# Chapter 414

**2009 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**414.001** [Repealed by 1953 c.378 §2]
**414.002** [Repealed by 1953 c.378 §2]
**414.003** [Repealed by 1953 c.378 §2]
**414.004** [Repealed by 1953 c.378 §2]
**414.005** [Repealed by 1953 c.378 §2]
**414.006** [Repealed by 1953 c.378 §2]
**414.007** [Repealed by 1953 c.378 §2]
**414.008** [Repealed by 1953 c.378 §2]
**414.009** [Repealed by 1953 c.378 §2]
**414.010** [Repealed by 1953 c.378 §2]
**414.011** [Repealed by 1953 c.378 §2]
**414.012** [Repealed by 1953 c.378 §2]
**414.013** [Repealed by 1953 c.378 §2]
**414.014** [Repealed by 1953 c.378 §2]
**414.015** [Repealed by 1953 c.30 §2]
**414.016** [Repealed by 1953 c.30 §2]
**414.017** [Repealed by 1953 c.30 §2]

## GENERAL PROVISIONS

**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 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.

**414.019** [1993 c.815 §2; 1999 c.547 §4; 2005 c.22 §284; repealed by 2009 c.595 §1204]

**414.020** [Repealed by 1953 c.204 §9]

**414.021** [1993 c.815 §3; 1995 c.727 §19; 1997 c.683 §14; 1999 c.547 §5; 2003 c.47 §1; 2003 c.784 §6; repealed by 2009 c.595 §1204]

**414.022** [1993 c.815 §29; 1995 c.806 §3; 1995 c.807 §4; 1999 c.835 §1; 2001 c.900 §100; repealed by 2009 c.595 §1204]

**414.023** [1993 c.815 §30; 1997 c.249 §128; repealed by 2009 c.595 §1204]

**414.024** [1993 c.815 §31; 1997 c.683 §15; 1999 c.547 §6; repealed by 2009 c.595 §1204]

**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 a category of aid 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.

(k) Is under the age of 22 years and is in a psychiatric hospital.

(L) 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.

(m) 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.

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

(o) 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.

(p) Is an individual or member of a group who, subject to the rules of the department, 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.

(q) 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.

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

(s) 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.

(t) 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).

(u) Is eligible for the Health Care for All Oregon Children program established in ORS 414.231.

(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 Oregon Health Authority according to the standards established pursuant to ORS 413.032, 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 §18,18a; 2009 c.595 §264; 2009 c.867 §36]

**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]

**414.031** [2003 c.784 §9; repealed by 2009 c.595 §1204]

**414.032** [1967 c.502 §4; 1985 c.747 §10; repealed by 2009 c.595 §1204]

**414.033 Expenditures for medical assistance authorized.** The Oregon Health Authority 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; 2009 c.595 §265]

**414.034 Acceptance of federal billing, reimbursement and reporting forms.** The Oregon Health Authority shall accept federal Centers for Medicare and Medicaid Services billing, reimbursement and reporting 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; 2009 c.595 §266]

**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** [1983 c.415 §2; 1989 c.836 §1; 1991 c.753 §1; repealed by 2009 c.595 §1204]

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

**414.038** [1975 c.509 §§3,4 (enacted in lieu of 414.037); repealed by 2009 c.595 §1204]

**414.039** [1985 c.747 §12; 1989 c.31 §1; 1991 c.66 §7; 1997 c.581 §23; repealed by 2009 c.595 §1204]

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

**414.041 Application process; outreach and enrollment.** (1) The Department of Human Services, under the direction of the Oregon Health Policy Board and in collaboration with the Oregon Health Authority, shall implement a streamlined and simple application process for the medical assistance and premium assistance programs administered by the Oregon Health Authority and the Office of Private Health Partnerships. The process shall include, but not be limited to:

(a) An online application that may be submitted via the Internet;

(b) Application forms that are readable at a sixth grade level and that request the minimum amount of information necessary to begin processing the application; and

(c) Application assistance from qualified staff to aid individuals who have language, cognitive, physical or geographic barriers to applying for medical assistance or premium assistance.

(2) In developing the simplified application forms, the department shall consult with persons not employed by the department who

have experience in serving vulnerable and hard-to-reach populations.

(3) The Oregon Health Authority shall facilitate outreach and enrollment efforts to connect eligible individuals with all available publicly funded health programs, including but not limited to the Family Health Insurance Assistance Program. [2009 c.867 §35; 2009 c.828 §58]

**Note:** 414.041 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.

**414.042** [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; 2009 c.595 §269; 2009 c.867 §42; renumbered 411.404 in 2009]

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

**414.047** [1967 c.502 §7; 1969 c.68 §8; 1971 c.779 §46; 1991 c.66 §9; 2003 c.14 §189; renumbered 411.400 in 2009]

**414.049** [2003 c.810 §17; 2009 c.595 §272; renumbered 411.402 in 2009]

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

**414.051** [1979 c.296 §2; 1991 c.66 §10; 2009 c.595 §273; renumbered 411.459 in 2009]

**414.055** [1965 c.556 §4; 1971 c.734 §45; 1971 c.779 §47; 1991 c.66 §11; renumbered 411.408 in 2009]

**414.057** [1967 c.502 §8; 1971 c.779 §48; 1991 c.66 §12; renumbered 411.406 in 2009]

**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 Oregon Health Authority 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 Oregon Health Authority 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 authority may require a recipient to pay toward the cost of medical and remedial care or services.

(b) Notwithstanding ORS 414.720 (8), the authority 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 authority 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 authority 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; 2009 c.595 §276]

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

**414.073** [1971 c.188 §2; 1991 c.66 §14; 2009 c.595 §277; renumbered 411.463 in 2009]

**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** [1965 c.556 §10; 1991 c.66 §15; repealed by 2009 c.595 §1204]

**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** [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; 2009 c.595 §278; renumbered 416.350 in 2009]

**414.106** [1995 c.642 §2; 2001 c.900 §224; 2009 c.595 §279; renumbered 416.351 in 2009]

**414.107** [1991 c.753 §5a; 1993 c.815 §15; repealed by 2009 c.595 §1204]

**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.

(3) On June 26, 2009, all moneys in the Oregon Health Plan Fund shall be transferred to the Oregon Health Authority Fund established in ORS 413.031. [2002 s.s.3 c.2 §9; 2009 c.595 §280]

**Note:** 414.109 was enacted into law but was not added to or made a part of ORS chapter 414 or any series therein by law. 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 Oregon Health Authority 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. 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 authority; 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 authority 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 authority as may be required by the authority for its records, reports and audits. [1967 c.502 §9; 1975 c.401 §1; 1981 c.825 §5; 1991 c.66 §17; 2009 c.595 §281]

**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 Oregon Health Authority 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 demon-

stration 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; 2009 c.595 §282]

**414.135 Contracts relating to direct providers of care and services.** The Oregon Health Authority 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 authority pursuant to the number of days and the fees, charges and costs established under ORS 414.065. The contractor must guarantee the authority 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 authority as may be required by the authority. [1967 c.502 §11; 1991 c.66 §19; 2009 c.595 §283]

**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 Oregon Health Authority that such implementation will provide comparable benefits at equal or less cost than provision thereof by direct payments by the authority 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 authority 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; 2009 c.595 §284]

## 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** [1991 c.337 §2; 1993 c.18 §100; 2001 c.900 §101; 2009 c.595 §285; renumbered 411.435 in 2009]

**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 Oregon Health Authority 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; 2009 c.595 §286]

**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 the Oregon Health Authority 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 Oregon Health Authority Fund. [1995 c.727 §43; 2007 c.70 §192; 2009 c.595 §287]

**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 the Oregon Health Authority 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; 2009 c.595 §288]

**Note:** See note under 414.211.

**414.225 Oregon Health Authority to consult with committee.** The Oregon Health Authority 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; 2009 c.595 §289]

**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 Oregon Health Authority or the Oregon Health Policy Board 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; 2009 c.595 §290]

**414.229 Office for Oregon Health Policy and Research Advisory Committee.** (1) There is established in the Oregon Health Authority the Office for Oregon Health Policy and Research Advisory Committee com-

posed of members appointed by the Governor. Members shall include:

(a) Representatives of managed care health services organizations under contract with the Oregon Health Authority 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 Oregon Health Authority 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; and

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

(2) Members of the advisory committee shall not be entitled to compensation or per diem. [Formerly 414.751]

**Note:** 414.229 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.

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

## HEALTH CARE FOR ALL OREGON CHILDREN PROGRAM

**414.231 Eligibility for Healthy Kids program; 12-month continuous enrollment; verification of eligibility; uninsurance requirement; rules.** (1) As used in this section:

(a) "Child" means a person under 19 years of age.

(b) "Health benefit plan" has the meaning given that term in ORS 414.841.

