Chapter 414

2017 EDITION

Medical Assistance

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GENERAL PROVISIONS

414.018 Legislative intent; 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 integrated and coordinated health care systems has significant potential to reduce the growth of health care costs incurred by the people of this state.

(3) The Legislative Assembly finds that achieving its goals of improving health, increasing the quality, reliability, availability and continuity of care and reducing the cost of care requires an integrated and coordinated health care system in which:

(a) Medical assistance recipients and individuals who are dually eligible for both Medicare and Medicaid participate.

(b) Health care services, other than Medicaid-funded long term care services, are delivered through coordinated care contracts that use alternative payment methodologies to focus on prevention, improving health equity and reducing health disparities, utilizing patient centered primary care homes, behavioral health homes, evidence-based practices and health information technology to improve health and health care.

(c) High quality information is collected and used to measure health outcomes, health care quality and costs and clinical health information.

(d) Communities and regions are accountable for improving the health of their communities and regions, reducing avoidable health gaps among different cultural groups and managing health care resources.

(e) Care and services emphasize preventive services and services supporting individuals to live independently at home or in their community.

(f) Services are person centered, and provide choice, independence and dignity reflected in individual plans and provide assistance in accessing care and services.

(g) Interactions between the Oregon Health Authority and coordinated care organizations are done in a transparent and public manner.

(h) Moneys provided by the federal government for medical education are allocated to the institutions that provide the education.

(4) The Legislative Assembly further finds that there is an extreme need for a skilled, diverse workforce to meet the rapidly growing demand for community-based health care. To meet that need, this state must:

(a) Build on existing training programs; and

(b) Provide an opportunity for frontline care providers to have a voice in their workplace in order to effectively advocate for quality care.

(5) As used in subsection (3) of this section:

(a) "Community" means the groups within the geographic area served by a coordinated care organization and includes groups that identify themselves by age, ethnicity, race, economic status, or other defining characteristic that may impact delivery of health care services to the group, as well as the governing body of each county located wholly or partially within the coordinated care organization's service area.

(b) "Region" means the geographical boundaries of the area served by a coordinated care organization as well as the governing body of each county that has jurisdiction over all or part of the coordinated care organization's service area. [1993 c.815 §1; 2011 c.602 §1; 2015 c.798 §9]

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 for ORS chapters 411, 413 and 414. As used in this chapter and ORS chapters 411 and 413, unless the context or a specially applicable statutory definition requires otherwise:

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

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

(A) Shared savings arrangements;

(B) Bundled payments; and

(C) Payments based on episodes.

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

(3) "Behavioral health clinician" means:

(a) A licensed psychiatrist;

(b) A licensed psychologist;

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

(d) A licensed clinical social worker;

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

(f) A certified clinical social work associate;

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

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

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

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

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

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

(a) Has expertise or experience in public health;

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

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

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

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

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

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

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

(8) "Coordinated care organization" means an organization meeting criteria adopted by the Oregon Health Authority under ORS 414.625.

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

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

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

(10)(a) "Family support specialist" means an individual who meets qualification criteria adopted by the authority under ORS

414.665 and who provides supportive services to and has experience parenting a child who:

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

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

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

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

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

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

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

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

(c) Prescription drugs;

(d) Laboratory and X-ray services;

(e) Medical equipment and supplies;

(f) Mental health services;

(g) Chemical dependency services;

(h) Emergency dental services;

(i) Nonemergency dental services;

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

(k) Emergency hospital services;

(L) Outpatient hospital services; and

(m) Inpatient hospital services.

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

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

(A) Mental illness.

(B) Substance use disorders.

(C) Health behaviors that contribute to chronic illness.

(D) Life stressors and crises.

(E) Developmental risks and conditions.

(F) Stress-related physical symptoms.

(G) Preventive care.

(H) Ineffective patterns of health care utilization.

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

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

(B) Peer wellness specialists;

(C) Peer support specialists;

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

(E) Personal health navigators; or

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

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

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

(18) "Medical assistance" includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. Except as provided in ORS 411.439 and 411.447,

"medical assistance" does not include care or services for a resident of a nonmedical public institution.

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

(a) Access to care;

(b) Accountability to consumers and to the community;

(c) Comprehensive whole person care;

(d) Continuity of care;

(e) Coordination and integration of care; and

(f) Person and family centered care.

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

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

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

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

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

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

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

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

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

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

(25) "Quality measure" means the health outcome and quality measures and benchmarks identified by the Health Plan Quality Metrics Committee and the metrics and scoring subcommittee in accordance with ORS 413.017 (4) and 414.638.

(26) "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.

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

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

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

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

(b) A "youth support specialist" may be a peer wellness specialist or a peer support specialist. [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; 2010 c.73 §1; 2011 c.69 §7; 2011 c.602 §§20,69; 2011 c.700 §5; 2013 c.688 §68; 2015 c.3 §45; 2015 c.389 §9; 2015 c.765 §25; 2015 c.792 §5; 2015 c.798 §3; 2015 c.836 §3; 2017 c.273 §3; 2017 c.618 §§2,3]

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 for:

(a) Providing medical assistance to individuals who are dually eligible for Medicare and Medicaid using global or alternative payment methodologies or integrated and coordinated health care and services; or

(b) Evaluating service delivery systems. [1991 c.66 §5; 2009 c.595 §265; 2011 c.602 §21; 2012 c.8 §24]

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 Simplified application process; outreach and enrollment. (1) The Oregon Health Authority, under the direction of the Oregon Health Policy Board and in collaboration with the Department of Human Services, shall implement a streamlined and simple application process for the medical assistance and premium assistance programs administered by the Oregon Health Authority. The process must meet the requirements of ORS 411.400, 411.402, 411.404, 411.406, 411.408 and 411.967.

(2) In developing the simplified application process, the authority shall consult with persons not employed by the authority who have experience in serving vulnerable and hard-to-reach populations.

(3) The authority and the department shall facilitate outreach and enrollment efforts to connect eligible individuals with all available publicly funded health programs. [2009 c.867 §35; 2009 c.828 §58; 2011 c.720 §130; 2013 c.681 §47; 2013 c.688 §69]

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]

414.044 Notice to Department of Veterans' Affairs of information regarding applications for health care coverage by uniformed service members and veterans; rules. (1) As used in this section:

(a) "Uniformed service" means the Armed Forces of the United States, the Army National Guard or the Air National Guard when the member is engaged in active duty for training, inactive duty for training or full-time National Guard duty, the commissioned corps of the United States Public Health Service and any other category of persons designated by the President of the United States in time of war or national emergency.

(b) "Written information" means information that is in written form and includes but is not limited to information obtained by electronic means, such as electronic mail, facsimile or other form of electronic communication.

(2)(a) Subject to subsection (3) of this section, the Director of the Oregon Health Authority shall notify the Director of Veterans' Affairs at least once each month regarding receipt of written information from a member or veteran of a uniformed service in connection with an application for health care coverage.

(b) The notification required under this subsection is limited to notifying the Director of Veterans' Affairs of the name and residence address or mailing address of the member or veteran.

(c) The authorization of a member or veteran as required by subsection (3) of this section may be contained in the written information at the time it is received by the Oregon Health Authority or separately at another time, but the authorization must specifically authorize the notification to be made under this section.

(3) The Director of the Oregon Health Authority shall notify the Director of

Veterans' Affairs as required by subsection (2) of this section only if authorized to do so in writing by the member or veteran of a uniformed service.

(4) The Oregon Health Authority, in consultation with the Department of Veterans' Affairs, shall adopt rules to implement the provisions of this section, including but not limited to the method of notification required under subsection (2) of this section. [2015 c.621 §1]

Note: 414.044 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.

414.045 [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 care and services covered; quality measures; reimbursement; cost sharing; payments by Oregon Health Authority as payment in full; rules. (1)(a) With respect to health care and services to be provided in medical assistance during any period, the Oregon Health Authority shall determine, subject to such revisions as it may make from time to time and subject to legislative funding and paragraph (b) of this subsection:

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

(B) Standards, including outcome and quality measures, to be observed in the provision of health care and services.

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

(D) Reasonable fees, charges, daily rates and global payments for meeting the costs of providing health 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 health care or services.

(b) The authority shall adopt rules establishing timelines for payment of health services under paragraph (a) of this subsection.

(2) The types and extent of health 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 medical assistance funds available to providers of health 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 health care and services for which such payments of medical assistance were made.

(4) Notwithstanding subsections (1) and (2) of this section, the Department of Human Services shall be responsible for determining the payment for Medicaid-funded long term care services and for contracting with the providers of long term care services.

(5) In determining a global budget for a coordinated care organization:

(a) The allocation of the payment, the risk and any cost savings shall be determined by the governing body of the organization;

(b) The authority shall consider the community health assessment conducted by the organization and reviewed annually, and the organization's health care costs; and

(c) The authority shall take into account the organization's provision of innovative, nontraditional health services.

(6) Under the supervision of the Governor, the authority may work with the Centers for Medicare and Medicaid Services to develop, in addition to global budgets, payment streams:

(a) To support improved delivery of health care to recipients of medical assistance; and

(b) That are funded by coordinated care organizations, counties or other entities other than the state whose contributions qualify for federal matching funds under Title XIX or XXI of the Social Security Act. [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; 2011 c.602 §22; 2012 c.8 §19; 2013 c.534 §1; 2013 c.688 §70]

414.066 Billing patient for services covered by medical assistance prohibited. (1) A health care provider may not bill or solicit payment from a medical assistance applicant or recipient for services, except for copayments or other charges authorized by the Oregon Health Authority by rule.

(2)(a) A health care provider that submits a claim for payment to the authority or a coordinated care organization shall wait to receive payment for at least 90 days after submitting the claim before assigning the claim to a collection agency or similar entity to recover from the patient.

(b) If the claim remains unpaid 90 days after a health care provider submits the claim to the authority or a coordinated care organization, the health care provider shall first query the medical assistance program database to confirm the patient's eligibility for medical assistance.

(c) The health care provider may not assign the claim for collection if the authority confirms that the patient was eligible for medical assistance at the time the services were provided. [2017 c.287 §2]

Note: Section 3, chapter 287, Oregon Laws 2017, provides:

Sec. 3. Not later than September 15, 2018, the Oregon Health Authority shall convene a stakeholder group to discuss the implementation of section 2 of this 2017 Act [414.066] and shall report to the interim committees of the Legislative Assembly related to health on the extent to which the implementation of section 2 of this 2017 Act has reduced or eliminated improper billings to or collection of claims from medical assistance recipients. [2017 c.287 §3]

414.067 Coordinated care organization assumption of costs; reports to Legislative Assembly. (1) If the Oregon Health Authority or the Department of Human Services requires a coordinated care organization to provide a service, paid for out of the organization's global budget, that was previously reimbursed by the authority or the department on a fee-for-service basis, the authority or the department must provide the organization with a statement of the costs incurred by the authority or the department in reimbursing the service during the three-year period prior to the organization's assumption of the cost of the service.

(2) If the authority or the department requires a coordinated care organization to assume the cost of a service as described in subsection (1) of this section, the authority or the department shall report to the Legislative Assembly, not later than February 1 of the following year, a statement of the increased cost to the coordinated care organization of providing the service, calculated as the average annual cost incurred by the authority or the department in reimbursing the service during the three-year period prior to the organization's assumption of the cost of the service. [2013 c.534 §4]

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

414.071 Timely payment for dental services. The Oregon Health Authority and the Department of Human Services shall approve or deny prior authorization requests for dental services not later than 30 days after submission thereof by the provider, and shall make payments to providers of prior authorized dental services not later than 30 days after receipt of the invoice of the provider. [Formerly 411.459]

Note: 414.071 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.

414.073 [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 medical 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; 2013 c.688 §71]

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 413.101. [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 health care and services available under medical assistance by direct payments to providers thereof and in lieu of providing such health care and services made available pursuant to ORS 414.065, the Oregon Health Authority may 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 health care and services available under medical assistance. Notwithstanding other specific provisions, the use of available medical assistance funds to purchase health 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 health care and services of the type, within the extent and according to standards prescribed under ORS 414.065;

(b) To pay providers of health 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 health 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 health care and services to the authority as may be required by the authority for its records, reports and audits.

(3) The authority may purchase insurance under this section through the health insurance exchange. [1967 c.502 §9; 1975 c.401 §1; 1981 c.825 §5; 1991 c.66 §17; 2009 c.595 §281; 2011 c.602 §36; 2013 c.688 §72]

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 demonstration project entered into under ORS 411.135 special rates may be established.

(2) No premium or other periodic charge on any policy of insurance, health care service contract, or medical or hospital service contract shall be paid from available medical assistance funds unless the insurer or contractor issuing such policy or contract is by law authorized to transact business as an insurance company, health care service contractor or hospital association in this state. [1967 c.502 §10; 1975 c.509 §6; 1991 c.66 §18; 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 local level. [1991 c.337 §1; 2015 c.736 §58]

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 Duty of state agencies to work with local health departments. To capitalize on the successful public health programs provided by local health departments and the sizable investment by state and local governments in the public health system, state agencies shall encourage agreements that allow local 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; 2015 c.736 §59]

Note: See note under 414.150.

