce Committee shall conduct an inventory of all grants and other  
29 state resources available for addressing the need to expand the health care workforce to meet the  
30 needs of Oregonians for health care.

31           “(4)(a) The Health Plan Quality Metrics Committee shall include the following members ap-  
32 pointed by the Oregon Health Policy Board:

33           “(A) An individual representing the Oregon Health Authority;

34           “(B) An individual representing the Oregon Educators Benefit Board;

35           “(C) An individual representing the Public Employees’ Benefit Board;

36           “(D) An individual representing the Department of Consumer and Business Services;

37           “(E) Two health care providers;

38           “(F) One individual representing hospitals;

39           “(G) One individual representing insurers, large employers or multiple employer welfare ar-  
40 rangements;

41           “(H) Two individuals representing health care consumers;

42           “(I) Two individuals representing coordinated care organizations;

43           “(J) One individual with expertise in health care research;

44           “(K) One individual with expertise in health care quality measures; and

45           “(L) One individual with expertise in mental health and addiction services.

1 “(b) The committee shall work collaboratively with the Oregon Educators Benefit Board, the  
2 Public Employees’ Benefit Board, the authority and the department to adopt health outcome and  
3 quality measures that are focused on specific goals and provide value to the state, employers,  
4 insurers, health care providers and consumers. The committee shall be the single body to align  
5 health outcome and quality measures used in this state with the requirements of health care data  
6 reporting to ensure that the measures and requirements are coordinated, evidence-based and focused  
7 on a long term statewide vision.

8 “(c) The committee shall use a public process that includes an opportunity for public comment  
9 to identify health outcome and quality measures that may be applied to services provided by coord-  
10 inated care organizations or paid for by health benefit plans sold through the health insurance  
11 exchange or offered by the Oregon Educators Benefit Board or the Public Employees’ Benefit Board.  
12 The authority, the department, the Oregon Educators Benefit Board and the Public Employees’  
13 Benefit Board are not required to adopt all of the health outcome and quality measures identified  
14 by the committee but may not adopt any health outcome and quality measures that are different  
15 from the measures identified by the committee. The measures must take into account the recom-  
16 mendations of the metrics and scoring subcommittee created in ORS 414.638 and the differences in  
17 the populations served by coordinated care organizations and by commercial insurers.

18 “(d) In identifying health outcome and quality measures, the committee shall prioritize measures  
19 that:

20 “(A) Utilize existing state and national health outcome and quality measures, including measures  
21 adopted by the Centers for Medicare and Medicaid Services, that have been adopted or endorsed  
22 by other state or national organizations and have a relevant state or national benchmark;

23 “(B) Given the context in which each measure is applied, are not prone to random variations  
24 based on the size of the denominator;

25 “(C) Utilize existing data systems, to the extent practicable, for reporting the measures to min-  
26 imize redundant reporting and undue burden on the state, health benefit plans and health care pro-  
27 viders;

28 “(D) Can be meaningfully adopted for a minimum of three years;

29 “(E) Use a common format in the collection of the data and facilitate the public reporting of the  
30 data; and

31 “(F) Can be reported in a timely manner and without significant delay so that the most current  
32 and actionable data is available.

33 “(e) The committee shall evaluate on a regular and ongoing basis the health outcome and quality  
34 measures adopted under this section.

35 “(f) The committee may convene subcommittees to focus on gaining expertise in particular areas  
36 such as data collection, health care research and mental health and substance use disorders in order  
37 to aid the committee in the development of health outcome and quality measures. A subcommittee  
38 may include stakeholders and staff from the authority, the Department of Human Services, the De-  
39 partment of Consumer and Business Services, the Early Learning Council or any other agency staff  
40 with the appropriate expertise in the issues addressed by the subcommittee.

41 “(g) This subsection does not prevent the authority, the Department of Consumer and Business  
42 Services, commercial insurers, the Public Employees’ Benefit Board or the Oregon Educators Benefit  
43 Board from establishing programs that provide financial incentives to providers for meeting specific  
44 health outcome and quality measures adopted by the committee.