(2) The Health Care for All Oregon Children program is established to make affordable, accessible health care available to all of Oregon's children. The program is composed of:

(a) Medical assistance funded in whole or in part by Title XIX of the Social Security Act, by the State Children's Health Insurance Program under Title XXI of the Social Security Act and by moneys appropriated or allocated for that purpose by the Legislative Assembly; and

(b) A private health option administered by the Office of Private Health Partnerships under ORS 414.826.

(3) A child is eligible for the program if the child is lawfully present in this state and the income of the child's family is at or below 300 percent of the federal poverty guidelines. There is no asset limit to qualify for the program.

(4)(a) A child receiving medical assistance under the program is continuously eligible for a minimum period of 12 months.

(b) The Department of Human Services shall reenroll a child for successive 12-month periods of enrollment as long as the child is eligible for medical assistance on the date of reenrollment.

(c) The department may not require a new application as a condition of reenrollment under paragraph (b) of this subsection and must determine the person's eligibility for medical assistance using information and sources available to the department or documentation readily available to the person.

(5) Except for medical assistance funded by Title XIX of the Social Security Act, the department may prescribe by rule a period of uninsurance prior to enrollment in the program. [2009 c.867 §27; 2009 c.867 §28]

**Note:** The amendments to 414.231 by section 28, chapter 867, Oregon Laws 2009, become operative January 1, 2010, subject to receipt of federal approval. See section 32, chapter 867, Oregon Laws 2009, as amended by section 55, chapter 828, Oregon Laws 2009. The text that is operative until January 1, 2010, or until receipt of federal approval, is set forth for the user's convenience.

**414.231.** (1) As used in this section, "child" means a person under 19 years of age.

(2) The Health Care for All Oregon Children program is established to make affordable, accessible health care available to all of Oregon's children. The program is composed of:

(a) Medical assistance funded in whole or in part by Title XIX of the Social Security Act, by the State Children's Health Insurance Program under Title XXI of the Social Security Act and by moneys appropriated or allocated for that purpose by the Legislative Assembly; and

(b) A private health option administered by the Office of Private Health Partnerships under ORS 414.826.

(3) A child is eligible for the program if the child is lawfully present in this state and the income of the child's family is at or below 200 percent of the federal poverty guidelines. There is no asset limit to qualify for the program.

(4)(a) A child receiving medical assistance under the program is continuously eligible for a minimum period of 12 months.

(b) The Department of Human Services shall reenroll a child for successive 12-month periods of enrollment as long as the child is eligible for medical assistance on the date of reenrollment.

(c) The department may not require a new application as a condition of reenrollment under paragraph (b) of this subsection and must determine the child's eligibility for medical assistance using information and sources available to the department or documentation readily available.

(5) Except for medical assistance funded by Title XIX of the Social Security Act, the department may prescribe by rule a period of uninsurance prior to enrollment in the program.

**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 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 Oregon Health Authority. The purpose of the program is to:

(a) Purchase prescription drugs, replenish prescription drugs dispensed 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 as a means to promote health;

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

(d) Promote health through the purchase and provision of discount prescription drugs and coordination of comprehensive prescription benefit services for eligible entities and members.

(3) The Director of the Oregon Health Authority shall appoint an administrator of the Oregon Prescription Drug Program. The administrator may:

(a) Negotiate price discounts and rebates on prescription drugs with prescription drug manufacturers or group purchasing organizations;

(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 or replenish pharmacies for prescription drugs dispensed or transferred;

(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, Oregon Educators Benefit Board and Public Employees Retirement System;

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

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

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

(f) Private entities; and

(g) 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 program prices for pharmacies in rural areas to maintain statewide access to the program.

(7) The administrator may 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 (10) 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 perform any of the functions of the program, including but not limited to:

(a) Contracting with a pharmacy benefit manager and directly or indirectly with such pharmacy networks as the administrator considers necessary to maintain statewide access to the program.

(b) Negotiating with prescription drug manufacturers on behalf of the administrator.

(10) Notwithstanding subsection (4)(e) of this section, individuals who are eligible for Medicare Part D prescription drug coverage may participate in the program.

(11) The program may contract with vendors as necessary to utilize discount purchasing programs, including but not limited to group purchasing organizations established to meet the criteria of the Nonprofit Institutions Act, 15 U.S.C. 13c, or that are exempt under the Robinson-Patman Act, 15 U.S.C. 13. [2003 c.714 §1; 2007 c.2 §1; 2007 c.67 §1; 2007 c.697 §17; 2009 c.263 §2; 2009 c.466 §1; 2009 c.595 §291]

**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 Oregon Health Authority. The authority may charge participants a nominal fee to participate in the program. The authority shall issue a prescription drug identification card to participants of the program.

(2) The authority 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 authority.

(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; 2009 c.595 §292]

**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 Oregon Health Authority 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; 2009 c.595 §293]

**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 Oregon Health Authority 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 authority and shall be used to purchase prescription drugs, reimburse pharmacies for prescription drugs and reimburse the authority 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; 2009 c.595 §294]

**Note:** See note under 414.312.

**414.320 Rules.** The Oregon Health Authority 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; 2009 c.595 §295]

**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:

(a) "Legend drug" means any drug requiring a prescription by a practitioner, as defined in ORS 689.005.

(b) "Mental health drug" means a type of legend drug defined by the Oregon Health Authority by rule that includes, but is not limited to:

(A) Therapeutic class 7 ataractics-tranquilizers; and

(B) Therapeutic class 11 psychostimulants-antidepressants.

(c) "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.

(2) The authority shall reimburse the cost of a legend drug prescribed for a recipient of medical assistance only if the legend drug:

(a) Is on the drug list of the Practitioner-Managed Prescription Drug Plan adopted under ORS 414.334;

(b) Is in a therapeutic class of nonsedating antihistamines and nasal inhalers, as defined by the authority by rule, and is prescribed by an allergist for the treatment of:

(A) Asthma;

(B) Sinusitis;

(C) Rhinitis; or

(D) Allergies; or

(c) Is prescribed and dispensed under this chapter by a licensed practitioner at a rural health clinic for an urgent medical condition and:

(A) There is no 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.

(3) The authority shall pay only for drugs in the generic form unless an exception has been granted by the authority through the prior authorization process adopted by the authority under subsection (4) of this section.

(4) Notwithstanding subsection (2) of this section, the authority shall provide reimbursement for a legend drug that does not meet the criteria in subsection (2) of this section if:

(a) It is a mental health drug.

(b) The authority grants approval through a prior authorization process adopted by the authority by rule.

(c) The prescriber contacts the authority requesting prior authorization and the authority or its agent fails to respond to the telephone call or to a prescriber's request made by electronic mail within 24 hours.

(d) After consultation with the authority or its agent, the prescriber, in the prescriber's professional judgment, determines that the drug is medically appropriate.

(e) The original prescription was written prior to July 28, 2009, or the request is for a refill of a prescription for:

(A) The treatment of seizures, cancer, HIV or AIDS; or

(B) An immunosuppressant.

(f) It is a drug in a class not evaluated for the Practitioner-Managed Prescription Drug Plan adopted under ORS 414.334.

(5) Notwithstanding subsections (1) to (4) of this section, the authority is authorized to:

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

(b) Require prior authorization of payment for drugs that the authority has determined should be limited to those conditions generally recognized as appropriate by the medical profession; and

(c) Withhold payment for a legend drug that is not a funded health service on the prioritized list of health services established by the Health Services Commission under ORS 414.720.

(6) Notwithstanding ORS 414.334, the authority 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.

(7) Notwithstanding subsection (3) of this section, the authority 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.

(8)(a) Within 180 days after the United States patent expires on an immunosuppressant drug used in connection with an organ transplant, the authority shall determine whether the drug is a narrow therapeutic index drug.

(b) As used in this subsection, "narrow therapeutic index drug" means a drug that has a narrow range in blood concentrations between efficacy and toxicity and requires therapeutic drug concentration or pharmacodynamic monitoring.

(9) The authority shall appoint an advisory committee in accordance with ORS 183.333 for any rulemaking conducted pursuant to this section. [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; 2009 c.473 §1; 2009 c.827 §2; 2009 c.828 §35]

**Note:** Section 2, chapter 473, Oregon Laws 2009, provides:

**Sec. 2.** Notwithstanding ORS 414.325 (8)(a), if the United States patent on an immunosuppressant drug used in connection with an organ transplant expired on or after July 1, 2007, and before the effective date of chapter 473, Oregon Laws 2009 [June 23, 2009], the Oregon Health Authority shall determine whether the drug is a narrow therapeutic index drug as defined in ORS 414.325 (8)(b) before January 1, 2010. [2009 c.473 §2; 2009 c.827 §16; 2009 c.828 §36]

**Note:** The amendments to 414.325 by section 8, chapter 827, Oregon Laws 2009, become operative January 2, 2014. See section 13, chapter 827, Oregon Laws 2009. The text that is operative on and after January 2, 2014, is set forth for the user's convenience.

**414.325.** (1) As used in this section:

(a) "Legend drug" means any drug requiring a prescription by a practitioner, as defined in ORS 689.005.

