Chapter 414

2007 EDITION

Medical Assistance

414.001 [Repealed by 1953 c.378 §2]
414.002 [Repealed by 1953 c.378 §2]
414.003 [Repealed by 1953 c.378 §2]
414.004 [Repealed by 1953 c.378 §2]
414.005 [Repealed by 1953 c.378 §2]
414.006 [Repealed by 1953 c.378 §2]
414.007 [Repealed by 1953 c.378 §2]
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414.013 [Repealed by 1953 c.378 §2]
414.014 [Repealed by 1953 c.378 §2]
414.015 [Repealed by 1953 c.30 §2]
414.016 [Repealed by 1953 c.30 §2]
414.017 [Repealed by 1953 c.30 §2]

OREGON HEALTH PLAN

414.018 Goals; findings. (1) It is the intention of the Legislative Assembly to achieve the goals of universal access to an adequate level of high quality health care at an affordable cost.

(2) The Legislative Assembly finds:

(a) A significant level of public and private funds is expended each year for the provision of health care to Oregonians;

(b) The state has a strong interest in assisting Oregon businesses and individuals to obtain reasonably available insurance or other coverage of the costs of necessary basic health care services;

(c) The lack of basic health care coverage is detrimental not only to the health of individuals lacking coverage, but also to the public welfare and the state's need to encourage employment growth and economic development, and the lack results in substantial expenditures for emergency and remedial health care for all purchasers of health care including the state; and

(d) The use of managed health care systems has significant potential to reduce the growth of health care costs incurred by the people of this state. [1993 c.815 §1]

Note: 414.018 to 414.024 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

414.019 Laws comprising Oregon Health Plan. As used in ORS 414.018 to 414.024, 414.042, 414.107, 414.710 and 414.720, as of November 4, 1993, "Oregon Health Plan" means chapter 815, Oregon Laws 1993, and the seven pieces of legislation enacted during the 1987, 1989 and 1991 legislative sessions, the goal of which is to ensure that Oregonians have access to health care coverage, including the high-risk pool created by chapter 838, Oregon Laws 1989, the employer-based coverage reforms contained in chapter 591, Oregon Laws 1987, chapter 381, Oregon Laws 1989, and chapter 916, Oregon Laws 1991, the cost containment and technology assessments contained in chapter 470, Oregon Laws 1991, and the prioritization and medical assistance reforms contained in chapter 836, Oregon Laws 1989, and chapter 753, Oregon Laws 1991. [1993 c.815 §2; 1999 c.547 §4; 2005 c.22 §284]

Note: See note under 414.018.

414.020 [Repealed by 1953 c.204 §9]

414.021 Duties of administrator; staff; advisory committees; grants; meetings. (1) The Administrator of the Office for Oregon Health Policy and Research shall be responsible for analyzing and reporting on the implementation of the elements of the Oregon Health Plan that are assigned to various state agencies, including but not limited to the Department of Human Services and the Department of Consumer and Business Services.

(2) The administrator shall administer the Health Services Commission, the Medicaid Advisory Committee and the Health Resources Commission and provide administrative support to the Oregon Health Policy Commission. Pursuant to the responsibilities described in this subsection and subsection (1) of this section, the administrator may review and monitor the progress of the various activities that comprise Oregon's efforts to reform health care through state-funded and employer-based coverage. Except for administration of the Health Services Commission, the Medicaid Advisory Committee and the Health Resources Commission and providing administrative support to the Oregon Health Policy Commission and as specifically authorized in ORS 414.018 to 414.024, 414.042, 414.107, 414.710, 414.720 and 735.712, the administrator shall not be responsible for the day-to-day operations of the Oregon Health Plan, but shall exercise such oversight responsibilities as are necessary to further the Oregon Health Plan's goals.

(3) The administrator shall employ such staff or utilize such state agency personnel as are necessary to fulfill the responsibilities and duties of the administrator. In addition, the administrator may contract with third parties for technical and administrative services necessary to carry out Oregon Health Plan activities where contracting promotes economy, avoids duplication of effort and makes best use of available expertise. The administrator may call upon other state agencies to provide available information as necessary to assist the administrator in meeting the responsibilities under ORS 414.018 to 414.024, 414.042, 414.107, 414.710,

414.720 and 735.712. The information shall be supplied as promptly as circumstances permit.

(4) The Oregon Health Policy Commission shall serve as the primary advisory committee to the administrator, the Governor and the Legislative Assembly. The administrator also may appoint other technical or advisory committees to assist the Oregon Health Policy Commission in formulating its advice. Individuals appointed to any technical or other advisory committee shall serve without compensation for their services as members, but may be reimbursed for their travel expenses pursuant to ORS 292.495.

(5) The administrator may apply for, receive and accept grants, gifts and other payments, including property and services, from any governmental or other public or private entity or person and may make arrangements for the use of these receipts, including the undertaking of special studies and other projects relating to health care costs and access to health care.

(6) The directors of the Departments of Human Services and Consumer and Business Services and other state agency personnel responsible for implementing elements of the Oregon Health Plan shall cooperate fully with the administrator in carrying out their responsibilities under the Oregon Health Plan.

(7) All health policy advisory committees reporting to the Office for Oregon Health Policy and Research and all advisory task forces on health policy appointed by the administrator shall report directly to the Oregon Health Policy Commission.

(8)(a) ORS 192.610 to 192.690 apply to any meeting of any technical or advisory committee or advisory task force with the authority to make decisions for, conduct policy research for or make recommendations to the Office for Oregon Health Policy and Research.

(b) Paragraph (a) of this subsection applies only to meetings attended by two or more committee or task force members who are not employed by a public body. [1993 c.815 §3; 1995 c.727 §19; 1997 c.683 §14; 1999 c.547 §5; 2003 c.47 §1; 2003 c.784 §6]

Note: See note under 414.018.

414.022 Provision of mental health services; goals; criteria; reports. Mental health services shall be provided by the Department of Human Services, in collaboration with the Health Services Commission, for the purpose of determining how best to serve the range of mental health conditions statewide utilizing a capitated managed care system. The services shall begin as soon as feasible following receipt of the necessary waiver in anticipation that the services are to be available not later than January 1, 1995, and shall cover up to 25 percent of state-funded mental health services until July 1, 1997. After July 1, 1997, the services shall cover all of the state-funded eligible mental health services. The provision of services under this section shall support and be consistent with community mental health and developmental disabilities programs established and operated or contracted for under ORS chapter 430. The goals and criteria are:

(1) Test actuarial assumptions used to project costs and utilization rates, and revise estimates of cost for statewide implementation.

(2) Compare current medical assistance fee for service with capitated managed care mental health system, using state determined quality assurance standards to evaluate capacity, diagnosis, utilization and treatment:

(a) Including components for testing full integration of physical medicine and mental health services and measuring the impact of mental health services on utilization of physical health services.

(b) Comparing current medical assistance fee for service with capitated managed care system for utilization and length of stay in private and public hospitals, and in nonhospital residential care facilities.

(c) Comparing for specific conditions, treatment configuration, effectiveness and disposition rates.

(3) Design the services to assure geographic coverage of urban and rural areas including significant population bases, and areas with and without existing capacity to provide fully capitated managed care services including:

(a) Requiring providers to maintain and report information about clients by type and amount of services in a predetermined uniform format for comparison with state established quality assurance standards.

(b) Within the geographic areas in which services are provided, requiring providers to serve the full range of mental health populations and conditions.

(c) Requiring providers to have the full range of eligible mental health services available including, but not limited to, assessment, case management, outpatient treatment and hospitalization.

(4) The department shall report to the Emergency Board and other appropriate interim legislative committees and task forces by October 1, 1996, on the implementation of the services. [1993 c.815 §29; 1995 c.806 §3; 1995 c.807 §4; 1999 c.835 §1; 2001 c.900 §100]

Note: See note under 414.018.

414.023 Chemical dependency services; goal. Chemical dependency services shall begin on January 1, 1995, to operate through June 30, 1996, in the Department of Human Services for the purpose of demonstrating the relationship of alcohol and drug services to the costs of physical medicine. After July 1, 1996, the services shall cover all of the eligible state-funded chemical dependency services. The goal of the services is to reduce the inappropriate use of physical medicine by providing treatment services in an integrated and managed care system. The services shall consist of outpatient services only and may be either statewide or geographically limited depending on the waiver agreement negotiated with the federal government. [1993 c.815 §30; 1997 c.249 §128]

Note: See note under 414.018.

414.024 Guidelines for selecting areas for initial operation of programs. In the selection of any area of the state for the initial operation of the programs authorized by ORS 414.018 to 414.024, 414.042, 414.107, 414.710, 414.720 and 735.712, the Administrator of the Office for Oregon Health Policy and Research shall take into account the levels and rates of unemployment in different areas of the state, the need to provide basic health care coverage to a population reasonably representative of the portion of the state's population that lacks such coverage and the need for geographic, demographic and economic diversity. [1993 c.815 §31; 1997 c.683 §15; 1999 c.547 §6]

Note: See note under 414.018.

414.025 Definitions. As used in this chapter, unless the context or a specially applicable statutory definition requires otherwise:

(1) "Category of aid" means assistance provided by the Oregon Supplemental Income Program, aid granted under ORS 412.001 to 412.069 and 418.647 or federal Supplemental Security Income payments.

(2) "Categorically needy" means, insofar as funds are available for the category, a person who is a resident of this state and who:

(a) Is receiving a category of aid.

(b) Would be eligible for, but is not receiving a category of aid.

(c) Is in a medical facility and, if the person left such facility, would be eligible for a category of aid.

(d) Is under the age of 21 years and would be a dependent child as defined in ORS 412.001 except for age and regular attendance in school or in a course of professional or technical training.

(e)(A) Is a caretaker relative, as defined in ORS 412.001, who cares for a child who would be a dependent child except for age and regular attendance in school or in a course of professional or technical training; or

(B) Is the spouse of the caretaker relative.

(f) Is under the age of 21 years, is in a foster family home or licensed child-caring agency or institution under a purchase of care agreement and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part.

(g) Is a spouse of an individual receiving a category of aid and who is living with the recipient of a category of aid, whose needs and income are taken into account in determining the cash needs of the recipient of a category of aid, and who is determined by the Department of Human Services to be essential to the well-being of the recipient of a category of aid.

(h) Is a caretaker relative as defined in ORS 412.001 who cares for a dependent child receiving aid granted under ORS 412.001 to 412.069 and 418.647 or is the spouse of the caretaker relative.

(i) Is under the age of 21 years, is in a youth care center and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part.

(j) Is under the age of 21 years and is in an intermediate care facility which includes institutions for persons with mental retardation; or is under the age of 22 years and is in a psychiatric hospital.

(k) Is under the age of 21 years and is in an independent living situation with all or part of the maintenance cost paid by the Department of Human Services.

(L) Is a member of a family that received aid under ORS 412.006 or 412.014 in at least three of the six months immediately preceding the month in which the family became ineligible for aid due to increased hours of or increased income from employment. As long as the member of the family is employed, such families will continue to be eligible for medical assistance for a period of at least six calendar months beginning with the month in which such family became in-

eligible for assistance due to increased hours of employment or increased earnings.

(m) Is an adopted person under 21 years of age for whom a public agency is assuming financial responsibility in whole or in part.

(n) Is an individual or is a member of a group who is required by federal law to be included in the state's medical assistance program in order for that program to qualify for federal funds.

(o) Is an individual or member of a group who, subject to the rules of the department and within available funds, may optionally be included in the state's medical assistance program under federal law and regulations concerning the availability of federal funds for the expenses of that individual or group.

(p) Is a pregnant woman who would be eligible for aid granted under ORS 412.001 to 412.069 and 418.647, whether or not the woman is eligible for cash assistance.

(q) Except as otherwise provided in this section and to the extent of available funds, is a pregnant woman or child for whom federal financial participation is available under Title XIX of the federal Social Security Act.

(r) Is not otherwise categorically needy and is not eligible for care under Title XVIII of the federal Social Security Act or is not a full-time student in a post-secondary education program as defined by the Department of Human Services by rule, but whose family income is less than the federal poverty level and whose family investments and savings equal less than the investments and savings limit established by the department by rule.

(s) Would be eligible for a category of aid but for the receipt of qualified long term care insurance benefits under a policy or certificate issued on or after January 1, 2008. As used in this paragraph, "qualified long term care insurance" means a policy or certificate of insurance as defined in ORS 743.652 (6).

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

(4) "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 of Human Services may establish by rule that are available to the applicant or recipient to contribute toward meeting the needs of the applicant or recipient.

(5) "Medical assistance" means so much of the following medical and remedial care and services as may be prescribed by the Department of Human Services according to the standards established pursuant to ORS 414.065, including payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of medical care:

(a) Inpatient hospital services, other than services in an institution for mental diseases;

(b) Outpatient hospital services;

(c) Other laboratory and X-ray services;

(d) Skilled nursing facility services, other than services in an institution for mental diseases;

(e) Physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere;

(f) Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;

(g) Home health care services;

(h) Private duty nursing services;

(i) Clinic services;

(j) Dental services;

(k) Physical therapy and related services;

(L) Prescribed drugs, including those dispensed and administered as provided under ORS chapter 689;

(m) Dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(n) Other diagnostic, screening, preventive and rehabilitative services;

(o) Inpatient hospital services, skilled nursing facility services and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases;

(p) Any other medical care, and any other type of remedial care recognized under state law;

(q) Periodic screening and diagnosis of individuals under the age of 21 years to ascertain their physical or mental impairments, and such health care, treatment and other measures to correct or ameliorate impairments and chronic conditions discovered thereby;

(r) Inpatient hospital services for individuals under 22 years of age in an institution for mental diseases; and

(s) Hospice services.

(6) "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. "Medical assistance" includes "health services" as defined in ORS 414.705. "Medical assistance" does not include care or services for an inmate in a nonmedical public institution.

(7) "Medically needy" means a person who is a resident of this state and who is considered eligible under federal law for medically needy assistance.

(8) "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. [1965 c.556 §2; 1967 c.502 §3; 1969 c.507 §1; 1971 c.488 §1; 1973 c.651 §10; 1974 c.16 §1; 1977 c.114 §1; 1981 c.825 §3; 1983 c.415 §3; 1985 c.747 §9; 1987 c.872 §1; 1989 c.697 §2; 1989 c.836 §19; 1991 c.66 §6; 1995 c.343 §42; 1995 c.807 §1; 1997 c.581 §22; 1999 c.59 §107; 1999 c.350 §1; 1999 c.515 §1; 2003 c.14 §188; 2005 c.381 §13; 2007 c.70 §190; 2007 c.486 §11; 2007 c.861 §18]

Note: The amendments to 414.025 by section 18a, chapter 861, Oregon Laws 2007, become operative October 1, 2008. See section 25, chapter 861, Oregon Laws 2007. The text that is operative on and after October 1, 2008, is set forth for the user's convenience.

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

(1) "Category of aid" means assistance provided by the Oregon Supplemental Income Program, aid granted under ORS 412.001 to 412.069 and 418.647 or federal Supplemental Security Income payments.

(2) "Categorically needy" means, insofar as funds are available for the category, a person who is a resident of this state and who:

(a) Is receiving a category of aid.

(b) Would be eligible for, but is not receiving a category of aid.

(c) Is in a medical facility and, if the person left such facility, would be eligible for a category of aid.

(d) Is under the age of 21 years and would be a dependent child as defined in ORS 412.001 except for age and regular attendance in school or in a course of professional or technical training.

(e)(A) Is a caretaker relative, as defined in ORS 412.001, who cares for a child who would be a dependent child except for age and regular attendance in school or in a course of professional or technical training; or

(B) Is the spouse of the caretaker relative.

(f) Is under the age of 21 years, is in a foster family home or licensed child-caring agency or institution under a purchase of care agreement and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part.

(g) Is a spouse of an individual receiving a category of aid and who is living with the recipient of a category of aid, whose needs and income are taken into account in determining the cash needs of the recipient of a category of aid, and who is determined by the Department of Human Services to be essential to the well-being of the recipient of a category of aid.

(h) Is a caretaker relative as defined in ORS 412.001 who cares for a dependent child receiving aid granted under ORS 412.001 to 412.069 and 418.647 or is the spouse of the caretaker relative.

(i) Is under the age of 21 years, is in a youth care center and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part.

(j) Is under the age of 21 years and is in an intermediate care facility which includes institutions for persons with mental retardation; or is under the age of 22 years and is in a psychiatric hospital.

(k) Is under the age of 21 years and is in an independent living situation with all or part of the maintenance cost paid by the Department of Human Services.

(L) Is a member of a family that received aid in the preceding month under ORS 412.006 or 412.014 and became ineligible for aid due to increased hours of or increased income from employment. As long as the member of the family is employed, such families will continue to be eligible for medical assistance for a period of at least six calendar months beginning with the month in which such family became ineligible for assistance due to increased hours of employment or increased earnings.

(m) Is an adopted person under 21 years of age for whom a public agency is assuming financial responsibility in whole or in part.

(n) Is an individual or is a member of a group who is required by federal law to be included in the state's medical assistance program in order for that program to qualify for federal funds.

(o) Is an individual or member of a group who, subject to the rules of the department and within available funds, may optionally be included in the state's medical assistance program under federal law and regulations concerning the availability of federal funds for the expenses of that individual or group.

(p) Is a pregnant woman who would be eligible for aid granted under ORS 412.001 to 412.069 and 418.647, whether or not the woman is eligible for cash assistance.

(q) Except as otherwise provided in this section and to the extent of available funds, is a pregnant woman or child for whom federal financial participation is available under Title XIX of the federal Social Security Act.

(r) Is not otherwise categorically needy and is not eligible for care under Title XVIII of the federal Social Security Act or is not a full-time student in a post-secondary education program as defined by the Department of Human Services by rule, but whose family income is less than the federal poverty level and whose family investments and savings equal less than the investments and savings limit established by the department by rule.

(s) Would be eligible for a category of aid but for the receipt of qualified long term care insurance benefits under a policy or certificate issued on or after January 1, 2008. As used in this paragraph, "qualified long term care insurance" means a policy or certificate of insurance as defined in ORS 743.652 (6).

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

(4) "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 of Human Services may establish by rule that are available to the applicant or recipient to contribute toward meeting the needs of the applicant or recipient.

(5) "Medical assistance" means so much of the following medical and remedial care and services as may be prescribed by the Department of Human Services according to the standards established pursuant to ORS 414.065, including payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of medical care:

(a) Inpatient hospital services, other than services in an institution for mental diseases;

(b) Outpatient hospital services;

(c) Other laboratory and X-ray services;

(d) Skilled nursing facility services, other than services in an institution for mental diseases;

(e) Physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere;

(f) Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;

(g) Home health care services;

(h) Private duty nursing services;

(i) Clinic services;

(j) Dental services;

(k) Physical therapy and related services;

(L) Prescribed drugs, including those dispensed and administered as provided under ORS chapter 689;

(m) Dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(n) Other diagnostic, screening, preventive and rehabilitative services;

(o) Inpatient hospital services, skilled nursing facility services and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases;

(p) Any other medical care, and any other type of remedial care recognized under state law;

(q) Periodic screening and diagnosis of individuals under the age of 21 years to ascertain their physical or mental impairments, and such health care, treatment and other measures to correct or ameliorate impairments and chronic conditions discovered thereby;

(r) Inpatient hospital services for individuals under 22 years of age in an institution for mental diseases; and

(s) Hospice services.

(6) "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. "Medical assistance" includes "health services" as defined in ORS 414.705. "Medical assistance" does not include care or services for an inmate in a nonmedical public institution.

(7) "Medically needy" means a person who is a resident of this state and who is considered eligible under federal law for medically needy assistance.

(8) "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.

414.026 [2001 c.980 §2; renumbered 414.420 in 2005]

414.027 [2001 c.980 §3; renumbered 414.422 in 2005]

414.028 [Formerly 414.305; renumbered 414.426 in 2005]

414.029 [2003 c.76 §1; renumbered 414.428 in 2005]

414.030 [Repealed by 1953 c.204 §9]

MISCELLANEOUS PROVISIONS

414.031 Oregon Health Policy Commission to review changes proposed by Department of Human Services for medical assistance program and other health care programs. (1) The Department of Human Services shall submit to the Oregon Health Policy Commission any proposals to amend the State Medicaid Plan, modify Medicaid operational protocols, submit an application for a waiver to the Centers for Medicare and Medicaid Services or adopt or amend any administrative rules for the state's medical assistance program and other health care programs.