414.153 Services provided by local health departments. In order to make advantageous use of the system of public health care and services available through local health departments and other publicly supported programs and to ensure access to public health care and 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 coordinated care organizations 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 members of coordinated care organizations 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 coordinated care organization cannot adequately provide the services;

(3) Encourage and approve agreements between coordinated care organizations 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 care and 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 responsibility of counties under ORS 430.620 to operate community mental health programs by requiring a written agreement between each coordinated care organization and the local mental health authority in the area served by the coordinated care organization, unless cause can be shown why such an agreement is not feasible under criteria established by the Oregon Health Authority. The written agreements:

(a) May not prevent coordinated care organizations from contracting with other public or private providers for mental health or chemical dependency services;

(b) Must include agreed upon outcomes; and

(c) Must describe the authorization and payments necessary to maintain the mental health safety net system and to maintain the efficient and effective management of the following responsibilities of local mental health authorities, with respect to the service needs of members of the coordinated care organization:

(A) Management of children and adults at risk of entering or who are transitioning from the Oregon State Hospital or from residential care;

(B) Care coordination of residential services and supports for adults and children;

(C) Management of the mental health crisis system;

(D) Management of community-based specialized services, including but not limited to supported employment and education, early psychosis programs, assertive community treatment or other types of intensive case management programs and home-based services for children; and

(E) Management of specialized services to reduce recidivism of individuals with mental illness in the criminal justice system. [1991 c.337 §4; 1993 c.592 §1; 2009 c.595 §286; 2011 c.602 §24; 2015 c.27 §42; 2015 c.736 §60; 2015 c.798 §4]

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) The Director of Human Services or designee;

(f) Health care providers;

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

(h) 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; 2011 c.602 §37; 2011 c.720 §132]

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 Director of the Oregon Health Authority and the Director of Human Services on:

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

(2) The operation and administration of programs provided under ORS chapter 414. [1995 c.727 §44; 2003 c.784 §7; 2007 c.697 §16; 2009 c.595 §288; 2011 c.720 §133]

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, the Oregon Health Policy Board or the Department of Human Services on administration or policy related to the medical assistance program operated under this chapter.

(2) Subsection (1) of this section applies only to advisory committee meetings attended by two or more advisory committee

members who are not employed by a public body. [2001 c.353 §2; 2009 c.595 §290; 2011 c.720 §134]

414.229 [Formerly 414.751; 2011 c.602 §38; repealed by 2015 c.318 §56]

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. (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 provides medical assistance to children, 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.

(3) A child is eligible for medical assistance under subsection (2) of this section if the child resides in this state and the income of the child's family is at or below 300 percent of the federal poverty guidelines.

(4) There is no asset limit to qualify for the program.

(5)(a) A child receiving medical assistance through the Health Care for All Oregon Children program is continuously eligible for a minimum period of 12 months or until the child reaches 19 years of age, whichever comes first.

(b) The Department of Human Services or the Oregon Health Authority 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 and the child has not yet reached 19 years of age.

(c) A child may not be required to submit a new application as a condition of reenrollment under paragraph (b) of this subsection.

(6) The department or the authority must determine the child's eligibility for or reenrollment in medical assistance using information and sources available to the department or the authority. If information and sources available to the department or the authority are not adequate to verify the child's eligibility, the department or the authority may require the child or the child's caretaker to provide additional documentation in accordance with ORS 411.400 and 411.402. Information requested or obtained by the department or the authority under this subsection is subject to the requirements of ORS 410.150 and 413.175. [2009 c.867 §27; 2009 c.867 §28; 2011 c.9 §56; 2011 c.720 §135; 2013 c.365 §1; 2013 c.640 §§12,13; 2017 c.652 §2]

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

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

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

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

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

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

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

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

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

PRESCRIPTION DRUGS

(Oregon Prescription Drug Program)

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

(a) "Pharmacy benefit manager" means an entity that 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 administrator may establish different program prices for pharmacies in rural areas to maintain statewide access to the program.

(6) 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.

(7) Except as provided in subsection (8) 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.

(8) 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.

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

(10) 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; 2011 c.720 §136; 2013 c.14 §6; 2015 c.551 §1]

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 [2003 c.714 §3; 2007 c.697 §19; 2009 c.595 §293; repealed by 2015 c.318 §56]

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 in Medical Assistance Program)

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) "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 Evidence Review 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 in accordance with ORS 414.351 to 414.414.

(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. [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 §§2,8; 2009 c.828 §35; 2015 c.467 §§3,4; 2015 c.551 §2]

414.326 Supplemental rebates from pharmaceutical manufacturers. (1) The Oregon Health Authority 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 authority 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. [Formerly 414.747; 2013 c.14 §7]

Note: 414.326 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.

414.327 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.

414.328 Synchronization of prescription drug refills. (1) As used in this section, "synchronization policy" means a procedure for aligning the refill dates of a patient's prescription drugs so that drugs that are refilled at the same frequency may be refilled concurrently.

(2) Each coordinated care organization shall implement a synchronization policy for the dispensing of prescription drugs to members of the organization.

(3) The Oregon Health Authority shall implement a synchronization policy for the dispensing of prescription drugs to recipients of medical assistance who are not enrolled in a coordinated care organization. [2014 c.25 §4; 2015 c.800 §2]

414.329 Prescription drug benefits for certain persons who are eligible for Medicare Part D prescription drug coverage; rules. (1) Notwithstanding ORS 414.631, 414.651 and 414.688 to 414.745, 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 participation is not available and that are not covered classes of drugs;

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

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

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

(2) As used in this section, "covered classes of drugs" means classes of prescription drugs provided to persons eligible for prescription drug coverage under the state medical assistance program or Title XIX of the Social Security Act. [2005 c.754 §1; 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 considering, first, the effectiveness and safety of a given drug and, second, any substantial cost differences between drugs within the same therapeutic class. [2001 c.897 §2; 2009 c.595 §298b; 2011 c.720 §137]

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 in the medical assistance program receive the most effective prescription drug available at the best possible price.

(2) In adopting the plan, the authority shall consider recommendations of the Pharmacy and Therapeutics Committee.

(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. [2001 c.897 §3; 2009 c.595 §299; 2009 c.827 §§4,10; 2011 c.720 §§138,139]

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.

(Mental Health Clinical Advisory Group)

Note: Sections 2, 3 and 5, chapter 619, Oregon Laws 2017, provide:

Sec. 2. (1) The Mental Health Clinical Advisory Group is established in the Oregon Health Authority. The Mental Health Clinical Advisory Group shall develop evidence-based algorithms for mental health treatments with mental health drugs based on:

(a) The efficacy of the drug;

(b) The cost of the drug;

(c) Potential side effects of the drug;

(d) A patient's profile; and

(e) A patient's history with the drug.

(2) The Mental Health Clinical Advisory Group consists of 15 members appointed by the authority as follows:

(a) Two psychiatrists with active community practices;

(b) One child and adolescent psychiatrist;

(c) Two licensed clinical psychologists;

(d) One psychiatric nurse practitioner with prescribing privileges;

(e) Two primary care providers;

(f) Two pharmacists, one of whom must have experience in dispensing to long term care facilities and to patients with special needs;

(g) Two individuals, representing statewide mental health advocacy organizations for children and adults with mental illness, who have experience as consumers of mental health services or as a family member of a consumer of mental health services;

(h) Two individuals each representing a coordinated care organization; and

(i) One consumer of mental health services or one family member of a consumer of mental health services.

(3) The Mental Health Clinical Advisory Group shall, in developing treatment algorithms, consider all of the following:

(a) Peer-reviewed medical literature;

(b) Observational studies;

(c) Studies of health economics;

(d) Input from patients and physicians; and

(e) Any other information that the group deems appropriate.

(4) The Mental Health Clinical Advisory Group shall make recommendations to the authority and the Pharmacy and Therapeutics Committee including but not limited to:

(a) Implementation of evidence-based algorithms.

(b) Any changes needed to any preferred drug list used by the authority.

(c) Practice guidelines for the treatment of mental health disorders with mental health drugs.

(5) Recommendations of the Mental Health Clinical Advisory Group shall be posted to the website of the authority no later than 30 days after the group approves the recommendations.

(6) The Mental Health Clinical Advisory Group shall report to the interim committees of the Legislative Assembly related to health:

(a) No later than December 31, 2017, its progress in developing evidence-based algorithms for mental health drugs; and

(b) No later than December 31, 2018, its final recommendations under subsection (4) of this section and any legislative changes needed to fully implement the recommendations.

(7) A member of the Mental Health Clinical Advisory Group is not entitled to compensation but may be reimbursed for necessary travel expenses incurred in the performance of the member's official duties.

(8) The Mental Health Clinical Advisory Group shall select one of its members as chairperson and another as vice chairperson, for terms and with duties and powers necessary for the performance of the functions of the group.

(9) A majority of the members of the Mental Health Clinical Advisory Group constitutes a quorum for the transaction of business.

(10) The Mental Health Clinical Advisory Group shall meet at least once every two months at a time and place determined by the chairperson. The group also may meet at other times and places specified by the call of the chairperson or of a majority of the members of the group. The group may meet in executive session when discussing factors listed in subsection (1) of this section.

(11) In accordance with applicable provisions of ORS chapter 183, the Mental Health Clinical Advisory Group may adopt rules necessary for the administration of this section.

(12) All agencies of state government, as defined in ORS 174.111, are directed to assist the Mental Health Clinical Advisory Group in the performance of duties of the group and, to the extent permitted by laws relating to confidentiality, to furnish information and advice the members of the group consider necessary to perform their duties. [2017 c.619 §2]

Sec. 3. (1) As used in this section, "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.

(2) Notwithstanding ORS 414.334, the authority shall reimburse the cost of a mental health drug prescribed for a medical assistance recipient if federal financial participation in the cost is available. [2017 c.619 §3]

Sec. 5. (1) Section 2 of this 2017 Act is repealed on December 31, 2018.

(2) Section 3 of this 2017 Act is repealed on January 2, 2020. [2017 c.619 §5]

414.338 [2001 c.869 §1; 2009 c.595 §301; repealed by 2011 c.720 §228]

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]

414.350 [1993 c.578 §1; 2009 c.595 §302; repealed by 2011 c.720 §228]

(Pharmacy and Therapeutics Committee)

414.351 Definitions for ORS 414.351 to 414.414. As used in ORS 414.351 to 414.414:

(1) "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 Service drug information.

(b) The United States Pharmacopeia drug information.

(c) The American Medical Association drug evaluations.

(d) Peer-reviewed medical literature.

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

(2) "Criteria" means the predetermined and explicitly accepted elements based on 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.

(3) "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.

(4) "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, metabolism, excretion or therapeutic efficacy of one or any of the drugs.

(5) "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.

(6) "Intervention" means an action taken by the Oregon Health Authority with a:

(a) Prescriber or pharmacist to inform about or to influence prescribing or dispensing practices; or

(b) Recipient, prescriber or pharmacist to inform about or to influence the utilization of drugs.

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

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

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

(10) "Prospective program" means the prospective drug use review program described in ORS 414.369.

(11) "Retrospective program" means the retrospective drug use review program described in ORS 414.371.

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

(13) "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 414.351 to 414.414.

(14) "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.

(15) "Underutilization" means that a drug is used by a recipient in insufficient quantity to achieve a desired therapeutic goal. [2011 c.720 §1; 2015 c.467 §5]

Note: 414.351 to 414.414 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.

414.353 Committee established; membership. (1) There is created an 11-member Pharmacy and Therapeutics Committee responsible for advising the Oregon Health Authority on the implementation of the retrospective and prospective programs and on the Practitioner-Managed Prescription Drug Plan.

(2) The Director of the Oregon Health Authority shall appoint the members of the committee, who shall serve at the pleasure of the director for a term of three years. An individual appointed to the committee may be reappointed upon completion of the individual's term. The membership of the committee shall be composed of the following:

(a) Five persons licensed as physicians under ORS 677.100 to 677.228 and actively engaged in the practice of medicine in Oregon, who may be from among persons recommended by organizations representing physicians;

(b) Four persons licensed in and actively practicing pharmacy in Oregon who may be from among persons recommended by organizations representing pharmacists whether affiliated or unaffiliated with any association; and

(c) Two persons who are not physicians or pharmacists.

(3) If the committee determines that it lacks current clinical or treatment expertise with respect to a particular therapeutic class, or at the request of an interested outside party, the director shall appoint one or more medical experts otherwise qualified as described in subsection (2)(a) of this section who have such expertise. The medical experts shall have full voting rights with respect to recommendations made under ORS 414.361 (3) and (4). The medical experts may participate but may not vote in any other activities of the committee.

(4) The director shall fill a vacancy on the committee by appointing a new member to serve the remainder of the unexpired term. [2011 c.720 §2; 2017 c.409 §9]

Note: See note under 414.351.

414.354 Meetings; advisory committees; public notice and testimony. (1) Except as provided in ORS 414.356, the Pharmacy and Therapeutics Committee shall operate in accordance with ORS chapter 192. The committee shall annually elect a chairperson from the members of the committee.

(2) A committee member is not entitled to compensation but 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 six members of the committee.

(4) The committee may establish advisory committees to assist in carrying out the committee's duties under ORS 414.351 to 414.414, with the approval of the Director of the Oregon Health Authority.

(5) The Oregon Health Authority shall provide staff and support services to the committee.

(6) The committee shall meet no less than four times each year at a place, day and hour determined by the director. The committee also shall meet at other times and places specified by the call of the director or a majority of the members of the committee. No less than 30 days prior to a meeting the committee shall post to the authority website:

(a) The agenda for the meeting;

(b) A list of the drug classes to be considered at the meeting; and

(c) Background materials and supporting documentation provided to committee members with respect to drugs and drug classes that are before the committee for review.

(7) The committee shall provide appropriate opportunity for public testimony at each regularly scheduled committee meeting. Immediately prior to deliberating on any recommendations regarding a drug or a class of drugs, the committee shall accept testimony, in writing or in person, that is offered by a manufacturer of those drugs or another interested party.

(8) The committee may consider more than 20 classes of drugs at a meeting only if:

(a) There is no new clinical evidence for the additional class of drugs; and

(b) The committee is considering only substantial cost differences between drugs within the same therapeutic class. [2011 c.720 §11]

Note: See note under 414.351.