(b) "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.

(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 Oregon Health Authority unless the practitioner prescribes otherwise and an exception is granted by the authority.

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

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

(5)(a) Notwithstanding subsections (1) to (4) of this section and except as provided in paragraph (b) of this subsection, the authority 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 authority has determined should be limited to those conditions generally recognized as appropriate by the medical profession.

(b) The authority may not require prior authorization for therapeutic classes of nonsedating antihistamines and nasal inhalers, as defined by rule by the authority, 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) The authority 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.

(7) Notwithstanding ORS 414.334, the authority 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 authority 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.

(9)(a) Within 180 days after the United States patent expires on an immunosuppressant drug used in connection with an organ transplant, the authority shall determine whether the drug is a narrow therapeutic index drug.

(b) As used in this subsection, "narrow therapeutic index drug" means a drug that has a narrow range in blood concentrations between efficacy and toxicity and requires therapeutic drug concentration or pharmacodynamic monitoring.

**Note:** Section 5, chapter 827, Oregon Laws 2009, provides:

**Sec. 5.** The Oregon Health Authority shall report to the health related committees and the Joint Committee on Ways and Means of the Seventy-sixth Legislative Assembly on the implementation and effectiveness of the amendments to ORS 414.325 and 414.334 by sections 2 and 4 of this 2009 Act. [2009 c.827 §5; 2009 c.827 §6]

**414.327 Electronically transmitted prescriptions; rules.** The Oregon Health Authority shall adopt rules permitting a practitioner to communicate prescription drug orders by electronic means directly to the dispensing pharmacist. [2001 c.623 §8; 2003 c.14 §192; 2009 c.595 §297]

**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 Oregon Health Authority 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 partic-

ipation 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; 2009 c.595 §298]

**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 medical assistance program 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; 2009 c.595 §298a]

**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 medical assistance program 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; 2009 c.595 §298b]

**Note:** See note under 414.330.

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

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

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

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

(5) 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; 2009 c.595 §299; 2009 c.827 §4]

**Note:** The amendments to 414.334 by section 10, chapter 827, Oregon Laws 2009, become operative January 2, 2014. See section 13, chapter 827, Oregon Laws 2009. The text that is operative on and after January 2, 2014, is set forth for the user's convenience.

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

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

(3) The authority shall consult with representatives of the regulatory boards and associations representing practitioners who are prescribers under the medical assistance program 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 authority, 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 authority a decision of a practitioner or the authority 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.

**Note:** See note under 414.330.

**414.336** [2003 c.810 §22; repealed by 2009 c.827 §14]

**414.337 Limitation on rules regarding Practitioner-Managed Prescription Drug Plan.** The Oregon Health Authority may not adopt or amend any rule that requires a prescribing practitioner to contact the authority 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. [2009 c.827 §11; 2009 c.827 §12]

**Note:** 414.337 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:** 414.336 was repealed by section 14, chapter 827, Oregon Laws 2009. The text of section 11, chapter 827, Oregon Laws 2009 [414.337], as amended by section 12, chapter 827, Oregon Laws 2009, is the same as the text of 414.336 except for the substitution of the words "Oregon Health Authority" for "Department of Human Services" and the substitution of the word "authority" for "department."

### (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 Oregon Health Authority; 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 authority enters into a contract described in paragraph (b) of this subsection.

(b) For periods on or after July 1, 2003, the authority may contract with any pharmacy provider to operate the Patient Prescription Drug Assistance Program. [2001 c.869 §1; 2009 c.595 §301]

**Note:** 414.338 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.

**414.340** [2001 c.869 §3; 2005 c.381 §15; repealed by 2009 c.263 §1]

**414.342** [2001 c.869 §4; repealed by 2009 c.263 §1]

**414.344** [2001 c.869 §10; repealed by 2009 c.263 §1]

**414.346** [2001 c.869 §8; repealed by 2009 c.263 §1]

**414.348** [2001 c.869 §6; 2005 c.22 §285; repealed by 2009 c.263 §1]

### 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 Oregon Health Authority 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; 2009 c.595 §302]

**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 Oregon Health Policy Board on the implementation of the retrospective and prospective drug utilization review programs.

(2) The members of the Drug Use Review Board shall be appointed by the Director of the Oregon Health Authority 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 Pharma-

cists 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; 2009 c.595 §303]

**Note:** See note under 414.350.

**414.360 Duties of Drug Use Review Board regarding retrospective and prospective drug use review programs; rules.** (1) The Drug Use Review Board shall advise the Oregon Health Policy Board 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 Drug Use Review 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 Drug Use Review 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; 2009 c.595 §304]

**Note:** See note under 414.350.

**414.365 Educational and informational duties of Drug Use Review Board; procedures to insure confidentiality.** In addition to advising the Oregon Health Policy Board, the Drug Use Review Board shall do the following subject to the approval of the Oregon Health Policy Board:

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

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

(a) Identifying and reducing the frequency of patterns of fraud, abuse or inap-

propriate 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 Drug Use Review Board, staff of the board or contractors to the drug use review programs that identifies individual prescribers, pharmacists or recipients. [1993 c.578 §7; 2009 c.595 §305]

**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 Oregon Health Policy Board 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; 2009 c.595 §306]

**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 Oregon Health Policy Board based upon recommendations from 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; 2009 c.595 §307]

**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, the Oregon Health Policy Board or the Oregon

Health Authority to any person other than a health care provider appearing on a recipient's medication profile.

(2) The staff of the Drug Use Review 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, Oregon Health Policy Board, Oregon Health Authority 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 Oregon Health Authority, to the Department of Justice.

(3) The Drug Use Review Board may release cumulative, nonidentifying information for the purposes of legitimate research and for educational purposes. [1993 c.578 §10; 2009 c.595 §308]

**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 Drug Use Review 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 Oregon Health Authority shall provide staff to the Drug Use Review Board. [1993 c.578 §5; 2009 c.595 §309]

**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** [Formerly 414.026; 2009 c.595 §309a; renumbered 411.443 in 2009]

**414.422** [Formerly 414.027; renumbered 411.445 in 2009]

**414.424** [2005 c.494 §2; 2007 c.70 §193; 2009 c.414 §1; renumbered 411.439 in 2009]

**414.426 Payment of cost of medical care for institutionalized persons.** The Oregon Health Authority 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; 2009 c.595 §310]

**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)(s) 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 414.707 (1) if:

(a) The Oregon Health Authority receives 100 percent federal medical assistance percentage for payments made by the authority for the health care services provided as part of the benefit package described in ORS 414.707 (1); or

(b) The authority 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; 2009 c.595 §311]

**Note:** Section 2, chapter 76, Oregon Laws 2003, provides:

**Sec. 2.** (1) Section 1, chapter 76, Oregon Laws 2003 [414.428], becomes operative on the day after the date the Oregon Health Authority receives approval from the federal Centers for Medicare and Medicaid Services to amend Oregon's Medicaid waiver.

(2) The authority shall notify the Legislative Counsel upon receipt of approval or disapproval to amend Oregon's Medicaid waiver. [2003 c.76 §2; 2009 c.595 §312]

**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.

**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 Oregon Health Authority 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 authority;

(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 of Human Services 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; 2009 c.595 §313]

**Note:** See note under 414.532.

**414.536 Presumptive eligibility for medical assistance for treatment of breast or cervical cancer.** (1) If the Department of Human Services determines that a woman likely is eligible for medical assistance under ORS 414.534, the department shall determine her to be presumptively eligible for medical assistance until a formal determination on eligibility is made.

(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; 2009 c.595 §314]

**Note:** See note under 414.532.

**414.538 Prohibition on coverage limitations; priority to low-income women.** (1) The Department of Human Services 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 determining eligibility for medical assistance under ORS 414.534 or 414.536, the department shall give priority to low-income women. [2001 c.902 §4; 2009 c.595 §315]

**Note:** See note under 414.532.

**414.540 Rules.** The Oregon Health Authority shall adopt rules necessary for the implementation and administration of ORS 414.534 to 414.538. [2001 c.902 §5; 2009 c.595 §316]

**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 Oregon Health Authority 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 Oregon Health Authority or the Oregon Health Policy Board 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 Oregon Health Authority 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; 2009 c.595 §317]

**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 Oregon Health Authority, from among available providers participating in the program.

(2) The authority 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 authority 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; 2009 c.595 §318]

**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** [1983 c.590 §5; 1985 c.747 §3; 1991 c.66 §27; 2009 c.11 §57; repealed by 2009 c.595 §1204]

**414.670** [1983 c.590 §6; 1985 c.747 §3a; 1991 c.66 §28; repealed by 2009 c.595 §1204]

## 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)(o) and (p);

(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; 2009 c.867 §37]

**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) Persons described in ORS 414.706 (1), (2), (3) and (5) are eligible to receive all the health services approved and funded by the Legislative Assembly.