(2) If the commission has concerns regarding a State Medicaid Plan amendment, a modification in Medicaid operational protocols, an application for a waiver or adoption or amendment of an administrative rule proposed by the department, the department shall consider the concerns expressed by the commission during administrative decision-making. [2003 c.784 §9]

Note: 414.031 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

414.032 Medical assistance to categorically needy and medically needy. Within the limits of funds available therefor, medical assistance shall be made available to persons who are categorically needy or medically needy. [1967 c.502 §4; 1985 c.747 §10]

414.033 Expenditures for medical assistance authorized. The Department of Human Services may:

(1) Subject to the allotment system provided for in ORS 291.234 to 291.260, expend such sums as are required to be expended in this state to provide medical assistance. Expenditures for medical assistance include, but are not limited to, expenditures for deductions, cost sharing, enrollment fees, premiums or similar charges imposed with respect to hospital insurance benefits or supplementary health insurance benefits, as established by federal law.

(2) Enter into agreements with, join with or accept grants from, the federal government for cooperative research and demonstration projects for public welfare purposes, including, but not limited to, any project which determines the cost of providing medical assistance to the medically needy and evaluates service delivery systems. [1991 c.66 §5]

414.034 Acceptance of federal billing, reimbursement and reporting forms. The Department of Human Services shall accept federal Centers for Medicare and Medicaid Services billing, reimbursement and report-

ing forms instead of department billing, reimbursement and reporting forms if the federal forms contain substantially the same information as required by the department forms. [2003 c.135 §1]

Note: 414.034 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

414.035 [1965 c.556 §1; repealed by 1967 c.502 §21]

414.036 Policy on persons without access to health services. (1) The Legislative Assembly finds that:

(a) Hundreds of thousands of Oregonians have no health insurance or other coverage and lack the income and resources needed to obtain health care;

(b) The number of persons without access to health services increases dramatically during periods of high unemployment;

(c) Without health coverage, persons who lack access to health services may receive treatment, but through costly, inefficient, acute care;

(d) The unpaid cost of health services for such persons is shifted to paying patients, driving up the cost of hospitalization and health insurance for all Oregonians; and

(e) The state's medical assistance program is increasingly unable to fund the health care needs of low-income citizens.

(2) In order to provide access to health services for those in need, to contain rising health services costs through appropriate incentives to providers, payers and consumers, to reduce or eliminate cost shifting and to promote the stability of the health services delivery system and the health and well-being of all Oregonians, it is the policy of the State of Oregon to provide medical assistance to those individuals in need whose family income is below the federal poverty level and who are eligible for services under the programs authorized by this chapter. [1983 c.415 §2; 1989 c.836 §1; 1991 c.753 §1]

414.037 [1967 c.502 §5; repealed by 1975 c.509 §2 (414.038 enacted in lieu of 414.037)]

PROCEDURE TO OBTAIN MEDICAL ASSISTANCE

414.038 Medically needy program; determination of income. (1) Payments in behalf of medically needy individuals may be made for a member of a family which has annual income within the following levels:

(a) One hundred thirty-three and one-third (133-1/3) percent of the highest money payment which would ordinarily be made under the state's ADC plan to a family of the same size without any income or resources.

(b) In the case of a single individual, an amount reasonably related to amounts payable to families consisting of two or more individuals who are without income or resources.

(2) In computing a family's or individual's income, as provided in subsection (1) of this section, any costs, whether in the form of insurance premiums or otherwise, incurred by the family or individual for medical care or for any other type of remedial care recognized under state law may be excluded, except to the extent that they are reimbursed by a third party. [1975 c.509 §§3,4 (enacted in lieu of 414.037)]

414.039 Medically needy program; rules. (1) The Department of Human Services shall establish by rule a medically needy program providing services to which the categorically eligible are entitled.

(2) These services shall be provided to persons who meet categorical eligibility requirements, other than requirements relating to income limitations. Maximum income eligibility for services through the medically needy program shall be set at up to 133-1/3 percent of the payment standard for temporary assistance for needy families eligibility, the percent to be set by the department in consultation with the Legislative Assembly. [1985 c.747 §12; 1989 c.31 §1; 1991 c.66 §7; 1997 c.581 §23]

414.040 [1953 c.204 §2; renumbered 414.810 and then 566.310]

414.042 Determination of need for and amount of medical assistance; rules. (1) The need for and the amount of medical assistance to be made available for each eligible group of recipients of medical assistance shall be determined, in accordance with the rules of the Department of Human Services, taking into account:

(a) The requirements and needs of the person, the spouse and other dependents;

(b) The income, resources and maintenance available to the person but, except as provided in ORS 414.025 (2)(r), resources shall be disregarded for those eligible by reason of having income below the federal poverty level and who are eligible for medical assistance only because of the enactment of chapter 836, Oregon Laws 1989;

(c) The responsibility of the spouse and, with respect to a person who is blind or is permanently and totally disabled or is under 21 years of age, the responsibility of the parents; and

(d) The report of the Health Services Commission as funded by the Legislative Assembly and such other programs as the Legislative Assembly may authorize. However, medical assistance, including health services, shall not be provided to persons described in

ORS 414.025 (2)(r) unless the Legislative Assembly specifically appropriates funds to provide such assistance.

(2) Such amounts of income and resources may be disregarded as the department may prescribe by rules, except that the department may not require any needy person over 65 years of age, as a condition of entering or remaining in a hospital, nursing home or other congregate care facility, to sell any real property normally used as such person's home. Any rule of the department inconsistent with this section is to that extent invalid. The amounts to be disregarded shall be within the limits required or permitted by federal law, rules or orders applicable thereto.

(3) In the determination of the amount of medical assistance available to a medically needy person, all income and resources available to the person in excess of the amounts prescribed in ORS 414.038, within limits prescribed by the department, shall be applied first to costs of needed medical and remedial care and services not available under the medical assistance program and then to the costs of benefits under the medical assistance program. [1967 c.502 §6; 1971 c.503 §1; 1989 c.836 §20; 1991 c.66 §8; 1991 c.753 §2; 1993 c.815 §20; 1995 c.807 §2; 1997 c.581 §24; 2007 c.861 §21]

414.045 [1965 c.556 §3; repealed by 1967 c.502 §21]

414.047 Application for medical assistance. (1) Application for any category of aid shall also constitute application for medical assistance.

(2) Except as otherwise provided in this section, each person requesting medical assistance shall make application therefor to the Department of Human Services. The department shall determine eligibility for and fix the date on which such assistance may begin, and shall obtain such other information required by the rules of the department.

(3) If an applicant is unable to make application for medical assistance, an application may be made by someone acting responsibly for the applicant. [1967 c.502 §7; 1969 c.68 §8; 1971 c.779 §46; 1991 c.66 §9; 2003 c.14 §189]

414.049 Documentation required for person applying for medical assistance under ORS 414.705 to 414.750. For each person applying for health services under ORS 414.705 to 414.750, the Department of Human Services shall fully document:

(1) The category of aid as defined in ORS 414.025 that makes the person eligible for medical assistance or the way in which the person qualifies as categorically needy as defined in ORS 414.025;

(2) The status of the person as a resident of this state; and

(3) The financial income and resources of the person. [2003 c.810 §17]

Note: 414.049 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

414.050 [1953 c.204 §2; renumbered 414.820 and then 566.320]

414.051 Authorization and payment for dental services. The Department of Human Services shall approve or deny prior authorization requests for dental services not later than 30 days after submission thereof by the provider, and shall make payments to providers of prior authorized dental services not later than 30 days after receipt of the invoice of the provider. [1979 c.296 §2; 1991 c.66 §10]

414.055 Hearing on eligibility. Any individual whose claim for medical assistance is denied or is not acted upon with reasonable promptness may petition the Department of Human Services for a fair hearing. The hearing shall be held at a time and place and shall be conducted in accordance with the rules of the department. [1965 c.556 §4; 1971 c.734 §45; 1971 c.779 §47; 1991 c.66 §11]

414.057 Notice of change in circumstances. Upon the receipt of property or income or upon any other change in circumstances which directly affects the eligibility of the recipient to receive medical assistance or the amount of medical assistance available to the recipient, the recipient shall immediately notify the Department of Human Services of the receipt or possession of such property or income, or other change in circumstances. Failure to give the notice shall entitle the Department of Human Services to recover from the recipient the amount of assistance improperly disbursed by reason thereof. [1967 c.502 §8; 1971 c.779 §48; 1991 c.66 §12]

414.060 [1953 c.204 §3; renumbered 414.830 and then 566.330]

MEDICAL ASSISTANCE

414.065 Determination of health services covered; standards; cost sharing; payments by department as payment in full; rules. (1)(a) With respect to medical and remedial care and services to be provided in medical assistance during any period, and within the limits of funds available therefor, the Department of Human Services shall determine, subject to such revisions as it may make from time to time and with respect to the "health services" defined in ORS 414.705, subject to legislative funding in response to the report of the Health Services Commission and paragraph (b) of this subsection:

(A) The types and extent of medical and remedial care and services to be provided to each eligible group of recipients of medical assistance.

(B) Standards to be observed in the provision of medical and remedial care and services.

(C) The number of days of medical and remedial care and services toward the cost of which public assistance funds will be expended in the care of any person.

(D) Reasonable fees, charges and daily rates to which public assistance funds will be applied toward meeting the costs of providing medical and remedial care and services to an applicant or recipient.

(E) Reasonable fees for professional medical and dental services which may be based on usual and customary fees in the locality for similar services.

(F) The amount and application of any copayment or other similar cost-sharing payment that the department may require a recipient to pay toward the cost of medical and remedial care or services.

(b) Notwithstanding ORS 414.720 (8), the department shall adopt rules establishing timelines for payment of health services under paragraph (a) of this subsection.

(2) The types and extent of medical and remedial care and services and the amounts to be paid in meeting the costs thereof, as determined and fixed by the department and within the limits of funds available therefor, shall be the total available for medical assistance and payments for such medical assistance shall be the total amounts from public assistance funds available to providers of medical and remedial care and services in meeting the costs thereof.

(3) Except for payments under a cost-sharing plan, payments made by the department for medical assistance shall constitute payment in full for all medical and remedial care and services for which such payments of medical assistance were made.

(4) Medical benefits, standards and limits established pursuant to subsection (1)(a)(A), (B) and (C) of this section for the eligible medically needy, except for persons receiving assistance under ORS 411.706, may be less than but may not exceed medical benefits, standards and limits established for the eligible categorically needy, except that, in the case of a research and demonstration project entered into under ORS 411.135, medical benefits, standards and limits for the eligible medically needy may exceed those established for specific eligible groups of the categorically needy. [1965 c.556 §5; 1967 c.502 §12; 1975 c.509 §5; 1981 c.825 §4; 1987 c.918 §4; 1989 c.836 §21; 1991 c.66 §13; 1991 c.753 §3; 1995 c.271 §1; 1995 c.807 §3; 1999 c.546 §1; 2001 c.875 §1; 2005 c.381 §14; 2005 c.806 §1]

414.070 [1953 c.204 §4; renumbered 414.840 and then 566.340]

414.073 Information on all licensed healing arts to be made available. When giving information concerning medical assistance, the Department of Human Services shall make available to applicants or recipients materials which include at least a listing of all the healing arts licensed in this state. [1971 c.188 §2; 1991 c.66 §14]

414.075 Payment of deductibles imposed under federal law. Medical assistance provided to any individual who is covered by the hospital insurance benefits or supplementary health insurance benefits, or either of them, as established by federal law, may include:

(1) The full amount of any deductible imposed with respect to such individual under the hospital insurance benefits; and

(2) All or any part of any deductible, cost sharing, or similar charge imposed with respect to such individual under the health insurance benefits. [1965 c.556 §§8,9; 1967 c.502 §13; 1977 c.114 §2]

414.080 [1953 c.204 §5; renumbered 414.850 and then 566.350]

414.085 Cooperative agreements authorized. (1) The Department of Human Services may enter into cooperative arrangements with other state agencies and with public or private local agencies:

(a) To establish and maintain standards for private or public institutions in which recipients of medical assistance may receive care or services.

(b) To obtain maximum utilization of health services and vocational rehabilitation services in the provision of medical assistance.

(c) To provide medical assistance in a manner consistent with simplicity of administration and the best interests of the recipients.

(d) To arrange for joint planning and for development of alternate methods of care, making maximum utilization of available resources, with respect to recipients with mental diseases or tuberculosis, and to provide an individual plan for each such patient to assure that the institutional care provided is in the best interests of the patient.

(e) To obtain satisfactory progress toward attaining a comprehensive mental health program, utilizing community mental health centers, nursing homes and other alternatives to care in a public institution for mental diseases.

(2) Nothing in subsection (1) of this section shall be construed to impose upon or grant to the department responsibility or authority for state programs relating to standards, licensing, vocational rehabilitation, mental health or tuberculosis not otherwise expressly so imposed or granted by law. [1965 c.556 §10; 1991 c.66 §15]

414.090 [1953 c.204 §6; renumbered 414.860 and then 566.360]

414.095 Exemptions applicable to payments. Neither medical assistance nor amounts payable to vendors out of public assistance funds are transferable or assignable at law or in equity and none of the money paid or payable under the provisions of this chapter is subject to execution, levy, attachment, garnishment or other legal process. [1965 c.556 §11; 1967 c.502 §14; 2001 c.900 §222]

414.105 Recovery of medical assistance; estate claims; transfer of assets; rules. (1) The Department of Human Services may recover from any person the amounts of medical assistance incorrectly paid on behalf of such person.

(2) Medical assistance pursuant to this chapter paid on behalf of an individual who was 55 years of age or older when the individual received such assistance, or paid on behalf of a person of any age who was a permanently institutionalized inpatient in a nursing facility, intermediate care facility for persons with mental retardation or other medical institution, may be recovered from the estate of the individual or from any recipient of property or other assets held by the individual at the time of death including the estate of the surviving spouse. Claim for such medical assistance correctly paid to the individual may be established against the estate, but there shall be no adjustment or recovery thereof until after the death of the surviving spouse, if any, and only at a time when the individual has no surviving child who is under 21 years of age or who is blind or permanently and totally disabled. Transfers of real or personal property by recipients of such aid without adequate consideration are voidable and may be set aside under ORS 411.620 (2).

(3) Nothing in this section authorizes the recovery of the amount of any aid from the estate or surviving spouse of a recipient to the extent that the need for aid resulted from a crime committed against the recipient.

(4) In any action or proceeding under this section to recover medical assistance paid, it shall be the legal burden of the person who receives the property or other assets from a Medicaid recipient to establish the extent and value of the Medicaid recipient's legal title or interest in the property or assets in accordance with rules established by the department.

(5) As used in this section, "estate" includes all real and personal property and other assets in which the deceased individual had any legal title or interest at the time of death including assets conveyed to a survivor, heir or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust or other similar arrangement. [1965 c.556 §12; 1967 c.502 §15; 1969 c.507 §2; 1971 c.334 §1; 1973 c.334 §1; part renumbered 416.280; 1975 c.386 §4; 1985 c.522 §4; 1991 c.66 §16; 1993 c.249 §5; 1995 c.642 §1; 2001 c.620 §5; 2001 c.900 §223; 2007 c.70 §191]

414.106 Possible limitation on recovery of certain medical assistance; federal law. (1) Subject to the requirements of subsection (2) of this section, if 42 U.S.C. 1396p (b)(1)(B) as in effect on January 1, 1995, is repealed without replacement or is declared unconstitutional, the Director of Human Services shall limit the recovery of medical assistance paid pursuant to ORS chapter 414 from the estate of an individual or a recipient of property or other assets held by an individual at the time of death, including a surviving spouse of the individual, to the recovery of medical assistance payments paid on behalf of the individual on or after the date that the individual attained 65 years of age.

(2) The director shall limit the recovery of medical assistance as described under subsection (1) of this section only if the director determines, after receiving the written opinion of the Attorney General, that the recovery limitation will not violate any federal law in effect on the operative date of the recovery limitation. The director may condition, limit, modify or terminate any recovery limitation as the director considers necessary to avoid a violation of federal law. [1995 c.642 §2; 2001 c.900 §224]

Note: 414.106 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

414.107 Entitlement to mental health care and chemical dependency services. Until such time as mental health care and chemical dependency services are integrated into the Health Services Commission priority list and the integrated list is funded by the Legislative Assembly and the necessary federal waivers are obtained, persons eligible for care and treatment under this chapter shall be entitled to such care and services. [1991 c.753 §5a; 1993 c.815 §15]

Note: 414.107 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 414 by legislative action. See Preface to Oregon Revised Statutes for further explanation.

414.109 Oregon Health Plan Fund. (1) The Oregon Health Plan Fund is established, separate and distinct from the General Fund. Interest earned by the Oregon Health Plan Fund shall be retained by the Oregon Health Plan Fund.

(2) Moneys in the Oregon Health Plan Fund are continuously appropriated to the Department of Human Services for the purposes of funding the maintenance and expansion of the number of persons eligible for medical assistance under the Oregon Health Plan and funding the maintenance of the benefits available under the Oregon Health Plan. [2002 s.s.3 c.2 §9]

Note: 414.109 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

INSURANCE AND SERVICE CONTRACTS

414.115 Medical assistance by insurance or service contracts; rules. (1) In lieu of providing one or more of the medical and remedial care and services available under medical assistance by direct payments to providers thereof and in lieu of providing such medical and remedial care and services made available pursuant to ORS 414.065, the Department of Human Services shall use available medical assistance funds to purchase and pay premiums on policies of insurance, or enter into and pay the expenses on health care service contracts, or medical or hospital service contracts that provide one or more of the medical and remedial care and services available under medical assistance for the benefit of the categorically needy or the medically needy, or both. Notwithstanding other specific provisions, the use of available medical assistance funds to purchase medical or remedial care and services may provide the following insurance or contract options:

(a) Differing services or levels of service among groups of eligibles as defined by rules of the department; and

(b) Services and reimbursement for these services may vary among contracts and need not be uniform.

(2) The policy of insurance or the contract by its terms, or the insurer or contractor by written acknowledgment to the department must guarantee:

(a) To provide medical and remedial care and services of the type, within the extent and according to standards prescribed under ORS 414.065;

(b) To pay providers of medical and remedial care and services the amount due, based on the number of days of care and the fees, charges and costs established under ORS 414.065, except as to medical or hospital service contracts which employ a method of accounting or payment on other than a fee-for-service basis;

(c) To provide medical and remedial care and services under policies of insurance or contracts in compliance with all laws, rules and regulations applicable thereto; and

(d) To provide such statistical data, records and reports relating to the provision, administration and costs of providing medical and remedial care and services to the department as may be required by the department for its records, reports and audits. [1967 c.502 §9; 1975 c.401 §1; 1981 c.825 §5; 1991 c.66 §17]

414.125 Rates on insurance or service contracts; requirements for insurer or contractor. (1) Any payment of available medical assistance funds for policies of insurance or service contracts shall be according to such uniform area-wide rates as the Department of Human Services shall have established and which it may revise from time to time as may be necessary or practical, except that, in the case of a research and demonstration project entered into under ORS 411.135 special rates may be established.

(2) No premium or other periodic charge on any policy of insurance, health care service contract, or medical or hospital service contract shall be paid from available medical assistance funds unless the insurer or contractor issuing such policy or contract is by law authorized to transact business as an insurance company, health care service contractor or hospital association in this state. [1967 c.502 §10; 1975 c.509 §6; 1991 c.66 §18]

414.135 Contracts relating to direct providers of care and services. The Department of Human Services may enter into nonexclusive contracts under which funds available for medical assistance may be administered and disbursed by the contractor to direct providers of medical and remedial care and services available under medical assistance in consideration of services rendered and supplies furnished by them in accordance with the provisions of this chapter. Payment shall be made according to the rules of the department pursuant to the number of days and the fees, charges and costs established under ORS 414.065. The contractor must guarantee the department by written acknowledgment:

(1) To make all payments under this chapter promptly but not later than 30 days after receipt of the proper evidence establishing the validity of the provider's claim.