414.355 [1993 c.578 §2; 2009 c.595 §303; repealed by 2011 c.720 §228]

414.356 Executive session. (1) Notwithstanding ORS 192.610 to 192.690, the Pharmacy and Therapeutics Committee shall meet in an executive session for purposes of:

(a) Reviewing the prescribing or dispensing practices of individual physicians or pharmacists;

(b) Discussing drug use review data pertaining to individual physicians or pharmacists;

(c) Reviewing profiles of individual patients; or

(d) Reviewing confidential drug pricing information, including substantial cost differences between drugs within the same therapeutic class, that is necessary for the committee to make final recommendations under ORS 414.361 or to comply with ORS 414.414.

(2) A meeting held in executive session is subject to the requirements of ORS 192.650 (2). [2011 c.720 §10]

Note: See note under 414.351.

414.360 [1993 c.578 §6; 2003 c.70 §1; 2009 c.595 §304; repealed by 2011 c.720 §228]

414.361 Committee to advise and make recommendations on drug utilization review standards and interventions; preferred drug list; rules. (1) The Pharmacy and Therapeutics Committee shall advise the Oregon Health Authority on:

(a) Adoption of rules to implement ORS 414.351 to 414.414 in accordance with ORS chapter 183.

(b) Implementation of the medical assistance program retrospective and prospective programs as described in ORS 414.351 to 414.414, 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 program.

(c) Development of and application of the criteria and standards to be used in retrospective and prospective drug use review in a manner that ensures that such criteria and standards are based on 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 committee 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 committee shall establish an explicit ongoing process for soliciting and considering input from interested

parties. The committee 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 that are educational and not punitive in nature for medical assistance program prescribers, dispensers and patients.

(2) In reviewing retrospective and prospective drug use, the committee may consider only drugs that have received final approval from the federal Food and Drug Administration.

(3) The committee shall make recommendations to the authority, subject to approval by the Director of the Oregon Health Authority or the director's designee, for drugs to be included on any preferred drug list adopted by the authority and on the Practitioner-Managed Prescription Drug Plan. The committee shall also recommend all utilization controls, prior authorization requirements or other conditions for the inclusion of a drug on a preferred drug list.

(4) In making recommendations under subsection (3) of this section, the committee may use any information the committee deems appropriate. The recommendations must be based upon the following factors in order of priority:

(a) Safety and efficacy of the drug.

(b) The ability of Oregonians to access effective prescription drugs that are appropriate for their clinical conditions.

(c) Substantial differences in the costs of drugs within the same therapeutic class.

(5) The committee shall post a recommendation to the website of the authority no later than 30 days after the date the committee approves the recommendation. The director shall approve, disapprove or modify any recommendation of the committee as soon as practicable, shall publish the decision on the website and shall notify persons who have requested notification of the decision. A recommendation adopted by the director, in whole or in part, with respect to the inclusion of a drug on a preferred drug list or the Practitioner-Managed Prescription Drug Plan may not become effective less than 60 days after the date that the director's decision is published.

(6) The director shall reconsider any decision to adopt or modify a recommendation of the committee with respect to the inclusion of a particular drug on a preferred drug list or the Practitioner-Managed Prescription Drug Plan, upon the request of any interested person filed no later than 30 days after the director's decision is published on the website. The decision on reconsideration shall be sent to the requester and posted to the website without undue delay. [2011 c.720 §4]

Note: See note under 414.351.

414.364 Intervention approaches. In appropriate instances, interventions developed under ORS 414.361 (1)(d) may include the following:

(1) Information disseminated to prescribers and pharmacists to ensure that they are aware of the duties and powers of the Pharmacy and Therapeutics Committee.

(2) Written, oral or electronic reminders of recipient-specific or drug-specific information that are designed to ensure 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.

(8) The actions specified in ORS 414.372. [2011 c.720 §6; 2015 c.467 §6]

Note: See note under 414.351.

414.365 [1993 c.578 §7; 2009 c.595 §305; repealed by 2011 c.720 §228]

414.369 Prospective drug use review program. The prospective drug use review program must use guidelines established by the Oregon Health Authority that are based on the recommendations of the Pharmacy and Therapeutics Committee. The program must ensure 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. [2011 c.720 §7]

Note: See note under 414.351.

414.370 [1993 c.578 §8; 2003 c.70 §2; repealed by 2011 c.720 §228]

414.371 Retrospective drug use review program. The retrospective drug use review program must use:

(1) Guidelines established by the Oregon Health Authority that are based on the recommendations of the Pharmacy and Therapeutics Committee; and

(2) The mechanized drug claims processing and information retrieval system to analyze claims data on drug use against explicit predetermined standards that are based on 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. [2011 c.720 §8]

Note: See note under 414.351.

414.372 Pharmacy lock-in program; rules. (1)(a) If necessary to avoid overutilization by a recipient of medical assistance, the Oregon Health Authority may restrict, for 18 months or less, the recipient's pharmacy choices for filling and refilling prescriptions to a mail order pharmacy that contracts with the authority, a retail pharmacy selected by the recipient and a specialty pharmacy selected by the recipient, if the recipient:

(A) Uses three or more pharmacies in a six-month period;

(B) Fills prescriptions from more than one prescriber for the same or comparable medications for the same time period;

(C) Alters a prescription; or

(D) Exhibits behaviors or patterns of behavior that the Pharmacy and Therapeutics Committee has identified as indicative of intentional overutilization or misuse.

(b) This subsection does not apply to a recipient who:

(A) Is a member of a coordinated care organization;

(B) Has Medicare drug coverage, in addition to medical assistance, but no other drug coverage;

(C) Is a child in the custody of the Department of Human Services; or

(D) Is a patient in a hospital or other medical institution or a resident in a long term care facility.

(c) The authority shall prescribe by rule:

(A) Exceptions to the limitation imposed under paragraph (a) of this subsection; and

(B) The conditions under which a recipient who is restricted under paragraph (a) of this subsection may change to a different pharmacy.

(2) The authority may conduct prospective drug utilization review, in accordance with rules adopted under ORS 414.361, prior to payment for drugs for a patient who has filled prescriptions for more than 15 drugs in the preceding six-month period. [2015 c.467 §2]

Note: See note under 414.351.

414.375 [1993 c.578 §13; 2009 c.595 §306; repealed by 2011 c.720 §228]

414.380 [1993 c.578 §12; 2009 c.595 §307; repealed by 2011 c.720 §228]

414.381 Annual reports; educational materials; procedures to protect confidential information. In addition to the duties described in ORS 414.361, the Pharmacy and Therapeutics Committee shall do the following subject to the approval of the Director of the Oregon Health Authority:

(1) Publish an annual report, as described in ORS 414.382.

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

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

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

(c) Therapeutic appropriateness.

(d) Overutilization or underutilization.

(e) Appropriate use of generic products.

(f) Therapeutic duplication.

(g) Drug-disease contraindications.

(h) Drug-drug interactions.

(i) Drug allergy interactions.

(j) Clinical abuse and misuse.

(3) Adopt and implement procedures designed to ensure the confidentiality of any information that identifies individual prescribers, pharmacists or recipients and that is collected, stored, retrieved, assessed or analyzed by the committee, staff of the committee, the Oregon Health Authority or contractors to the committee or the authority. [2011 c.720 §5]

Note: See note under 414.351.

414.382 Requirements for annual report. (1) The annual report required under ORS 414.381 (1) is subject to public comment prior to its submission to the Director of the Oregon Health Authority and must include the following:

(a) An overview of the activities of the Pharmacy and Therapeutics Committee and the prospective and retrospective programs;

(b) A summary of interventions made, including the number of cases brought before the committee 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 the 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.

(2) Copies of the annual report shall be submitted to the President of the Senate, the Speaker of the House of Representatives and other persons who request copies of the report. [2011 c.720 §12]

Note: See note under 414.351.

414.385 [1993 c.578 §11; repealed by 2011 c.720 §228]

414.390 [1993 c.578 §10; 2009 c.595 §308; repealed by 2011 c.720 §228]

414.395 [1993 c.578 §14; repealed by 2011 c.720 §228]

414.400 [1993 c.578 §4; 2001 c.900 §103; repealed by 2011 c.720 §228]

414.410 [1993 c.578 §5; 2009 c.595 §309; repealed by 2011 c.720 §228]

414.414 Use and disclosure of confidential information. (1) Information collected under ORS 414.351 to 414.414 that identifies an individual is confidential and may not be disclosed by the Pharmacy and Therapeutics Committee, the retrospective program 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 committee may have access to identifying information for purposes of carrying out intervention activities. The identifying information may not be released to anyone other than a staff member of the committee, the retrospective program, the authority or a health care provider appearing on a recipient's medication profile or, for purposes of investigating potential fraud in programs administered by the authority, the Department of Justice.

(3) The committee may release cumulative, nonidentifying information for the purposes of legitimate research and for educational purposes. [2011 c.720 §9]

Note: See note under 414.351.

414.415 [1993 c.578 §9; repealed by 2011 c.720 §228]

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]

MEDICAL ASSISTANCE FOR CERTAIN INDIVIDUALS

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 who is eligible for or receiving medical assistance, as defined in ORS 414.025, pursuant to a demonstration project under section 1115 of the Social Security Act and who is an American Indian and Alaskan Native beneficiary shall receive the same package of health services as individuals described in ORS 414.706 (1), (2) and (3) if:

(a) The Oregon Health Authority receives 100 percent federal medical assistance percentage for payments made by the authority for the package of health services provided; 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" has the meaning given that term in ORS 414.631. [Formerly 414.029; 2007 c.861 §22; 2009 c.595 §311; 2011 c.602 §39; 2013 c.688 §74]

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.

414.430 Access to dental care for pregnant women; rules. (1) The Oregon Health Authority shall prescribe by rule appropriate time frames within which a pregnant medical assistance recipient whose medical assistance is reimbursed on a fee-for-service basis and who needs general or specialty dental care must have the opportunity to be seen, or referred for, and provided:

(a) Emergency dental services;

(b) Urgent dental services;

(c) Routine dental services; and

(d) An initial dental screening or examination.

(2) The time frames prescribed by the authority for recipients whose medical assistance is reimbursed on a fee-for-service basis shall be the same as or shorter than the time frames for pregnant recipients enrolled in coordinated care organizations and dental care organizations. [2015 c.750 §2]

Note: Sections 3 and 5, chapter 750, Oregon Laws 2015, provide:

Sec. 3. (1) The Oregon Health Authority shall adopt procedures to ensure that the authority collects and processes the information necessary to determine if the requirements of section 2 of this 2015 Act [414.430] are met.

(2) No later than February 1, 2017, and each year thereafter, the authority shall report to the Legislative Assembly, in the manner provided by ORS 192.245, on whether the wait times for pregnant women to be seen, or referred for, and provided dental care are in accordance with the rules prescribed by the authority under section 2 of this 2015 Act. [2015 c.750 §3]

Sec. 5. Section 3 of this 2015 Act is repealed on February 1, 2019. [2015 c.750 §5]

414.432 Reproductive health services for noncitizens. (1) The Oregon Health Authority shall administer a program to reimburse the cost of medically appropriate services, drugs, devices, products and procedures described in ORS 743A.067, for individuals who can become pregnant and who would be eligible for medical assistance if not for 8 U.S.C. 1611 or 1612.

(2) The authority shall provide the medical assistance for pregnant women that is authorized by Title XXI, section 2112, of the Social Security Act (42 U.S.C. 1397ll) for 60 days immediately postpartum.

(3) The authority shall collect data and analyze the cost-effectiveness of the services, drugs, devices, products and procedures paid for under this section.

(4) The authority, in collaboration with the Department of Consumer and Business Services if necessary, shall explore any and all opportunities to obtain federal financial participation in the costs of implementing this section, including but not limited to waivers or demonstration projects under Title X of the Public Health Service Act or Title XIX or XXI of the Social Security Act. However, the implementation of this section is not contingent upon the authority's receipt of a waiver or authorization to operate a demonstration project. [2017 c.721 §5]

Note: Section 6, chapter 721, Oregon Laws 2017, provides:

Sec. 6. Not later than September 15, 2018, the Oregon Health Authority shall report to the interim committees of the Legislative Assembly related to health on the implementation of section 5 of this 2017 Act [414.432]. [2017 c.721 §6]

414.440 [2011 c.207 §1; 2013 c.640 §1; renumbered 411.447 in 2013]

MEDICAL ASSISTANCE BASED ON CONDITION

(Hemophilia)

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.

(Breast and Cervical Cancer)

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 743B.001. [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; rules. (1) The Oregon Health Authority shall provide medical assistance, as defined in ORS 414.025, to a woman who:

(a) Is found by a provider to be in need of treatment for breast or cervical cancer;

(b) Meets the eligibility criteria for the Oregon Breast and Cervical Cancer Program prescribed by rule by the authority;

(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 or the Oregon Health Authority 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 or the authority determines the woman no longer meets the eligibility criteria of subsection (1) of this section. [2001 c.902 §2; 2009 c.595 §313; 2011 c.555 §1; 2013 c.688 §75]

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 or the Oregon Health Authority determines that a woman likely is eligible for medical assistance under ORS 414.534, the department or the authority 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 or the authority 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 or the authority that the woman is presumptively eligible for medical assistance, the date on which a formal determination on eligibility is made by the department or the authority in accordance with ORS 414.534; or

(B) If the woman does not apply for medical assistance following the determination by the department or the authority 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; 2013 c.688 §76]

Note: See note under 414.532.

414.538 Prohibition on coverage limitations; priority to low-income women. (1) The Department of Human Services and the Oregon Health Authority 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 establishing eligibility requirements for medical assistance under ORS 414.534, the department and the authority shall give priority to low-income women. [2001 c.902 §4; 2009 c.595 §315; 2011 c.720 §141]

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.

