Senate Bill 62

Sponsored by Senator HAYDEN (Presession filed.)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.** The statement includes a measure digest written in compliance with applicable readability standards.

Digest: The Act creates new programs for increasing consumers' voice in the mental health care system. (Flesch Readability Score: 67.5).

Requires the Oregon Health Authority to develop, implement and administer a program to support consumer engagement efforts aimed at increasing and optimizing consumer involvement in planning and decision-making surrounding the access to, and delivery of, behavioral health services in this state. Requires coordinated care organizations to contribute $1 per member per month toward the consumer engagement program.

Requires the authority to administer a pilot program in eastern Oregon to develop an innovative model for providing residential treatment to young adults experiencing early psychosis in conjunction with a substance use disorder.

Sunsets the pilot program on January 2, 2036.

Declares an emergency, effective on passage.

A BILL FOR AN ACT

Relating to consumer engagement in the behavioral health care system; creating new provisions; amending ORS 414.572; and declaring an emergency.

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

SECTION 1. Sections 2 to 4 of this 2025 Act shall be known and may be cited as the Oregon Mental Wellness and Community Stability Act of 2025.

SECTION 2. The Legislative Assembly finds and declares that:

(1) Increased participation by consumers of behavioral health services promotes identification of existing gaps in the delivery of services provided within the mental and behavioral health system, improves the quality of behavioral health services delivered and results in positive experiences and improved behavioral health outcomes for consumers.

(2) A coordinated system is necessary to increase consumer engagement in decision-making and strategic input regarding the service delivery options that are available within the existing behavioral health system.

SECTION 3. (1) As used in this section:

(a) "Consumer" means a person who has received or is receiving behavioral health services.

(b) "Consumer engagement and peer workforce development center" means a nonprofit organization that operates as a peer-run organization.

(c) "Medical assistance" has the meaning given that term in ORS 414.025.

(d) "Nonprofit organization" means an organization described in section 501(c)(3) of the Internal Revenue Code that is exempt from income tax under section 501(a) of the Internal Revenue Code.

(e) "Peer" means a consumer who provides behavioral health services or supports based on the consumer's lived experience.

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

(f) "Peer-run organization" means an organization:

(A) That is fully independent, separate and autonomous from other behavioral health services; and

(B) In which a majority of the leadership and staff who perform oversight and decision-making on governance, financial, personnel, policy and program issues in the organization are peers.

(g) "Residential treatment facility" has the meaning given that term in ORS 443.400.

(h) "Secure residential treatment facility" means a facility described in ORS 443.465.

(2) The Oregon Health Authority shall develop, implement and administer a program to support consumer engagement efforts aimed at increasing and optimizing consumer involvement in planning and decision-making surrounding the access to, and the delivery of, behavioral health services in this state. In implementing the program, the authority shall enter into a contract with a consumer engagement and peer workforce development center to:

(a) Conduct research that is informed by lived experience to:

(A) Answer critical questions about the long-term experiences of consumers transitioning from acute care settings to community-based psychosocial rehabilitation programs by:

(i) Examining the effectiveness of support services, housing models and employment programs in this state in promoting long-term stability and preventing relapse;

(ii) Investigating systemic challenges, social determinants of health and individual factors that hinder successful community reintegration; and

(iii) Developing data-driven programs, policies and interventions to empower consumers and reduce reliance on emergency services and acute care; and

(B) Evaluate the long-term outcomes, treatment efficacy and variations in treatment models at residential treatment facilities and secure residential treatment facilities in this state;

(b) Support the development of new residential treatment facilities and secure residential treatment facilities;

(c) Empower consumers and peers to co-design innovative treatment models based on lived experience;

(d) Support the development and implementation of the pilot program described in section 4 of this 2025 Act;

(e) Foster alliances between consumers, peers and public universities listed in ORS 352.002 to conduct research; and

(f) Serve as a statewide technical assistance center to:

(A) Empower consumers who are medical assistance recipients to navigate the health care system, advocate for their needs and actively participate in their recovery; and

(B) Offer training, professional development and mentorship to enhance the professional skills and capacity of peers.

(3) The authority shall prescribe by rule the requirements for a consumer engagement and peer workforce development center that receives funding under this section.

(4) A consumer engagement and peer workforce development center that contracts with the authority shall submit an annual progress report to the authority describing the center's progress in achieving the requirements of this section.