(2) To provide such data, records and reports to the department as may be required by the department. [1967 c.502 §11; 1991 c.66 §19]

414.145 Implementation of ORS 414.115, 414.125 or 414.135. (1) The provisions of ORS 414.115, 414.125 or 414.135 shall be implemented whenever it appears to the Department of Human Services that such implementation will provide comparable benefits at equal or less cost than provision thereof by direct payments by the department to the providers of medical assistance, but in no case greater than the legislatively approved budgeted cost per eligible recipient at the time of contracting.

(2) When determining comparable benefits at equal or less cost as provided in subsection (1) of this section, the department must take into consideration the recipients' need for reasonable access to preventive and remedial care, and the contractor's ability to assure continuous quality delivery of both routine and emergency services. [1967 c.502 §11a; 1975 c.401 §3; 1983 c.590 §9; 1985 c.747 §12a; 1991 c.66 §20]

STATE AND LOCAL PUBLIC HEALTH PARTNERSHIP

414.150 Purpose of ORS 414.150 to 414.153. It is the purpose of ORS 414.150 to 414.153 to take advantage of opportunities to:

(1) Enhance the state and local public health partnership;

(2) Improve the access to care and health status of women and children; and

(3) Strengthen public health programs and services at the county health department level. [1991 c.337 §1]

Note: 414.150 to 414.153 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 414 by legislative action. See Preface to Oregon Revised Statutes for further explanation.

414.151 Enrollment of poverty level medical assistance program clients; agreements with local governments. The Department of Human Services shall endeavor to develop agreements with local governments to facilitate the enrollment of poverty level medical assistance program clients. Subject to the availability of funds therefor, the agreement shall be structured to allow flexibility by the state and local governments and may allow any of the following options for enrolling clients in poverty level medical assistance programs:

(1) Initial processing shall be done at the county health department by employees of the county, with eligibility determination completed at the local office of the Department of Human Services;

(2) Initial processing and eligibility determination shall be done at the county health department by employees of the local health department; or

(3) Application forms shall be made available at the county health department with initial processing and eligibility determination shall be done at the local office of the Department of Human Services. [1991 c.337 §2; 1993 c.18 §100; 2001 c.900 §101]

Note: See note under 414.150.

414.152 Duties of state agencies. To capitalize on the successful public health programs provided by county health departments and the sizable investment by state and local governments in the public health system, state agencies shall encourage agreements that allow county health departments and other publicly supported programs to continue to be the providers of those prevention and health promotion services now available, plus other maternal and child health services such as prenatal outreach and care, child health services and family planning services to women and children who become eligible for poverty level medical assistance program benefits pursuant to ORS 414.153. [1991 c.337 §3]

Note: See note under 414.150.

414.153 Authorization for payment for certain services. In order to make advantageous use of the system of public health services available through county health departments and other publicly supported programs and to insure access to public health services through contract under ORS chapter 414, the state shall:

(1) Unless cause can be shown why such an agreement is not feasible, require and approve agreements between prepaid health plans and publicly funded providers for authorization of payment for point of contact services in the following categories:

(a) Immunizations;

(b) Sexually transmitted diseases; and

(c) Other communicable diseases;

(2) Allow enrollees in prepaid health plans to receive from fee-for-service providers:

(a) Family planning services;

(b) Human immunodeficiency virus and acquired immune deficiency syndrome prevention services; and

(c) Maternity case management if the Department of Human Services determines that a prepaid plan cannot adequately provide the services;

(3) Encourage and approve agreements between prepaid health plans and publicly funded providers for authorization of and payment for services in the following categories:

(a) Maternity case management;

(b) Well-child care;

(c) Prenatal care;

(d) School-based clinics;

(e) Health services for children provided through schools and Head Start programs; and

(f) Screening services to provide early detection of health care problems among low income women and children, migrant workers and other special population groups; and

(4) Recognize the social value of partnerships between county health departments and other publicly supported programs and other health providers, and take appropriate measures to involve publicly supported health care and service programs in the development and implementation of managed health care programs in their areas of responsibility. [1991 c.337 §4; 1993 c.592 §1]

Note: See note under 414.150.

414.205 [1967 c.502 §18; 1981 c.825 §1; repealed by 1995 c.727 §48]

414.210 [1957 c.692 §1; repealed by 1963 c.631 §2]

ADVISORY COMMITTEES

414.211 Medicaid Advisory Committee. (1) There is established a Medicaid Advisory Committee consisting of not more than 15 members appointed by the Governor.

(2) The committee shall be composed of:

(a) A physician licensed under ORS chapter 677;

(b) Two members of health care consumer groups that include Medicaid recipients;

(c) Two Medicaid recipients, one of whom shall be a person with a disability;

(d) The Director of Human Services or designee;

(e) Health care providers;

(f) Persons associated with health care organizations, including but not limited to managed care plans under contract to the Medicaid program; and

(g) Members of the general public.

(3) In making appointments, the Governor shall consult with appropriate professional and other interested organizations. All members appointed to the committee shall be familiar with the medical needs of low income persons.

(4) The term of office for each member shall be two years, but each member shall serve at the pleasure of the Governor.

(5) Members of the committee shall receive no compensation for their services but, subject to any applicable state law, shall be allowed actual and necessary travel expenses incurred in the performance of their duties from the Public Welfare Account. [1995 c.727 §43; 2007 c.70 §192]

Note: 414.211 and 414.221 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

414.215 [1967 c.502 §19; 1991 c.66 §21; repealed by 1995 c.727 §48]

414.220 [1957 c.692 §2; repealed by 1963 c.631 §2]

414.221 Duties of committee. The Medicaid Advisory Committee shall advise the Administrator of the Office for Oregon Health Policy and Research and the Director of Human Services on:

(1) Medical care, including mental health and alcohol and drug treatment and remedial care to be provided under ORS chapter 414; and

(2) The operation and administration of programs provided under ORS chapter 414. [1995 c.727 §44; 2003 c.784 §7; 2007 c.697 §16]

Note: See note under 414.211.

414.225 Department to consult with committee. The Department of Human Services shall consult with the Medicaid Advisory Committee concerning the determinations required under ORS 414.065. [1967 c.502 §20; 1991 c.66 §22; 1995 c.727 §46; 2003 c.784 §8]

414.227 Application of public meetings law to advisory committees. (1) ORS 192.610 to 192.690 apply to any meeting of an advisory committee with the authority to make decisions for, conduct policy research for or make recommendations to the Department of Human Services on administration or policy related to the medical assistance program operated under this chapter.

(2) Subsection (1) of this section applies only to advisory committee meetings attended by two or more advisory committee members who are not employed by a public body. [2001 c.353 §2]

414.230 [1957 c.692 §5; repealed by 1963 c.631 §2]

414.240 [1957 c.692 §3; repealed by 1963 c.631 §2]

414.250 [1957 c.692 §4; repealed by 1963 c.631 §2]

414.260 [1957 c.692 §6; repealed by 1963 c.631 §2]

414.270 [1957 c.692 §7(1); repealed by 1963 c.631 §2]

414.280 [1957 c.692 §7(2); repealed by 1963 c.631 §2]

414.290 [1957 c.692 §7(3); repealed by 1963 c.631 §2]

414.300 [1957 c.692 §8; repealed by 1963 c.631 §2]

414.305 [1969 c.507 §3; 1971 c.33 §1; 1977 c.384 §5; 1991 c.66 §23; 2001 c.900 §102; renumbered 414.028 in 2001]

414.310 [1957 c.692 §9; 1961 c.130 §2; repealed by 1963 c.631 §2]

PRESCRIPTION DRUGS
(Oregon Prescription Drug Program)

414.312 Oregon Prescription Drug Program. (1) As used in ORS 414.312 to 414.318:

(a) "Pharmacy benefit manager" means an entity that, in addition to being a prescription drug claims processor, negotiates and executes contracts with pharmacies, manages preferred drug lists, negotiates rebates with prescription drug manufacturers and serves as an intermediary between the Oregon Prescription Drug Program, prescription drug manufacturers and pharmacies.

(b) "Prescription drug claims processor" means an entity that processes and pays prescription drug claims, adjudicates pharmacy claims, transmits prescription drug prices and claims data between pharmacies and the Oregon Prescription Drug Program and processes related payments to pharmacies.

(c) "Program price" means the reimbursement rates and prescription drug prices established by the administrator of the Oregon Prescription Drug Program.

(2) The Oregon Prescription Drug Program is established in the Department of Human Services. The purpose of the program is to:

(a) Purchase prescription drugs or reimburse pharmacies for prescription drugs in order to receive discounted prices and rebates;

(b) Make prescription drugs available at the lowest possible cost to participants in the program; and

(c) Maintain a list of prescription drugs recommended as the most effective prescription drugs available at the best possible prices.

(3) The Director of Human Services shall appoint an administrator of the Oregon Prescription Drug Program. The administrator shall:

(a) Negotiate price discounts and rebates on prescription drugs with prescription drug manufacturers;

(b) Purchase prescription drugs on behalf of individuals and entities that participate in the program;

(c) Contract with a prescription drug claims processor to adjudicate pharmacy claims and transmit program prices to pharmacies;

(d) Determine program prices and reimburse pharmacies for prescription drugs;

(e) Adopt and implement a preferred drug list for the program;

(f) Develop a system for allocating and distributing the operational costs of the program and any rebates obtained to participants of the program; and

(g) Cooperate with other states or regional consortia in the bulk purchase of prescription drugs.

(4) The following individuals or entities may participate in the program:

(a) Public Employees' Benefit Board;

(b) Local governments as defined in ORS 174.116 and special government bodies as defined in ORS 174.117 that directly or indirectly purchase prescription drugs;

(c) Enrollees in the Senior Prescription Drug Assistance Program created under ORS 414.342;

(d) Oregon Health and Science University established under ORS 353.020;

(e) State agencies that directly or indirectly purchase prescription drugs, including agencies that dispense prescription drugs directly to persons in state-operated facilities;

(f) Residents of this state who lack or are underinsured for prescription drug coverage;

(g) Private entities; and

(h) Labor organizations.

(5) The state agency that receives federal Medicaid funds and is responsible for implementing the state's medical assistance program may not participate in the program.

(6) The administrator may establish different reimbursement rates or prescription drug prices for pharmacies in rural areas to maintain statewide access to the program.

(7) The administrator shall establish the terms and conditions for a pharmacy to enroll in the program. A licensed pharmacy that is willing to accept the terms and conditions established by the administrator may apply to enroll in the program.

(8) Except as provided in subsection (9) of this section, the administrator may not:

(a) Contract with a pharmacy benefit manager;

(b) Establish a state-managed wholesale or retail drug distribution or dispensing system; or

(c) Require pharmacies to maintain or allocate separate inventories for prescription drugs dispensed through the program.

(9) The administrator shall contract with one or more entities to provide the functions of a prescription drug claims processor. The administrator may also contract with a pharmacy benefit manager to negotiate with prescription drug manufacturers on behalf of the administrator.

(10) Notwithstanding subsection (4)(f) of this section, individuals who are eligible for Medicare Part D prescription drug coverage may participate in the program. [2003 c.714 §1; 2007 c.2 §1; 2007 c.67 §1; 2007 c.697 §17]

Note: 414.312 to 414.320 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

414.314 Application and participation in Oregon Prescription Drug Program; prescription drug charges; fees. (1) An individual or entity described in ORS 414.312 (4) may apply to participate in the Oregon Prescription Drug Program. Participants shall apply on an application provided by the Department of Human Services. The department may charge participants a nominal fee to participate in the program. The department shall issue a prescription drug identification card to participants of the program.

(2) The department shall provide a mechanism to calculate and transmit the program prices for prescription drugs to a pharmacy. The pharmacy shall charge the participant the program price for a prescription drug.

(3) A pharmacy may charge the participant the professional dispensing fee set by the department.

(4) Prescription drug identification cards issued under this section must contain the information necessary for proper claims adjudication or transmission of price data. [2003 c.714 §2; 2007 c.67 §2; 2007 c.697 §18]

Note: See note under 414.312.

414.316 Preferred drug list for Oregon Prescription Drug Program. The Office for Oregon Health Policy and Research shall develop and recommend to the Department of Human Services a preferred drug list that identifies preferred choices of prescription drugs within therapeutic classes for particular diseases and conditions, including generic alternatives, for use in the Oregon Prescription Drug Program. The office shall conduct public hearings and use evidence-based evaluations on the effectiveness of similar prescription drugs to develop the preferred drug list. [2003 c.714 §3; 2007 c.697 §19]

Note: See note under 414.312.

414.318 Prescription Drug Purchasing Fund. The Prescription Drug Purchasing Fund is established separate and distinct from the General Fund. The Prescription Drug Purchasing Fund shall consist of moneys appropriated to the fund by the Legislative Assembly and moneys received by the Department of Human Services for the purposes established in this section in the form of gifts, grants, bequests, endowments or donations. The moneys in the Prescription Drug Purchasing Fund are continuously appropriated to the department and shall be used to purchase prescription drugs, reimburse pharmacies for prescription drugs and reimburse the department for the costs of administering the Oregon Prescription Drug Program, including contracted services costs, computer costs, professional dispensing fees paid to retail pharmacies and other reasonable program costs. Interest earned on the fund shall be credited to the fund. [2003 c.714 §4; 2007 c.697 §20]

Note: See note under 414.312.

414.320 Rules. The Department of Human Services shall adopt rules to implement and administer ORS 414.312 to 414.318. The rules shall include but are not limited to establishing procedures for:

(1) Issuing prescription drug identification cards to individuals and entities that participate in the Oregon Prescription Drug Program; and

(2) Enrolling pharmacies in the program. [2003 c.714 §5; 2007 c.697 §21]

Note: See note under 414.312.

(Prescription Drug Coverage by Medical Assistance)

414.325 Prescription drugs; use of legend or generic drugs; prior authorization; rules. (1) As used in this section, "legend drug" means any drug requiring a prescription by a practitioner, as defined in ORS 689.005.

(2) A licensed practitioner may prescribe such drugs under this chapter as the practitioner in the exercise of professional judgment considers appropriate for the diagnosis or treatment of the patient in the practitioner's care and within the scope of practice. Prescriptions shall be dispensed in the generic form pursuant to ORS 689.515 and pursuant to rules of the Department of Human Services unless the practitioner prescribes otherwise and an exception is granted by the department.

(3) Except as provided in subsections (4) and (5) of this section, the department shall place no limit on the type of legend drug that may be prescribed by a practitioner, but the department shall pay only for drugs in the generic form unless an exception has been granted by the department.

(4) Notwithstanding subsection (3) of this section, an exception must be applied for and granted before the department is required to pay for minor tranquilizers and amphetamines and amphetamine derivatives, as defined by rule of the department.

(5)(a) Notwithstanding subsections (1) to (4) of this section and except as provided in paragraph (b) of this subsection, the department is authorized to:

(A) Withhold payment for a legend drug when federal financial participation is not available; and

(B) Require prior authorization of payment for drugs that the department has determined should be limited to those conditions generally recognized as appropriate by the medical profession.

(b) The department may not require prior authorization for therapeutic classes of nonsedating antihistamines and nasal inhalers, as defined by rule by the department, when prescribed by an allergist for treatment of any of the following conditions, as described by the Health Services Commission on the funded portion of its prioritized list of services:

(A) Asthma;

(B) Sinusitis;

(C) Rhinitis; or

(D) Allergies.

(6)(a) The department shall pay a rural health clinic for a legend drug prescribed and dispensed under this chapter by a licensed practitioner at the rural health clinic for an urgent medical condition if:

(A) There is not a pharmacy within 15 miles of the clinic;

(B) The prescription is dispensed for a patient outside of the normal business hours of any pharmacy within 15 miles of the clinic; or

(C) No pharmacy within 15 miles of the clinic dispenses legend drugs under this chapter.

(b) As used in this subsection, "urgent medical condition" means a medical condition that arises suddenly, is not life-threatening and requires prompt treatment to avoid the development of more serious medical problems.

(7) Notwithstanding ORS 414.334, the department may conduct prospective drug utilization review prior to payment for drugs for a patient whose prescription drug use exceeded 15 drugs in the preceding six-month period.

(8) Notwithstanding subsection (3) of this section, the department may pay a pharmacy for a particular brand name drug rather than the generic version of the drug after notifying the pharmacy that the cost of the particular brand name drug, after receiving discounted prices and rebates, is equal to or less than the cost of the generic version of the drug. [1977 c.818 §§2,3; 1979 c.777 §45; 1979 c.785 §3; 1983 c.608 §2; 1999 c.529 §1; 2001 c.897 §§5,6; 2003 c.14 §§190,191; 2003 c.91 §§1,2; 2003 c.810 §§20,21; 2005 c.692 §§8,9]

414.327 Electronically transmitted prescriptions; federal waiver; rules. (1) The Department of Human Services shall seek a waiver from the federal Centers for Medicare and Medicaid Services to allow the department to communicate prescription drug orders by electronic means from a practitioner authorized to prescribe drugs directly to the dispensing pharmacist.

(2) The Department of Human Services shall adopt rules permitting the department to communicate prescription drug orders by electronic means from a practitioner authorized to prescribe drugs directly to the dispensing pharmacist. [2001 c.623 §8; 2003 c.14 §192]

Note: 414.327 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

414.329 Prescription drug benefits for certain persons who are eligible for Medicare Part D prescription drug coverage; rules. (1) Notwithstanding ORS 414.705 to 414.750, the Department of Human Services shall adopt rules modifying the prescription drug benefits for persons who are eligible for Medicare Part D prescription drug coverage and who receive prescription drug benefits under the state medical assistance program or Title XIX of the Social Security Act. The rules shall include but need not be limited to:

(a) Identification of the Part D classes of drugs for which federal financial participation is not available and that are not covered classes of drugs;

(b) Identification of the Part D classes of drugs for which federal financial participation is not available and that are covered classes of drugs;

(c) Identification of the classes of drugs not covered under Medicare Part D prescription drug coverage for which federal financial participation is available and that are covered classes of drugs; and

(d) Cost-sharing obligations related to the provision of Part D classes of drugs for which federal financial participation is not available.

(2) As used in this section, "covered classes of drugs" means classes of prescription drugs provided to persons eligible for prescription drug coverage under the state medical assistance program or Title XIX of the Social Security Act. [2005 c.754 §1]

Note: 414.329 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 414 or any series therein by legislative

action. See Preface to Oregon Revised Statutes for further explanation.

(Practitioner-Managed Prescription Drug Plan)

414.330 Legislative findings on prescription drugs. The Legislative Assembly finds that:

(1) The cost of prescription drugs in the Oregon Health Plan is growing and will soon be unsustainable;

(2) The benefit of prescription drugs when appropriately used decreases the need for other expensive treatments and improves the health of Oregonians; and

(3) Providing the most effective drugs in the most cost-effective manner will benefit both patients and taxpayers. [2001 c.897 §1]

Note: 414.330 to 414.334 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

414.332 Policy for Practitioner-Managed Prescription Drug Plan. It is the policy of the State of Oregon that a Practitioner-Managed Prescription Drug Plan will ensure that:

(1) Oregonians have access to the most effective prescription drugs appropriate for their clinical conditions;

(2) Decisions concerning the clinical effectiveness of prescription drugs are made by licensed health practitioners, are informed by the latest peer-reviewed research and consider the health condition of a patient or characteristics of a patient, including the patient's gender, race or ethnicity; and

(3) The cost of prescription drugs in the Oregon Health Plan is managed through market competition among pharmaceutical manufacturers by publicly considering, first, the effectiveness of a given drug and, second, its relative cost. [2001 c.897 §2]

Note: See note under 414.330.

414.334 Practitioner-Managed Prescription Drug Plan for Oregon Health Plan. (1) The Department of Human Services shall adopt a Practitioner-Managed Prescription Drug Plan for the Oregon Health Plan. The purpose of the plan is to ensure that enrollees of the Oregon Health Plan receive the most effective prescription drug available at the best possible price.

(2) Before adopting the plan, the department shall conduct public meetings and consult with the Health Resources Commission.

(3) The department shall consult with representatives of the regulatory boards and associations representing practitioners who are prescribers under the Oregon Health Plan and ensure that practitioners receive educational materials and have access to training on the Practitioner-Managed Prescription Drug Plan.

(4) Notwithstanding the Practitioner-Managed Prescription Drug Plan adopted by the department, a practitioner may prescribe any drug that the practitioner indicates is medically necessary for an enrollee as being the most effective available.