(Cystic Fibrosis)

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 physician, physician assistant, naturopathic physician or nurse practitioner 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; 2014 c.45 §38; 2017 c.356 §33]

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.

414.610 [1983 c.590 §1; 1985 c.747 §8; repealed by 2011 c.602 §§64,70, 2012 c.8 §23 and 2015 c.792 §2]

414.615 [Formerly 414.640; 2017 c.356 §34; repealed by 2011 c.602 §§64,70, 2012 c.8 §23 and 2015 c.792 §2]

414.618 [Formerly 414.630; 2014 c.45 §39; 2017 c.356 §35; repealed by 2011 c.602 §§64,70, 2012 c.8 §23 and 2015 c.792 §2]

OREGON INTEGRATED AND COORDINATED CARE DELIVERY SYSTEM

(Coordinated Care Organizations)

414.620 System established. (1) There is established the Oregon Integrated and Coordinated Health Care Delivery System. The system shall consist of state policies and actions that make coordinated care organizations accountable for care management and provision of integrated and coordinated health care for each organization's members, managed within fixed global budgets, by providing care so that efficiency and quality improvements reduce medical cost inflation while supporting the development of regional and community accountability for the health of the residents of each region and community, and while maintaining regulatory controls necessary to ensure quality and affordable health care for all Oregonians.

(2) The Oregon Health Authority shall seek input from groups and individuals who are part of underserved communities, including ethnically diverse populations, geographically isolated groups, seniors, people with disabilities and people using mental health services, and shall also seek input from providers, coordinated care organizations and communities, in the development of strategies that promote person centered care and encourage healthy behaviors, healthy lifestyles and prevention and wellness activities and promote the development of patients' skills in self-management and illness management.

(3) The authority shall regularly report to the Oregon Health Policy Board, the Gov-

ernor and the Legislative Assembly on the progress of payment reform and delivery system change including:

(a) The achievement of benchmarks;

(b) Progress toward eliminating health disparities;

(c) Results of evaluations;

(d) Rules adopted;

(e) Customer satisfaction;

(f) Use of patient centered primary care homes and behavioral health homes;

(g) The involvement of local governments in governance and service delivery; and

(h) Other developments with respect to coordinated care organizations. [1983 c.590 §2; 1985 c.747 §2; 2011 c.602 §2; 2015 c.798 §10]

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

(a) Managing financial risk and establishing financial reserves.

(b) Meeting the following minimum financial requirements:

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

(B) Maintaining a net worth in an amount equal to at least five percent of the average combined revenue in the prior two quarters of the participating health care entities.

(c) Operating within a fixed global budget and, by January 1, 2023, spending on primary care, as defined in section 2, chapter 575, Oregon Laws 2015, at least 12 percent of the coordinated care organization's total expenditures for physical and mental health care provided to members, except for expenditures on prescription drugs, vision care and dental care.

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

(e) Coordinating the delivery of physical health care, mental health and chemical dependency services, oral health care and covered long-term care services.

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

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

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

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

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

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

(e) Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, including through the use of certified health care interpreters and qualified health care interpreters, as those terms are defined in ORS 413.550.

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

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

(h) Each coordinated care organization complies with the safeguards for members described in ORS 414.635.

(i) Each coordinated care organization convenes a community advisory council that meets the criteria specified in ORS 414.627.

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

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

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

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

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

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

(E) Include providers of specialty care.

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

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

(L) Each coordinated care organization reports on outcome and quality measures adopted under ORS 414.638 and participates in the health care data reporting system established in ORS 442.464 and 442.466.

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

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

(o) Each coordinated care organization has a governing body of which a majority of the members are persons that share in the financial risk of the organization and that includes:

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

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

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

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

(ii) A mental health or chemical dependency treatment provider;

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

(E) At least one member of the community advisory council.

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

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

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

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

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

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

(5) On or before July 1, 2014, each coordinated care organization must have a formal contractual relationship with any dental care organization that serves members of the coordinated care organization in the area where they reside. [2011 c.602 §4; 2012 c.8 §20; 2013 c.535 §3; 2015 c.798 §11; 2017 c.101 §25; 2017 c.273 §6; 2017 c.429 §1; 2017 c.489 §1]

Note: The amendments to 414.625 by section 14, chapter 489, Oregon Laws 2017, become operative January 1, 2023. See section 20, chapter 489, Oregon Laws 2017. The text that is operative on and after January 1, 2023, is set forth for the user's convenience.

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

(a) Managing financial risk and establishing financial reserves.

(b) Meeting the following minimum financial requirements:

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

(B) Maintaining a net worth in an amount equal to at least five percent of the average combined revenue in the prior two quarters of the participating health care entities.

(c) Operating within a fixed global budget and spending on primary care, as defined by the authority by rule, at least 12 percent of the coordinated care organization's total expenditures for physical and mental health care provided to members, except for expenditures on prescription drugs, vision care and dental care.

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

(e) Coordinating the delivery of physical health care, mental health and chemical dependency services, oral health care and covered long-term care services.

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

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

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

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

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

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

(e) Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, including through the use of certified health care interpreters and qualified health care interpreters, as those terms are defined in ORS 413.550.

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

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

(h) Each coordinated care organization complies with the safeguards for members described in ORS 414.635.

(i) Each coordinated care organization convenes a community advisory council that meets the criteria specified in ORS 414.627.

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

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

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

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

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

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

(E) Include providers of specialty care.

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

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

(L) Each coordinated care organization reports on outcome and quality measures adopted under ORS 414.638 and participates in the health care data reporting system established in ORS 442.464 and 442.466.

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

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

(o) Each coordinated care organization has a governing body of which a majority of the members are persons that share in the financial risk of the organization and that includes:

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

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

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

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

(ii) A mental health or chemical dependency treatment provider;

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

(E) At least one member of the community advisory council.

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

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

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

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

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

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

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

Note: Section 3, chapter 489, Oregon Laws 2017, provides:

Sec. 3. (1) As used in this section, "primary care" has the meaning given that term in section 2, chapter 575, Oregon Laws 2015.

(2) A coordinated care organization that spends on primary care less than 12 percent of its total expenditures on physical and mental health care, as required by ORS 414.625 (1)(c), shall submit to the Oregon Health Authority a plan to increase spending on primary care as a percentage of its total expenditures by at least one percent each year. [2017 c.489 §3]

Note: Section 5 (2), chapter 575, Oregon Laws 2015, provides:

Sec. 5. (2) Section 3 of this 2017 Act is repealed on December 31, 2027. [2015 c.575 §5; 2016 c.26 §8; 2017 c.489 §19 (2)]

414.627 Community advisory councils. (1) A coordinated care organization must have a community advisory council to ensure that the health care needs of the consumers and the community are being addressed. The council must:

(a) Include representatives of the community and of each county government served by the coordinated care organization, but consumer representatives must constitute a majority of the membership; and

(b) Have its membership selected by a committee composed of equal numbers of county representatives from each county served by the coordinated care organization and members of the governing body of the coordinated care organization.

(2) The duties of the council include, but are not limited to:

(a) Identifying and advocating for preventive care practices to be utilized by the coordinated care organization;

(b) Overseeing a community health assessment and adopting a community health improvement plan to serve as a strategic population health and health care system service plan for the community served by the coordinated care organization; and

(c) Annually publishing a report on the progress of the community health improvement plan.

(3) The community health improvement plan adopted by the council should describe the scope of the activities, services and responsibilities that the coordinated care organization will consider upon implementation of the plan. The activities, services and responsibilities defined in the plan shall include a plan and a strategy for integrating physical, behavioral and oral health care services and may include, but are not limited to:

(a) Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;

(b) Health policy;

(c) System design;

(d) Outcome and quality improvement;

(e) Integration of service delivery; and

(f) Workforce development.

(4) The council shall meet at least once every three months. The council shall post a report of its meetings and discussions to the website of the coordinated care organization and other websites appropriate to keeping the community informed of the council's activities. The council, the governing body of the coordinated care organization or a designee of the council or governing body has discretion as to whether public comments received at meetings that are open to the public will be included in the reports posted to the website and, if so, which comments are appropriate for posting.

(5) If the regular council meetings are not open to the public and do not provide an opportunity for members of the public to provide written and oral comments, the council shall hold quarterly meetings:

(a) That are open to the public and attended by the members of the council;

(b) At which the council shall report on the activities of the coordinated care organization and the council;

(c) At which the council shall provide written reports on the activities of the coordinated care organization; and

(d) At which the council shall provide the opportunity for the public to provide written or oral comments.

(6) The coordinated care organization shall post to the organization's website contact information for, at a minimum, the chairperson, a member of the community advisory council or a designated staff member of the organization.

(7) Meetings of the council are not subject to ORS 192.610 to 192.690. [2012 c.8 §13; 2013 c.535 §§4,5; 2017 c.82 §1]

Note: 414.627 to 414.629 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.

414.628 Innovator agents. (1) Upon the request of a coordinated care organization, the Oregon Health Authority shall assign to the coordinated care organization one employee of the authority, called an innovator agent, to act as the single point of contact between the coordinated care organization and the authority. The innovator agent must be available to the organization on a day-to-day basis to facilitate the exchange of information between the coordinated care organization and the authority. The organization may provide a work space to enable the agent to be colocated at a site of the coordinated care organization if practical.

(2) Innovator agents must observe the meetings of the community advisory councils and report on the meetings to the authority.

(3) Not less than once every calendar quarter, all of the innovator agents must meet in person to discuss the ideas, projects and creative innovations planned or undertaken by their assigned coordinated care organizations.

(4) The innovator agent shall be made available by the authority for a period of four years beginning on the date that the coordinated care organization first contracts with the authority to be a coordinated care organization. Upon the request of the coordinated care organization, the authority may extend the period. [2012 c.8 §14]

Note: See note under 414.627.

414.629 Community health improvement plan. (1) A community health improvement plan adopted by a coordinated care organization and its community advisory council in accordance with ORS 414.627 shall include, to the extent practicable, a strategy and a plan for:

(a) Working with programs developed by the Early Learning Council, Early Learning Hubs, the Youth Development Council and the school health providers in the region; and

(b) Coordinating the effective and efficient delivery of health care to children and adolescents in the community.

(2) A community health improvement plan must be based on research, including research into adverse childhood experiences, and must identify funding sources and additional funding necessary to address the health needs of children and adolescents in the community and to meet the goals of the plan. The plan must also:

(a) Evaluate the adequacy of the existing school-based health resources including school-based health centers and school nurses to meet the specific pediatric and adolescent health care needs in the community;

(b) Make recommendations to improve the school-based health center and school nurse system, including the addition or improvement of electronic medical records and billing systems;

(c) Take into consideration whether integration of school-based health centers with the larger health system or system of community clinics would further advance the goals of the plan;

(d) Improve the integration of all services provided to meet the needs of children, adolescents and families;

(e) Focus on primary care, behavioral health and oral health; and

(f) Address promotion of health and prevention and early intervention in the treatment of children and adolescents.

(3) A coordinated care organization shall involve in the development of its community health improvement plan, school-based health centers, school nurses, school mental health providers and individuals representing:

(a) Programs developed by the Early Learning Council and Early Learning Hubs;

(b) Programs developed by the Youth Development Council in the region;

(c) The Healthy Start Family Support Services program in the region;

(d) The Health Care for All Oregon Children program and other medical assistance programs;

(e) Relief nurseries in the region;

(f) Community health centers;

(g) Oral health care providers;

(h) Community mental health providers;

(i) Administrators of county health department programs that offer preventive health services to children;

(j) Hospitals in the region; and

(k) Other appropriate child and adolescent health program administrators.

(4) The Oregon Health Authority may provide incentive grants to coordinated care organizations for the purpose of contracting with individuals or organizations to help coordinate integration strategies identified in the community health improvement plan adopted by the community advisory council. The authority may also provide funds to coordinated care organizations to improve systems of services that will promote the implementation of the plan.

(5) Each coordinated care organization shall report to the authority, in the form and manner prescribed by the authority, on the progress of the integration strategies and implementation of the plan for working with the programs developed by the Early Learning Council, Early Learning Hubs, the Youth Development Council and school health care providers in the region, as part of the development and implementation of the community health improvement plan. The authority shall compile the information biennially and report the information to the Legislative Assembly by December 31 of each even-numbered year. [2013 c.598 §1; 2015 c.402 §3]

Note: See note under 414.627.

414.630 [1983 c.590 §3; 1991 c.66 §24; 2003 c.794 §275; 2009 c.595 §317; 2011 c.602 §40; renumbered 414.618 in 2011]

414.631 Mandatory enrollment in coordinated care organization; exemptions. (1) Except as provided in subsections (2), (3), (4) and (5) of this section and ORS 414.632 (2), a person who is eligible for or receiving health services must be enrolled in a coordinated care organization to receive the health services for which the person is eligible. For purposes of this subsection, Medicaid-funded long term care services do not constitute health services.

(2) Subsections (1) and (4) of this section do 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;

(c) An individual described in ORS 414.632 (2) who is dually eligible for Medicare and Medicaid and enrolled in a program of all-inclusive care for the elderly; and

(d) 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 an area that is not served by a coordinated care organization or where the organization's provider network is inadequate.

(4) In any area that is not served by a coordinated care organization but is served by a prepaid managed care health services organization, a person must enroll with the prepaid managed care health services organization to receive any of the health services offered by the prepaid managed care health services organization.