(2) Persons described in ORS 414.708 are eligible to receive the health services described in ORS 414.705 (1)(c), (f) and (g). [2003 c.735 §4; 2009 c.595 §319; 2009 c.867 §44]

**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 (2) 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 Oregon Health Policy Board; 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 (2) shall pay up to a percentage of the Medicaid price of the prescription drug established by the authority by rule and the dispensing fee. [2003 c.735 §11; 2005 c.381 §16; 2007 c.70 §194; 2009 c.595 §320]

**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 Oregon Health Authority for the biennium.

(2) The Oregon Health Authority may periodically limit enrollment of persons described in ORS 414.708 in order to stay within the legislatively adopted budget for the authority. [2003 c.735 §4a; 2009 c.595 §321]

**Note:** See note under 414.706.

**414.710 Services not subject to prioritized list.** The following services are not subject to ORS 414.720:

(1) Nursing facilities, institutional and home- and community-based waivered ser-

vices funded through the Department of Human Services; and

(2) 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; 2009 c.595 §322; 2009 c.867 §45]

**Note:** See note under 414.705.

**414.712 Medical assistance for certain eligible persons.** The Oregon Health Authority shall provide medical assistance under ORS 414.705 to 414.750 to eligible persons who are determined eligible for medical assistance by the Department of Human Services according to ORS 411.706. The Oregon Health Authority shall also provide the following:

(1) Ombudsman services for eligible persons who receive assistance under ORS 411.706. With the concurrence of the Governor and the Oregon Health Policy Board, the Director of the Oregon Health Authority 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 and the Oregon Health Policy Board 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; 2009 c.595 §323; 2009 c.867 §46]

**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 12 members appointed by the Governor in consultation with professional and other interested organizations and confirmed by the Senate, as follows:

(a) Five members must be physicians licensed to practice medicine in this state who have clinical expertise in the general areas of obstetrics, perinatal health, pediatrics, adult medicine, mental health and chemical dependency, disabilities, geriatrics or public health. One of the physicians must be a doctor of osteopathy.

(b) One member must be a dentist licensed under ORS chapter 679 who has clinical expertise in general, pediatric or public health dentistry related to the delivery of dental services under the Oregon Health Plan.

(c) One member must be a public health nurse.

(d) One member must be a social services worker.

(e) Four members must be consumers of health care.

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

(3) Members are not entitled to compensation, but may be reimbursed for actual and necessary travel and other expenses incurred by them in the performance of their official duties in the manner and amounts provided for in ORS 292.495. Claims for expenses shall be paid out of funds available to the Oregon Department of Administrative Services for purposes of the commission.

(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; 2009 c.469 §1]

**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 411.404, 414.065, 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; 2009 c.595 §324]

**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.

**414.721 Federal approval for funding services with assessments.** The Oregon Health Authority shall promptly seek federal approval necessary to obtain federal financial participation in the costs of programs and services funded with assessments paid under ORS 743.951 and 743.961 and section 9, chapter 867, Oregon Laws 2009. [2009 c.867 §16; 2009 c.828 §50]

**Note:** 414.721 was added to and made a part of 414.705 to 414.750 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 Oregon Health Authority, the authority 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 authority 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 authority 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 authority may not discriminate against any contractors that offer services within their providers' lawful scopes of practice.

(d) The authority shall establish annual financial reporting requirements for prepaid managed care health services organizations. The authority shall prescribe a reporting procedure that elicits sufficiently detailed information for the authority 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 authority 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.

(f)(A) The authority shall adopt rules and procedures to ensure that a rural health clinic that provides a health service to an enrollee of a prepaid managed care health services organization receives total aggregate payments from the organization, other payers on the claim and the authority that are no less than the amount the rural health clinic would receive in the authority's fee-for-service payment system. The authority shall issue a payment to the rural health clinic in accordance with this subsection within 45 days of receipt by the authority of a completed billing form.

(B) "Rural health clinic," as used in this paragraph, shall be defined by the authority by rule and shall conform, as far as practicable or applicable in this state, to the definition of that term in 42 U.S.C. 1395x(aa)(2).

(2) The authority 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 authority 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 authority 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; 2009 c.595 §325; 2009 c.795 §3]

**Note:** Section 4, chapter 795, Oregon Laws 2009, provides:

**Sec. 4.** The amendments to ORS 414.725 by section 3 of this 2009 Act apply to claims billed by a rural health clinic to a prepaid managed care health services organization on or after May 17, 2011. [2009 c.795 §4]

**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 Oregon Health Authority 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 authority 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; 2009 c.595 §326]

**Note:** See note under 414.705.

**414.728 Reimbursement of rural hospitals by Oregon Health Authority.** 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 Oregon Health Authority 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; 2009 c.595 §327]

**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 Oregon Health Policy Board shall obtain the approval of the Legislative Assembly, or the 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.

(4) This section does not apply to reductions made by the Legislative Assembly in a legislatively adopted or approved budget. [1989 c.836 §8; 1991 c.753 §9; 2003 c.14 §195; 2009 c.595 §328; 2009 c.827 §18]

**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 and 414.743 and section 9, chapter 867, Oregon Laws 2009:

(1) "Designated area" means a geographic area of the state defined by the Oregon Health Authority 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 Oregon Health Authority or the Oregon Health Policy Board 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 Oregon Health Authority or the Oregon Health Policy Board 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 authority or the board 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 authority or the board 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; 2009 c.595 §329; 2009 c.867 §47]

**Note:** The amendments to 414.736 by section 6, chapter 886, Oregon Laws 2009, become operative January 2, 2014. See section 8, chapter 886, Oregon Laws 2009. The text that is operative on and after January 2, 2014, is set forth for the user's convenience.

**414.736.** As used in this section and ORS 414.725, 414.737, 414.738, 414.739, 414.740, 414.741 and 414.742 and section 9, chapter 867, Oregon Laws 2009:

(1) "Designated area" means a geographic area of the state defined by the Oregon Health Authority 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 Oregon Health Authority or the Oregon Health Policy Board 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 Oregon Health Authority or the Oregon Health Policy Board 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 authority or the board 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 authority or the board 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.

**Note:** 414.736 to 414.743 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 Oregon Health Authority 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; 2009 c.595 §330]

**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, including amendments by section 331, chapter 595, Oregon Laws 2009, 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 Oregon Health Authority 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 second note under 414.736.

**414.738 Use of physician care organizations.** (1) If the Oregon Health Authority has not been able to contract with the fully capitated health plan or plans in a designated area, the authority 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 authority shall consider when determining the circumstances under which the authority 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; 2009 c.595 §332]

**Note:** See second 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 Oregon Health Authority to contract with the authority 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 authority must use to determine the circumstances under which the authority may accept an application by a fully capitated health plan to contract as a physician 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; 2009 c.595 §333]

**Note:** See second note under 414.736.

**414.740 Contracts with certain prepaid group practice health plan.** (1) Notwithstanding ORS 414.738 (1), the Oregon Health Authority 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 authority on a prepaid capitated basis to provide the health services described in ORS 414.705 (1)(k) and (L). The authority may accept financial contributions from any public or private entity to help implement and administer the contract. The authority 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 authority shall contract

with prepaid managed care health services organizations to provide health services under ORS 414.705 to 414.750. [2003 c.810 §6; 2009 c.595 §334]

**Note:** See second 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 medical assistance program;

(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 the Oregon Health Authority and the Legislative Fiscal Officer no later than August 1 of every even-numbered year.

(5) The Oregon Health Authority shall retain an actuary to determine:

(a) Per capita rates for health services that the authority shall use to develop the authority'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 Oregon Health Authority 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 authority is based with the rates developed by the actuary retained by the Health Services Commission. If the rates differ, the authority shall disclose, by provider categories described in subsection (2) of this section, the amount of and reason for each variance. [2003 c.810 §9; 2009 c.595 §335]

**Note:** See second note under 414.736.

**414.742 Payment for mental health drugs.** The Oregon Health Authority may not establish capitation rates that include payment for mental health drugs. The authority shall reimburse pharmacy providers for mental health drugs only on a fee-for-service payment basis. [2003 c.810 §11; 2009 c.595 §336]

**Note:** See second note under 414.736.

**414.743 Payment to noncontracting hospital by fully capitated health plan; rules.** (1) 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, using a Medicare payment methodology, reimburse the noncontracting hospital for services provided to an enrollee of the plan at a rate no less than a percentage of the Medicare reimbursement rate for those services. The percentage of the Medicare reimbursement rate that is used to determine the reimbursement rate under this subsection is equal to two percentage points less than the percentage of Medicare cost used by the authority in calculating the base hospital capitation payment to the plan, excluding any supplemental payments.

(2) A hospital that does not have a contract with a fully capitated health plan to provide inpatient or outpatient hospital ser-

vices under ORS 414.705 to 414.750 must accept as payment in full for hospital services the rates described in subsection (1) of this section.

(3) 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.