(5) An enrollee may appeal to the department a decision of a practitioner or the department to not provide a prescription drug requested by the enrollee.

(6) This section does not limit the decision of a practitioner as to the scope and duration of treatment of chronic conditions, including but not limited to arthritis, diabetes and asthma. [2001 c.897 §3]

Note: See note under 414.330.

414.336 Limitation on rules regarding Practitioner-Managed Prescription Drug Plan. The Department of Human Services may not adopt or amend any rule that requires a prescribing practitioner to contact the department to request an exception for a medically appropriate or medically necessary drug that is not listed on the Practitioner-Managed Prescription Drug Plan drug list for that class of drugs adopted under ORS 414.334, unless otherwise authorized by enabling legislation setting forth the requirement for prior authorization. [2003 c.810 §22]

Note: 414.336 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

(Patient Prescription Drug Assistance Program)

414.338 Patient Prescription Drug Assistance Program; College of Pharmacy at Oregon State University to operate program. (1) The Patient Prescription Drug Assistance Program is established. The purpose of the program is to match low-income Oregonians who lack prescription drug benefit coverage with prescription drug assistance programs offered by pharmaceutical companies.

(2) The program shall:

(a) Provide information on:

(A) Eligibility requirements and coverage provided by publicly funded prescription drug benefit programs administered by the Department of Human Services; and

(B) The process for applying to receive publicly funded prescription drug benefits;

(b) Assist a patient in applying to pharmaceutical companies for free or discounted prescription drug medications if the patient is not eligible for any publicly funded prescription drug benefit program;

(c) Provide information, in an organized and easily understood manner, to patients, physicians, pharmacists and pharmacies regarding patient qualifications for prescription drug assistance programs;

(d) Increase awareness of the various prescription drug assistance programs offered by pharmaceutical companies; and

(e) Establish a toll-free hotline and Internet website to increase public awareness of the Patient Prescription Drug Assistance Program and to provide public access to the information and services provided through the program.

(3)(a) The College of Pharmacy at Oregon State University shall operate the Patient Prescription Drug Assistance Program until June 30, 2003, and may operate the program thereafter unless the Department of Human Services enters into a contract described in paragraph (b) of this subsection.

(b) For periods on or after July 1, 2003, the Department of Human Services may contract with any pharmacy provider to operate the Patient Prescription Drug Assistance Program. [2001 c.869 §1]

Note: 414.338 to 414.348 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

(Senior Prescription Drug Assistance Program)

414.340 Definitions for ORS 414.340, 414.342 and 414.348. As used in this section and ORS 414.342 and 414.348:

(1) "Eligible person" means a resident of this state who:

(a) Is 65 years of age or older;

(b) Has a gross annual income that does not exceed the lesser of the maximum amount established by the Department of Human Services by rule or 185 percent of the federal poverty guidelines;

(c) Has not been covered under any public or private prescription drug benefit program for the previous six months; and

(d) Has less than $2,000 in resources.

(2) "Enrollee" means a person who has been found to be eligible for the Senior Prescription Drug Assistance Program, who has paid an enrollment fee of up to $50 and who has a Senior Prescription Drug Assistance Program enrollment card issued by the Department of Human Services.

(3) "Federal poverty guidelines" means the most recent poverty guidelines as published annually in the Federal Register by the United States Department of Health and Human Services.

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

(5) "Resources" includes but is not limited to cash, checking and savings accounts, certificates of deposit, money market funds, stocks and bonds. "Resources" does not include the primary residence or car of an eligible person.

(6) "Senior Prescription Drug Assistance Program price" means the price of a prescription drug paid by an enrollee that is equal to or less than the Medicaid price. [2001 c.869 §3; 2005 c.381 §15]

Note: See note under 414.338.

414.342 Senior Prescription Drug Assistance Program; application and enrollment; enrollment fee; critical access pharmacies; rules. (1) The Senior Prescription Drug Assistance Program is created in the Department of Human Services. The purpose of the program is to provide financial assistance to eligible persons for the purchase of prescription drugs.

(2) A pharmacy shall charge an enrollee the Senior Prescription Drug Assistance Program price for a prescription drug upon presentation of a Senior Prescription Drug Assistance Program enrollment card.

(3) A pharmacy may charge the enrollee an amount established by the Department of Human Services to cover the professional dispensing fee, which may not exceed the fee paid by the state Medicaid program.

(4) This section does not apply to over-the-counter medications.

(5) The department shall provide a mechanism to calculate and transmit the Senior Prescription Drug Assistance Program price to the pharmacy.

(6) A person seeking to participate in the Senior Prescription Drug Assistance Program shall apply annually by completing and mailing a one-page application and including payment of an enrollment fee established by the department, not to exceed $50. The department shall issue an enrollment card annually to enrollees of the program. Each individual's application shall be considered separately, regardless of the number of persons in the individual's household.

(7) The maximum prescription drug assistance available annually to an enrollee is $2,000.

(8) Subject to funds available, the Department of Human Services may adjust the Senior Prescription Drug Assistance Pro-

gram price to subsidize up to 50 percent of the Medicaid price of the prescription drug, using a sliding scale based on the income and resources of an enrollee.

(9)(a) The department shall adopt rules that:

(A) Identify critical access pharmacies; and

(B) Provide for additional reimbursement to critical access pharmacies that participate in the Senior Prescription Drug Assistance Program.

(b) In addition, a critical access pharmacy may charge an enrollee a fee of not more than $2 per prescription. The $2 charge shall be annually adjusted for inflation using the U.S. City Average Consumer Price Index, as defined in ORS 316.037. [2001 c.869 §4]

Note: See note under 414.338.

414.344 Contracts to provide services under Senior Prescription Drug Assistance Program. The Department of Human Services may contract with a pharmacy provider or a pharmacy benefits manager to provide services under the Senior Prescription Drug Assistance Program established under ORS 414.342. [2001 c.869 §10]

Note: See note under 414.338.

414.346 Rules. The Department of Human Services shall adopt rules necessary to implement ORS 414.342. [2001 c.869 §8]

Note: See note under 414.338.

414.348 Senior Prescription Drug Assistance Fund. The Senior Prescription Drug Assistance Fund is established separate and distinct from the General Fund. The Senior Prescription Drug Assistance Fund may receive any appropriations, allocations, federal moneys or gifts designated for the Senior Prescription Drug Assistance Program. The moneys in the Senior Prescription Drug Assistance Fund are continuously appropriated to the Department of Human Services and shall be used to reimburse retail pharmacies for subsidized prices provided to enrollees and to reimburse the department for the costs of administering the program, including contracted services costs, computer costs, professional fees paid to retail pharmacies and other reasonable program costs. Interest earned on the fund accrues to the fund. [2001 c.869 §6; 2005 c.22 §285]

Note: See note under 414.338.

DRUG USE REVIEW BOARD

414.350 Definitions for ORS 414.350 to 414.415. As used in ORS 414.350 to 414.415:

(1) "Appropriate and medically necessary use" means drug prescribing, drug dispensing and patient medication usage in conformity with the criteria and standards developed under ORS 414.350 to 414.415.

(2) "Board" means the Drug Use Review Board created under ORS 414.355.

(3) "Compendia" means those resources widely accepted by the medical profession in the efficacious use of drugs, including the following sources:

(a) The American Hospital Formulary Services drug information.

(b) The United States Pharmacopeia drug information.

(c) The American Medical Association drug evaluations.

(d) The peer-reviewed medical literature.

(e) Drug therapy information provided by manufacturers of drug products consistent with the federal Food and Drug Administration requirements.

(4) "Counseling" means the effective communication of information by a pharmacist, as defined by rules of the State Board of Pharmacy.

(5) "Criteria" means the predetermined and explicitly accepted elements based on the compendia that are used to measure drug use on an ongoing basis to determine if the use is appropriate, medically necessary and not likely to result in adverse medical outcomes.

(6) "Drug-disease contraindication" means the potential for, or the occurrence of, an undesirable alteration of the therapeutic effect of a given prescription because of the presence, in the patient for whom it is prescribed, of a disease condition or the potential for, or the occurrence of, a clinically significant adverse effect of the drug on the patient's disease condition.

(7) "Drug-drug interaction" means the pharmacological or clinical response to the administration of at least two drugs different from that response anticipated from the known effects of the two drugs when given alone, which may manifest clinically as antagonism, synergism or idiosyncrasy. Such interactions have the potential to have an adverse effect on the individual or lead to a clinically significant adverse reaction, or both, that:

(a) Is characteristic of one or any of the drugs present; or

(b) Leads to interference with the absorption, distribution, metabolizing, excretion or therapeutic efficacy of one or any of the drugs.

(8) "Drug use review" means the programs designed to measure and assess on a retrospective and a prospective basis, through an evaluation of claims data, the proper utilization, quantity, appropriateness

as therapy and medical necessity of prescribed medication in the medical assistance program.

(9) "Intervention" means an action taken by the Department of Human Services with a prescriber or pharmacist to inform about or to influence prescribing or dispensing practices or utilization of drugs.

(10) "Overutilization" means the use of a drug in quantities or for durations that put the recipient at risk of an adverse medical result.

(11) "Pharmacist" means an individual who is licensed as a pharmacist under ORS chapter 689.

(12) "Prescriber" means any person authorized by law to prescribe drugs.

(13) "Prospective program" means the prospective drug use review program described in ORS 414.375.

(14) "Retrospective program" means the retrospective drug use review program described in ORS 414.380.

(15) "Standards" means the acceptable prescribing and dispensing methods determined by the compendia, in accordance with local standards of medical practice for health care providers.

(16) "Therapeutic appropriateness" means drug prescribing based on scientifically based and clinically relevant drug therapy that is consistent with the criteria and standards developed under ORS 414.350 to 414.415.

(17) "Therapeutic duplication" means the prescribing and dispensing of two or more drugs from the same therapeutic class such that the combined daily dose puts the recipient at risk of an adverse medical result or incurs additional program costs without additional therapeutic benefits.

(18) "Underutilization" means that a drug is used by a recipient in insufficient quantity to achieve a desired therapeutic goal. [1993 c.578 §1]

Note: 414.350 to 414.415 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

414.355 Drug Use Review Board created; duties; members; term; qualifications. (1) There is created a 12-member Drug Use Review Board responsible for advising the Department of Human Services on the implementation of the retrospective and prospective drug utilization review programs.

(2) The members of the board shall be appointed by the Director of Human Services and shall serve a term of two years. An individual appointed to the board may be reappointed upon completion of the individual's term. The membership of the board shall be composed of the following:

(a) Four persons licensed as physicians and actively engaged in the practice of medicine or osteopathic medicine in Oregon, who may be from among persons recommended by the Oregon Medical Association, the Osteopathic Physicians and Surgeons of Oregon or other organization representing physicians;

(b) One person licensed as a physician in Oregon who is actively engaged in academic medicine;

(c) Three persons licensed and actively practicing pharmacy in Oregon who may be from among persons recommended by the Oregon State Pharmacists Association, the National Association of Chain Drug Stores, the Oregon Society of Hospital Pharmacists, the Oregon Society of Consultant Pharmacists or other organizations representing pharmacists whether affiliated or unaffiliated with any association;

(d) One person licensed as a pharmacist in Oregon who is actively engaged in academic pharmacy;

(e) Two persons who shall represent persons receiving medical assistance; and

(f) One person licensed and actively practicing dentistry in Oregon who may be from among persons recommended by the Oregon Dental Association or other organizations representing dentists.

(3) Board members must have expertise in one or more of the following:

(a) Clinically appropriate prescribing of outpatient drugs covered by the medical assistance program.

(b) Clinically appropriate dispensing and monitoring of outpatient drugs covered by the medical assistance program.

(c) Drug use review, evaluation and intervention.

(d) Medical quality assurance.

(4) The director shall fill a vacancy on the board by appointing a new member to serve the remainder of the unexpired term based upon qualifications described in subsections (2) and (3) of this section.

(5) A board member may be removed only by a vote of eight members of the board and the removal must be approved by the director. The director may remove a member, without board action, if a member fails to attend two consecutive meetings unless such member is prevented from attending by serious illness of the member or in the member's family. [1993 c.578 §2]

Note: See note under 414.350.

414.360 Duties of board regarding retrospective and prospective drug use review programs; rules. (1) The Drug Use Review Board shall advise the Department of Human Services on:

(a) Adoption of rules to implement ORS 414.350 to 414.415 in accordance with the provisions of ORS 183.710 to 183.725, 183.745 and 183.750 and ORS chapter 183.

(b) Implementation of the medical assistance program retrospective and prospective programs as described in ORS 414.350 to 414.415, including the type of software programs to be used by the pharmacist for prospective drug use review and the provisions of the contractual agreement between the state and any entity involved in the retrospective drug use review program.

(c) Development of and application of the criteria and standards to be used in retrospective and prospective drug utilization review in a manner that insures that such criteria and standards are based on the compendia, relevant guidelines obtained from professional groups through consensus-driven processes, the experience of practitioners with expertise in drug therapy, data and experience obtained from drug utilization review program operations. The board shall have an open professional consensus process for establishing and revising criteria and standards. Criteria and standards shall be available to the public. In developing recommendations for criteria and standards, the board shall establish an explicit ongoing process for soliciting and considering input from interested parties. The board shall make timely revisions to the criteria and standards based upon this input in addition to revisions based upon scheduled review of the criteria and standards. Further, the drug utilization review standards shall reflect the local practices of prescribers in order to monitor:

(A) Therapeutic appropriateness.

(B) Overutilization or underutilization.

(C) Therapeutic duplication.

(D) Drug-disease contraindications.

(E) Drug-drug interactions.

(F) Incorrect drug dosage or drug treatment duration.

(G) Clinical abuse or misuse.

(H) Drug allergies.

(d) Development, selection and application of and assessment for interventions for medical assistance program prescribers, dispensers and patients that are educational and not punitive in nature.

(2) In reviewing retrospective and prospective drug use, the board may consider only drugs that have received final approval from the federal Food and Drug Administration. [1993 c.578 §6; 2003 c.70 §1]

Note: See note under 414.350.

414.365 Educational and informational duties of board; procedures to insure confidentiality. In addition to advising the Department of Human Services, the Drug Use Review Board shall do the following subject to the approval of the Director of Human Services:

(1) Publish an annual report, as described in ORS 414.415.

(2) Publish and disseminate educational information to prescribers and pharmacists regarding the board and the drug use review programs, including information on the following:

(a) Identifying and reducing the frequency of patterns of fraud, abuse or inappropriate or medically unnecessary care among prescribers, pharmacists and recipients.

(b) Potential or actual severe or adverse reactions to drugs.

(c) Therapeutic appropriateness.

(d) Overutilization or underutilization.

(e) Appropriate use of generic products.

(f) Therapeutic duplication.

(g) Drug-disease contraindications.

(h) Drug-drug interactions.

(i) Drug allergy interactions.

(j) Clinical abuse and misuse.

(3) Adopt and implement procedures designed to insure the confidentiality of any information collected, stored, retrieved, assessed or analyzed by the board, staff of the board or contractors to the drug use review programs that identifies individual prescribers, pharmacists or recipients. [1993 c.578 §7]

Note: See note under 414.350.

414.370 Authorized intervention procedures. In appropriate instances, interventions developed under ORS 414.360 (1)(d) may include the following:

(1) Information disseminated to prescribers and pharmacists to insure that they are aware of the duties and powers of the Drug Use Review Board.

(2) Written, oral or electronic reminders of recipient-specific or drug-specific information that are designed to insure recipient, prescriber and pharmacist confidentiality, and suggested changes in the prescribing or dispensing practices designed to improve the quality of care.

(3) Face-to-face discussions between experts in drug therapy and the prescriber or

pharmacist who has been targeted for educational intervention.

(4) Intensified reviews or monitoring of selected prescribers or pharmacists.

(5) Educational outreach through the retrospective program focusing on improvement of prescribing and dispensing practices.

(6) The timely evaluation of interventions to determine if the interventions have improved the quality of care.

(7) The review of case profiles before the conducting of an intervention. [1993 c.578 §8; 2003 c.70 §2]

Note: See note under 414.350.

414.375 Standards for prospective drug use review program. The prospective drug use review program must be based on the guidelines established by the Department of Human Services in consultation with the Drug Use Review Board. The program must provide that prior to the prescription being filled or delivered a review will be conducted by the pharmacist at the point of sale to screen for potential drug therapy problems resulting from the following:

(1) Therapeutic duplication.

(2) Drug-drug interactions, including serious interactions with nonprescription or over-the-counter drugs.

(3) Incorrect dosage and duration of treatment.

(4) Drug-allergy interactions.

(5) Clinical abuse and misuse.

(6) Drug-disease contraindications. [1993 c.578 §13]

Note: See note under 414.350.

414.380 Standards for retrospective drug use review program. The retrospective drug use review program must:

(1) Be based on the guidelines established by the Department of Human Services in consultation with the Drug Use Review Board; and

(2) Use the mechanized drug claims processing and information retrieval system to analyze claims data on drug use against explicit predetermined standards that are based on the compendia and other sources to monitor the following:

(a) Therapeutic appropriateness.

(b) Overutilization or underutilization.

(c) Fraud and abuse.

(d) Therapeutic duplication.

(e) Drug-disease contraindications.

(f) Drug-drug interactions.

(g) Incorrect drug dosage or duration of drug treatment.

(h) Clinical abuse and misuse. [1993 c.578 §12]

Note: See note under 414.350.

414.385 Compliance with Omnibus Budget Reconciliation Act of 1990. The Drug Use Review Board, retrospective and prospective programs, and related educational programs shall be operated in accordance with the requirements of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508). [1993 c.578 §11]

Note: See note under 414.350.

414.390 Unauthorized disclosure of information prohibited; staff access to information. (1) Information collected under ORS 414.350 to 414.415 that identifies an individual is confidential and shall not be disclosed by the Drug Use Review Board, the retrospective drug use review program, or the Department of Human Services to any person other than a health care provider appearing on a recipient's medication profile.

(2) The staff of the board may have access to identifying information for purposes of carrying out intervention activities. The identifying information shall not be released to anyone other than a staff member of the board, retrospective drug use review program, Department of Human Services, or to any health care provider appearing on a recipient's medication profile or, for purposes of investigating potential fraud in programs administered by the Department of Human Services, to the Department of Justice.

(3) The board may release cumulative, nonidentifying information for the purposes of legitimate research and for educational purposes. [1993 c.578 §10]

Note: See note under 414.350.

414.395 When executive session authorized; public testimony. (1) Notwithstanding ORS 192.660, the Drug Use Review Board may meet in an executive session for purposes of reviewing the prescribing or dispensing practices of individual physicians or pharmacists or to discuss drug use review data pertaining to individual physicians or pharmacists or to review profiles of individual clients. The meeting is subject to the requirements of ORS 192.650 (2).

(2) The board shall provide appropriate opportunity for public testimony at the regularly scheduled board meetings. [1993 c.578 §14]

Note: See note under 414.350.

414.400 Board subject to public record laws; chairperson; expenses; quorum; advisory committees. (1) The Drug Use Review Board shall operate in accordance with ORS chapter 192. The board shall annually elect a chairperson from the members of the board.

(2) Each board member is entitled to reimbursement for actual and necessary travel expenses incurred in connection with the member's duties, pursuant to ORS 292.495.

(3) A quorum consists of eight members of the board.

(4) The board may establish advisory committees to assist in carrying out the board's duties under ORS 414.350 to 414.415 with approval of the Director of Human Services. [1993 c.578 §4; 2001 c.900 §103]

Note: See note under 414.350.

414.410 Staff. The Department of Human Services shall provide staff to the Drug Use Review Board. [1993 c.578 §5]

Note: See note under 414.350.

414.415 Contents of annual report; public comment. (1) The annual report under ORS 414.365 (1) shall be subject to public comments prior to its submission to the Director of Human Services. Copies of the annual report shall also be submitted to the President of the Senate, the Speaker of the House of Representatives and other persons who request copies of the report.

(2) The annual report must include information on the following:

(a) An overview of the activities of the Drug Use Review Board and the prospective and retrospective programs;

(b) A summary of interventions made, including the number of cases brought before the board, and the number of interventions made;

(c) An assessment of the impact of the interventions, criteria and standards used, including an overall assessment of the impact of the educational programs and interventions on prescribing and dispensing patterns;

(d) An assessment of the impact of these criteria, standards and educational interventions on quality of care; and

(e) An estimate of the cost savings generated as a result of the prospective and retrospective programs, including an overview of the fiscal impact of the programs to other areas of the medical assistance program such as hospitalization or long term care costs. This analysis should include a cost-benefit analysis of both the prospective and retrospective programs and should take into account the administrative costs of the drug utilization review program. [1993 c.578 §9]

Note: See note under 414.350.