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

(a) A member of a federally recognized Indian tribe;

(b) An individual who resides in an urban center and:

(A) Is a member of a tribe, band or other organized group of Indians, including those tribes, bands or groups whose recognition was terminated since 1940 and those recognized now or in the future by the state in which the member resides, or who is a descendant in the first or second degree of such a member;

(B) Is an Eskimo or Aleut or other Alaskan Native; or

(C) Is determined to be an Indian under regulations promulgated by the United States Secretary of the Interior;

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

(d) An individual who is considered by the United States Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut or other Alaskan Native. [Formerly 414.737]

414.632 Services to individuals who are dually eligible for Medicare and Medicaid. (1) Subject to the Oregon Health Authority obtaining any necessary authorization from the Centers for Medicare and Medicaid Services, coordinated care organizations that meet the criteria adopted under ORS 414.625 are responsible for providing covered Medicare and Medicaid services, other than Medicaid-funded long term care services, to members who are dually eligible for Medicare and Medicaid in addition to medical assistance recipients.

(2) An individual who is dually eligible for Medicare and Medicaid shall be permitted to enroll in and remain enrolled in a:

(a) Program of all-inclusive care for the elderly, as defined in 42 C.F.R. 460.6; and

(b) Medicare Advantage plan, as defined in 42 C.F.R. 422.2, until the plan is fully integrated into a coordinated care organization.

(3) Except for the enrollment in coordinated care organizations of individuals who are dually eligible for Medicare and Medicaid, the rights and benefits of Medicare beneficiaries under Title XVIII of the Social Security Act shall be preserved. [2011 c.602 §7; 2012 c.8 §25]

414.635 Consumer and provider protections; rules. (1) The Oregon Health Authority shall adopt by rule safeguards for members enrolled in coordinated care organizations that protect against underutilization of services and inappropriate denials of services. In addition to any other consumer rights and responsibilities established by law, each member:

(a) Must be encouraged to be an active partner in directing the member's health care and services and not a passive recipient of care.

(b) Must be educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system.

(c) Must have access to advocates, including qualified peer wellness specialists, peer support specialists, personal health navigators, and qualified community health workers who are part of the member's care team to provide assistance that is culturally and linguistically appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services.

(d) Shall be encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices.

(e) Shall be encouraged to work with the member's care team, including providers and community resources appropriate to the member's needs as a whole person.

(2) The authority shall establish and maintain an enrollment process for individuals who are dually eligible for Medicare and Medicaid that promotes continuity of care and that allows the member to disenroll from a coordinated care organization that fails to promptly provide adequate services and:

(a) To enroll in another coordinated care organization of the member's choice; or

(b) If another organization is not available, to receive Medicare-covered services on a fee-for-service basis.

(3) Members and their providers and coordinated care organizations have the right to appeal decisions about care and services through the authority in an expedited manner and in accordance with the contested case procedures in ORS chapter 183.

(4) A health care entity may not unreasonably refuse to contract with an organization seeking to form a coordinated care organization if the participation of the entity is necessary for the organization to qualify as a coordinated care organization.

(5) A health care entity may refuse to contract with a coordinated care organization if the reimbursement established for a service provided by the entity under the contract is below the reasonable cost to the entity for providing the service.

(6) A health care entity that unreasonably refuses to contract with a coordinated care organization may not receive fee-for-service reimbursement from the authority for services that are available through a coordinated care organization either directly or by contract.

(7)(a) The authority shall adopt by rule a process for resolving disputes involving:

(A) A health care entity's refusal to contract with a coordinated care organization under subsections (4) and (5) of this section.

(B) The termination, extension or renewal of a health care entity's contract with a coordinated care organization.

(b) The processes adopted under this subsection must include the use of an independent third party arbitrator.

(8) A coordinated care organization may not unreasonably refuse to contract with a licensed health care provider.

(9) The authority shall:

(a) Monitor and enforce consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System and ensure a consistent response to

complaints of violations of consumer rights or protections.

(b) Monitor and report on the statewide health care expenditures and recommend actions appropriate and necessary to contain the growth in health care costs incurred by all sectors of the system. [2011 c.602 §§8,9; 2012 c.8 §5; 2013 c.27 §1; 2017 c.618 §4]

414.637 Limits on use of step therapy. (1) As used in this section, "step therapy" means a drug protocol in which the cost of a prescribed drug is reimbursed only if the patient has first tried a specified drug or series of drugs.

(2) A coordinated care organization that requires step therapy shall make easily accessible to any provider who is reimbursed by the organization, directly or through a risk-bearing entity, to provide health services to members of the organization, clear explanations of:

(a) The clinical criteria for each step therapy protocol;

(b) The procedure by which a provider may submit to the organization or risk-bearing entity, the provider's medical rationale for determining that a particular step therapy protocol is not appropriate for a particular patient based on the patient's medical condition and history; and

(c) The documentation, if any, that a provider must submit to the organization or risk-bearing entity for the organization or entity to determine the appropriateness of step therapy for a specific patient. [2014 c.55 §6]

414.638 Metrics and scoring subcommittee; identification of outcome and quality measures and benchmarks. (1) There is created in the Health Plan Quality Metrics Committee a nine-member metrics and scoring subcommittee appointed by the Director of the Oregon Health Authority. The members of the subcommittee serve two-year terms and must include:

(a) Three members at large;

(b) Three individuals with expertise in health outcomes measures; and

(c) Three representatives of coordinated care organizations.

(2) The subcommittee shall select, from the health outcome and quality measures identified by the Health Plan Quality Metrics Committee, the health outcome and quality measures applicable to services provided by coordinated care organizations. The Oregon Health Authority shall incorporate these measures into coordinated care organization contracts to hold the organizations accountable for performance and customer satisfaction requirements. The authority shall notify each coordinated care organization of any changes in the measures at least three months before the beginning of the contract period during which the new measures will be in place.

(3) The subcommittee shall evaluate the health outcome and quality measures annually, reporting recommendations based on its findings to the Health Plan Quality Metrics Committee, and adjust the measures to reflect:

(a) The amount of the global budget for a coordinated care organization;

(b) Changes in membership of the organization;

(c) The organization's costs for implementing outcome and quality measures; and

(d) The community health assessment and the costs of the community health assessment conducted by the organization under ORS 414.627.

(4) The authority shall evaluate on a regular and ongoing basis the outcome and quality measures selected by the subcommittee under this section for members in each coordinated care organization and for members statewide. [2011 c.602 §10; 2012 c.8 §21; 2015 c.389 §10]

414.640 [1983 c.590 §4; 1991 c.66 §25; 2003 c.794 §276; 2009 c.595 §318; renumbered 414.615 in 2011]

414.645 Network adequacy; member transfers. (1) A coordinated care organization that contracts with the Oregon Health Authority must maintain a network of providers sufficient in numbers and areas of practice and geographically distributed in a manner to ensure that the health services provided under the contract are reasonably accessible to members.

(2) A member may transfer from one organization to another organization no more than once during each enrollment period. [2011 c.417 §2; 2015 c.27 §43]

414.646 Discrimination based on scope of practice prohibited; appeals; rules. (1) A coordinated care organization may not discriminate with respect to participation in the organization or coverage against any health care provider who is acting within the scope of the provider's license or certification under applicable state law. This section does not require that an organization contract with any health care provider willing to abide by the terms and conditions for participation established by the organization. This section does not prevent an organization from establishing varying reimbursement rates based on quality or performance measures.

(2) An organization may establish an internal review process for a provider aggrieved under this section, including an

alternative dispute resolution or peer review process. An aggrieved provider may appeal the determination of the internal review to the Oregon Health Authority.

(3) The authority shall adopt by rule a process for resolving claims of discrimination under this section and, in making a determination of whether there has been discrimination, must consider the organization's:

(a) Network adequacy;

(b) Provider types and qualifications;

(c) Provider disciplines; and

(d) Provider reimbursement rates.

(4) A prevailing party in an appeal under this section shall be awarded the costs of the appeal. [2012 c.80 §4; 2012 c.80 §5]

414.647 Transfer of 500 or more members of coordinated care organization. (1) The Oregon Health Authority may approve the transfer of 500 or more members from one coordinated care organization to another coordinated care organization if:

(a) The members' provider has contracted with the receiving organization and has stopped accepting patients from or has terminated providing services to members of the transferring organization; and

(b) Members are offered the choice of remaining members of the transferring organization.

(2) Members may not be transferred under this section until the authority has evaluated the receiving organization and determined that the organization meets criteria established by the authority by rule, including but not limited to criteria that ensure that the organization meets the requirements of ORS 414.645 (1).

(3) The authority shall provide notice of a transfer under this section to members that will be affected by the transfer at least 90 days before the scheduled date of the transfer.

(4)(a) The authority may not approve the transfer of members under this section if:

(A) The transfer results from the termination of a provider's contract with a coordinated care organization for just cause; and

(B) The coordinated care organization has notified the authority that the provider's contract was terminated for just cause.

(b) A provider is entitled to a contested case hearing in accordance with ORS chapter 183, on an expedited basis, to dispute the denial of a transfer of members under this subsection.

(c) As used in this subsection, "just cause" means that the contract was terminated for reasons related to quality of care, competency, fraud or other similar reasons prescribed by the authority by rule.

(5) The provider and the organization shall be the parties to any contested case proceeding to determine whether the provider's contract was terminated for just cause. The authority may award attorney fees and costs to the party prevailing in the proceeding, applying the factors in ORS 20.075. [2011 c.417 §3; 2013 c.234 §1; 2015 c.27 §44]

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

414.651 Coordinated care organization contracts; financial reporting; rules. (1)(a) The Oregon Health Authority shall use, to the greatest extent possible, coordinated care organizations to provide fully integrated physical health services, chemical dependency and mental health services and oral health services. This section, and any contract entered into pursuant to this section, does not affect and may not alter the delivery of Medicaid-funded long term care services.

(b) The authority shall execute contracts with coordinated care organizations that meet the criteria adopted by the authority under ORS 414.625. Contracts under this subsection are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235.

(c) The authority shall establish financial reporting requirements for coordinated care organizations. The authority shall prescribe a reporting procedure that elicits sufficiently detailed information for the authority to assess the financial condition of each coordinated care organization and that:

(A) Enables the authority to verify that the coordinated care organization's reserves and other financial resources are adequate to ensure against the risk of insolvency; and

(B) Includes information on the three highest executive salary and benefit packages of each coordinated care organization.

(d) The authority shall hold coordinated care organizations, contractors and providers accountable for timely submission of outcome and quality data, including but not limited to data described in ORS 442.466, prescribed by the authority by rule.

(e) The authority shall require compliance with the provisions of paragraphs (c) and (d) of this subsection as a condition of entering into a contract with a coordinated care organization. A coordinated care organization, contractor or provider that fails to comply with paragraph (c) or (d) of this subsection may be subject to sanctions, including but not limited to civil penalties, barring any new enrollment in the coordinated care organization and termination of the contract.

(f)(A) The authority shall adopt rules and procedures to ensure that if a rural health clinic provides a health service to a member of a coordinated care organization, and the rural health clinic is not participating in the member's coordinated care organization, the rural health clinic receives total aggregate payments from the member's coordinated care 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 contract with providers other than coordinated care organizations to provide integrated and coordinated health care in areas that are not served by a coordinated care organization or where the organization's provider network is inadequate. Contracts authorized by this subsection are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235.

(3) As provided in subsections (1) and (2) of this section, the aggregate expenditures by the authority for health services provided pursuant to ORS 414.631, 414.651 and 414.688 to 414.745 may not exceed the total dollars appropriated for health services under ORS 414.631, 414.651 and 414.688 to 414.745.

(4) Actions taken by providers, potential providers, contractors and bidders in specific accordance with ORS 414.631, 414.651, 414.654 and 414.688 to 414.745 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 414.631, 414.651 and 414.688 to 414.745 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 coordinated care organization shall provide information to a member as prescribed by the authority by rule, including but not limited to written information, within 30 days of enrollment with the coordinated care organization about available providers.

(7) Each coordinated care organization shall work to provide assistance that is culturally and linguistically appropriate to the needs of the member to access appropriate services and participate in processes affecting the member's care and services.

(8) Each coordinated care organization shall provide upon the request of a member or prospective member annual summaries of the organization's aggregate data regarding:

(a) Grievances and appeals; and

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

(9) A coordinated care organization may not limit enrollment in a geographic area based on the zip code of a member or prospective member. [Formerly 414.725; 2015 c.792 §6]

414.652 Coordinated care organization contracts; terms and amendments; 60 days' advance notice. (1) A contract entered into between the Oregon Health Authority and a coordinated care organization under ORS 414.625 (1):

(a) Shall be for a term of five years;

(b) Except as provided in subsection (3) of this section, may not be amended more than once in each 12-month period; and

(c) May be terminated if a coordinated care organization fails to meet outcome and quality measures specified in the contract or is otherwise in breach of the contract.

(2) This section does not prohibit the authority from allowing a coordinated care organization a reasonable amount of time in which to cure any failure to meet outcome and quality measures specified in the contract prior to the termination of the contract.

(3) A contract entered into between the authority and a coordinated care organization may be amended more than once in each 12-month period if:

(a) The authority and the coordinated care organization mutually agree to amend the contract; or

(b) Amendments are necessitated by changes in federal or state law.

(4) The authority must give a coordinated care organization at least 60 days' advance notice of any amendments the authority proposes to existing contracts between the authority and the coordinated care organization, or to contracts to be renewed, including the global budget paid to the coordinated care organization under the contract.

(5) An amendment to a contract may apply retroactively only if:

(a) The amendment does not result in a claim by the authority for the recovery of amounts paid by the authority to the coordinated care organization prior to the date of the amendment; or

(b) The Centers for Medicare and Medicaid Services notifies the authority, in writing, that the amendment is a condition for approval of the contract by the Centers for Medicare and Medicaid Services. [2013 c.535 §2; 2015 c.799 §1; 2016 c.79 §1]

414.653 Alternative payment methodologies. (1) The Oregon Health Authority shall encourage coordinated care organizations to use alternative payment methodologies that:

(a) Reimburse providers on the basis of health outcomes and quality measures instead of the volume of care;

(b) Hold organizations and providers responsible for the efficient delivery of quality care;

(c) Reward good performance;

(d) Limit increases in medical costs; and

(e) Use payment structures that create incentives to:

(A) Promote prevention;

(B) Provide person centered care; and

(C) Reward comprehensive care coordination using delivery models such as patient centered primary care homes and behavioral health homes.