(4) The Oregon Health Authority 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 §§1,2; 2009 c.595 §§337,338; 2009 c.886 §§4,5]

**Note:** 414.743 is repealed January 2, 2014. See section 7, chapter 886, Oregon Laws 2009.

**Note:** See second note under 414.736.

**414.744** [2003 c.810 §13; repealed by 2009 c.595 §1204]

**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.

**414.746 Hospital add-on to managed care organization capitation rate.** (1) The Oregon Health Authority shall establish an adjustment to the capitation rate paid to a Medicaid managed care organization defined in section 9, chapter 867, Oregon Laws 2009.

(2) The contracts entered into between the authority and Medicaid managed care organizations must include provisions that ensure that the adjustment to the capitation rate established under subsection (1) of this section is distributed by the Medicaid managed care organizations to hospitals located in Oregon that receive Medicare reimbursement based upon diagnostic related groups.

(3) The adjustment to the capitation rate paid to Medicaid managed care organizations shall be established in an amount consistent with the legislatively adopted budget and the aggregate assessment imposed pursuant to section 2, chapter 736, Oregon Laws 2003. [2009 c.867 §15; 2009 c.828 §49]

**Note:** 414.746 was added to and made a part of 414.705 to 414.750 by legislative action but was not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

**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 414.705 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; 2009 c.595 §340]

**Note:** See note under 414.705.

**414.751** [1997 c.683 §35; 2001 c.69 §2; 2009 c.595 §341; renumbered 414.229 in 2009]

**414.755 Hospital reimbursement rates.** The Oregon Health Authority shall establish fee-for-service reimbursement rates for inpatient hospital services provided by hospitals that receive Medicare reimbursement on the basis of diagnostic related groups as follows:

(1) For the period from October 1, 2009, through September 30, 2013, at the same rate paid by Medicare on the date of the service.

(2) For the period beginning October 1, 2013, at a rate that is 70 percent of the rate paid by Medicare on the date of the service. [2009 c.867 §29; 2009 c.828 §54]

**414.760 Payment for patient centered primary care home services.** (1) As funds are available, the Oregon Health Authority may provide reimbursement in the state's medical assistance program for services provided by patient centered primary care homes. If practicable, efforts to align financial incentives to support patient centered primary care homes for enrollees in medical assistance programs should be aligned with efforts of the learning collaborative described in ORS 442.210 (3)(d).

(2) The authority may reimburse patient centered primary care homes for interpretive services provided to people in the state's medical assistance programs if interpretive services qualify for federal financial participation.

(3) The authority shall require patient centered primary care homes receiving these reimbursements to report on quality mea-

sures described in ORS 442.210 (1)(c). [2009 c.595 §1164]

**Note:** 414.760 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 Oregon Health Authority for any charges or expenses paid by the authority 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 authority 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 authority who shall pay the account out of the Law Enforcement Medical Liability Account.

(b) A bill submitted to the authority 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 authority, the provider shall repay the authority 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; 2009 c.595 §342]

**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 Oregon Health Authority 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 Oregon Health Authority 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 Oregon Health Authority 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 Oregon Health Authority 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 Oregon Health Authority shall be subrogated to the rights of the provider to the extent of payments made by the authority to the provider for the medical services. The authority may foreclose the lien as provided in ORS 87.585.

(4) The authority shall deposit in the Law Enforcement Medical Liability Account all moneys received by the authority from:

(a) Providers of medical services as repayment;

(b) Individuals whose medical expenses were paid by the authority 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; 2009 c.595 §343]

**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 Oregon Health Authority 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 authority may contract with persons experienced in medical claims processing to provide claims processing for the account.

(4) The authority 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 Oregon Health Authority 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 authority 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; 2009 c.595 §344]

**Note:** See note under 414.805.

**414.820** [Formerly 414.050; renumbered 566.320]

## PREMIUM ASSISTANCE

**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.

**414.826 Private health option; rules.** (1) As used in this section:

(a) "Child" means a person under 19 years of age who is lawfully present in this state.

(b) "Health benefit plan" has the meaning given that term in ORS 414.841.

(2) The Office of Private Health Partnerships shall administer a private health option to expand access to private health insurance for Oregon's children.

(3) The office shall adopt by rule criteria for health benefit plans to qualify for premium assistance under the private health option. The criteria may include, but are not limited to, the following:

(a) The health benefit plan meets or exceeds the requirements for a basic benchmark health benefit plan under ORS 414.856.

(b) The health benefit plan offers a benefit package comparable to the health services provided to children receiving medical assistance, including mental health, vision and dental services, and without any exclusion of or delay of coverage for preexisting conditions.

(c) The health benefit plan imposes copayments or other cost sharing that is based upon a family's ability to pay.

(d) Expenditures for the health benefit plan qualify for federal financial participation.

(4) The amount of premium assistance provided under this section shall be:

(a) Equal to the full cost of the premium for children whose family income is at or below 200 percent of the federal poverty guidelines and who have access to employer sponsored health insurance; and

(b) Based on a sliding scale under criteria established by the office by rule for children whose family income is above 200 percent but at or below 300 percent of the federal poverty guidelines, regardless of whether the child has access to coverage under an employer sponsored health benefit plan.

(5) A child whose family income is more than 300 percent of the federal poverty guidelines shall be offered the opportunity to purchase a health benefit plan through the private health option but may not receive premium assistance. [2009 c.867 §30]

**Note:** 414.826 becomes operative on the later of January 1, 2010, or the date on which federal approval is received. See section 32, chapter 867, Oregon Laws 2009, as amended by section 55, chapter 828, Oregon Laws 2009.

**Note:** 414.826 and 414.828 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]

**414.828 Assistance subject to legislative appropriation.** Notwithstanding eligibility criteria and premium assistance amounts determined pursuant to ORS 414.826, the Office of Private Health Partnerships shall provide premium assistance under the private health option to eligible children to the extent the Legislative Assembly appropriates funds for that purpose or establishes expenditure limitations to provide such premium assistance. [2009 c.867 §31]

**Note:** See second note under 414.826.

**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 Expanding group coverage in 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 Premium assistance for health insurance coverage.** Subject to funds available, the Oregon Health Authority may provide medical assistance in the form of premium assistance for the purchase of health insurance coverage provided by public programs or private insurance, including but not limited to:

(1) The Family Health Insurance Assistance Program;

(2) Medical assistance described in ORS 414.115; and

(3) The Health Care for All Oregon Children program established in ORS 414.231. [2001 c.898 §11; 2003 c.14 §206; 2003 c.684 §7; 2003 c.735 §9; 2009 c.595 §344a; 2009 c.867 §38]

**Note:** See note under 414.825.

**414.840** [Formerly 414.070; renumbered 566.340]

**414.841 Definitions for ORS 414.841 to 414.864.** For purposes of ORS 414.841 to 414.864:

(1) "Carrier" has the meaning given that term in ORS 735.700.

(2) "Eligible individual" means an individual who:

(a) Is a resident of the State of Oregon;

(b) Is not eligible for Medicare;

(c) Either has been without health benefit plan coverage for a period of time established by the Office of Private Health Partnerships, or meets exception criteria established by the office;

(d) Except as otherwise provided by the office, has family income less than 200 percent of the federal poverty level;

(e) Has investments and savings less than the limit established by the office; and

(f) Meets other eligibility criteria established by the office.

(3)(a) "Family" means:

(A) A single individual;

(B) An adult and the adult's spouse;

(C) An adult and the adult's spouse, all unmarried, dependent children under 23 years of age, including adopted children, children placed for adoption and children under the legal guardianship of the adult or the adult's spouse, and all dependent children of a dependent child; or

(D) An adult and the adult's unmarried, dependent children under 23 years of age, including adopted children, children placed for adoption and children under the legal guardianship of the adult, and all dependent children of a dependent child.

(b) A family includes a dependent elderly relative or a dependent adult child with a disability who meets the criteria established by the office and who lives in the home of the adult described in paragraph (a) of this subsection.

(4)(a) "Health benefit plan" means a policy or certificate of group or individual health insurance, as defined in ORS 731.162, providing payment or reimbursement for hospital, medical and surgical expenses. "Health benefit plan" includes a health care service contractor or health maintenance organization subscriber contract, the Oregon Medical Insurance Pool and any plan provided by a less than fully insured multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

(b) "Health benefit plan" does not include coverage for accident only, specific disease or condition only, credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance, student accident and health insurance, long term care insurance, hospital indemnity only, dental only, vision only, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, insurance under which the benefits are payable with or without regard to fault and that is legally required to be contained in any liability insurance policy or equivalent self-insurance or coverage obtained or provided in another state but not available in Oregon.

(5) "Income" means gross income in cash or kind available to the applicant or the applicant's family. Income does not include earned income of the applicant's children or income earned by a spouse if there is a legal separation.

(6) "Investment 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 office may establish that are available to the applicant or the applicant's family to contribute toward meeting the needs of an applicant or eligible individual.