MEDICAL ASSISTANCE FOR CERTAIN INDIVIDUALS

414.420 Suspension of medical assistance for pregnant women who are incarcerated. (1) When a woman who is enrolled in the Oregon Health Plan as a pregnant woman becomes an inmate residing in a public institution, the Department of Human Services shall suspend medical assistance under the plan.

(2) The department shall continue to determine the eligibility of the pregnant woman as categorically needy as defined in ORS 414.025.

(3) Upon notification that a pregnant woman described under subsection (1) of this section is no longer an inmate residing in a public institution, the department shall reinstate medical assistance under the plan if the woman is otherwise eligible for medical assistance. [Formerly 414.026]

414.422 Conditions for coverage for pregnant women who are incarcerated. ORS 414.420 does not extend eligibility to an otherwise ineligible individual or extend medical assistance to an individual if matching federal funds are not available to pay for medical assistance. [Formerly 414.027]

414.424 Suspension of medical assistance of persons with serious mental illness under certain circumstances. (1) As used in this section:

(a) "Person with a serious mental illness" means a person who is diagnosed by a psychiatrist, a licensed clinical psychologist or a certified nonmedical examiner as having dementia, schizophrenia, bipolar disorder, major depression or other affective disorder or psychotic mental disorder other than a disorder caused primarily by substance abuse.

(b) "Public institution" means:

(A) A state hospital as defined in ORS 162.135;

(B) A local correctional facility as defined in ORS 169.005;

(C) A Department of Corrections institution as defined in ORS 421.005; or

(D) A youth correction facility as defined in ORS 162.135.

(2) Except as provided in subsection (6) of this section, the Department of Human Services shall suspend the medical assistance of a person with a serious mental illness when:

(a) The person receives medical assistance because of a serious mental illness; and

(b) The person becomes an inmate residing in a public institution.

(3) The department shall continue to determine the eligibility of the person as categorically needy as defined in ORS 414.025.

(4) Upon notification that a person described in subsection (2) of this section is no longer an inmate residing in a public institution, the department shall reinstate the person's medical assistance if the person is otherwise eligible for medical assistance.

(5) This section does not extend eligibility to an otherwise ineligible person or extend medical assistance to a person if matching federal funds are not available to pay for medical assistance.

(6) Subsection (2) of this section does not apply to a person with a serious mental illness residing in a state hospital as defined in ORS 162.135 who is under 22 years of age or who is 65 years of age or older. [2005 c.494 §2; 2007 c.70 §193]

414.426 Payment of cost of medical care for institutionalized persons. The Department of Human Services is hereby authorized to pay the cost of care for patients in institutions operated under ORS 179.321 under the medical assistance program established by ORS chapter 414. [Formerly 414.028]

Note: 414.426 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

414.428 Coverage for American Indian and Alaskan Native beneficiaries. (1) An individual described in ORS 414.025 (2)(r) who is eligible for or receiving medical assistance and who is an American Indian and Alaskan Native beneficiary shall receive the benefit package of health care services described in ORS 414.835 if:

(a) The Department of Human Services receives 100 percent federal medical assistance percentage for payments made by the department for the health care services provided as part of the benefit package described in ORS 414.835 that are not included in the benefit package described in ORS 414.834; or

(b) The department receives funding from the Indian tribes for which federal financial participation is available.

(2) As used in this section, "American Indian and Alaskan Native beneficiary" means:

(a) A member of a federally recognized Indian tribe, band or group;

(b) An Eskimo or Aleut or other Alaskan native enrolled by the United States Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601; or

(c) A person who is considered by the United States Secretary of the Interior to be an Indian for any purpose. [Formerly 414.029; 2007 c.861 §22]

Note: 414.428 becomes operative the day after the date the Department of Human Services receives approval from the federal Centers for Medicare and Medicaid Services to amend Oregon's Medicaid waiver. See section 2, chapter 76, Oregon Laws 2003.

Note: 414.428 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

Note: 414.834 and 414.835 were repealed by section 5, chapter 735, Oregon Laws 2003. The text of 414.428 was not amended by enactment of the Legislative Assembly to reflect the repeal. Editorial adjustment of 414.428 for the repeal of 414.834 and 414.835 has not been made.

414.500 Findings regarding medical assistance for persons with hemophilia. The Legislative Assembly finds that there are citizens of this state who have the disease of hemophilia and that hemophilia is generally excluded from any private medical insurance coverage except in an employment situation under group coverage which is usually ended upon termination of employment. The Legislative Assembly further finds that there is a need for a statewide program for the medical care of persons with hemophilia who are unable to pay for their necessary medical services, wholly or in part. [1975 c.513 §1; 1989 c.224 §81]

Note: 414.500 to 414.530 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 414 by legislative action. See Preface to Oregon Revised Statutes for further explanation.

414.510 Definitions. (1) "Eligible individual" means a resident of the State of Oregon over the age of 20 years.

(2) "Hemophilia services" means a program for medical care, including the cost of blood transfusions and the use of blood derivatives. [1975 c.513 §2]

Note: See note under 414.500.

414.520 Hemophilia services. Within the limit of funds expressly appropriated and available for medical assistance to hemophiliacs, hemophilia services under ORS 414.500 to 414.530 shall be made available to eligible persons as recommended by the Medical Advisory Committee of the Oregon Chapter of the National Hemophilia Foundation. [1975 c.513 §3]

Note: See note under 414.500.

414.530 When payments not made for hemophilia services. Payments under ORS 414.500 to 414.530 shall not be made for any services which are available to the recipient under any other private, state or federal programs or under other contractual or legal entitlements. However, no provision of ORS

414.500 to 414.530 is intended to limit in any way state participation in any federal program for medical care of persons with hemophilia. [1975 c.513 §4]

Note: See note under 414.500.

414.532 Definitions for ORS 414.534 to 414.538. As used in ORS 414.534 to 414.538:

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

(2) "Provider" has the meaning given that term in ORS 743.801. [2001 c.902 §1]

Note: 414.532 to 414.540 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

414.534 Treatment for breast or cervical cancer; eligibility criteria for medical assistance. (1) The Department of Human Services shall provide medical assistance to a woman who:

(a) Is screened for breast or cervical cancer through the Oregon Breast and Cervical Cancer Program operated by the department;

(b) As a result of a screening in accordance with paragraph (a) of this subsection, is found by a provider to be in need of treatment for breast or cervical cancer;

(c) Does not otherwise have creditable coverage, as defined in 42 U.S.C. 300gg(c); and

(d) Is 64 years of age or younger.

(2) The period of time a woman can receive medical assistance based on the eligibility criteria of subsection (1) of this section:

(a) Begins:

(A) On the date the department makes a formal determination that the woman is eligible for medical assistance in accordance with subsection (1) of this section; or

(B) Up to three months prior to the month in which the woman applied for medical assistance if on the earlier date the woman met the eligibility criteria of subsection (1) of this section.

(b) Ends when:

(A) The woman is no longer in need of treatment; or

(B) The department determines the woman no longer meets the eligibility criteria of subsection (1) of this section. [2001 c.902 §2]

Note: See note under 414.532.

414.536 Presumptive eligibility for medical assistance for treatment of breast or cervical cancer. (1) The Department of Human Services shall provide medical assistance to a woman whom the department determines is presumptively eligible for medical assistance. As used in this section, a woman is "presumptively eligible for medical assistance" if the department determines that the woman likely is eligible for medical assistance under ORS 414.534.

(2) The period of time a woman may receive medical assistance based on presumptive eligibility is limited. The period of time:

(a) Begins on the date that the department determines the woman likely meets the eligibility criteria under ORS 414.534; and

(b) Ends on the earlier of the following dates:

(A) If the woman applies for medical assistance following the determination by the department that the woman is presumptively eligible for medical assistance, the date on which a formal determination on eligibility is made by the department in accordance with ORS 414.534; or

(B) If the woman does not apply for medical assistance following the determination by the department that the woman is presumptively eligible for medical assistance, the last day of the month following the month in which presumptive eligibility begins. [2001 c.902 §3]

Note: See note under 414.532.

414.538 Prohibition on coverage limitations; priority to low-income women. (1) The Department of Human Services shall provide medical assistance under ORS 414.534 or 414.536 to a woman who meets general coverage requirements applicable to recipients of medical assistance. The department may not impose income or resource limitations or a prior period of uninsurance on a woman who otherwise qualifies for medical assistance under ORS 414.534 or 414.536.

(2) In providing medical assistance under ORS 414.534 or 414.536, the Department of Human Services shall give priority to low-income women. [2001 c.902 §4]

Note: See note under 414.532.

414.540 Rules. The Department of Human Services shall adopt rules necessary for the implementation and administration of ORS 414.534 to 414.538. [2001 c.902 §5]

Note: See note under 414.532.

414.550 Definitions for ORS 414.550 to 414.565. As used in ORS 414.550 to 414.565:

(1) "Cystic fibrosis services" means a program for medical care, including the cost of prescribed medications and equipment, respiratory therapy, physical therapy, counseling services that pertain directly to cystic fibrosis related health needs and outpatient services including physicians' fees, X-rays and necessary clinical tests to insure proper

ongoing monitoring and maintenance of the patient's health.

(2) "Eligible individual" means a resident of the State of Oregon over 18 years of age. [1985 c.532 §2]

Note: 414.550 to 414.565 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 414 by legislative action. See Preface to Oregon Revised Statutes for further explanation.

414.555 Findings regarding medical assistance for persons with cystic fibrosis. The Legislative Assembly finds that there are citizens of this state who have the disease of cystic fibrosis and that cystic fibrosis is generally excluded from any private medical insurance coverage except in an employment situation under group coverage which is usually ended upon termination of employment. The Legislative Assembly further finds that there is a need for a statewide program for the medical care of persons with cystic fibrosis who are unable to pay for their necessary medical services, wholly or in part. [1985 c.532 §1; 1989 c.224 §82]

Note: See note under 414.550.

414.560 Cystic fibrosis services. (1) Within the limit of funds expressly appropriated and available for medical assistance to individuals who have cystic fibrosis, cystic fibrosis services under ORS 414.550 to 414.565 shall be made available by the Services for Children with Special Health Needs to eligible individuals as recommended by the review committee. The review committee shall consist of the Cystic Fibrosis Center Director, the Oregon Cystic Fibrosis Chapter Medical Advisory Committee and other recognized and knowledgeable community leaders in the area of health care delivery designated to serve on the review committee by the Director of the Services for Children with Special Health Needs.

(2) No member of the review committee shall be held criminally or civilly liable for actions pursuant to this section provided the member acts in good faith, on probable cause and without malice. [1985 c.532 §3; 1989 c.224 §83]

Note: See note under 414.550.

414.565 When payments not made for cystic fibrosis services. Payments under ORS 414.550 to 414.565 shall not be made for any services which are available to the recipient under any other private, state or federal programs or under other contractual or legal entitlements. However, no provision of ORS 414.550 to 414.565 is intended to limit in any way state participation in any federal program for medical care of persons with cystic fibrosis. [1985 c.532 §4]

Note: See note under 414.550.

OREGON HEALTH CARE COST CONTAINMENT SYSTEM

414.610 Legislative intent. It is the intent of the Legislative Assembly to develop and implement new strategies for persons eligible to receive medical assistance that promote and change the incentive structure in the delivery and financing of medical care, that encourage cost consciousness on the part of the users and providers while maintaining quality medical care and that strive to make state payments for such medical care sufficient to compensate providers adequately for the reasonable costs of such care in order to minimize inappropriate cost shifts onto other health care payers. [1983 c.590 §1; 1985 c.747 §8]

414.620 System established. There is established the Oregon Health Care Cost Containment System. The system shall consist of state policies and actions that encourage price competition among health care providers, that monitor services and costs of the health care system in Oregon, and that maintain the regulatory controls necessary to assure quality and affordable health services to all Oregonians. The system shall also include contracts with providers on a prepaid capitation basis for the provision of at least hospital or physician medical care, or both, to eligible persons as described in ORS 414.025. [1983 c.590 §2; 1985 c.747 §2]

414.630 Prepaid capitated health care service contracts; when fee for services to be paid. (1) The Department of Human Services shall execute prepaid capitated health service contracts for at least hospital or physician medical care, or both, with hospital and medical organizations, health maintenance organizations and any other appropriate public or private persons.

(2) For purposes of ORS 279A.025, 279A.140, 414.145 and 414.610 to 414.640, instrumentalities and political subdivisions of the state are authorized to enter into prepaid capitated health service contracts with the Department of Human Services and shall not thereby be considered to be transacting insurance.

(3) In the event that there is an insufficient number of qualified bids for prepaid capitated health services contracts for hospital or physician medical care, or both, in some areas of the state, the department may continue a fee for service payment system.

(4) Payments to providers may be subject to contract provisions requiring the retention of a specified percentage in an incentive fund or to other contract provisions by which adjustments to the payments are made based on utilization efficiency. [1983 c.590 §3; 1991 c.66 §24; 2003 c.794 §275]

414.640 Selection of providers; reimbursement for services not covered; actions as trade practice; actions not insurance; rules. (1) Eligible persons shall select, to the extent practicable as determined by the Department of Human Services, from among available providers participating in the program.

(2) The department by rule shall define the circumstances under which it may choose to reimburse for any medical services not covered under the prepaid capitation or costs of related services provided by or under referral from any physician participating in the program in which the eligible person is enrolled.

(3) The department shall establish requirements as to the minimum time period that an eligible person is assigned to specific providers in the system.

(4) Actions taken by providers, potential providers, contractors and bidders in specific accordance with this chapter in forming consortiums or in otherwise entering into contracts to provide medical care shall be considered to be conducted at the direction of this state, shall be considered to be lawful trade practices and shall not be considered to be the transaction of insurance for purposes of ORS 279A.025, 279A.140, 414.145 and 414.610 to 414.640. [1983 c.590 §4; 1991 c.66 §25; 2003 c.794 §276]

414.650 [1983 c.590 §7; 1987 c.660 §19; 1989 c.513 §1; 1991 c.66 §26; repealed by 1995 c.727 §48]

414.660 Demonstration projects for medical service contracts. The Department of Human Services shall pursue demonstration projects for medical service contracts in at least the four standard metropolitan statistical areas in this state and is authorized to seek the necessary federal waivers in order to accomplish such contracts including but not limited to:

(1) Limiting the scope of the system to selected geographic areas;

(2) Allowing participating health plans to offer benefit enhancements;

(3) Limiting the choice of eligible persons to those providers affiliated with a participating health plan;

(4) Allowing primary care providers access to data concerning clients' utilization of service from other providers; and

(5) Allowing the department the reimbursement flexibility necessary to implement a prospective reimbursement system for hospital care. [1983 c.590 §5; 1985 c.747 §3; 1991 c.66 §27]

414.670 Phasing in eligible clients. For the purpose of insuring that a maximum number of eligible persons are served by the Oregon Health Care Cost Containment System through prepaid capitated provider contracts, the Department of Human Services is directed to phase eligible clients into the newly formed systems as rapidly as possible. [1983 c.590 §6; 1985 c.747 §3a; 1991 c.66 §28]

SCOPE OF COVERED HEALTH SERVICES

414.705 Definitions for ORS 414.705 to 414.750. (1) As used in ORS 414.705 to 414.750, "health services" means at least so much of each of the following as are approved and funded by the Legislative Assembly:

(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 certified under ORS 678.375 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 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.

(2) Health services approved and funded under subsection (1) of this section are subject to the prioritized list of health services required in ORS 414.720. [1989 c.836 §2; 1991 c.753 §4; 2003 c.735 §1; 2003 c.810 §7]

Note: 414.705 to 414.750 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

414.706 Legislative approval and funding of health services to certain persons. The Legislative Assembly shall approve and fund health services to the following persons:

(1) Persons who are categorically needy as described in ORS 414.025 (2)(n) and (o);

(2) Pregnant women with incomes no more than 185 percent of the federal poverty guidelines;

(3) Persons under 19 years of age with incomes no more than 200 percent of the federal poverty guidelines;

(4) Persons described in ORS 414.708; and

(5) Persons 19 years of age or older with incomes no more than 100 percent of the federal poverty guidelines who do not have federal Medicare coverage. [2003 c.735 §3]

Note: 414.706 to 414.709 were added to and made a part of 414.705 to 414.750 by legislative action but were not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

414.707 Level of health services provided to certain persons. (1) Subject to funds available:

(a) Persons who are categorically needy as described in ORS 414.025 (2)(n) and (o), and persons under 19 years of age and pregnant women who are eligible to receive health services under ORS 414.706, are eligible to receive all the health services approved and funded by the Legislative Assembly.

(b) Persons described in ORS 414.708 are eligible to receive the health services described in ORS 414.705 (1)(c), (f) and (g).

(c) Persons 19 years of age and older who are eligible to receive health services under ORS 414.706 are eligible to receive the health services described in ORS 414.705 (1)(b) to (m).

(2) Persons who are categorically needy as described in ORS 414.025 (2)(n) and (o), and persons under 19 years of age and pregnant women who are eligible to receive health services under ORS 414.706, must be provided, at a minimum, the health services described in ORS 414.705 (1)(a) to (g).

(3) Persons 19 years of age and older who are eligible to receive health services under ORS 414.706 must be provided, at a minimum, health services described in ORS 414.705 (1)(b) to (h).

(4) Persons described in ORS 414.708 must be provided, at a minimum, the health services described in ORS 414.705 (1)(c).

(5) The Department of Human Services shall:

(a) Develop at least three benefit packages of provider services to be offered under ORS 414.705 (1)(j); and

(b) Define by rule the services to be offered under ORS 414.705 (1)(k).

(6) Notwithstanding ORS 414.735, the Legislative Assembly shall adjust health services funded under ORS 414.705 (1) by increasing or reducing benefit packages or health services and, subject to ORS 414.709, by increasing or reducing the population of eligible persons. [2003 c.735 §4]

Note: See note under 414.706.

414.708 Conditions for coverage for certain elderly persons, blind persons or persons who have disabilities. (1) A person is eligible to receive the health services described in ORS 414.707 (1)(b) when the person is a resident of this state who:

(a) Is 65 years of age or older, or is blind or has a disability as those terms are defined in ORS 411.704;

(b) Has a gross annual income that does not exceed the standard established by the Department of Human Services; and

(c) Is not covered under any public or private prescription drug benefit program.

(2) A person receiving prescription drug services under ORS 414.707 (1)(b) shall pay up to a percentage of the Medicaid price of the prescription drug established by the department by rule and the dispensing fee. [2003 c.735 §11; 2005 c.381 §16; 2007 c.70 §194]

Note: See note under 414.706.

414.709 Adjustment of population of eligible persons in event of insufficient resources. (1) Except as provided in subsection (2) of this section, if insufficient resources are available during a biennium, the population of eligible persons receiving health services may not be reduced below the population of eligible persons approved and funded in the legislatively adopted budget for the Department of Human Services for the biennium.

(2) The Department of Human Services may periodically limit enrollment of persons described in ORS 414.708 in order to stay within the legislatively adopted budget for the department. [2003 c.735 §4a]

Note: See note under 414.706.

414.710 Services available to certain eligible persons. The following services are available to persons eligible for services under ORS 414.025, 414.036, 414.042, 414.065 and 414.705 to 414.750 but such services are not subject to ORS 414.720:

(1) Nursing facilities and home- and community-based waivered services funded through the Department of Human Services;

(2) Medical assistance to eligible persons who receive assistance under ORS 411.706 or to children described in ORS 414.025 (2)(f), (i), (j), (k) and (m), 418.001 to 418.034, 418.189 to 418.970 and 657A.020 to 657A.460;

(3) Institutional, home- and community-based waivered services or community mental health program care for persons with mental retardation, developmental disabilities or severe mental illness and for the treatment of alcohol and drug dependent persons; and

(4) Services to children who are wards of the Department of Human Services by order

of the juvenile court and services to children and families for health care or mental health care through the department. [1989 c.836 §3; 1991 c.67 §107; 1991 c.753 §5; 1993 c.815 §17; 1997 c.581 §25; 1999 c.1084 §52; 2005 c.381 §17; 2007 c.70 §195]

Note: See note under 414.705.