45 “(5)(a) **The Behavioral Health Committee shall include the following members appointed**

1 by the Director of the Oregon Health Authority:

2 “(A) The chairperson of the Health Plan Quality Metrics Committee;

3 “(B) The chairperson of the committee appointed by the board to address health equity,  
4 if any;

5 “(C) A behavioral health director for a coordinated care organization;

6 “(D) A representative of a community mental health program;

7 “(E) An individual with expertise in data analysis;

8 “(F) A member of the Consumer Advisory Council, established under ORS 430.073, that  
9 represents adults with mental illness;

10 “(G) A representative of the System of Care Advisory Council established in ORS 418.978;

11 “(H) A member of the Oversight and Accountability Council, described in section 2,  
12 chapter 2, Oregon Laws 2021 (Ballot Measure 110 (2020)), who represents adults with ad-  
13 dictions or co-occurring conditions;

14 “(I) One member representing a system of care, as defined in ORS 418.976;

15 “(J) One consumer representative;

16 “(K) One representative of a tribal government;

17 “(L) One representative of an organization that advocates on behalf of individuals with  
18 intellectual or developmental disabilities;

19 “(M) One representative of providers of behavioral health services;

20 “(N) The director of the division of the authority responsible for behavioral health ser-  
21 vices, as a nonvoting member;

22 “(O) The Director of the Alcohol and Drug Policy Commission appointed under ORS  
23 430.220, as a nonvoting member;

24 “(P) The authority’s Medicaid director, as a nonvoting member;

25 “(Q) A representative of the Department of Human Services, as a nonvoting member; and

26 “(R) Any other member that the director deems appropriate.

27 “(b) The board may modify the membership of the committee as needed.

28 “(c) The division of the authority responsible for behavioral health services and the di-  
29 rector of the division shall staff the committee.

30 “(d) The committee, in collaboration with the Health Plan Quality Metrics Committee,  
31 as needed, shall:

32 “(A) Establish quality metrics for behavioral health services provided by coordinated care  
33 organizations, health care providers, counties and other government entities; and

34 “(B) Establish incentives to improve the quality of behavioral health services.

35 “(e) The quality metrics and incentives shall be designed to:

36 “(A) Improve timely access to behavioral health care;

37 “(B) Reduce hospitalizations;

38 “(C) Reduce overdoses;

39 “(D) Improve the integration of physical and behavioral health care; and

40 “(E) Ensure individuals are supported in the least restrictive environment that meets  
41 their behavioral health needs.

42 “[5] (6) Members of the committees described in subsections (2) to [(4)] (5) of this section who  
43 are not members of the Oregon Health Policy Board are not entitled to compensation but shall be  
44 reimbursed from funds available to the board for actual and necessary travel and other expenses  
45 incurred by them by their attendance at committee meetings, in the manner and amount provided

1 in ORS 292.495.

2 **“SECTION 17. Section 18 of this 2021 Act is added to and made a part of ORS chapter 414.**

3 **“SECTION 18. Notwithstanding ORS 414.590:**

4 **“(1) Contracts between the Oregon Health Authority and coordinated care organizations**  
5 **or individual providers for the provision of behavioral health services must align with the**  
6 **quality metrics and incentives developed by the Behavioral Health Committee under ORS**  
7 **413.017 and contain provisions that ensure that:**

8 **“(a) Individuals have easy access to needed care;**

9 **“(b) Services are responsive to individual and community needs; and**

10 **“(c) Services will lead to meaningful improvement in individuals’ lives.**

11 **“(2) The authority must provide at least 90 days’ notice of changes needed to contracts**  
12 **that are necessary to comply with subsection (1) of this section.**

13 **“SECTION 19. ORS 413.032 is amended to read:**

14 **“413.032. (1) The Oregon Health Authority is established. The authority shall:**

15 **“(a) Carry out policies adopted by the Oregon Health Policy Board;**

16 **“(b) Administer the Oregon Integrated and Coordinated Health Care Delivery System established**  
17 **in ORS 414.570;**

18 **“(c) Administer the Oregon Prescription Drug Program;**

19 **“(d) Develop the policies for and the provision of publicly funded medical care and medical as-**  
20 **sistance in this state;**

21 **“(e) Develop the policies for and the provision of mental health treatment and treatment of ad-**  
22 **dictions;**

23 **“(f) Assess, promote and protect the health of the public as specified by state and federal law;**

24 **“(g) Provide regular reports to the board with respect to the performance of health services**  
25 **contractors serving recipients of medical assistance, including reports of trends in health services**  
26 **and enrollee satisfaction;**

27 **“(h) Guide and support, with the authorization of the board, community-centered health initi-**  
28 **atives designed to address critical risk factors, especially those that contribute to chronic disease;**

29 **“(i) Be the state Medicaid agency for the administration of funds from Titles XIX and XXI of the**  
30 **Social Security Act and administer medical assistance under ORS chapter 414;**