SECTION 4. (1) As used in this section:

(a) "Consumer" and "peer" have the meanings given those terms in section 3 of this 2025 Act.

(b) "Medical assistance" has the meaning given that term in ORS 414.025.

(c) "Young adult" means an individual who is between 18 and 25 years of age.

(2) The Oregon Health Authority shall administer a pilot program in eastern Oregon to develop an innovative model for providing residential treatment to young adults experiencing early psychosis in conjunction with a substance use disorder.

(3) The program shall:

(a) Provide a structured, therapeutic living environment to participating young adults for a period of nine to 18 months;

(b) Use a holistic, trauma-informed approach to addressing participating young adults' mental health needs and addiction, including evidence-based therapies and innovative approaches informed by lived experience; and

(c) Prioritize family involvement and support during participating young adults' recovery process.

(4) To accomplish the objectives described in subsection (3) of this section, the program shall:

(a) Develop property suitable for long-term residential treatment;

(b) Recruit and train specialized staff;

(c) Implement and evaluate an innovative clinical model; and

(d) Foster collaboration with consumers, peers and public universities listed in ORS 352.002 to conduct research and improve the quality of services provided by the program.

(5) The authority shall:

(a) Explore any and all opportunities to obtain federal financial participation in the costs of implementing the pilot program administered under this section; and

(b) Revise billing codes, as necessary, to ensure that the pilot program may seek reimbursement from the medical assistance program.

(6) Beginning in 2026, the authority shall submit a report no later than September 15 of each even-numbered year, in the manner provided in ORS 192.245, to the interim committees of the Legislative Assembly related to health describing the progress of the pilot program in achieving the objectives identified under this section.

SECTION 5. ORS 414.572 is amended to read:

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

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

(b) Meet the following minimum financial requirements:

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

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

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

(D) Contribute $1 per member per month toward the consumer engagement program described in section 3 of this 2025 Act.

(c) Operate within a fixed global budget and other payment mechanisms described in subsection (6) of this section and spend on primary care, as defined by the authority by rule, at least 12 percent of the coordinated care organization's total expenditures for physical and mental health care provided to members, except for expenditures on prescription drugs, vision care and dental care.

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

(e) Coordinate the delivery of physical health care, behavioral health care, oral health care and covered long-term care services.

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

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

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

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

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

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

(e) Members are provided:

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

(B) Assistance in accessing community and social support services and statewide resources;

(C) Meaningful language access as required by federal and state law including, but not limited to, 42 U.S.C. 18116, Title VI of the Civil Rights Act of 1964, Title VI Guidance issued by the United States Department of Justice and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care as issued by the United States Department of Health and

Human Services; and

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

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

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

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

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

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

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

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

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

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

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

(E) Include providers of specialty care.

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

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

(L) Each coordinated care organization reports on outcome and quality measures adopted under ORS 413.022 and participates in the health care data reporting system established in ORS 442.372 and 442.373.

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

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

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

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

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

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

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

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

(ii) A behavioral health provider;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) In addition to global budgets, the authority may employ other payment mechanisms to reimburse coordinated care organizations for specified health services during limited periods of time if:

(a) Global budgets remain the primary means of reimbursing coordinated care organizations for care and services provided to the coordinated care organization's members;

(b) The other payment mechanisms are consistent with the legislative intent expressed in ORS 414.018 and the system design described in ORS 414.570 (1); and

(c) The payment mechanisms are employed only for health-related social needs services, such as housing supports, nutritional assistance and climate-related assistance, approved for the demonstration project under 42 U.S.C. 1315 by the Centers for Medicare and Medicaid Services.

SECTION 6. In addition to and not in lieu of any other appropriation, there is appropriated to the Oregon Health Authority, for the biennium beginning July 1, 2025, out of the General Fund, the amount of $_____, which may be expended to carry out the provisions of section 3 of this 2025 Act.

SECTION 7. In addition to and not in lieu of any other appropriation, there is appropriated to the Oregon Health Authority, for the biennium beginning July 1, 2025, out of the General Fund, the amount of $_____, which may be expended to administer the pilot program under section 4 of this 2025 Act.

SECTION 8. Section 4 of this 2025 Act is repealed on January 2, 2036.

SECTION 9. (1) Section 3 of this 2025 Act becomes operative on January 1, 2026.

(2) The Oregon Health Authority may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the authority to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the authority by section 3 of this 2025 Act.

SECTION 10. This 2025 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2025 Act takes effect on its passage.