414.712 Medical assistance for certain eligible persons. The Department of Human Services shall provide medical assistance under ORS 414.705 to 414.750 to eligible persons who receive assistance under ORS 411.706 and to children described in ORS 414.025 (2)(f), (i), (j), (k) and (m), 418.001 to 418.034, 418.189 to 418.970 and 657A.020 to 657A.460 and those mental health and chemical dependency services recommended according to standards of medical assistance and according to the schedule of implementation established by the Legislative Assembly. In providing medical assistance services described in ORS 414.018 to 414.024, 414.042, 414.107, 414.710, 414.720 and 735.712, the Department of Human Services shall also provide the following:

(1) Ombudsman services for eligible persons who receive assistance under ORS 411.706. With the concurrence of the Governor, the Director of Human Services shall appoint ombudsmen and may terminate an ombudsman. Ombudsmen are under the supervision and control of the director. An ombudsman shall serve as a patient's advocate whenever the patient or a physician or other medical personnel serving the patient is reasonably concerned about access to, quality of or limitations on the care being provided by a health care provider. Patients shall be informed of the availability of an ombudsman. Ombudsmen shall report to the Governor in writing at least once each quarter. A report shall include a summary of the services that the ombudsman provided during the quarter and the ombudsman's recommendations for improving ombudsman services and access to or quality of care provided to eligible persons by health care providers.

(2) Case management services in each health care provider organization for those eligible persons who receive assistance under ORS 411.706. Case managers shall be trained in and shall exhibit skills in communication with and sensitivity to the unique health care needs of people who receive assistance under ORS 411.706. Case managers shall be reasonably available to assist patients served by the organization with the coordination of the patient's health care services at the reasonable request of the patient or a physician or other medical personnel serving the patient. Patients shall be informed of the availability of case managers.

(3) A mechanism, established by rule, for soliciting consumer opinions and concerns regarding accessibility to and quality of the services of each health care provider.

(4) A choice of available medical plans and, within those plans, choice of a primary care provider.

(5) Due process procedures for any individual whose request for medical assistance coverage for any treatment or service is denied or is not acted upon with reasonable promptness. These procedures shall include an expedited process for cases in which a patient's medical needs require swift resolution of a dispute. [1991 c.753 §14; 1993 c.815 §18; 1997 c.581 §26; 1999 c.547 §7; 1999 c.1084 §53; 2003 c.14 §§193,193a; 2003 c.591 §§1,2; 2005 c.381 §18]

Note: See note under 414.705.

414.715 Health Services Commission; confirmation; qualifications; terms; expenses; subcommittees. (1) The Health Services Commission is established, consisting of 11 members appointed by the Governor and confirmed by the Senate. Five members shall be physicians licensed to practice medicine in this state who have clinical expertise in the general areas of obstetrics, perinatal, pediatrics, adult medicine, mental health and chemical dependency, disabilities, geriatrics or public health. One of the physicians shall be a doctor of osteopathy. Other members shall include a public health nurse, a social services worker and four consumers of health care. In making the appointments, the Governor shall consult with professional and other interested organizations.

(2) Members of the Health Services Commission shall serve for a term of four years, at the pleasure of the Governor.

(3) Members shall receive no compensation for their services, but subject to any applicable state law, shall be allowed actual and necessary travel expenses incurred in the performance of their duties.

(4) The commission may establish such subcommittees of its members and other medical, economic or health services advisers as it determines to be necessary to assist the commission in the performance of its duties. [1989 c.836 §4; 1991 c.753 §12]

Note: See note under 414.705.

414.720 Public hearings; public involvement; biennial reports on health services priorities; funding. (1) The Health Services Commission shall conduct public hearings prior to making the report described in subsection (3) of this section. The commission shall solicit testimony and information from advocates representing seniors, persons with disabilities, mental health services consumers and low-income Oregonians, representatives of commercial carriers, representatives of small and large Oregon employers and providers of health care,

including but not limited to physicians licensed to practice medicine, dentists, oral surgeons, chiropractors, naturopaths, hospitals, clinics, pharmacists, nurses and allied health professionals.

(2) The commission shall actively solicit public involvement in a community meeting process to build a consensus on the values to be used to guide health resource allocation decisions.

(3) The commission shall report to the Governor a list of health services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the entire population to be served. The list submitted by the commission pursuant to this subsection is not subject to alteration by any other state agency. The recommendation may include practice guidelines reviewed and adopted by the commission pursuant to subsection (4) of this section.

(4) In order to encourage effective and efficient medical evaluation and treatment, the commission:

(a) May include clinical practice guidelines in its prioritized list of services. The commission shall actively solicit testimony and information from the medical community and the public to build a consensus on clinical practice guidelines developed by the commission.

(b) Shall consider both the clinical effectiveness and cost-effectiveness of health services in determining their relative importance using peer-reviewed medical literature as defined in ORS 743A.060.

(5) The commission shall make its report by July 1 of the year preceding each regular session of the Legislative Assembly and shall submit a copy of its report to the Governor, the Speaker of the House of Representatives and the President of the Senate.

(6) The commission may alter the list during interim only under the following conditions:

(a) Technical changes due to errors and omissions; and

(b) Changes due to advancements in medical technology or new data regarding health outcomes.

(7) If a service is deleted or added and no new funding is required, the commission shall report to the Speaker of the House of Representatives and the President of the Senate. However, if a service to be added requires increased funding to avoid discontinuing another service, the commission must report to the Emergency Board to request the funding.

(8) The report listing services to be provided pursuant to ORS 414.036, 414.042, 414.065, 414.107, 414.705 to 414.725 and 414.735 to 414.750 shall remain in effect from October 1 of the odd-numbered year through September 30 of the next odd-numbered year. [1989 c.836 §4a; 1991 c.753 §6; 1991 c.916 §2a; 1993 c.754 §1; 1993 c.815 §19; 1997 c.245 §2; 2003 c.735 §10; 2003 c.810 §8]

Note: 414.720 was added to and made a part of ORS chapter 414 by legislative action but was not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

414.725 Prepaid managed care health services contracts; financial reporting; rules. (1)(a) Pursuant to rules adopted by the Department of Human Services, the department shall execute prepaid managed care health services contracts for health services funded by the Legislative Assembly. The contract must require that all services are provided to the extent and scope of the Health Services Commission's report for each service provided under the contract. The contracts are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235. Notwithstanding ORS 414.720 (8), the rules adopted by the department shall establish timelines for executing the contracts described in this paragraph.

(b) It is the intent of ORS 414.705 to 414.750 that the state use, to the greatest extent possible, prepaid managed care health services organizations to provide physical health, dental, mental health and chemical dependency services under ORS 414.705 to 414.750.

(c) The department shall solicit qualified providers or plans to be reimbursed for providing the covered services. The contracts may be with hospitals and medical organizations, health maintenance organizations, managed health care plans and any other qualified public or private prepaid managed care health services organization. The department may not discriminate against any contractors that offer services within their providers' lawful scopes of practice.

(d) The department shall establish annual financial reporting requirements for prepaid managed care health services organizations. The department shall prescribe a reporting procedure that elicits sufficiently detailed information for the department to assess the financial condition of each prepaid managed care health services organization and that includes information on the three highest executive salary and benefit packages of each prepaid managed care health services organization.

(e) The department shall require compliance with the provisions of paragraph (d) of this subsection as a condition of entering

into a contract with a prepaid managed care health services organization.

(2) The department may institute a fee-for-service case management system or a fee-for-service payment system for the same physical health, dental, mental health or chemical dependency services provided under the health services contracts for persons eligible for health services under ORS 414.705 to 414.750 in designated areas of the state in which a prepaid managed care health services organization is not able to assign an enrollee to a person or entity that is primarily responsible for coordinating the physical health, dental, mental health or chemical dependency services provided to the enrollee. In addition, the department may make other special arrangements as necessary to increase the interest of providers in participation in the state's managed care system, including but not limited to the provision of stop-loss insurance for providers wishing to limit the amount of risk they wish to underwrite.

(3) As provided in subsections (1) and (2) of this section, the aggregate expenditures by the department for health services provided pursuant to ORS 414.705 to 414.750 may not exceed the total dollars appropriated for health services under ORS 414.705 to 414.750.

(4) Actions taken by providers, potential providers, contractors and bidders in specific accordance with ORS 414.705 to 414.750 in forming consortiums or in otherwise entering into contracts to provide health care services shall be performed pursuant to state supervision and shall be considered to be conducted at the direction of this state, shall be considered to be lawful trade practices and may not be considered to be the transaction of insurance for purposes of the Insurance Code.

(5) Health care providers contracting to provide services under ORS 414.705 to 414.750 shall advise a patient of any service, treatment or test that is medically necessary but not covered under the contract if an ordinarily careful practitioner in the same or similar community would do so under the same or similar circumstances.

(6) A prepaid managed care health services organization shall provide information on contacting available providers to an enrollee in writing within 30 days of assignment to the health services organization.

(7) Each prepaid managed care health services organization shall provide upon the request of an enrollee or prospective enrollee annual summaries of the organization's aggregate data regarding:

(a) Grievances and appeals; and

(b) Availability and accessibility of services provided to enrollees.

(8) A prepaid managed care health services organization may not limit enrollment in a designated area based on the zip code of an enrollee or prospective enrollee. [1989 c.836 §6; 1991 c.753 §8; 2003 c.14 §194; 2003 c.735 §13; 2003 c.794 §277; 2003 c.810 §4; 2005 c.806 §8; 2007 c.458 §1]

Note: See note under 414.705.

414.727 Reimbursement of rural hospitals by prepaid managed care health services organization. (1) A prepaid managed care health services organization, as defined in ORS 414.736, that contracts with the Department of Human Services under ORS 414.725 (1) to provide prepaid managed care health services, including hospital services, shall reimburse Type A and Type B hospitals and rural critical access hospitals, as described in ORS 442.470 and identified by the Office of Rural Health as rural hospitals, fully for the cost of covered services based on the cost-to-charge ratio used for each hospital in setting the capitation rates paid to the prepaid managed care health services organization for the contract period.

(2) The department shall base the capitation rates described in subsection (1) of this section on the most recent audited Medicare cost report for Oregon hospitals adjusted to reflect the Medicaid mix of services.

(3) This section may not be construed to prohibit a prepaid managed care health services organization and a hospital from mutually agreeing to reimbursement other than the reimbursement specified in subsection (1) of this section.

(4) Hospitals reimbursed under subsection (1) of this section are not entitled to any additional reimbursement for services provided. [1997 c.642 §2; 1999 c.546 §2; 2005 c.806 §2]

Note: See note under 414.705.

414.728 Reimbursement of rural hospitals by Department of Human Services. For services provided to persons who are entitled to receive medical assistance and whose medical assistance benefits are not administered by a prepaid managed care health services organization, as defined in ORS 414.736, the Department of Human Services shall reimburse Type A and Type B hospitals and rural critical access hospitals, as described in ORS 442.470 and identified by the Office of Rural Health as rural hospitals, fully for the cost of covered services based on the most recent audited Medicare cost report for Oregon hospitals adjusted to reflect the Medicaid mix of services. [2005 c.806 §4]

Note: See note under 414.705.

414.730 Subcommittee on Mental Health Care and Chemical Dependency. The Health Services Commission shall establish a Subcommittee on Mental Health Care and Chemical Dependency to assist the commission in determining priorities for mental health care and chemical dependency. The subcommittee shall include mental health and chemical dependency professionals who provide inpatient and outpatient mental health and chemical dependency care. [1989 c.836 §7; 1995 c.79 §209; 2005 c.22 §286]

Note: See note under 414.705.

414.735 Adjustment of reimbursement in event of insufficient resources; approval of Legislative Assembly or Emergency Board; notice to providers. (1) If insufficient resources are available during a contract period:

(a) The population of eligible persons determined by law shall not be reduced.

(b) The reimbursement rate for providers and plans established under the contractual agreement shall not be reduced.

(2) In the circumstances described in subsection (1) of this section, reimbursement shall be adjusted by reducing the health services for the eligible population by eliminating services in the order of priority recommended by the Health Services Commission, starting with the least important and progressing toward the most important.

(3) The Department of Human Services shall obtain the approval of the Legislative Assembly or Emergency Board, if the Legislative Assembly is not in session, before instituting the reductions. In addition, providers contracting to provide health services under ORS 414.705 to 414.750 must be notified at least two weeks prior to any legislative consideration of such reductions. Any reductions made under this section shall take effect no sooner than 60 days following final legislative action approving the reductions. [1989 c.836 §8; 1991 c.753 §9; 2003 c.14 §195]

Note: See note under 414.705.

414.736 Definitions. As used in this section and ORS 414.725, 414.737, 414.738, 414.739, 414.740, 414.741, 414.742, 414.743 and 414.744:

(1) "Designated area" means a geographic area of the state defined by the Department of Human Services by rule that is served by a prepaid managed care health services organization.

(2) "Fully capitated health plan" means an organization that contracts with the Department of Human Services on a prepaid capitated basis under ORS 414.725 to provide an adequate network of providers to ensure that the health services provided under the contract are reasonably accessible to enrollees.

(3) "Physician care organization" means an organization that contracts with the Department of Human Services on a prepaid capitated basis under ORS 414.725 to provide an adequate network of providers to ensure that the health services described in ORS 414.705 (1)(b), (c), (d), (e), (g) and (j) are reasonably accessible to enrollees. A physician care organization may also contract with the department on a prepaid capitated basis to provide the health services described in ORS 414.705 (1)(k) and (L).

(4) "Prepaid managed care health services organization" means a managed physical health, dental, mental health or chemical dependency organization that contracts with the Department of Human Services on a prepaid capitated basis under ORS 414.725. A prepaid managed care health services organization may be a dental care organization, fully capitated health plan, physician care organization, mental health organization or chemical dependency organization. [2003 c.810 §2]

Note: 414.736 to 414.744 were added to and made a part of 414.705 to 414.750 by legislative action but were not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

414.737 Mandatory enrollment in prepaid managed care health services organization. (1) Except as provided in subsections (2) and (3) of this section, a person who is eligible for or receiving physical health, dental, mental health or chemical dependency services under ORS 414.705 to 414.750 must be enrolled in the prepaid managed care health services organizations to receive the health services for which the person is eligible.

(2) Subsection (1) of this section does not apply to:

(a) A person who is a noncitizen and who is eligible only for labor and delivery services and emergency treatment services;

(b) A person who is an American Indian and Alaskan Native beneficiary; and

(c) A person whom the department may by rule exempt from the mandatory enrollment requirement of subsection (1) of this section, including but not limited to:

(A) A person who is also eligible for Medicare;

(B) A woman in her third trimester of pregnancy at the time of enrollment;

(C) A person under 19 years of age who has been placed in adoptive or foster care out of state;

(D) A person under 18 years of age who is medically fragile and who has special health care needs; and

(E) A person with major medical coverage.

(3) Subsection (1) of this section does not apply to a person who resides in a designated area in which a prepaid managed care health services organization providing physical health, dental, mental health or chemical dependency services is not able to assign an enrollee to a person or entity that is primarily responsible for coordinating the physical health, dental, mental health or chemical dependency services provided to the enrollee.

(4) As used in this section, "American Indian and Alaskan Native beneficiary" means:

(a) A member of a federally recognized Indian tribe, band or group;

(b) An Eskimo or Aleut or other Alaskan Native enrolled by the United States Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601; or

(c) A person who is considered by the United States Secretary of the Interior to be an Indian for any purpose. [2003 c.810 §3]

Note: The amendments to 414.737 by section 8, chapter 751, Oregon Laws 2007, become operative upon receipt of necessary federal approval. See section 9, chapter 751, Oregon Laws 2007. The text that is operative on and after receipt of federal approval is set forth for the user's convenience.

414.737. (1) Except as provided in subsections (2) and (3) of this section, a person who is eligible for or receiving physical health, dental, mental health or chemical dependency services under ORS 414.705 to 414.750 must be enrolled in the prepaid managed care health services organizations to receive the health services for which the person is eligible.

(2) Subsection (1) of this section does not apply to:

(a) A person who is a noncitizen and who is eligible only for labor and delivery services and emergency treatment services;

(b) A person who is an American Indian and Alaskan Native beneficiary; and

(c) A person whom the department may by rule exempt from the mandatory enrollment requirement of subsection (1) of this section, including but not limited to:

(A) A person who is also eligible for Medicare;

(B) A woman in her third trimester of pregnancy at the time of enrollment;

(C) A person under 19 years of age who has been placed in adoptive or foster care out of state;

(D) A person under 18 years of age who is medically fragile and who has special health care needs;

(E) A person receiving services under the Medically Involved Home-Care Program created by ORS 417.345 (1); and

(F) A person with major medical coverage.

(3) Subsection (1) of this section does not apply to a person who resides in a designated area in which a prepaid managed care health services organization providing physical health, dental, mental health or chemical dependency services is not able to assign an enrollee to a person or entity that is primarily responsible for coordinating the physical health, dental, mental health or chemical dependency services provided to the enrollee.

(4) As used in this section, "American Indian and Alaskan Native beneficiary" means:

(a) A member of a federally recognized Indian tribe, band or group;

(b) An Eskimo or Aleut or other Alaskan Native enrolled by the United States Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601; or

(c) A person who is considered by the United States Secretary of the Interior to be an Indian for any purpose.

Note: See note under 414.736.

414.738 Use of physician care organizations. (1) If the Department of Human Services has not been able to contract with the fully capitated health plan or plans in a designated area, the department may contract with a physician care organization in the designated area.

(2) The Office for Oregon Health Policy and Research shall develop criteria that the department shall consider when determining the circumstances under which the department may contract with a physician care organization. The criteria developed by the office shall include but not be limited to the following:

(a) The physician care organization must be able to assign an enrollee to a person or entity that is primarily responsible for coordinating the physical health services provided to the enrollee;

(b) The contract with a physician care organization does not threaten the financial viability of other fully capitated health plans in the designated area; and

(c) The contract with a physician care organization must be consistent with the legislative intent of using prepaid managed care health services organizations to provide services under ORS 414.705 to 414.750. [2003 c.810 §5]

Note: See note under 414.736.

414.739 Circumstances under which fully capitated health plan may contract as physician care organization. (1) A fully capitated health plan may apply to the Department of Human Services to contract with the department as a physician care organization rather than as a fully capitated health plan to provide services under ORS 414.705 to 414.750.

(2) The Office for Oregon Health Policy and Research shall develop the criteria that the department must use to determine the circumstances under which the department may accept an application by a fully capitated health plan to contract as a physi-

cian care organization. The criteria developed by the office shall include but not be limited to the following:

(a) The fully capitated health plan must show documented losses due to hospital risk and must show due diligence in managing those risks; and

(b) Contracting as a physician care organization is financially viable for the fully capitated health plan. [2003 c.810 §5a]

Note: See note under 414.736.

414.740 Contracts with certain prepaid group practice health plan. (1) Notwithstanding ORS 414.738 (1), the Department of Human Services shall contract under ORS 414.725 with a prepaid group practice health plan that serves at least 200,000 members in this state and that has been issued a certificate of authority by the Department of Consumer and Business Services as a health care service contractor to provide health services as described in ORS 414.705 (1)(b), (c), (d), (e), (g) and (j). A health plan may also contract with the Department of Human Services on a prepaid capitated basis to provide the health services described in ORS 414.705 (1)(k) and (L). The Department of Human Services may accept financial contributions from any public or private entity to help implement and administer the contract. The Department of Human Services shall seek federal matching funds for any financial contributions received under this section.

(2) In a designated area, in addition to the contract described in subsection (1) of this section, the Department of Human Services shall contract with prepaid managed care health services organizations to provide health services under ORS 414.705 to 414.750. [2003 c.810 §6]

Note: See note under 414.736.

414.741 Determination of benchmarks for setting per capita rates. (1) The Health Services Commission shall retain an actuary to determine the benchmark for setting per capita rates necessary to reimburse prepaid managed care health services organizations and fee-for-service providers for the cost of providing health services under ORS 414.705 to 414.750.