(2) The authority shall encourage coordinated care organizations to utilize alternative payment methodologies that move from a predominantly fee-for-service system to payment methods that base reimbursement on the quality rather than the quantity of services provided.

(3) A coordinated care organization that participates in a national primary care medical home payment model, conducted by the Center for Medicare and Medicaid Innovation in accordance with 42 U.S.C. 1315a, that includes performance-based incentive payments for primary care, shall offer similar alternative payment methodologies to all patient centered primary care homes identified in accordance with ORS 413.259 that serve members of the coordinated care organization.

(4) The authority shall assist and support coordinated care organizations in identifying cost-cutting measures.

(5) If a service provided in a health care facility is not covered by Medicare because the service is related to a health care acquired condition, the cost of the service may not be:

(a) Charged by a health care facility or any health services provider employed by or with privileges at the facility, to a coordinated care organization, a patient or a third-party payer; or

(b) Reimbursed by a coordinated care organization.

(6)(a) Notwithstanding subsections (1) and (2) of this section, until July 1, 2014, a coordinated care organization that contracts with a Type A or Type B hospital or a rural critical access hospital, as described in ORS 442.470, shall reimburse the hospital fully for the cost of covered services based on the cost-to-charge ratio used for each hospital in setting the global payments to the coordinated care organization for the contract period.

(b) The authority shall base the global payments to coordinated care organizations that contract with rural hospitals described in this section on the most recent audited Medicare cost report for Oregon hospitals adjusted to reflect the Medicaid mix of services.

(c) The authority shall identify any rural hospital that would not be expected to remain financially viable if paid in a manner other than as prescribed in paragraphs (a) and (b) of this subsection based upon an evaluation by an actuary retained by the authority. On and after July 1, 2014, the authority may, on a case-by-case basis, require a coordinated care organization to continue to reimburse a rural hospital determined to be at financial risk, in the manner prescribed in paragraphs (a) and (b) of this subsection.

(d) This subsection does not prohibit a coordinated care organization and a hospital from mutually agreeing to reimbursement other than the reimbursement specified in paragraph (a) of this subsection.

(e) Hospitals reimbursed under paragraphs (a) and (b) of this subsection are not entitled to any additional reimbursement for services provided.

(7) Notwithstanding subsections (1) and (2) of this section, coordinated care organizations must comply with federal requirements for payments to providers of Indian health services, including but not limited to the requirements of 42 U.S.C. 1396j and 42 U.S.C. 1396u-2(a)(2)(C). [2011 c.602 §5; 2015 c.798 §12; 2017 c.489 §4]

414.654 Persons served by prepaid managed care health services organizations; funding of health information technology. (1)(a) The Oregon Health Authority shall continue to contract with one or more prepaid managed care health ser-

vices organizations, as defined in ORS 414.025, that are in compliance with contractual obligations owed to the state or local government on July 27, 2015, and that serve:

(A) A geographic area of the state that a coordinated care organization has not been certified to serve; or

(B) Individuals described in ORS 414.631 (2), (3) and (4).

(b) Contracts authorized by this subsection are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235.

(2) Prepaid managed care health services organizations contracting with the authority under this section are subject to the applicable requirements for, and are permitted to exercise the rights of, coordinated care organizations under ORS 414.153, 414.625, 414.635, 414.638, 414.651, 414.655, 414.679, 414.712, 414.728, 414.743, 414.746, 414.760, 416.510 to 416.610, 441.094, 442.464, 655.515, 659.830 and 743B.470.

(3) To facilitate the full adoption of health information technology by coordinated care organizations, patient centered primary care homes and behavioral health homes, the authority shall explore options for assisting providers and coordinated care organizations in funding their use of health information technology. [2011 c.602 §14; 2012 c.8 §2; 2015 c.792 §1; 2015 c.798 §16]

414.655 Utilization of patient centered primary care homes and behavioral health homes by coordinated care organizations. (1) The Oregon Health Authority shall establish standards for the utilization of patient centered primary care homes and behavioral health homes by coordinated care organizations.

(2) Each coordinated care organization shall implement, to the maximum extent feasible, patient centered primary care homes and behavioral health homes, including developing capacity for services in settings that are accessible to families, diverse communities and underserved populations, including the provision of integrated health care. The organization shall require its other health and services providers to communicate and coordinate care with the patient centered primary care home or behavioral health home in a timely manner using electronic health information technology.

(3) Standards established by the authority for the utilization of patient centered primary care homes and behavioral health homes by coordinated care organizations may require the use of federally qualified health centers, rural health clinics, school-based health clinics and other safety net providers that qualify as patient centered primary care homes or behavioral health homes to ensure the continued critical role of those providers in meeting the needs of underserved populations.

(4) In order to promote the full integration of behavioral health and physical health services in primary care, behavioral health care and urgent care settings, providers in patient centered primary care homes and behavioral health homes may use billing codes applicable to the behavioral health and physical health services that are provided.

(5) Each coordinated care organization shall report to the authority on uniform quality measures prescribed by the authority by rule for patient centered primary care homes and behavioral health homes.

(6) Patient centered primary care homes and behavioral health homes must participate in the learning collaborative described in ORS 413.259 (3). [2011 c.602 §6; 2015 c.798 §5]

414.660 [1983 c.590 §5; 1985 c.747 §3; 1991 c.66 §27; 2009 c.11 §57; repealed by 2009 c.595 §1204]

414.661 External quality reviews of coordinated care organizations; limits on documentation and reporting requirements. (1) As used in this section:

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

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

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

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

(4) The authority or a contracted review organization may not request information from a coordinated care organization that is duplicative of or redundant with information previously provided by the coordinated care organization or a subcontractor if the information was provided within the preceding

12-month period and the relevant content of the information has not changed.

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

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

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

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

(c) Permit the authority or a contracted review organization to disclose to a coordinated care organization confidential or proprietary information reported to the authority or contracted review organization by another coordinated care organization or a subcontractor. [2015 c.552 §1]

Note: 414.661 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.

414.665 Traditional health workers utilized by coordinated care organizations; rules. (1) As used in this section, "traditional health worker" includes any of the following:

(a) A community health worker.

(b) A personal health navigator.

(c) A peer wellness specialist.

(d) A peer support specialist.

(e) A doula.

(2) In consultation with the Traditional Health Workers Commission established under ORS 413.600, the Oregon Health Authority, for purposes related to the regulation of traditional health workers, shall adopt by rule:

(a) The qualification criteria, including education and training requirements, for the traditional health workers utilized by coordinated care organizations;

(b) Appropriate professional designations for supervisors of the traditional health workers; and

(c) Processes by which other occupational classifications may be approved to supervise the traditional health workers.

(3) The criteria and requirements established under subsection (2) of this section:

(a) Must be broad enough to encompass the potential unique needs of any coordinated care organization;

(b) Must meet requirements of the Centers for Medicare and Medicaid Services to qualify for federal financial participation; and

(c) May not require certification by the Home Care Commission. [2011 c.602 §11; 2013 c.752 §4; 2017 c.618 §5]

414.667 Definition for ORS 414.667, 414.668 and 414.768. As used in ORS 414.667, 414.668 and 414.768, "doula" means an individual who meets criteria for a doula adopted by the Oregon Health Authority in accordance with ORS 414.665. [2017 c.281 §2]

414.668 Access to doula services. A coordinated care organization shall make information about how to access doula services available on a website operated by or on behalf of the coordinated care organization and shall provide the information in print whenever a printed explanation of benefits is available. [2017 c.281 §4]

Note: Sections 6 and 8, chapter 281, Oregon Laws 2017, provide:

Sec. 6. (1) The Oregon Health Authority shall provide to the Oregon Health Policy Board and the Oregon Public Health Advisory Board, and shall make available free of charge on the primary website operated by or on behalf of the authority, a report on the status of doulas in this state. The report must include, but not be limited to, information on:

(a) The number of claims for reimbursement of doulas submitted to the authority and the percentage of those claims that are reimbursed;

(b) Any barriers experienced by doulas to accessing the claims process;

(c) The annual increase or decrease in the number of doulas listed on a registry managed by the authority;

(d) The demographics of the registry of doulas managed by the authority;

(e) Doula training or certification programs offered in this state;

(f) The relationship between the registry of doulas managed by the authority and the perceived doula workforce need; and

(g) Recommendations on achieving cultural specificity goals for doula services.

(2) The authority shall provide the report required by subsection (1) of this section annually beginning on September 15, 2018. [2017 c.281 §6]

Sec. 8. Section 6 of this 2017 Act is repealed on January 1, 2024. [2017 c.281 §8]

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

414.679 Use and disclosure of member information; access by member to personal health information. (1) The Oregon

Health Authority shall ensure the appropriate use of member information by coordinated care organizations, including the use of electronic health information and administrative data that is available when and where the data is needed to improve health and health care through a secure, confidential health information exchange.

(2) A member of a coordinated care organization must have access to the member's personal health information in the manner provided in 45 C.F.R. 164.524 so the member can share the information with others involved in the member's care and make better health care and lifestyle choices.

(3) Notwithstanding ORS 179.505, a coordinated care organization, its provider network and programs administered by the Department of Human Services for seniors and persons with disabilities shall use and disclose member information for purposes of service and care delivery, coordination, service planning, transitional services and reimbursement, in order to improve the safety and quality of care, lower the cost of care and improve the health and well-being of the organization's members.

(4) A coordinated care organization and its provider network shall use and disclose sensitive diagnosis information including HIV and other health and mental health diagnoses, within the coordinated care organization for the purpose of providing whole-person care. Individually identifiable health information must be treated as confidential and privileged information subject to ORS 192.553 to 192.581 and applicable federal privacy requirements. Redisclosure of individually identifiable information outside of the coordinated care organization and the organization's providers for purposes unrelated to this section or the requirements of ORS 413.032, 414.625, 414.632, 414.635, 414.638, 414.653 or 414.655 remains subject to any applicable federal or state privacy requirements.

(5) This section does not prohibit the disclosure of information between a coordinated care organization and the organization's provider network, and the Oregon Health Authority and the Department of Human Services for the purpose of administering the laws of Oregon.

(6) The Health Information Technology Oversight Council shall develop readily available informational materials that can be used by coordinated care organizations and providers to inform all participants in the health care workforce about the appropriate uses and limitations on disclosure of electronic health records, including need-based access and privacy mandates. [2011 c.602 §12; 2015 c.389 §11]

414.685 Coordination between Oregon Health Authority and Department of Human Services. (1) The Oregon Health Authority and the Department of Human Services shall cooperate with each other by coordinating actions and responsibilities necessary to implement the Oregon Integrated and Coordinated Health Care Delivery System established in ORS 414.620.

(2) The authority and the department may delegate to each other any duties, functions or powers that the authority or department are authorized to perform if necessary to carry out ORS 414.625, 414.632, 414.635, 414.638, 414.653, 414.654, 414.655, 414.665, 414.679 and 414.685. [2011 c.602 §15; 2017 c.17 §34]

414.686 Health assessments for foster children. (1) A coordinated care organization shall provide an initial health assessment on any child enrolled in the coordinated care organization who is in the custody of the Department of Human Services no later than 60 days after the date that the Oregon Health Authority notifies the coordinated care organization that the child has been taken into the department's custody. The assessment must be performed in accordance with metrics established by the metrics and scoring subcommittee created in ORS 414.638.

(2) If a child has not received an initial health assessment by the date specified in subsection (1) of this section, the coordinated care organization shall act affirmatively to locate the child and make arrangements for an initial health assessment. [2017 c.277 §2]

Note: Section 3, chapter 277, Oregon Laws 2017, provides:

Sec. 3. (1) Each coordinated care organization shall report to the Oregon Health Authority aggregate data specified by the authority that is expected to identify barriers to coordinated care organizations' ability to comply with section 2 of this 2017 Act [414.686]. The authority shall collect and compile the data reported and use the data to develop and implement changes to address the barriers to compliance.

(2) The authority shall report to the interim committees of the Legislative Assembly related to health:

(a) The rate of compliance with section 2 of this 2017 Act by each coordinated care organization; and

(b) The steps taken by the authority, the Department of Human Services and coordinated care organizations to improve the rates of compliance.

(3) The authority shall submit the report described in subsection (2) of this section no later than September 15, 2018, and shall provide an updated report 12 months later. [2017 c.277 §3]

(Health Evidence Review Commission)

414.688 Commission established; membership. (1) As used in this section:

(a) "Practice of pharmacy" has the meaning given that term in ORS 689.005.

(b) "Retail drug outlet" has the meaning given that term in ORS 689.005.

(2) The Health Evidence Review Commission is established in the Oregon Health Authority, consisting of 13 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 areas of family medicine, internal medicine, obstetrics, perinatal health, pediatrics, disabilities, geriatrics or general surgery. One of the physicians must be a doctor of osteopathic medicine, and one must be a hospital representative or a physician whose practice is significantly hospital-based.

(b) One member must be a dentist licensed under ORS chapter 679 who has clinical expertise in general, pediatric or public health dentistry.

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

(d) One member must be a behavioral health representative who may be a social services worker, alcohol and drug treatment provider, psychologist or psychiatrist.

(e) Two members must be consumers of health care who are patient advocates or represent the areas of indigent services, labor, business, education or corrections.

(f) One member must be a complementary or alternative medicine provider who is a chiropractic physician licensed under ORS chapter 684, a naturopathic physician licensed under ORS chapter 685 or an acupuncturist licensed under ORS chapter 677.