31 **“(j) In consultation with the Director of the Department of Consumer and Business Services,**  
32 **periodically review and recommend standards and methodologies to the Legislative Assembly for:**

33 **“(A) Review of administrative expenses of health insurers;**

34 **“(B) Approval of rates; and**

35 **“(C) Enforcement of rating rules adopted by the Department of Consumer and Business Services;**

36 **“(k) Structure reimbursement rates for providers that serve recipients of medical assistance to**  
37 **reward comprehensive management of diseases, quality outcomes and the efficient use of resources**  
38 **and to promote cost-effective procedures, services and programs including, without limitation, pre-**  
39 **ventive health, dental and primary care services, web-based office visits, telephone consultations and**  
40 **telemedicine consultations;**

41 **“(L) Guide and support community three-share agreements in which an employer, state or local**  
42 **government and an individual all contribute a portion of a premium for a community-centered health**  
43 **initiative or for insurance coverage;**

44 **“(m) Develop, in consultation with the Department of Consumer and Business Services, one or**  
45 **more products designed to provide more affordable options for the small group market;**

1 “(n) Implement policies and programs to expand the skilled, diverse workforce as described in  
2 ORS 414.018 (4); and

3 “(o) Implement a process for collecting the health outcome and quality measure data identified  
4 by the Health Plan Quality Metrics Committee **and the Behavioral Health Committee** and report  
5 the data to the Oregon Health Policy Board.

6 “(2) The Oregon Health Authority is authorized to:

7 “(a) Create an all-claims, all-payer database to collect health care data and monitor and evaluate  
8 health care reform in Oregon and to provide comparative cost and quality information to consumers,  
9 providers and purchasers of health care about Oregon’s health care systems and health plan net-  
10 works in order to provide comparative information to consumers.

11 “(b) Develop uniform contracting standards for the purchase of health care, including the fol-  
12 lowing:

13 “(A) Uniform quality standards and performance measures;

14 “(B) Evidence-based guidelines for major chronic disease management and health care services  
15 with unexplained variations in frequency or cost;

16 “(C) Evidence-based effectiveness guidelines for select new technologies and medical equipment;

17 “(D) A statewide drug formulary that may be used by publicly funded health benefit plans; and

18 “(E) Standards that accept and consider tribal-based practices for mental health and substance  
19 abuse prevention, counseling and treatment for persons who are Native American or Alaska Native  
20 as equivalent to evidence-based practices.

21 “(3) The enumeration of duties, functions and powers in this section is not intended to be ex-  
22 clusive nor to limit the duties, functions and powers imposed on or vested in the Oregon Health  
23 Authority by ORS 413.006 to 413.042, 415.012 to 415.430 and 741.340 or by other statutes.

24 “**SECTION 20.** ORS 414.025 is amended to read:

25 “414.025. As used in this chapter and ORS chapters 411 and 413, unless the context or a spe-  
26 cially applicable statutory definition requires otherwise:

27 “(1)(a) ‘Alternative payment methodology’ means a payment other than a fee-for-services pay-  
28 ment, used by coordinated care organizations as compensation for the provision of integrated and  
29 coordinated health care and services.

30 “(b) ‘Alternative payment methodology’ includes, but is not limited to:

31 “(A) Shared savings arrangements;

32 “(B) Bundled payments; and

33 “(C) Payments based on episodes.

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

36 “(3) ‘Behavioral health clinician’ means:

37 “(a) A licensed psychiatrist;

38 “(b) A licensed psychologist;

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

40 “(d) A licensed clinical social worker;

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

42 “(f) A certified clinical social work associate;

43 “(g) An intern or resident who is working under a board-approved supervisory contract in a  
44 clinical mental health field; or

45 “(h) Any other clinician whose authorized scope of practice includes mental health diagnosis and



1 treatment.

2 “(4) ‘Behavioral health crisis’ means a disruption in an individual’s mental or emotional stability  
3 or functioning resulting in an urgent need for immediate outpatient treatment in an emergency de-  
4 partment or admission to a hospital to prevent a serious deterioration in the individual’s mental or  
5 physical health.

6 “(5) ‘Behavioral health home’ means a mental health disorder or substance use disorder treat-  
7 ment organization, as defined by the Oregon Health Authority by rule, that provides integrated  
8 health care to individuals whose primary diagnoses are mental health disorders or substance use  
9 disorders.