(2) The actuary retained by the commission shall use the following information to determine the benchmark for setting per capita rates:

(a) For hospital services, the most recently available Medicare cost reports for Oregon hospitals;

(b) For services of physicians licensed under ORS chapter 677 and other health professionals using procedure codes, the Medicare Resource Based Relative Value system conversion rates for Oregon;

(c) For prescription drugs, the most recent payment methodologies in the fee-for-service payment system for the Oregon Health Plan;

(d) For durable medical equipment and supplies, 80 percent of the Medicare allowable charge for purchases and rentals;

(e) For dental services, the most recent payment rates obtained from dental care organization encounter data; and

(f) For all other services not listed in paragraphs (a) to (e) of this subsection:

(A) The Medicare maximum allowable charge, if available; or

(B) The most recent payment rates obtained from the data available under subsection (3) of this section.

(3) The actuary shall use the most current encounter data and the most current fee-for-service data that is available, reasonable trends for utilization and cost changes to the midpoint of the next biennium, appropriate differences in utilization and cost based on geography, state and federal mandates and other factors that, in the professional judgment of the actuary, are relevant to the fair and reasonable estimation of costs. The Department of Human Services shall provide the actuary with the data and information in the possession of the department or contractors of the department reasonably necessary to develop a benchmark for setting per capita rates.

(4) The commission shall report the benchmark per capita rates developed under this section to the Director of the Oregon Department of Administrative Services, the Director of Human Services and the Legislative Fiscal Officer no later than August 1 of every even-numbered year.

(5) The Department of Human Services shall retain an actuary to determine:

(a) Per capita rates for health services that the department shall use to develop the department's proposed biennial budget; and

(b) Capitation rates to reimburse physician care organizations for the cost of providing health services under ORS 414.705 to 414.750 using the same methodologies used to develop capitation rates for fully capitated health plans. The rates may not advantage or disadvantage fully capitated health plans for similar services.

(6) The Department of Human Services shall submit to the Legislative Assembly no later than February 1 of every odd-numbered year a report comparing the per capita rates for health services on which the proposed budget of the department is based with the rates developed by the actuary retained by the Health Services Commission. If the rates

differ, the department shall disclose, by provider categories described in subsection (2) of this section, the amount of and reason for each variance. [2003 c.810 §9]

Note: See note under 414.736.

414.742 Payment for mental health drugs. The Department of Human Services may not establish capitation rates that include payment for mental health drugs. The department shall reimburse pharmacy providers for mental health drugs only on a fee-for-service payment basis. [2003 c.810 §11]

Note: See note under 414.736.

414.743 Payment to noncontracting hospital by fully capitated health plan; rules. (1) As used in this section, "fully capitated health plan" means an organization that contracts with the Department of Human Services on a prepaid capitated basis under ORS 414.725 to provide an adequate network of providers to ensure that all health services described in ORS 414.705 are reasonably accessible to enrollees.

(2) A fully capitated health plan that does not have a contract with a hospital to provide inpatient or outpatient hospital services under ORS 414.705 to 414.750 must pay for hospital services at 80 percent of the Medicare rate for the noncontracting hospital.

(3) A hospital that does not have a contract with a fully capitated health plan to provide inpatient or outpatient hospital services under ORS 414.705 to 414.750 must accept as payment in full the rates described in subsection (2) of this section.

(4) This section does not apply to type A and type B hospitals, as described in ORS 442.470, and rural critical access hospitals, as defined in ORS 315.613.

(5) The Department of Human Services shall adopt rules to implement and administer this section. [Subsection (1) of 2003 Edition enacted as 2003 c.735 §16(1); subsections (2) to (5) of 2003 Edition enacted as 2003 c.735 §16(2) to (5) and 2003 c.810 §12(1) to (4); 2007 c.886 §1]

Note: The amendments to 414.743 by section 2, chapter 886, Oregon Laws 2007, become operative January 2, 2010. See section 3, chapter 886, Oregon Laws 2007. The text that is operative on and after January 2, 2010, is set forth for the user's convenience.

414.743. (1) As used in this section, "fully capitated health plan" means an organization that contracts with the Department of Human Services on a prepaid capitated basis under ORS 414.725 to provide an adequate network of providers to ensure that all health services described in ORS 414.705 are reasonably accessible to enrollees.

(2) A fully capitated health plan that does not have a contract with a hospital to provide inpatient or outpatient hospital services under ORS 414.705 to 414.750 must pay for hospital services as follows:

(a) For inpatient hospital services, based on the capitation rates developed for the budget period, at the level of the statewide average unit cost, multiplied by the geographic factor, the payment discount factor and an adjustment factor of 0.925.

(b) For outpatient hospital services, based on the capitation rates developed for the budget period, at the level of charges multiplied by the statewide average cost-to-charge ratio, the geographic factor, the payment discount factor and an adjustment factor of 0.925.

(3) A hospital that does not have a contract with a fully capitated health plan to provide inpatient or outpatient hospital services under ORS 414.705 to 414.750 must accept as payment in full for hospital services, rates:

(a) For inpatient hospital services, based on the capitation rates developed for the budget period, at the level of the statewide average unit cost, multiplied by the geographic factor, the payment discount factor and an adjustment factor of 0.925.

(b) For outpatient hospital services, based on the capitation rates developed for the budget period, at the level of charges multiplied by the statewide average cost-to-charge ratio, the geographic factor, the payment discount factor and an adjustment factor of 0.925.

(4) This section does not apply to type A and type B hospitals, as described in ORS 442.470, and rural critical access hospitals, as defined in ORS 315.613.

(5) The Department of Human Services shall adopt rules to implement and administer this section.

Note: See note under 414.736.

414.744 Pharmacy benefit manager to manage prescription drug benefits. (1) Subject to the provisions of subsection (4) of this section, the Department of Human Services shall contract with a pharmacy benefit manager to manage prescription drug benefits for the medical assistance program. The pharmacy benefit manager shall purchase prescription drugs in bulk or reimburse pharmacies for prescription drugs prescribed for eligible persons in the medical assistance program.

(2) The pharmacy benefit manager shall establish two programs for the medical assistance program. One program shall purchase prescription drugs for or reimburse fully capitated health plans that use the pharmacy benefit manager under contract with the department. The second program shall reimburse fee-for-service pharmacy providers directly or provide for payment by the Department of Human Services.

(3) Fully capitated health plans may use the pharmacy benefit manager under contract with the department under subsection (1) of this section.

(4) In awarding a contract under this section, the department must ensure that the contractor has the capacity and competence to administer the services and that the contract is cost-neutral to the department.

(5) ORS 414.325 and 414.334 apply to the management of prescription drug benefits under this section. [2003 c.810 §13]

Note: 414.744 becomes operative the day after the date the Department of Human Services receives the necessary waivers from the Centers for Medicare and

Medicaid Services. See section 18, chapter 810, Oregon Laws 2003.

Note: See note under 414.736.

414.745 Liability of health care providers and plans. Any health care provider or plan contracting to provide services to the eligible population under ORS 414.705 to 414.750 shall not be subject to criminal prosecution, civil liability or professional disciplinary action for failing to provide a service which the Legislative Assembly has not funded or has eliminated from its funding pursuant to ORS 414.735. [1989 c.836 §10; 1991 c.753 §10]

Note: See note under 414.705.

414.747 Supplemental rebates from pharmaceutical manufacturers. (1) The Department of Human Services shall negotiate and enter into agreements with pharmaceutical manufacturers for supplemental rebates that are in addition to the discount required under federal law to participate in the medical assistance program.

(2) The department may participate in a multistate prescription drug purchasing pool for the purpose of negotiating supplemental rebates.

(3) ORS 414.325 and 414.334 apply to prescription drugs purchased for the medical assistance program under this section. [2003 c.810 §15]

Note: 414.747 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

414.750 Authority of Legislative Assembly to authorize services for other persons. Nothing in ORS 414.036 and 414.705 to 414.750 is intended to limit the authority of the Legislative Assembly to authorize services for persons whose income exceeds 100 percent of the federal poverty level for whom federal medical assistance matching funds are available if state funds are available therefor. [1989 c.836 §18; 1991 c.753 §11]

Note: See note under 414.705.

414.751 Office for Oregon Health Policy and Research Advisory Committee. (1) There is established in the Office for Oregon Health Policy and Research the Office for Oregon Health Policy and Research Advisory Committee composed of members appointed by the Governor. Members shall include:

(a) Representatives of managed care health services organizations under contract with the Department of Human Services pursuant to ORS 414.725 and serving primarily rural areas of the state;

(b) Representatives of managed care health services organizations under contract with the Department of Human Services pursuant to ORS 414.725 and serving primarily urban areas of the state;

(c) Representatives of medical organizations representing health care providers under contract with managed care health services organizations pursuant to ORS 414.725 who serve patients in both rural and urban areas of the state;

(d) One representative from Type A hospitals and one representative from Type B hospitals; and

(e) Representatives of the Department of Human Services.

(2) Members of the advisory committee shall not be entitled to compensation or per diem. [1997 c.683 §35; 2001 c.69 §2]

Note: 414.751 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

PAYMENT OF MEDICAL EXPENSES OF PERSON IN CUSTODY OF LAW ENFORCEMENT OFFICER

414.805 Liability of individual for medical services received while in custody of law enforcement officer. (1) An individual who receives medical services while in the custody of a law enforcement officer is liable:

(a) To the provider of the medical services for the charges and expenses therefor; and

(b) To the Department of Human Services for any charges or expenses paid by the Department of Human Services out of the Law Enforcement Medical Liability Account for the medical services.

(2) A person providing medical services to an individual described in subsection (1)(a) of this section shall first make reasonable efforts to collect the charges and expenses thereof from the individual before seeking to collect them from the Department of Human Services out of the Law Enforcement Medical Liability Account.

(3)(a) If the provider has not been paid within 45 days of the date of the billing, the provider may bill the Department of Human Services who shall pay the account out of the Law Enforcement Medical Liability Account.

(b) A bill submitted to the Department of Human Services under this subsection must be accompanied by evidence documenting that:

(A) The provider has billed the individual or the individual's insurer or health care service contractor for the charges or expenses owed to the provider; and

(B) The provider has made a reasonable effort to collect from the individual or the individual's insurer or health care service contractor the charges and expenses owed to the provider.

(c) If the provider receives payment from the individual or the insurer or health care service contractor after receiving payment from the Department of Human Services, the provider shall repay the department the amount received from the public agency less any difference between payment received from the individual, insurer or contractor and the amount of the billing.

(4) As used in this section:

(a) "Law enforcement officer" means an officer who is commissioned and employed by a public agency as a peace officer to enforce the criminal laws of this state or laws or ordinances of a public agency.

(b) "Public agency" means the state, a city, port, school district, mass transit district or county. [1991 c.778 §7; 2007 c.71 §105]

Note: 414.805 to 414.815 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

414.807 Department to pay for medical services related to law enforcement activity; certification of injury. (1)(a) When charges and expenses are incurred for medical services provided to an individual for injuries related to law enforcement activity and subject to the availability of funds in the account, the cost of such services shall be paid by the Department of Human Services out of the Law Enforcement Medical Liability Account established in ORS 414.815 if the provider of the medical services has made all reasonable efforts to collect the amount, or any part thereof, from the individual who received the services.

(b) When a law enforcement agency involved with an injury certifies that the injury is related to law enforcement activity, the Department of Human Services shall pay the provider:

(A) If the provider is a hospital, in accordance with current fee schedules established by the Director of the Department of Consumer and Business Services for purposes of workers' compensation under ORS 656.248; or

(B) If the provider is other than a hospital, 75 percent of the customary and usual rates for the services.

(2) After the injured person is incarcerated and throughout the period of incarceration, the Department of Human Services shall continue to pay, out of the Law Enforcement Medical Liability Account, charges and expenses for injuries related to law enforcement activities as provided in subsection (1) of this section. Upon release of the injured person from actual physical custody, the Law Enforcement Medical Liability Account is no longer liable for the payment of medical expenses of the injured person.

(3) If the provider of medical services has filed a medical services lien as provided in ORS 87.555, the Department of Human Services shall be subrogated to the rights of the provider to the extent of payments made by the Department of Human Services to the provider for the medical services. The Department of Human Services may foreclose the lien as provided in ORS 87.585.

(4) The Department of Human Services shall deposit in the Law Enforcement Medical Liability Account all moneys received by the department from:

(a) Providers of medical services as repayment;

(b) Individuals whose medical expenses were paid by the department under this section; and

(c) Foreclosure of a lien as provided in subsection (3) of this section.

(5) As used in this section:

(a) "Injuries related to law enforcement activity" means injuries sustained prior to booking, citation in lieu of arrest or release instead of booking that occur during and as a result of efforts by a law enforcement officer to restrain or detain, or to take or retain custody of, the individual.

(b) "Law enforcement officer" has the meaning given that term in ORS 414.805. [1991 c.778 §2; 1993 c.196 §9]

Note: See note under 414.805.

414.810 [Formerly 414.040; renumbered 566.310]

414.815 Law Enforcement Medical Liability Account; limited liability; rules; report. (1) The Law Enforcement Medical Liability Account is established separate and distinct from the General Fund. Interest earned, if any, shall inure to the benefit of the account. The moneys in the Law Enforcement Medical Liability Account are appropriated continuously to the Department of Human Services to pay expenses in administering the account and paying claims out of the account as provided in ORS 414.807.

(2) The liability of the Law Enforcement Medical Liability Account is limited to funds accrued to the account from assessments collected under ORS 137.309 (6), (8) or (9), or collected from individuals under ORS 414.805.

(3) The Department of Human Services may contract with persons experienced in medical claims processing to provide claims processing for the account.

(4) The Department of Human Services shall adopt rules to implement administration of the Law Enforcement Medical Liability Account including, but not limited to, rules that establish reasonable deadlines for submission of claims.

(5) Each biennium, the Department of Human Services shall submit a report to the Legislative Assembly regarding the status of the Law Enforcement Medical Liability Account. Within 30 days of the convening of each regular legislative session, the department shall submit the report to the chair of the Senate Judiciary Committee and the chair of the House Judiciary Committee. The report shall include, but is not limited to, the number of claims submitted and paid during the biennium and the amount of money in the fund at the time of the report. [1991 c.778 §1; 1993 c.196 §10; 1999 c.1051 §256; 2005 c.804 §8]

Note: See note under 414.805.

414.820 [Formerly 414.050; renumbered 566.320]

EXPANSION OF OREGON HEALTH PLAN

414.821 [2001 c.898 §1; 2003 c.14 §196; repealed by 2003 c.735 §5]

414.823 [2001 c.898 §2; 2003 c.14 §197; repealed by 2003 c.735 §5]

414.825 Policy. It is the policy of the State of Oregon that:

(1) The state, in partnership with the private sector, move toward providing affordable access to basic health care services for Oregon's low-income, uninsured children and families;

(2) Subject to funds available, the state provide subsidies to low-income Oregonians, using federal and state resources, to make health care services affordable to Oregon's low-income, uninsured children and families and that those subsidies should encourage the shared responsibility of employers and individuals in a public-private partnership;

(3) The respective roles and responsibilities of government, employers, providers, individuals and the health care delivery system be clearly defined;

(4) All public subsidies be clearly defined and based on an individual's ability to pay, not exceeding the cost of purchasing a basic package of health care services, except for those individuals with the greatest medical needs; and

(5) The health care delivery system encourage the use of evidence-based health care services, including appropriate education, early intervention and prevention, and procedures that are effective and appropriate in producing good health. [2001 c.898 §3; 2003 c.14 §198]

Note: 414.825, 414.831 and 431.839 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

414.827 [2001 c.898 §4; 2003 c.14 §199; repealed by 2003 c.735 §5]

414.829 [2001 c.898 §5; 2003 c.14 §200; repealed by 2003 c.684 §13 and 2003 c.735 §5]

414.830 [Formerly 414.060; renumbered 566.330]

414.831 Family Health Insurance Assistance Program. The Office of Private Health Partnerships shall focus on expanding group coverage provided by the Family Health Insurance Assistance Program. [2001 c.898 §5a; 2003 c.14 §201; 2003 c.684 §6; 2005 c.744 §37]

Note: See note under 414.825.

414.833 [2001 c.898 §6; 2003 c.14 §202; repealed by 2003 c.735 §5]

414.834 [2001 c.898 §7; 2003 c.14 §203; repealed by 2003 c.735 §5]

414.835 [2001 c.898 §8; 2003 c.14 §204; repealed by 2003 c.735 §5]

414.837 [2001 c.898 §10; 2003 c.14 §205; repealed by 2003 c.735 §5]

414.839 Subsidies for health insurance coverage. (1) Subject to funds available, the Department of Human Services may provide public subsidies for the purchase of health insurance coverage provided by public programs or private insurance, including but not limited to the Family Health Insurance Assistance Program, for currently uninsured individuals based on incomes up to 200 percent of the federal poverty level. The objective is to create a transition from dependence on public programs to privately financed health insurance.

(2) Public subsidies shall apply only to health benefit plans that meet or exceed the basic benchmark health benefit plan or plans established under ORS 735.733.

(3) Cost sharing shall be permitted and structured in such a manner to encourage appropriate use of preventive care and avoidance of unnecessary services.

(4) Cost sharing shall be based on an individual's ability to pay and may not exceed the cost of purchasing a plan.

(5) The state may pay a portion of the cost of the subsidy, based on the individual's income and other resources. [2001 c.898 §11; 2003 c.14 §206; 2003 c.684 §7; 2003 c.735 §9]

Note: See note under 414.825.

(Temporary provisions relating to Healthy Oregon Act)

Note: Sections 1 to 13 and 27, chapter 697, Oregon Laws 2007, provide:

Sec. 1. Sections 2 to 13 of this 2007 Act shall be known and may be cited as the Healthy Oregon Act. [2007 c.697 §1]

Sec. 2. As used in sections 2 to 13 of this 2007 Act, except as otherwise specifically provided or unless the context requires otherwise:

(1) "Accountable health plan" means a prepaid managed care health services organization described in ORS 414.725 or an entity that contracts with the Oregon Health Fund Board to provide a health benefit plan, as defined in ORS 743.730, through the Oregon Health Fund program.

(2) "Core health care safety net provider" means a safety net provider that is especially adept at serving persons who experience significant barriers to accessing health care, including homelessness, language and cultural barriers, geographic isolation, mental illness, lack of health insurance and financial barriers, and that has a mission or mandate to deliver services to persons who experience barriers to accessing care and serves a substantial share of persons without health insurance and persons who are enrolled in Medicaid or Medicare, as well as other vulnerable or special populations.

(3) "Defined set of essential health services" means the services:

(a) Identified by the Health Services Commission using the methodology in ORS 414.720 or an alternative methodology developed pursuant to section 9 (3)(c) of this 2007 Act; and

(b) Approved by the Oregon Health Fund Board.

(4) "Employer" has the meaning given that term in ORS 657.025.

(5) "Oregon Health Card" means the card issued by the Oregon Health Fund Board that verifies the eligibility of the holder to participate in the Oregon Health Fund program.

(6) "Oregon Health Fund" means the fund established in section 8 of this 2007 Act.

(7) "Oregon Health Fund Board" means the board established in section 5 of this 2007 Act.

(8) "Safety net provider" means providers that deliver health services to persons experiencing cultural, linguistic, geographic, financial or other barriers to accessing appropriate, timely, affordable and continuous health care services. "Safety net providers" includes health care safety net providers, core health care safety net providers, tribal and federal health care organizations and local nonprofit organizations, government agencies, hospitals and individual providers. [2007 c.697 §2]

Sec. 3. The Oregon Health Fund program shall be based on the following principles:

(1) Expanding access. The state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program must be expanded to include the current uninsured population in Oregon to the greatest extent possible.

(2) Equity. All individuals must be eligible for and have timely access to at least the same set of essential and effective health services.

(3) Financing of the health care system must be equitable, broadly based and affordable.

(4) Population benefit. The public must set priorities to optimize the health of Oregonians.

(5) Responsibility for optimizing health must be shared by individuals, employers, health care systems and communities.

(6) Education is a powerful tool for health promotion. The health care system, health plans, providers and government must promote and engage in education activities for individuals, communities and providers.

(7) Effectiveness. The relationship between specific health interventions and their desired health outcomes must be backed by unbiased, objective medical evidence.

(8) Efficiency. The administration and delivery of health services must use the fewest resources necessary to produce the most effective health outcome.

(9) Explicit decision-making. Decision-making will be clearly defined and accessible to the public, including lines of accountability, opportunities for public engagement and how public input will be used in decision-making.