(7) "Medicaid" means medical assistance provided under 42 U.S.C. section 1396a (section 1902 of the Social Security Act).

(8) "Resident" means an individual who meets the residency requirements established by rule by the office.

(9) "Subsidy" means payment or reimbursement to an eligible individual toward the purchase of a health benefit plan, and may include a net billing arrangement with carriers or a prospective or retrospective payment for health benefit plan premiums and eligible copayments or deductible expenses directly related to the eligible individual.

(10) "Third-party administrator" means any insurance company or other entity licensed under the Insurance Code to administer health insurance benefit programs. [Formerly 735.720]

**Note:** 414.841 to 414.864 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.

**414.842 Purpose; administration.** (1) There is established the Family Health Insurance Assistance Program in the Office of Private Health Partnerships. The purpose of the program is to remove economic barriers to health insurance coverage for residents of the State of Oregon with family income less than 200 percent of the federal poverty level, and investment and savings less than the limit established by the office, while encouraging individual responsibility, promoting health benefit plan coverage of children, building on the private sector health benefit plan system and encouraging employer and employee participation in employer-sponsored health benefit plan coverage.

(2) The Office of Private Health Partnerships shall be responsible for the implementation and operation of the Family Health Insurance Assistance Program. The Administrator of the Office for Oregon Health Policy and Research, in consultation with the Oregon Health Policy Board, shall make recommendations to the Office of Private Health Partnerships regarding program policy, including but not limited to eligibility requirements, assistance levels, benefit criteria and carrier participation.

(3) The Office of Private Health Partnerships may contract with one or more third-party administrators to administer one or more components of the Family Health Insurance Assistance Program. Duties of a

third-party administrator may include but are not limited to:

(a) Eligibility determination;

(b) Data collection;

(c) Assistance payments;

(d) Financial tracking and reporting; and

(e) Such other services as the office may deem necessary for the administration of the program.

(4) If the office decides to enter into a contract with a third-party administrator pursuant to subsection (3) of this section, the office shall engage in competitive bidding. The office shall evaluate bids according to criteria established by the office, including but not limited to:

(a) The bidder's proven ability to administer a program of the size of the Family Health Insurance Assistance Program;

(b) The efficiency of the bidder's payment procedures;

(c) The estimate provided of the total charges necessary to administer the program; and

(d) The bidder's ability to operate the program in a cost-effective manner. [Formerly 735.722]

**Note:** See note under 414.841.

**414.844 Application to participate in program; issuance of subsidies; restrictions; enrollment in employer-sponsored coverage.** (1) To enroll in the Family Health Insurance Assistance Program established in ORS 414.841 to 414.864, an applicant shall submit a written application to the Office of Private Health Partnerships or to the third-party administrator contracted by the office to administer the program pursuant to ORS 414.842 in the form and manner prescribed by the office. Except as provided in ORS 414.848, if the applicant qualifies as an eligible individual, the applicant shall either be enrolled in the program or placed on a waiting list for enrollment.

(2) After an eligible individual has enrolled in the program, the individual shall remain eligible for enrollment for the period of time established by the office.

(3) After an eligible individual has enrolled in the program, the office or third-party administrator shall issue subsidies in an amount determined pursuant to ORS 414.846 to either the eligible individual or to the carrier designated by the eligible individual, subject to the following restrictions:

(a) Subsidies may not be issued to an eligible individual unless all eligible children, if any, in the eligible individual's family are covered under a health benefit plan or Medicaid.

(b) Subsidies may not be used to subsidize premiums on a health benefit plan whose premiums are wholly paid by the eligible individual's employer without contribution from the employee.

(c) Such other restrictions as the office may adopt.

(4) The office may issue subsidies to an eligible individual in advance of a purchase of a health benefit plan.

(5) To remain eligible for a subsidy, an eligible individual must enroll in a group health benefit plan if a plan is available to the eligible individual through the individual's employment and the employer makes a monetary contribution toward the cost of the plan, unless the office implements specific cost or benefit structure criteria that make enrollment in an individual health insurance plan more advantageous for the eligible individual.

(6) Notwithstanding ORS 414.841 (4)(b), if an eligible individual is enrolled in a group health benefit plan available to the eligible individual through the individual's employment and the employer requires enrollment in both a health benefit plan and a dental plan, the individual is eligible for a subsidy for both the health benefit plan and the dental plan. [Formerly 735.724]

**Note:** See note under 414.841.

**414.846 Determination of level of assistance.** (1) The Office of Private Health Partnerships shall determine the level of assistance to be granted under ORS 414.844 based on a sliding scale that considers:

(a) Family size;

(b) Family income;

(c) The number of members of a family who will receive health benefit plan coverage subsidized through the Family Health Insurance Assistance Program; and

(d) Such other factors as the office may establish.

(2) Notwithstanding the sliding scale established in subsection (1) of this section, the office may establish different assistance levels for otherwise similarly situated eligible individuals based on factors including but not limited to whether the individual is enrolled in an employer-sponsored group health benefit plan or an individual health benefit plan. [Formerly 735.726]

**Note:** See note under 414.841.

**414.848 Subsidies limited to funds appropriated; enrollment restrictions.** (1) Notwithstanding eligibility criteria and subsidy amounts established pursuant to ORS 414.841 to 414.864, subsidies shall be provided only to the extent the Legislative Assembly

specifically appropriates funds to provide such assistance.

(2) The Office of Private Health Partnerships shall prohibit or limit enrollment in the Family Health Insurance Assistance Program to ensure that program expenditures are within legislatively appropriated amounts. Prohibitions or limitations allowed under this section may include but are not limited to:

(a) Lowering the allowable income level necessary to qualify as an eligible individual; and

(b) Establishing a waiting list of eligible individuals who shall receive subsidies only when sufficient funds are available. [Formerly 735.728]

**Note:** See note under 414.841.

**414.850** [Formerly 414.080; renumbered 566.350]

**414.851 Establishment of minimum benefit requirements for plan subsidy.** The Office of Private Health Partnerships may, based on the recommendation of the Administrator of the Office for Oregon Health Policy and Research, establish minimum benefit requirements for individual health benefit plans subject to subsidy pursuant to the Family Health Insurance Assistance Program, including but not limited to the type of services covered and the amount of cost sharing to be allowed. [Formerly 735.730]

**Note:** See note under 414.841.

**414.852 Coverage of immunizations; rules.** (1) The Family Health Insurance Assistance Program shall provide coverage of age-appropriate immunizations or other health care services when an eligible individual is enrolled in a health benefit plan that does not provide coverage of age-appropriate immunizations or other health care services required by the state medical assistance program and the eligible individual is receiving a subsidy described in ORS 414.839.

(2) The Office of Private Health Partnerships shall adopt rules implementing subsection (1) of this section. [Formerly 735.731]

**Note:** See note under 414.841.

**414.854 Confidentiality of information in enrollment applications; exchange of information with governmental agencies; use of Social Security numbers.** (1) Except as otherwise provided in this section and ORS 735.710, the Office of Private Health Partnerships may not disclose information provided to the office as part of an application for enrollment in the Family Health Insurance Assistance Program.

(2) The office may exchange information provided to the office with other state and federal agencies for the purposes of verifying eligibility for the program, improving provision of services and identifying economic trends relevant to administration of the program.

(3) In accordance with applicable state and federal law, the office may require applicants to provide their Social Security numbers and use those numbers in the administration of the program. [Formerly 735.732]

**Note:** See note under 414.841.

**414.856 Basic benchmark health benefit plan eligible for subsidy.** The Office of Private Health Partnerships shall establish at least one basic benchmark health benefit plan that qualifies for a subsidy described by ORS 414.839. In establishing a basic benchmark plan, the office shall consider employer-sponsored health benefit plans offered to employees and dependents of employees in Oregon. [Formerly 735.733]

**Note:** See note under 414.841.

**414.858 Rules.** The Office of Private Health Partnerships, in consultation with the Administrator of the Office for Oregon Health Policy and Research and the Oregon Health Authority, shall adopt all rules necessary for the implementation and operation of the Family Health Insurance Assistance Program. [Formerly 735.734]

**Note:** See note under 414.841.

**414.860** [Formerly 414.090; renumbered 566.360]

**414.861 Family Health Insurance Assistance Program Account.** There is established in the State Treasury the Family Health Insurance Assistance Program Account, which shall consist of moneys appropriated to the account by the Legislative Assembly and interest earnings from the investment of moneys in the account. All moneys in the Family Health Insurance Assistance Program Account are continuously appropriated to the Office of Private Health Partnerships to carry out the provisions of ORS 414.841 to 414.864. [Formerly 735.736]

**Note:** See note under 414.841.

**414.862 Reports of program operation.** The Administrator of the Office for Oregon Health Policy and Research shall report biennially to the appropriate interim human resources committee and to the Legislative Assembly on the effectiveness and efficiency of the Family Health Insurance Assistance Program, including services and benefits covered under the purchased health insurance plans, consumer satisfaction and other program operational issues. [Formerly 735.738]

**Note:** See note under 414.841.

**414.864 Sanctions for violation of program requirements; civil penalties.** (1) The Office of Private Health Partnerships may impose sanctions against an individual

who violates any provision of ORS 414.841 to 414.864 or rules adopted pursuant thereto, including but not limited to suspension or termination from the Family Health Insurance Assistance Program and repayment of any subsidy amounts paid due to the omission or misrepresentation of an applicant or enrolled individual. Sanctions allowed under this subsection shall be imposed in the manner prescribed in ORS chapter 183.