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

13 “(7) ‘Community health worker’ means an individual who meets qualification criteria adopted  
14 by the authority under ORS 414.665 and who:

15 “(a) Has expertise or experience in public health;

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

18 “(c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experi-  
19 ences with the residents of the community where the worker serves;

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

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

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

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

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

27 “(8) ‘Coordinated care organization’ means an organization meeting criteria adopted by the  
28 Oregon Health Authority under ORS 414.572.

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

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

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

34 “(10)(a) ‘Family support specialist’ means an individual who meets qualification criteria adopted  
35 by the authority under ORS 414.665 and who provides supportive services to and has experience  
36 parenting a child who:

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

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

40 “(b) A ‘family support specialist’ may be a peer wellness specialist or a peer support specialist.

41 “(11) ‘Global budget’ means a total amount established prospectively by the Oregon Health Au-  
42 thority to be paid to a coordinated care organization for the delivery of, management of, access to  
43 and quality of the health care delivered to members of the coordinated care organization.

44 “(12) ‘Health insurance exchange’ or ‘exchange’ means an American Health Benefit Exchange  
45 described in 42 U.S.C. 18031, 18032, 18033 and 18041.

1 “(13) ‘Health services’ means at least so much of each of the following as are funded by the  
2 Legislative Assembly based upon the prioritized list of health services compiled by the Health Evi-  
3 dence Review Commission under ORS 414.690:

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

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

9 “(c) Prescription drugs;

10 “(d) Laboratory and X-ray services;

11 “(e) Medical equipment and supplies;

12 “(f) Mental health services;

13 “(g) Chemical dependency services;

14 “(h) Emergency dental services;

15 “(i) Nonemergency dental services;

16 “(j) Provider services, other than services described in paragraphs (a) to (i), (k), (L) and (m) of  
17 this subsection, defined by federal law that may be included in the state’s medical assistance pro-  
18 gram;

19 “(k) Emergency hospital services;

20 “(L) Outpatient hospital services; and

21 “(m) Inpatient hospital services.

22 “(14) ‘Income’ has the meaning given that term in ORS 411.704.

23 “(15)(a) ‘Integrated health care’ means care provided to individuals and their families in a pa-  
24 tient centered primary care home or behavioral health home by licensed primary care clinicians,  
25 behavioral health clinicians and other care team members, working together to address one or more  
26 of the following:

27 “(A) Mental illness.

28 “(B) Substance use disorders.

29 “(C) Health behaviors that contribute to chronic illness.

30 “(D) Life stressors and crises.

31 “(E) Developmental risks and conditions.

32 “(F) Stress-related physical symptoms.

33 “(G) Preventive care.

34 “(H) Ineffective patterns of health care utilization.

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

36 “(A) Qualified mental health professionals or qualified mental health associates meeting re-  
37 quirements adopted by the Oregon Health Authority by rule;

38 “(B) Peer wellness specialists;

39 “(C) Peer support specialists;

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

41 “(E) Personal health navigators; or

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

43 “(16) ‘Investments and savings’ means cash, securities as defined in ORS 59.015, negotiable in-  
44 struments as defined in ORS 73.0104 and such similar investments or savings as the department or  
45 the authority may establish by rule that are available to the applicant or recipient to contribute

1 toward meeting the needs of the applicant or recipient.

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

7 “(18) ‘Medical assistance’ includes any care or services for any individual who is a patient in  
8 a medical institution or any care or services for any individual who has attained 65 years of age  
9 or is under 22 years of age, and who is a patient in a private or public institution for mental dis-  
10 eases. Except as provided in ORS 411.439 and 411.447, ‘medical assistance’ does not include care or  
11 services for a resident of a nonmedical public institution.

12 “(19) ‘Patient centered primary care home’ means a health care team or clinic that is organized  
13 in accordance with the standards established by the Oregon Health Authority under ORS 414.655  
14 and that incorporates the following core attributes:

15 “(a) Access to care;

16 “(b) Accountability to consumers and to the community;

17 “(c) Comprehensive whole person care;

18 “(d) Continuity of care;

19 “(e) Coordination and integration of care; and

20 “(f) Person and family centered care.

21 “(20) ‘Peer support specialist’ means any of the following individuals who meet qualification  
22 criteria adopted by the authority under ORS 414.665 and who provide supportive services to a cur-  
23 rent or former consumer of mental health or addiction treatment:

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

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

27 “(21) ‘Peer wellness specialist’ means an individual who meets qualification criteria adopted by  
28 the authority under ORS 414.665 and who is responsible for assessing mental health and substance  
29 use disorder service and support needs of a member of a coordinated care organization through  
30 community outreach, assisting members with access to available services and resources, addressing  
31 barriers to services and providing education and information about available resources for individ-  
32 uals with mental health or substance use disorders in order to reduce stigma and discrimination  
33 toward consumers of mental health and substance use disorder services and to assist the member  
34 in creating and maintaining recovery, health and wellness.