(g) One member must be an insurance industry representative who may be a medical director or other administrator.

(h) One member must be a pharmacy representative who engages in the practice of pharmacy at a retail drug outlet.

(3) No more than six members of the commission may be physicians either in active practice or retired from practice.

(4) Members of the commission serve for a term of four years at the pleasure of the Governor. A member is eligible for reappointment.

(5) 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 Health Authority for purposes of the commission. [2011 c.720 §22; 2017 c.409 §10]

414.689 Members; meetings. (1) The Health Evidence Review Commission shall select one of its members as chairperson and another as vice chairperson, for terms and with duties and powers the commission determines necessary for the performance of the functions of the offices.

(2) A majority of the members of the commission constitutes a quorum for the transaction of business.

(3) The commission shall meet at least four times per year at a place, day and hour determined by the chairperson. The commission also shall meet at other times and places specified by the call of the chairperson or of a majority of the members of the commission.

(4) The commission may use advisory committees or subcommittees whose members are appointed by the chairperson of the commission subject to approval by a majority of the members of the commission. The advisory committees or subcommittees may contain experts appointed by the chairperson and a majority of the members of the commission. The conditions of service of the experts will be determined by the chairperson and a majority of the members of the commission.

(5) The Oregon Health Authority shall provide staff and support services to the commission. [2011 c.720 §23; 2015 c.318 §22]

414.690 Prioritized list of health services. (1) The Health Evidence Review Commission shall regularly solicit testimony and information from stakeholders representing consumers, advocates, providers, carriers and employers in conducting the work of the commission.

(2) The commission shall actively solicit public involvement through a public meeting process to guide health resource allocation decisions.

(3) The commission shall develop and maintain 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 population to be served. The list must be submitted by the commission pursuant to subsection (5) of this section and is not subject to alteration by any other state agency.

(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) May include statements of intent in its prioritized list of services. Statements of intent should give direction on coverage decisions where medical codes and clinical practice guidelines cannot convey the intent of the commission.

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

(5) The commission shall report the prioritized list of services to the Oregon Health Authority for budget determinations by July 1 of each even-numbered year.

(6) The commission shall make its report during 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.

(7) The commission may alter the list during the interim only as follows:

(a) To make technical changes to correct errors and omissions;

(b) To accommodate changes due to advancements in medical technology or new data regarding health outcomes;

(c) To accommodate changes to clinical practice guidelines; and

(d) To add statements of intent that clarify the prioritized list.

(8) If a service is deleted or added during an interim 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 shall report to the Emergency Board to request the funding.

(9) The prioritized list of services remains in effect for a two-year period beginning no earlier than October 1 of each odd-numbered year. [2011 c.720 §24]

414.694 Commission review of covered reproductive health services. The Health Evidence Review Commission shall review the coverage described in ORS 743A.067 (2) and, no later than November 1 of each even-numbered year, report to the interim committees of the Legislative Assembly related to health any recommended changes to the coverage described in ORS 743A.067 (2) based upon the latest clinical research. [2017 c.721 §9]

Note: 414.694 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.

414.695 Medical technology assessment. (1) As used in this section and ORS 414.698:

(a) "Medical technology" means medical equipment and devices, medical or surgical procedures and techniques used by health care providers in delivering medical care to individuals, and the organizational or supportive systems within which medical care is delivered.

(b) "Medical technology assessment" means evaluation of the use, clinical effectiveness and cost of a technology in comparison with its alternatives.

(2) The Health Evidence Review Commission shall develop a medical technology assessment process. The Oregon Health Authority shall direct the commission with regard to medical technologies to be assessed and the timing of the assessments.

(3) The commission shall appoint and work with an advisory committee whose members have the appropriate expertise to conduct a medical technology assessment.

(4) The commission shall present its preliminary findings at a public hearing and shall solicit testimony and information from health care consumers. The commission shall give strong consideration to the recommendations of the advisory committee and public testimony in developing its assessment.

(5) To ensure that confidentiality is maintained, identification of a patient or a person licensed to provide health services may not be included with the data submitted under this section, and the commission shall release such data only in aggregate statistical form. All findings and conclusions, interviews, reports, studies, communications and statements procured by or furnished to the commission in connection with obtaining the data necessary to perform its functions is confidential pursuant to ORS 192.338, 192.345 and 192.355. [2011 c.720 §25]

Note: 414.695 to 414.701 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.

414.698 Comparative effectiveness of medical technologies. (1) The Health Evidence Review Commission shall conduct comparative effectiveness research of medical technologies selected in accordance with ORS 414.695. The commission may conduct the research by comprehensive review of the comparative effectiveness research undertaken by recognized state, national or international entities. The commission may consider evidence relating to prescription drugs that is relevant to a medical technology assessment but may not conduct a drug class evidence review or medical technology

assessment solely of a prescription drug. The commission shall disseminate the research findings to health care consumers, providers and third-party payers and to other interested stakeholders.

(2) The commission shall develop or identify and shall disseminate evidence-based health care guidelines for use by providers, consumers and purchasers of health care in Oregon.

(3) The Oregon Health Authority shall vigorously pursue health care purchasing strategies that adopt the research findings described in subsection (1) of this section and the evidence-based health care guidelines described in subsection (2) of this section. [2011 c.720 §26]

Note: See note under 414.695.

414.701 Commission may not rely solely on comparative effectiveness research. The Health Evidence Review Commission, in ranking health services or developing guidelines under ORS 414.690 or in assessing medical technologies under ORS 414.698, and the Pharmacy and Therapeutics Committee, in considering a recommendation for a drug to be included on any preferred drug list or on the Practitioner-Managed Prescription Drug Plan, may not rely solely on the results of comparative effectiveness research. [2011 c.720 §26a]

Note: See note under 414.695.

414.704 Advisory committee. The Health Evidence Review Commission shall consult with an advisory committee in determining priorities for mental health care and chemical dependency. The advisory committee shall include mental health and chemical dependency professionals who provide inpatient and outpatient mental health and chemical dependency care. [Formerly 414.730]

414.705 [1989 c.836 §2; 1991 c.753 §4; 2003 c.735 §1; 2003 c.810 §7; repealed by 2011 c.602 §§64,70]

SCOPE OF COVERED HEALTH SERVICES

414.706 Persons eligible for medical assistance; rules. Within available funds and subject to the rules of the Oregon Health Authority, medical assistance shall be provided to an individual who is a resident of this state and who:

(1) Is receiving a category of aid;

(2) Would be eligible for a category of aid but is not receiving a category of aid;

(3) 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; and

(4) Is not described in subsection (3) of this section but for whom federal funding is available under Title XIX or XXI of the Social Security Act. [2003 c.735 §3; 2009 c.867 §37; 2011 c.602 §41; 2013 c.688 §77]

414.707 [2003 c.735 §4; 2009 c.595 §319; 2009 c.867 §44; 2011 c.602 §42; 2011 c.720 §143; repealed by 2013 c.688 §98]

414.708 [2003 c.735 §11; 2005 c.381 §16; 2007 c.70 §194; 2009 c.595 §320; 2011 c.720 §144; repealed by 2013 c.688 §98]

414.709 Adjustment of population of eligible persons in event of insufficient resources prohibited. 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. [2003 c.735 §4a; 2009 c.595 §321; 2013 c.688 §78]

414.710 Services not subject to prioritized list. The following services are not subject to ORS 414.690:

(1) Nursing facilities, institutional and home- and community-based waivered services 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; 2011 c.720 §145]

414.712 Health services for certain eligible persons. The Oregon Health Authority shall provide health services under ORS 414.631, 414.651 and 414.688 to 414.745 to eligible persons who are determined eligible for medical assistance as defined in ORS 414.025. The Oregon Health Authority shall also provide the following:

(1) Ombudsman services for individuals who receive medical assistance under ORS 411.706 and for recipients who are members of coordinated care organizations. 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 recipient's advocate whenever the recipient or a physician or other medical personnel serving the recipient is reasonably concerned about access to, quality of or limitations on the care being provided by a health care provider or a coordinated care organization. Recipients 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 and coordinated care organizations.

(2) Case management services in each health care provider organization or coordinated care organization for those individuals 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 individuals who receive assistance under ORS 411.706. Case managers shall be reasonably available to assist recipients served by the organization with the coordination of the recipient's health services at the reasonable request of the recipient or a physician or other medical personnel serving the recipient. Recipients 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 recipient's medical needs require swift resolution of a dispute. An ombudsman described in subsection (1) of this section may not act as the recipient's representative during any grievance or hearing process. [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; 2011 c.602 §25; 2011 c.720 §146]

414.715 [1989 c.836 §4; 1991 c.753 §12; 2009 c.469 §1; repealed by 2011 c.720 §228]

414.720 [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; 2011 c.545 §48; repealed by 2011 c.720 §228]

414.721 [2009 c.867 §16; 2009 c.828 §50; repealed by 2015 c.70 §18]

414.725 [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; 2011 c.602 §26; renumbered 414.651 in 2011]

414.727 [1997 c.642 §2; 1999 c.546 §2; 2005 c.806 §2; 2009 c.595 §326; 2013 c.688 §79; repealed by 2015 c.792 §14]

414.728 Reimbursement of rural hospitals on fee-for-service basis. For services provided on a fee-for-service basis to persons who are entitled to receive medical assistance, 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; 2011 c.602 §43]

414.730 [1989 c.836 §7; 1995 c.79 §209; 2005 c.22 §286; 2011 c.720 §148; renumbered 414.704 in 2011]

414.735 Reduction in scope of health services 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 may not be reduced.

(b) The reimbursement rate for providers and plans established under the contractual agreement may 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 Evidence Review Commission, starting with the least important and progressing toward the most important.

(3) The Oregon Health Authority 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 414.631, 414.651 and 414.688 to 414.745 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; 2011 c.720 §149]

414.736 [2003 c.810 §2; 2009 c.595 §329; 2009 c.867 §47; 2009 c.886 §6; 2011 c.417 §4; 2011 c.602 §45; 2011 c.720 §150; 2013 c.688 §80; 2015 c.3 §46; 2015 c.27 §45; 2015 c.792 §7; 2015 c.798 §13; 2017 c.273 §7; 2017 c.618 §7; repealed by 2011 c.602 §§64,70, 2012 c.8 §23 and 2015 c.792 §2]

414.737 [2003 c.810 §3; 2007 c.751 §8; 2009 c.595 §§330,331; 2011 c.602 §§27,28; renumbered 414.631 in 2011]

414.738 [2003 c.810 §5; 2009 c.595 §332; 2015 c.318 §23; repealed by 2011 c.602 §§64,70, 2012 c.8 §23 and 2015 c.792 §2]

414.739 [2003 c.810 §5a; 2009 c.595 §333; 2015 c.318 §24; repealed by 2011 c.602 §§64,70, 2012 c.8 §23 and 2015 c.792 §2]

414.740 [2003 c.810 §6; 2009 c.595 §334; 2012 c.8 §26; 2013 c.688 §81; 2015 c.3 §47; 2015 c.798 §14; 2017 c.273 §8;

2017 c.618 §8; repealed by 2011 c.602 §§64,70; 2012 c.8 §23 and 2015 c.792 §2]

414.741 [2003 c.810 §9; 2009 c.595 §335; repealed by 2011 c.720 §228]

414.742 Payment for mental health drugs. The Oregon Health Authority may not establish capitation rates or global budgets 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; 2011 c.602 §46]

414.743 Payment to noncontracting hospital by coordinated care organization; rules. (1) Except as provided in subsection (2) of this section, a coordinated care organization that does not have a contract with a hospital to provide inpatient or outpatient hospital services under ORS 414.631, 414.651 and 414.688 to 414.745 must, using Medicare payment methodology, reimburse the noncontracting hospital for services provided to a member of the organization 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 four percentage points less than the percentage of Medicare cost used by the Oregon Health Authority in calculating the base hospital capitation payment to the organization, excluding any supplemental payments.

(2)(a) If a coordinated care organization does not have a contract with a hospital, and the hospital provides less than 10 percent of the hospital admissions and outpatient hospital services to members of the organization, the percentage of the Medicare reimbursement rate that is used to determine the reimbursement rate under subsection (1) of this section is equal to two percentage points less than the percentage of Medicare cost used by the Oregon Health Authority in calculating the base hospital capitation payment to the organization, excluding any supplemental payments.

(b) This subsection is not intended to discourage a coordinated care organization and a hospital from entering into a contract and is intended to apply to hospitals that provide primarily, but not exclusively, specialty and emergency care to members of the organization.

(3) A hospital that does not have a contract with a coordinated care organization to provide inpatient or outpatient hospital services under ORS 414.631, 414.651 and 414.688 to 414.745 must accept as payment in full for hospital services the rates described in subsections (1) and (2) of this section.

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

(5) 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; 2011 c.602 §§47,71; 2015 c.27 §46; 2017 c.718 §8]

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 414.631, 414.651 and 414.688 to 414.745 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]

414.746 [2009 c.867 §15; 2009 c.828 §49; 2011 c.602 §48; 2013 c.608 §11; repealed by 2013 c.608 §12]

414.747 [2003 c.810 §15; renumbered 414.326 in 2011]

414.750 [1989 c.836 §18; 1991 c.753 §11; 2009 c.595 §340; repealed by 2013 c.688 §98]

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

414.755 Payment for hospital services. 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]

Note: Section 41, chapter 538, Oregon Laws 2017, provides:

Sec. 41. The Oregon Health Authority shall ensure that the Oregon Health and Science University receives net reimbursement of at least 84 percent but no more than 100 percent of the university's costs of providing services that are paid for, in whole or in part, with Medicaid funds. Net reimbursement means all Medicaid payments less any amount that is transferred by the university to the authority. [2017 c.538 §41]

Note: Section 41, chapter 538, Oregon Laws 2017, becomes operative on the later of January 1, 2018, or the date that the Centers for Medicare and Medicaid Services approves certain amendments to sections 1 and 2, chapter 736, Oregon Laws 2003, by sections 26 and 28, chapter 538, Oregon Laws 2017. See section 44, chapter 538, Oregon Laws 2017.