(2) In addition to the sanctions available pursuant to subsection (1) of this section, the office may impose a civil penalty not to exceed $1,000 against any individual who violates any provision of ORS 414.841 to 414.864 or rules adopted pursuant thereto. Civil penalties imposed pursuant to this section shall be imposed pursuant to ORS 183.745. [Formerly 735.740]

**Note:** See note under 414.841.

**414.866 Definitions for ORS 414.866 to 414.872.** As used in ORS 414.866 to 414.872:

(1) "Benefits plan" has the meaning given that term in ORS 735.605.

(2) "Other costs" means costs incurred by the Oregon Medical Insurance Pool that are not covered by the premiums received by the pool for a subsidized member.

(3) "Premium" has the meaning given that term in ORS 735.700.

(4) "Subsidized member" means a medical assistance program client who is enrolled in a benefits plan and who is receiving a subsidy from the Family Health Insurance Assistance Program established in ORS 414.841 to 414.864.

(5) "Subsidy" has the meaning given that term in ORS 414.841. [Formerly 735.750]

**Note:** 414.866 to 414.872 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.

**414.868 Eligibility for coverage for certain members.** Notwithstanding ORS 735.615 (3)(a) and (f), a subsidized member is eligible for coverage under ORS 735.600 to 735.650. [Formerly 735.752]

**Note:** See note under 414.866.

**414.870 Federal reimbursement of expenditures in Oregon Medical Insurance Pool for FHIAP enrollees.** (1) In order to increase public subsidies for the purchase of health insurance coverage provided by public programs or private insurance described by ORS 414.839, the Office of Private Health Partnerships, the Oregon Medical Insurance Pool Board and the Oregon Health Authority shall work cooperatively to obtain federal matching dollars. The office, the Oregon Medical Insurance Pool Board and the authority shall develop a system for payment or reimbursement of other costs and subsidies provided to subsidized members.

(2) For each subsidized member, the Oregon Medical Insurance Pool Board shall determine:

(a) The full cost of administering the benefits plan of the subsidized member; and

(b) The amount of other costs.

(3) The Oregon Medical Insurance Pool Board shall bill the Family Health Insurance Assistance Program for the total amount of the premium received by the Oregon Medical Insurance Pool Board and for the amount of other costs. The program shall forward the bill to the authority.

(4) The authority shall pay the program an amount equal to the portion of the premium that is a subsidy and for other costs. The program shall forward the payment to the Oregon Medical Insurance Pool Board. [Formerly 735.754]

**Note:** See note under 414.866.

**414.872 Determination of subsidies and costs.** (1) Of payments made to the Family Health Insurance Assistance Program by the Oregon Health Authority under ORS 414.870 (4), the authority shall determine:

(a) The portion of a subsidy of a subsidized member that is from the General Fund; and

(b) The portion of other costs that is from the General Fund.

(2) The authority shall bill the program for the amounts determined under subsection (1) of this section. The program shall forward the bill for the amount determined under subsection (1)(b) of this section to the Oregon Medical Insurance Pool Board.

(3) The board shall:

(a) Determine the amount of funds needed for the payment of other costs under subsection (1)(b) of this section; and

(b) Impose and collect assessments in that amount against insurers, using the methodology described in ORS 735.614 (2), (6) and (9).

(4) The board shall pay the program for the amounts determined under subsection (1)(b) of this section.

(5) The program shall forward to the authority the amounts determined under subsection (1) of this section.

(6) ORS 735.614 (3), (4), (5), (7) and (8) applies to assessments collected under this section. [Formerly 735.756]

**Note:** See note under 414.866.

## HOSPITAL ASSESSMENT

**Note:** Sections 1 to 10 and 12 to 14, chapter 736, Oregon Laws 2003, provide:

**Sec. 1.** As used in sections 1 to 9, chapter 736, Oregon Laws 2003:

(1) "Charity care" means costs for providing inpatient or outpatient care services free of charge or at a reduced charge because of the indigence or lack of health insurance of the patient receiving the care services.

(2) "Contractual adjustments" means the difference between the amounts charged based on the hospital's full established charges and the amount received or due from the payor.

(3) "Hospital" has the meaning given that term in ORS 442.015. "Hospital" does not include special inpatient care facilities.

(4) "Net revenue":

(a) Means the total amount of charges for inpatient or outpatient care provided by the hospital to patients, less charity care, bad debts and contractual adjustments;

(b) Does not include revenue derived from sources other than inpatient or outpatient operations, including but not limited to interest and guest meals; and

(c) Does not include any revenue that is taken into account in computing a long term care facility assessment under sections 15 to 22, chapter 736, Oregon Laws 2003 [series became sections 15 to 22, 24 and 29, chapter 736, Oregon Laws 2003].

(5) "Waivered hospital" means a type A or type B hospital, as described in ORS 442.470, a hospital that provides only psychiatric care or a hospital identified by the Department of Human Services as appropriate for inclusion in the application described in section 4, chapter 736, Oregon Laws 2003. [2003 c.736 §1; 2009 c.792 §34]

**Sec. 2.** (1) An assessment is imposed on the net revenue of each hospital in this state that is not a waivered hospital. The assessment shall be imposed at a rate determined by the Director of the Oregon Health Authority by rule that is the director's best estimate of the rate needed to fund the services and costs identified in section 9, chapter 736, Oregon Laws 2003. The rate of assessment shall be imposed on the net revenue of each hospital subject to assessment. The director shall consult with representatives of hospitals before setting the assessment.

(2) The assessment shall be reported on a form prescribed by the Oregon Health Authority and shall contain the information required to be reported by the authority. The assessment form shall be filed with the authority on or before the 75th day following the end of the calendar quarter for which the assessment is being reported. Except as provided in subsection (6) of this section, the hospital shall pay the assessment at the time the hospital files the assessment report. The payment shall accompany the report.

(3)(a) To the extent permitted by federal law, aggregate assessments imposed under this section may not exceed the total of the following amounts received by the hospitals that are reimbursed by Medicare based on diagnostic related groups:

(A) The adjustment to the capitation rate paid to Medicaid managed care organizations under section 15, chapter 867, Oregon Laws 2009 [414.746];

(B) 30 percent of payments made to hospitals on a fee-for-service basis by the authority for inpatient hospital services; and

(C) 41 percent of payments made to hospitals on a fee-for-service basis by the authority for outpatient hospital services.

(b) Notwithstanding paragraph (a) of this subsection, aggregate assessments imposed for the biennium beginning July 1, 2009, may exceed the total of the amounts described in paragraph (a) of this subsection to the extent necessary to compensate for any reduction of funding in the legislatively adopted budget for that biennium for hospital services under ORS 414.705 to 414.750.

(4) Notwithstanding subsection (3) of this section, a hospital is not guaranteed that any additional moneys paid to the hospital in the form of payments for services shall equal or exceed the amount of the assessment paid by the hospital.

(5) Hospitals operated by the United States Department of Veterans Affairs and pediatric specialty hospitals providing care to children at no charge are exempt from the assessment imposed under this section.

(6)(a) The authority shall develop a schedule for collection of the assessment for the calendar quarter ending September 30, 2013, that will result in the collection occurring between December 15, 2013, and the time all Medicaid cost settlements are finalized for that calendar quarter.

(b) The authority shall prescribe by rule criteria for late payment of assessments. [2003 c.736 §2; 2007 c.780 §1; 2009 c.828 §51; 2009 c.867 §17]

**Sec. 3.** Notwithstanding section 2 of this 2003 Act, the Director of Human Services shall reduce the rate of assessment imposed under section 2 of this 2003 Act to the maximum rate allowed under federal law if the reduction is required to comply with federal law. [2003 c.736 §3]

**Sec. 4.** (1) On or before January 1, 2004, the Department of Human Services shall submit an application to the Centers for Medicare and Medicaid Services to request a waiver of the broad-based tax requirement pursuant to 42 C.F.R. 433.68(e) to exempt waivered facilities from the assessment imposed under section 2 of this 2003 Act. The department shall ensure that the application requesting a waiver meets the requirements of 42 C.F.R. 433.68(e)(1).

(2) The Director of Human Services may include in the application requesting a waiver any hospital operated exclusively for 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 if the application requesting a waiver meets the requirements of 42 C.F.R. 433.68(e)(1).