(10) Transparency. The evidence used to support decisions must be clear, understandable and observable to the public.

(11) Economic sustainability. Health service expenditures must be managed to ensure long-term sustainability, using efficient planning, budgeting and coordination of resources and reserves, based on public values and recognizing the impact that public and private health expenditures have on each other.

(12) Aligned financial incentives. Financial incentives must be aligned to support and invest in activities that will achieve the goals of the Oregon Health Fund program.

(13) Wellness. Health and wellness promotion efforts must be emphasized and strengthened.

(14) Community-based. The delivery of care and distribution of resources must be organized to take place at the community level to meet the needs of the local population, unless outcomes or cost can be improved at regional or statewide levels.

(15) Coordination. Collaboration, coordination and integration of care and resources must be emphasized throughout the health care system.

(16) The health care safety net is a key delivery system element for the protection of the health of Oregonians and the delivery of community-based care. [2007 c.697 §3]

Sec. 4. The intent of the Healthy Oregon Act is to develop an Oregon Health Fund program comprehensive plan, based upon the principles set forth in section 3 of this 2007 Act, that meets the intended goals of the program to:

(1) As a primary goal, cover the current uninsured population in Oregon through the expansion of the state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program;

(2) Reform the health care delivery system to maximize federal and other public resources without compromising proven programs supported by federal law that ensure to vulnerable populations access to efficient and high quality care;

(3) Ensure that all Oregonians have timely access to and participate in a health benefit plan that provides high quality, effective, safe, patient-centered, evidence-based and affordable health care delivered at the lowest cost;

(4) Develop a method to finance the coverage of a defined set of essential health services for Oregonians that is not necessarily tied directly to employment;

(5) Allow the potential for employees, employers, individuals and unions to participate in the program, or to purchase primary coverage or offer, purchase or bargain for coverage of benefits beyond the defined set of essential health services;

(6) Allow for a system of public and private health care partnerships that integrate public involvement and

oversight, consumer choice and competition within the health care market;

(7) Use proven models of health care benefits, service delivery and payments that control costs and overutilization, with emphasis on preventive care and chronic disease management using evidence-based outcomes and a health benefit model that promotes a primary care medical home;

(8) Provide services for dignified end-of-life care;

(9) Restructure the health care system so that payments for services are fair and proportionate among various populations, health care programs and providers;

(10) Fund a high quality and transparent health care delivery system that will be held to high standards of transparency and accountability and allows users and purchasers to know what they are receiving for their money;

(11) Ensure that funding for health care is equitable and affordable for all Oregon residents, especially the uninsured; and

(12) Ensure, to the greatest extent possible, that annual inflation in the cost of providing access to essential health care services does not exceed the increase in the cost of living for the previous calendar year, based on the Portland-Salem, OR-WA, Consumer Price Index for All Urban Consumers for All Items, as published by the Bureau of Labor Statistics of the United States Department of Labor. [2007 c.697 §4]

Sec. 5. (1) There is established within the Department of Human Services the Oregon Health Fund Board that shall be responsible for developing the Oregon Health Fund program comprehensive plan. The board shall consist of seven members appointed by the Governor, subject to confirmation by the Senate pursuant to section 4, Article III of the Oregon Constitution. The members of the board shall be selected based upon their ability to represent the best interests of Oregon as a whole. Members of the board shall have expertise, knowledge and experience in the areas of consumer advocacy, management, finance, labor and health care, and to the extent possible shall represent the geographic and ethnic diversity of the state. A majority of the board members must consist of individuals who do not receive or have not received within the past two years more than 50 percent of the individual's income or the income of the individual's family from the health care industry or the health insurance industry.

(2) Each board member shall serve for a term of four years. However, a board member shall serve until a successor has been appointed and qualified. A member is eligible for reappointment.

(3) If there is a vacancy for any cause, the Governor shall make an appointment to become effective immediately for the balance of the unexpired term.

(4) The board shall select one of its members as chairperson and another as vice chairperson, for such terms and with duties and powers necessary for the performance of the functions of such offices as the board determines.

(5) A majority of the members of the board constitutes a quorum for the transaction of business.

(6) Official action by the board requires the approval of a majority of the members of the board.

(7) A member of the board is not entitled to compensation for services as a member, but is entitled to expenses as provided in ORS 292.495 (2). [2007 c.697 §5]

Sec. 6. (1) Within 30 days after the effective date of this 2007 Act [June 28, 2007], the Governor shall appoint an executive director of the Oregon Health Fund Board who will be responsible for establishing the administrative framework for the board.

(2) The executive director appointed under this section may employ and shall fix the duties and amounts of compensation of persons necessary to carry out the provisions of sections 2 to 13 of this 2007 Act. Those persons shall serve at the pleasure of the executive director.

(3) The executive director shall serve at the pleasure of the Governor. [2007 c.697 §6]

Sec. 7. Except as otherwise provided by law, and except for ORS 279A.250 to 279A.290, the provisions of ORS chapters 279A, 279B and 279C do not apply to the Oregon Health Fund Board. [2007 c.697 §7]

Sec. 8. (1) The Oregon Health Fund is established separate and distinct from the General Fund. Interest earned from the investment of moneys in the Oregon Health Fund shall be credited to the fund. The Oregon Health Fund may include:

(a) Employer and employee health care contributions.

(b) Individual health care premium contributions.

(c) Federal funds from Title XIX or XXI of the Social Security Act, and state matching funds, that are made available to the fund, excluding Title XIX funds for long term care supports, services and administration, and reimbursements for graduate medical education costs pursuant to 42 U.S.C. 1395ww(h) and disproportionate share adjustments made pursuant to 42 U.S.C. 1396a(a)(13)(A)(iv).

(d) Contributions from the United States Government and its agencies for which the state is eligible provided for purposes that are consistent with the goals of the Oregon Health Fund program.

(e) Moneys appropriated to the Oregon Health Fund Board by the Legislative Assembly for carrying out the provisions of the Healthy Oregon Act.

(f) Interest earnings from the investment of moneys in the fund.

(g) Gifts, grants or contributions from any source, whether public or private, for the purpose of carrying out the provisions of the Healthy Oregon Act.

(2)(a) All moneys in the Oregon Health Fund are continuously appropriated to the Oregon Health Fund Board to carry out the provisions of the Healthy Oregon Act.

(b) The Oregon Health Fund shall be segregated into subaccounts as required by federal law. [2007 c.697 §8]

Sec. 9. (1)(a) The Oregon Health Fund Board shall establish a committee to examine the impact of federal law requirements on reducing the number of Oregonians without health insurance, improving Oregonians' access to health care and achieving the goals of the Healthy Oregon Act, focusing particularly on barriers to reducing the number of uninsured Oregonians, including but not limited to:

(A) Medicaid requirements such as eligibility categories and household income limits;

(B) Federal tax code policies regarding the impact on accessing health insurance or self-insurance and the affect on the portability of health insurance;

(C) Emergency Medical Treatment and Active Labor Act regulations that make the delivery of health care more costly and less efficient; and

(D) Medicare policies that result in Oregon's health care providers receiving significantly less than the national average Medicare reimbursement rate. The committee shall survey providers and determine how this and other Medicare policies and procedures affect costs, quality and access. The committee shall assess how an increase in Medicare reimbursement rates to Oregon providers would benefit Oregon in health care costs, quality and access to services, including improved ac-

cess for persons with disabilities and improved access to long term care.

(b) With the approval of the Oregon Health Fund Board, the committee shall report its findings to the Oregon congressional delegation no later than July 31, 2008.

(c) The committee shall request that the Oregon congressional delegation:

(A) Participate in at least one hearing in each congressional district in this state on the impacts of federal policies on health care services; and

(B) Request congressional hearings in Washington, D.C.

(2) The Oregon Health Fund Board shall develop a comprehensive plan to achieve the Oregon Health Fund program goals listed in section 4 of this 2007 Act. The board shall establish subcommittees, organized to maximize efficiency and effectiveness and assisted, in the manner the board deems appropriate, by the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research, the Health Services Commission and the Medicaid Advisory Committee, to develop proposals for the Oregon Health Fund program comprehensive plan. The proposals may address, but are not limited to, the following:

(a) Financing the Oregon Health Fund program, including but not limited to proposals for:

(A) A model for rate setting that ensures providers will receive fair and adequate compensation for health care services.

(B) Collecting employer and employee contributions and individual health care premium contributions, and redirecting them to the Oregon Health Fund.

(C) Implementing a health insurance exchange to serve as a central forum for uninsured individuals and businesses to purchase affordable health insurance.

(D) Taking best advantage of health savings accounts and similar vehicles for making health insurance more accessible to uninsured individuals.

(E) Addressing the issue of medical liability and medical errors including, but not limited to, consideration of a patients' compensation fund.

(F) Requesting federal waivers under Titles XIX and XXI of the Social Security Act, or other federal matching funds that may be made available to implement the comprehensive plan and increase access to health care.

(G) Evaluating statutory and regulatory barriers to the provision of cost-effective services, including limitations on access to information that would enable providers to fairly evaluate contract reimbursement, the regulatory effectiveness of the certificate of need process, consideration of a statewide uniform credentialing process and the costs and benefits of improving the transparency of costs of hospital services and health benefit plans.

(b) Delivering health services in the Oregon Health Fund program, including but not limited to proposals for:

(A) An efficient and effective delivery system model that ensures the continued viability of existing prepaid managed care health services organizations, as described in ORS 414.725, to serve Medicaid populations.

(B) The design and implementation of a program to create a public partnership with accountable health plans to provide, through the use of an Oregon Health Card, health insurance coverage of the defined set of essential health services that meets standards of affordability based upon a calculation of how much individuals and families, particularly the uninsured, can be expected to spend for health insurance and still afford to pay for housing, food and other necessities. The proposal must ensure that each accountable health plan:

(i) Does not deny enrollment to qualified Oregonians eligible for Medicaid;

(ii) Provides coverage of the entire defined set of essential health services;

(iii) Will develop an information system to provide written information, and telephone and Internet access to information, necessary to connect enrollees with appropriate medical and dental services and health care advice;

(iv) Offers a simple and timely complaint process;

(v) Provides enrollees with information about the cost and quality of services offered by health plans and procedures offered by medical and dental providers;

(vi) Provides advance disclosure of the estimated out-of-pocket costs of a service or procedure;

(vii) Has contracts with a sufficient network of providers, including but not limited to hospitals and physicians, with the capacity to provide culturally appropriate, timely health services and that operate during hours that allow optimal access to health services;

(viii) Ensures that all enrollees have a primary care medical home;

(ix) Includes in its network safety net providers and local community collaboratives;

(x) Regularly evaluates its services, surveys patients and conducts other assessments to ensure patient satisfaction;

(xi) Has strategies to encourage enrollees to utilize preventive services and engage in healthy behaviors;

(xii) Has simple and uniform procedures for enrollees to report claims and for accountable health plans to make payments to enrollees and providers;

(xiii) Provides enrollment, encounter and outcome data for evaluation and monitoring purposes; and

(xiv) Meets established standards for loss ratios, rating structures and profit or nonprofit status.

(C) Using information technology that is cost-neutral or has a positive return on investment to deliver efficient, safe and quality health care and a voluntary program to provide every Oregonian with a personal electronic health record that is within the individual's control, use and access and that is portable.

(D) Empowering individuals through education as well as financial incentives to assume more personal responsibility for their own health status through the choices they make.

(E) Establishing and maintaining a registry of advance directives and Physician Orders for Life-Sustaining Treatment (POLST) forms and a process for assisting a person who chooses to execute an advance directive in accordance with ORS 127.531 or a POLST form.

(F) Designing a system for regional health delivery.

(G) Combining, reorganizing or eliminating state agencies involved in health planning and policy, health insurance and the delivery of health care services and integrating and streamlining their functions and programs to maximize their effectiveness and efficiency. The subcommittee may consider, but is not limited to considering, the following state agencies, functions or programs:

(i) The Health Services Commission;

(ii) The Oregon Health Policy Commission;

(iii) The Health Resources Commission;

(iv) The Medicaid Advisory Committee;

(v) The Department of Human Services, including but not limited to the state Medicaid agency, the Office for Oregon Health Policy and Research, offices involved in health systems planning, offices involved in carrying out the duties of the department with respect to certif-

icates of need under ORS 443.305 to 443.350 and the functions of the department under ORS chapter 430;

(vi) The Department of Consumer and Business Services;

(vii) The Oregon Patient Safety Commission;

(viii) The Office of Private Health Partnerships;

(ix) The Public Employees' Benefit Board;

(x) The State Accident Insurance Fund Corporation; and

(xi) The Office of Rural Health.

(c) Establishing the defined set of essential health services, including but not limited to proposals for a methodology, consistent with the principles in section 3 of this 2007 Act, for determining and continually updating the defined set of essential health services. The Oregon Health Fund Board may delegate this function to the Health Services Commission established under ORS 414.715.

(d) The eligibility requirements and enrollment procedures for the Oregon Health Fund program, including, but not limited to, proposals for:

(A) Public subsidies of premiums or other costs under the program.

(B) Streamlined enrollment procedures, including:

(i) A standardized application process;

(ii) Requirements to ensure that enrollees demonstrate Oregon residency;

(iii) A process to enable a provider to enroll an individual in the Oregon Health Fund program at the time the individual presents for treatment to ensure coverage as of the date of the treatment; and

(iv) Permissible waiting periods, preexisting condition limitations or other administrative requirements for enrollment.

(C) A grievance and appeal process for enrollees.

(D) Standards for disenrollment and changing enrollment in accountable health plans.

(E) An outreach plan to educate the general public, particularly uninsured and underinsured persons, about the program and the program's eligibility requirements and enrollment procedures.

(F) Allowing employers to offer health insurance coverage by insurers of the employer's choice or to contract for coverage of benefits beyond the defined set of essential health services.

(3) On the effective date of this 2007 Act [June 28, 2007], the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research, the Health Services Commission and the Medicaid Advisory Committee are directed to begin compiling data and conducting research to inform the decision-making of the subcommittees when they are convened. No later than February 1, 2008, the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research, the Health Services Commission and the Medicaid Advisory Committee shall present reports containing data and recommendations to the subcommittees as follows:

(a) The Oregon Health Policy Commission shall report on the financing mechanism for the comprehensive plan;

(b) The Administrator of the Office for Oregon Health Policy and Research shall report on the health care delivery model of the comprehensive plan;

(c) The Health Services Commission shall report on the methodology for establishing the defined set of essential health services under the comprehensive plan; and

(d) The Medicaid Advisory Committee shall report on eligibility and enrollment requirements under the comprehensive plan.

(4) The membership of the subcommittees shall, to the extent possible, represent the geographic and ethnic diversity of the state and include individuals with actuarial and financial management experience, individuals who are providers of health care, including safety net providers, and individuals who are consumers of health care, including seniors, persons with disabilities and individuals with complex medical needs.

(5) Each subcommittee shall select one of its members as chairperson for such terms and with such duties and powers necessary for performance of the functions of those offices. Each chairperson shall serve as an ex officio member of the Oregon Health Fund Board. Chairpersons shall collaborate to integrate the committee recommendations to the extent possible.

(6) The committee and the subcommittees are public bodies for purposes of ORS chapter 192 and must provide reasonable opportunity for public testimony at each meeting.

(7) All agencies of state government, as defined in ORS 174.111, are directed to assist the committee, the subcommittees and the Oregon Health Fund Board in the performance of their duties and, to the extent permitted by laws relating to confidentiality, to furnish such information and advice as the members of the committees, the subcommittees and the Oregon Health Fund Board consider necessary to perform their duties.

(8) The Oregon Health Fund Board shall report to the Legislative Assembly not later than February 29, 2008. The report must describe the progress of the subcommittees and the board toward developing a comprehensive plan to:

(a) Decrease the number of children and adults without health insurance;

(b) Ensure universal access to health care;

(c) Contain health care costs; and

(d) Address issues regarding the quality of health care services.

(9) The Oregon Health Fund Board shall present a plan to the Legislative Assembly not later than February 1, 2008, for the design and implementation of the health insurance exchange described in subsection (2)(a)(C) of this section. [2007 c.697 §9]

Sec. 10. The Oregon Health Fund Board shall conduct public hearings on the draft Oregon Health Fund program comprehensive plan developed under section 9 of this 2007 Act and solicit testimony and input from advocates representing seniors, persons with disabilities, tribes, consumers of mental health services, low-income Oregonians, employers, employees, insurers, health plans and providers of health care including, but not limited to, physicians, dentists, oral surgeons, chiropractors, naturopaths, hospitals, clinics, pharmacists, nurses and allied health professionals. [2007 c.697 §10]

Sec. 11. (1) The Oregon Health Fund Board shall finalize the Oregon Health Fund program comprehensive plan developed under section 9 of this 2007 Act with due consideration to the information provided in the public hearings under section 10 of this 2007 Act and shall present the finalized comprehensive plan to the Governor, the Speaker of the House of Representatives and the President of the Senate no later than October 1, 2008. The board is authorized to submit the finalized comprehensive plan as a measure request directly to the Legislative Counsel upon the convening of the Seventy-fifth Legislative Assembly.

(2) Upon legislative approval of the comprehensive plan, the board is authorized to request federal waivers deemed necessary and appropriate to implement the comprehensive plan.

(3) Upon legislative approval of the comprehensive plan, the board is authorized immediately to implement any elements necessary to implement the plan that do

not require legislative changes or federal approval. [2007 c.697 §11]

Sec. 12. (1) The Oregon Health Fund program comprehensive plan described in section 11 of this 2007 Act must ensure, except as provided in subsection (2) of this section, that a resident of Oregon who is not a beneficiary of a health benefit plan providing coverage of the defined set of essential health services and who is not eligible to be enrolled in a publicly funded medical assistance program providing primary care and hospital services participates in the Oregon Health Fund program. A resident of Oregon who is a beneficiary of a health benefit plan or enrolled in a medical assistance program described in this subsection may choose to participate in the program. An employee of an employer located in this state may participate in the program if Oregon is the location of the employee's physical worksite, regardless of the employee's state of residence.

(2) Oregon residents who are enrolled in commercial health insurance plans, self-insured programs, health plans funded by a Taft-Hartley trust, or state or local government health insurance pools may not be required to participate in the Oregon Health Fund Program. [2007 c.697 §12]

Sec. 13. (1) The Administrator of the Office for Oregon Health Policy and Research, in collaboration with the Oregon Health Research and Evaluation Collaborative and other persons with relevant expertise, shall be responsible for developing a plan for evaluating the implementation and outcomes of the legislation described in section 11 of this 2007 Act. The evaluation plan shall focus particularly on the individuals receiving health care covered through the state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program and shall include measures of:

(a) Access to care;

(b) Access to health insurance coverage;

(c) Quality of care;

(d) Consumer satisfaction;

(e) Health status;

(f) Provider capacity;

(g) Population demand;

(h) Provider and consumer participation;

(i) Utilization patterns;

(j) Health outcomes;

(k) Health disparities;

(L) Financial impacts, including impacts on medical debt;

(m) The extent to which employers discontinue coverage due to the availability of publicly financed coverage or other employer responses;

(n) Impacts on the financing of health care and uncompensated care;

(o) Adverse selection, including migration to Oregon primarily for access to health care;

(p) Use of technology;

(q) Transparency of costs; and

(r) Impact on health care costs.

(2) The administrator shall develop recommendations for a model quality institute that shall:

(a) Develop and promote methods for improving collection, measurement and reporting of information on quality in health care;

(b) Provide leadership and support to further the development of widespread and shared electronic health records;

(c) Develop the capacity of the workforce to capitalize on health information technology;

(d) Encourage purchasers, providers and state agencies to improve system transparency and public understanding of quality in health care;

(e) Support the Oregon Patient Safety Commission's efforts to increase collaboration and state leadership to improve health care safety; and

(f) Coordinate an effort among all state purchasers of health care and insurers to support delivery models and reimbursement strategies that will more effectively support infrastructure investments, integrated care and improved health outcomes. [2007 c.697 §13]

Sec. 27. Sections 1 to 13 of this 2007 Act are repealed on January 2, 2010. [2007 c.697 §27]

414.840 [Formerly 414.070; renumbered 566.340]

414.850 [Formerly 414.080; renumbered 566.350]

414.860 [Formerly 414.090; renumbered 566.360]