35 “(22) ‘Person centered care’ means care that:

36 “(a) Reflects the individual patient’s strengths and preferences;

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

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

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

44 “(24) ‘Prepaid managed care health services organization’ means a managed dental care, mental  
45 health or chemical dependency organization that contracts with the authority under ORS 414.654

1 or with a coordinated care organization on a prepaid capitated basis to provide health services to  
2 medical assistance recipients.

3 “(25) ‘Quality measure’ means the health outcome and quality measures and benchmarks identi-  
4 fied by the Health Plan Quality Metrics Committee and the metrics and scoring subcommittee in  
5 accordance with ORS 413.017 (4) and 414.638 **and the quality metrics developed by the Behav-**  
6 **ioral Health Committee in accordance with ORS 413.017 (5).**

7 “(26) ‘Resources’ has the meaning given that term in ORS 411.704. For eligibility purposes, ‘re-  
8 sources’ does not include charitable contributions raised by a community to assist with medical ex-  
9 penses.

10 “(27)(a) ‘Youth support specialist’ means an individual who meets qualification criteria adopted  
11 by the authority under ORS 414.665 and who, based on a similar life experience, provides supportive  
12 services to an individual who:

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

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

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

17 “(b) A ‘youth support specialist’ may be a peer wellness specialist or a peer support specialist.  
18

#### 19 “REPORTS TO LEGISLATIVE ASSEMBLY 20

21 “**SECTION 21. (1) No later than November 1, 2021, the Oregon Health Authority shall**  
22 **report to the Legislative Assembly, in the manner provided in ORS 192.245:**

23 “(a) **Any changes needed to contracts with counties, coordinated care organizations,**  
24 **providers or community based organizations to comply with the quality metrics and incen-**  
25 **tives developed by the Behavioral Health Committee in accordance with ORS 413.017; and**

26 “(b) **Recommendations to improve the referral process for all levels of care delivered by**  
27 **intensive behavioral treatment providers, as defined in ORS 430.717.**

28 “(2) **No later than December 31, 2021, the Oregon Health Authority shall report to the**  
29 **Legislative Assembly, in the manner provided in ORS 192.245:**

30 “(a) **Identified barriers, including legislative changes or changes to the demonstration**  
31 **project under section 1115 of the Social Security Act, that are needed to apply the quality**  
32 **metrics and incentives developed by the committee to contracts with coordinated care or-**  
33 **ganizations and counties;**

34 “(b) **The authority’s specific needs for data infrastructure to implement the quality**  
35 **metrics and incentives and recommendations for facilitating risk-sharing agreements within**  
36 **the health care delivery system to achieve the goals of the quality metrics; and**

37 “(c) **Recommendations for counties to share in the costs of a hospitalization at the**  
38 **Oregon State Hospital for a patient beginning 30 days after a county is notified that the pa-**  
39 **tient no longer needs hospital level care.**

40 “(3) **No later than December 1, 2022, the Oregon Health Authority shall report to the**  
41 **interim committees of the Legislative Assembly related to mental or behavioral health, in**  
42 **the manner provided in ORS 192.245 the findings of the study under section 4 of this 2021**  
43 **Act and recommendations for future rate development.**  
44

#### 45 “IMPLEMENTATION DEADLINES

1       **“SECTION 22. (1) The Behavioral Health Committee shall develop the quality metrics and**  
2 **incentives described in ORS 413.017 no later than February 1, 2022.**

3       **“(2) No later than January 1, 2023, the Oregon Health Authority shall amend contracts**  
4 **for the provision of behavioral health services to align with the quality metrics and incen-**  
5 **tives developed by the Behavioral Health Committee under ORS 413.017.”.**

6       In line 44, delete “16” and insert “23”.

7       On page 6, delete line 5 and insert:

8       **“SECTION 24. (1) Section 3 of this 2021 Act is repealed on June 30, 2023.**

9       **“(2) Section 4 of this 2021 Act is repealed on January 2, 2023.**

10       **“(3) Section 7 of this 2021 Act is repealed on June 30, 2022.**

11       **“(4) Section 14 of this 2021 Act is repealed on January 2, 2023.”.**

12       In line 9, delete “18” and insert “25”.

13

---