(3) The department shall notify waivered facilities that the department has submitted the application to the Centers for Medicare and Medicaid Services to request a waiver of the broad-based tax requirement pursuant to 42 C.F.R. 433.68(e) to exempt waivered facilities from the assessment imposed under section 2 of this 2003 Act.

(4) If an application to the Centers for Medicare and Medicaid Services for a waiver of the broad-based tax requirement pursuant to 42 C.F.R. 433.68(e) is denied, the Director of Human Services may resubmit the application with appropriate changes to receive a waiver of the broad-based tax requirement. [2003 c.736 §4]

**Sec. 5.** (1) A hospital that fails to file a report or pay an assessment under section 2, chapter 736, Oregon Laws 2003, by the date the report or payment is due shall be subject to a penalty of up to $500 per day of delinquency. The total amount of penalties imposed under this section for each reporting period may not exceed five percent of the assessment for the reporting period for which penalties are being imposed.

(2) Penalties imposed under this section shall be collected by the Oregon Health Authority and deposited in the Oregon Health Authority Fund established under section 18, chapter 595, Oregon Laws 2009 [413.031].

(3) Penalties paid under this section are in addition to and not in lieu of the assessment imposed under section 2, chapter 736, Oregon Laws 2003. [2003 c.736 §5; 2009 c.828 §52; 2009 c.867 §18]

**Sec. 6.** (1) Any hospital that has paid an amount that is not required under sections 1 to 9 of this 2003 Act may file a claim for refund with the Department of Human Services.

(2) Any hospital that is aggrieved by an action of the Department of Human Services or by an action of the Director of Human Services taken pursuant to subsection (1) of this section shall be entitled to notice and an opportunity for a contested case hearing under ORS chapter 183. [2003 c.736 §6]

**Sec. 7.** The Department of Human Services may audit the records of any hospital in this state to determine compliance with sections 1 to 9 of this 2003 Act. The department may audit records at any time for a period of five years following the date an assessment is due to be reported and paid under section 2 of this 2003 Act. [2003 c.736 §7]

**Sec. 8.** Amounts collected by the Department of Human Services from the assessments imposed under section 2, chapter 736, Oregon Laws 2003, shall be deposited in the Hospital Quality Assurance Fund established under section 9, chapter 736, Oregon Laws 2003. [2003 c.736 §8; 2005 c.757 §1]

**Sec. 9.** (1) The Hospital Quality Assurance Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Hospital Quality Assurance Fund shall be credited to the Hospital Quality Assurance Fund.

(2) Amounts in the Hospital Quality Assurance Fund are continuously appropriated to the Oregon Health Authority for the purpose of paying refunds due under section 6, chapter 736, Oregon Laws 2003, and funding services under ORS 414.705 to 414.750, including but not limited to:

(a) Increasing reimbursement rates for inpatient and outpatient hospital services under ORS 414.705 to 414.750;

(b) Maintaining, expanding or modifying services for persons described in ORS 414.025 (2)(s);

(c) Maintaining or increasing the number of persons described in ORS 414.025 (2)(s) who are enrolled in the medical assistance program; and

(d) Paying administrative costs incurred by the authority to administer the assessments imposed under section 2, chapter 736, Oregon Laws 2003.

(3) Except for assessments imposed pursuant to section 2 (3)(b), chapter 736, Oregon Laws 2003, the authority may not use moneys from the Hospital Quality Assurance Fund to supplant, directly or indirectly, other moneys made available to fund services described in subsection (2) of this section. [2003 c.736 §9; 2005 c.757 §2; 2007 c.780 §2; 2009 c.828 §53; 2009 c.867 §19]

**Sec. 10.** Sections 1 to 9, chapter 736, Oregon Laws 2003, apply to net revenues earned by hospitals during a period beginning October 1, 2009, and ending the earlier of September 30, 2013, or the date on which the assessment no longer qualifies for federal matching funds under Title XIX of the Social Security Act. [2003 c.736 §10; 2007 c.780 §3; 2009 c.867 §20]

**Sec. 12.** Sections 1 to 9, chapter 736, Oregon Laws 2003, are repealed on January 2, 2015. [2003 c.736 §12; 2007 c.780 §4; 2009 c.867 §21]

**Sec. 13.** Nothing in the repeal of sections 1 to 9, chapter 736, Oregon Laws 2003, by section 12, chapter 736, Oregon Laws 2003, affects the imposition and collection of a hospital assessment under sections 1 to 9, chapter 736, Oregon Laws 2003, for a calendar quarter beginning before September 30, 2013. [2003 c.736 §13; 2007 c.780 §5; 2009 c.867 §22]

**Sec. 14.** Any moneys remaining in the Hospital Quality Assurance Fund on December 31, 2017, are transferred to the General Fund. [2003 c.736 §14; 2007 c.780 §6; 2009 c.867 §23]

**Note:** Section 50, chapter 867, Oregon Laws 2009, provides:

**Sec. 50.** Notwithstanding section 9 (3), chapter 736, Oregon Laws 2003, moneys in the Hospital Quality Assurance Fund established under section 9, chapter 736, Oregon Laws 2003, that were received by the Department of Human Services or the Oregon Health Authority prior to January 1, 2010, or if received on or after January 1, 2010, were derived from an assessment liability incurred prior to October 1, 2009, may be used by the authority:

(1) During the biennium beginning July 1, 2009, to supplant, directly or indirectly, moneys appropriated to fund health services by the Seventy-fifth Legislative Assembly during the regular legislative session;

(2) To fund increased fee-for-service reimbursement rates for inpatient and outpatient hospital services provided prior to October 1, 2009; and

(3) To fund Medicaid cost settlements owed to hospitals due to the increase in fee-for-service rates under subsection (2) of this section. [2009 c.867 §50; 2009 c.828 §60]

## MANAGED CARE ORGANIZATION ASSESSMENT

**Note:** Sections 1, 9 and 11, chapter 867, Oregon Laws 2009, provide:

**Sec. 1.** (1) The Health System Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Health System Fund shall be credited to the fund.

(2) Amounts in the Health System Fund are continuously appropriated to the Oregon Health Authority for the purpose of funding the Health Care for All Oregon Children program established in section 27, chapter 867, Oregon Laws 2009 [414.231], health services described in ORS 414.705 (1)(a) to (j) and other health services. Moneys in the fund may also be used by the authority to:

(a) Provide grants to community health centers and safety net clinics under section 33, chapter 867, Oregon Laws 2009 [413.225].

(b) Pay refunds due under section 41, chapter 736, Oregon Laws 2003, and under section 11, chapter 867, Oregon Laws 2009.

(c) Pay administrative costs incurred by the authority to administer the assessment in section 9, chapter 867, Oregon Laws 2009.

(3) The authority shall develop a system for reimbursement by the authority to the Office of Private Health Partnerships out of the Health System Fund for costs associated with administering the private health option pursuant to section 30, chapter 867, Oregon Laws 2009 [414.826]. [2009 c.867 §1; 2009 c.828 §46]

**Sec. 9.** (1) As used in this section, "Medicaid managed care organization" means the following entities defined in or referred to in ORS 414.736:

(a) A fully capitated health plan.

(b) A physician care organization.

(c) A mental health organization.

(2) No later than 45 days following the end of a calendar quarter, a Medicaid managed care organization shall pay an assessment at a rate of one percent of the gross amount of capitation payments received by the Medicaid managed care organization during that calendar quarter for providing coverage of health services under ORS 414.705 to 414.750.

(3) The assessment shall be paid to the Oregon Health Authority in a manner and form prescribed by the authority.

(4) Assessments received by the authority under this section shall be deposited in the Health System Fund established in section 1, chapter 867, Oregon Laws 2009.

(5) The assessment imposed under this section is in addition to and not in lieu of any tax, surcharge or other assessment imposed on a Medicaid managed care organization. [2009 c.867 §9; 2009 c.828 §47]

**Sec. 11.** (1) A Medicaid managed care organization that has paid an amount that is not required under section 9, chapter 867, Oregon Laws 2009, may file a claim for refund with the Oregon Health Authority.

(2) Any Medicaid managed care organization that is aggrieved by an action of the authority taken pursuant to subsection (1) of this section shall be entitled to notice and an opportunity for a contested case hearing under ORS chapter 183. [2009 c.867 §11; 2009 c.828 §48]

**Note:** Sections 10 and 12, chapter 867, Oregon Laws 2009, provide:

**Sec. 10.** (1) A Medicaid managed care organization that fails to timely pay an assessment under section 9 of this 2009 Act shall be subject to a penalty of up to $500 per day of delinquency. The total amount of penalties imposed under this section for a calendar quarter may not exceed five percent of the assessment due for that calendar quarter.

(2) Any penalty imposed under this section is in addition to and not in lieu of the assessment imposed under section 9 of this 2009 Act. [2009 c.867 §10]

**Sec. 12.** Sections 9, 10 and 11 of this 2009 Act apply to capitation payments earned by a Medicaid managed care organization during the period from October 1, 2009, through September 30, 2013. [2009 c.867 §12]