414.760 Payment for patient centered primary care home and behavioral health home services. (1) The Oregon Health Authority shall provide reimbursement in the state's medical assistance program for ser-

vices provided by patient centered primary care homes and behavioral health homes. If practicable, efforts to align financial incentives to support patient centered primary care homes and behavioral health homes for enrollees in medical assistance programs should be aligned with efforts of the learning collaborative described in ORS 413.259 (3).

(2) The authority shall require each coordinated care organization, to the extent practicable, to offer patient centered primary care homes and behavioral health homes that meet the standards established in ORS 414.655.

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

(4) The authority shall require patient centered primary care homes and behavioral health homes receiving these reimbursements to report on quality measures described in ORS 413.259 (1)(c). [2009 c.595 §1164; 2011 c.602 §29; 2015 c.798 §15]

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.

414.762 Payment for child abuse medical assessment. (1) As used in this section:

(a) "Child abuse medical assessment" has the meaning given that term in ORS 418.782.

(b) "Community assessment center" has the meaning given that term in ORS 418.782.

(2) The Oregon Health Authority shall reimburse a community assessment center for the services the center provides:

(a) In conducting a child abuse medical assessment of a child who is eligible for medical assistance; and

(b) That are related to the child abuse medical assessment including, but not limited to:

(A) A forensic interview; and

(B) Mental health treatment.

(3) The authority shall adopt billing and payment mechanisms to ensure that the reimbursement is proportionate to the scope and intensity of the services provided by the community assessment center. [2015 c.100 §2]

414.764 Payment for services provided by pharmacy or pharmacist. (1) The Oregon Health Authority may reimburse a pharmacist or pharmacy for any health service:

(a) Provided to a medical assistance recipient who is not enrolled in a coordinated care organization or a prepaid managed care health services organization;

(b) That is within the lawful scope of practice of a pharmacist; and

(c) If the authority determines the service is within the types and extent of health care and services to be provided to medical assistance recipients under ORS 414.065.

(2) A coordinated care organization may reimburse a pharmacist or pharmacy for any health service:

(a) Provided to a medical assistance recipient who is enrolled in the coordinated care organization or a prepaid managed care health services organization that enters into a clinical pharmacy agreement with the pharmacist or pharmacy; and

(b) That is within the lawful scope of practice of a pharmacist. [2015 c.362 §6]

414.766 Behavioral health treatment; rules. Notwithstanding ORS 414.065 and 414.690, a coordinated care organization must provide behavioral health services to its members that include but are not limited to all of the following:

(1) For a member who is experiencing a behavioral health crisis:

(a) A behavioral health assessment; and

(b) Services that are medically necessary to transition the member to a lower level of care;

(2) At least the minimum level of services that are medically necessary to treat a member's behavioral health condition as determined in a behavioral health assessment of the member or specified in the member's care plan; and

(3) Coordinated care and case management as defined by the Department of Consumer and Business Services by rule. [2017 c.273 §2]

414.768 Payment for doula services. The Oregon Health Authority, in coordination with the Traditional Health Workers Commission, shall in each even-numbered year review, and revise if necessary, any rates of reimbursement for doulas. When reviewing and revising rates of reimbursement, the authority shall consider factors including retention of doulas, access to culturally specific doulas and evidence-based factors and empirical studies related to the cost-effectiveness of services provided by doulas. [2017 c.281 §3]

Note: Section 7, chapter 281, Oregon Laws 2017, provides:

Sec. 7. The Oregon Health Authority shall first perform the review required by section 3 of this 2017 Act [414.768] in 2020. [2017 c.281 §7]

414.770 Participants in clinical trials. (1) As used in this section:

(a) "Approved clinical trial" has the meaning given that term in ORS 743A.192.

(b) "Routine health care":

(A) Means the types and extent of health care and services that the Oregon Health Authority requires to be provided in medical assistance in accordance with ORS 414.065.

(B) Does not include:

(i) The drug, device or service being tested in an approved clinical trial, unless a coordinated care organization would provide or pay for the drug, device or service if provided to a member who is not enrolled in an approved clinical trial;

(ii) Items or services required solely for the provision of the drug, device or service being tested in an approved clinical trial;

(iii) Items or services required solely for the clinically appropriate monitoring of the drug, device or service being tested in an approved clinical trial;

(iv) Items or services that are provided solely to satisfy data collection and analysis needs associated with an approved clinical trial and that are not used in the direct clinical management of the member; or

(v) Items or services customarily provided by a clinical trial sponsor free of charge to any participant in an approved clinical trial.

(2) A coordinated care organization may not discriminate against a member on the basis of the member's participation in an approved clinical trial by:

(a) Denying the provision of or payment for routine health care; or

(b) Excluding, limiting or imposing additional conditions on the provision of or payment for routine health care furnished in connection with the member's participation in an approved clinical trial.

(3) A coordinated care organization that provides routine health care to a member enrolled in an approved clinical trial is not, based on the provision of that care, liable for any adverse effects of the approved clinical trial. [2016 c.26 §5]

Note: Sections 10 and 14, chapter 721, Oregon Laws 2017, provide:

Sec. 10. (1) As used in this section, "health benefit plan" has the meaning given that term in section 2 of this 2017 Act [743A.067].

(2) In consultation with the Department of Consumer and Business Services, the Oregon Health Authority shall design a program to provide statewide access to abortion coverage for Oregon residents enrolled in health benefit plans described in section 2 (7)(e) and (9) of this 2017 Act.

(3) In developing the design of the program described in subsection (2) of this section, the authority and the department shall consult with consumer advocates, insurers transacting insurance in this state that offer the health benefit plans described in section 2 (7)(e) and (9) of this 2017 Act and other stakeholders.

(4) The authority, in collaboration with the department, shall:

(a) If funding is available, take any actions authorized by state law to implement the program described in subsection (2) of this section; and

(b) Not later than November 1, 2017, report to the Speaker of the House of Representatives, the President of the Senate and the interim committees of the Legislative Assembly related to health:

(A) Any actions taken by the authority under paragraph (a) of this subsection; and

(B) Recommendations for legislative changes necessary to fully implement the program described in subsection (2) of this section. [2017 c.721 §10]

Sec. 14. Section 10 of this 2017 Act is repealed on January 2, 2019. [2017 c.721 §14]

Note: Sections 1 and 3, chapter 95, Oregon Laws 2014, provide:

Sec. 1. Durable medical equipment pilot project. (1) As used in this section:

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

(b) "Durable medical equipment" means equipment that is primarily and customarily used for a medical purpose, can withstand repeated use and is appropriate for use in the home.

(c) "Equipment" means durable medical equipment that was donated by an individual or organization.

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

(2) The Oregon Health Authority shall contract with one or more nonprofit organizations to operate a pilot project to test whether the authority and coordinated care organizations can achieve good outcomes for individuals who receive medical assistance by reusing durable medical equipment in a safe, functionally appropriate and cost-effective manner. The pilot project does not supplant the durable medical equipment coverage provided by the medical assistance program. The pilot project shall serve recipients of medical assistance who reside in Washington, Multnomah, Clackamas, Umatilla, Marion and Polk Counties. The pilot project may be expanded as the authority deems appropriate.

(3) The pilot project must have all of the following elements:

(a) The capacity to receive, store and transport used equipment.

(b) A web-based, searchable and regularly updated inventory of the equipment that is available for reuse.

(c) A strategy to facilitate sufficient and appropriate equipment donations.

(d) Procedures, adopted by the authority by rule, to ensure that:

(A) Reused equipment is safe and functionally appropriate;

(B) Reused equipment is properly cleaned, sanitized, repaired, refurbished and reconfigured;

(C) There is a streamlined and user-friendly process for requesting equipment, processing the requests, checking the status of requests and maintaining records of requests and distributions of equipment;

(D) The nonprofit organizations properly dispose of equipment or salvage parts from equipment if the equipment is unsuitable for reuse; and

(E) Assistive technology professionals or other appropriately licensed or certified providers, acting in accordance with quality standards adopted by the authority, have the responsibility to:

(i) Assess each individual's needs for equipment, consult with and advise the individual and the individual's care provider in the selection of equipment and continue to be available after the delivery of reused equipment to provide timely support, repairs and adjustments; and

(ii) Inspect, adjust, refurbish and fit the reused equipment.

(e) Limits of liability comparable to other providers of services to medical assistance recipients.

(4) The authority shall develop and collect data, including feedback from coordinated care organizations, consumers and health care providers, and analyze the data to assess the success of the pilot project and report the results of the assessment to the Seventy-eighth Legislative Assembly no later than February 1, 2016. The authority shall continue to report annually to the Legislative Assembly until the end of the pilot project.

(5) The authority shall reimburse the nonprofit organizations operating the pilot project, on a fee-for-service basis, for the costs of providing, delivering and servicing each item of equipment provided to individuals eligible for medical assistance who are not members of coordinated care organizations. The authority shall adopt the reimbursement rates by rule.

(6) The authority shall take all actions necessary to implement the pilot project no later than October 1, 2014.

(7) The authority may apply for and receive gifts or grants from any public or private source for the purpose of carrying out this section. [2014 c.95 §1]

Sec. 3. Section 1 of this 2014 Act is repealed April 20, 2018. [2014 c.95 §3]

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) 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:

(A) 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; or

(B) An authorized tribal police officer as defined ORS 181A.680.

(b) "Public agency" means the state, a city, university that has established a police department under ORS 352.121 or 353.125, port, school district, mass transit district or county. [1991 c.778 §7; 2007 c.71 §105; 2009 c.595 §342; 2011 c.506 §37; 2011 c.644 §§29,52; 2013 c.180 §§38,39; 2015 c.174 §20]

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 allocated to the account from the Criminal Fine Account, 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 odd-numbered year regular session of the Legislative Assembly, 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; 2011 c.545 §49; 2011 c.597 §62]

Note: See note under 414.805.

414.820 [Formerly 414.050; renumbered 566.320]

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 [2001 c.898 §3; 2003 c.14 §198; repealed by 2013 c.365 §9 and 2013 c.640 §16]

414.826 [2009 c.867 §30; 2011 c.700 §1; 2013 c.681 §49; 2015 c.3 §48; repealed by 2013 c.365 §9 and 2013 c.640 §16]

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

414.828 [2009 c.867 §31; 2013 c.681 §50; repealed by 2013 c.365 §9 and 2013 c.640 §16]

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 [2001 c.898 §5a; 2003 c.14 §201; 2003 c.684 §6; 2005 c.744 §37; repealed by 2013 c.681 §65 and 2013 c.640 §21]

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]

PREMIUM ASSISTANCE

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 medical assistance described in ORS 414.115. [2001 c.898 §11; 2003 c.14 §206; 2003 c.684 §7; 2003 c.735 §9; 2009 c.595 §344a; 2009 c.867 §38; 2013 c.365 §2; 2013 c.681 §51]

Note: 414.839 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.

414.840 [Formerly 414.070; renumbered 566.340]

414.841 [Formerly 735.720; 2011 c.70 §1; 2011 c.700 §2; repealed by 2013 c.681 §65 and 2013 c.640 §21]

414.842 [Formerly 735.722; 2011 c.70 §2; 2011 c.700 §6; repealed by 2013 c.681 §65 and 2013 c.640 §21]

414.844 [Formerly 735.724; 2011 c.70 §3; repealed by 2013 c.681 §65 and 2013 c.640 §21]

414.846 [Formerly 735.726; repealed by 2013 c.681 §65 and 2013 c.640 §21]

414.848 [Formerly 735.728; repealed by 2013 c.681 §65 and 2013 c.640 §21]

414.850 [Formerly 414.080; renumbered 566.350]

414.851 [Formerly 735.730; 2011 c.700 §4; repealed by 2013 c.681 §65 and 2013 c.640 §21]

414.852 [Formerly 735.731; repealed by 2013 c.681 §65 and 2013 c.640 §21]

414.854 [Formerly 735.732; repealed by 2013 c.681 §65 and 2013 c.640 §21]

414.856 [Formerly 735.733; repealed by 2013 c.681 §65 and 2013 c.640 §21]

414.858 [Formerly 735.734; repealed by 2013 c.681 §65 and 2013 c.640 §21]

414.860 [Formerly 414.090; renumbered 566.360]

414.861 [Formerly 735.736; repealed by 2013 c.681 §65 and 2013 c.640 §21]

414.862 [Formerly 735.738; repealed by 2013 c.681 §65 and 2013 c.640 §21]

414.864 [Formerly 735.740; 2011 c.70 §4; repealed by 2013 c.681 §65 and 2013 c.640 §21]

414.866 [Formerly 735.750; 2011 c.70 §5; repealed by 2013 c.681 §65, 2013 c.640 §21 and 2013 c.688 §98]

414.868 [Formerly 735.752; 2011 c.70 §6; repealed by 2013 c.681 §65, 2013 c.640 §§20,21, 2013 c.688 §98 and 2013 c.698 §42]

414.870 [Formerly 735.754; repealed by 2013 c.681 §65, 2013 c.640 §21 and 2013 c.688 §98]

414.872 [Formerly 735.756; repealed by 2013 c.681 §65, 2013 c.640 §§20,21, 2013 c.688 §98 and 2013 c.698 §42]

PROVIDER ASSESSMENT

Note: Sections 1 to 3, 5 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)(a) "Hospital" means a hospital licensed under ORS chapter 441.

(b) "Hospital" does not include:

(A) Special inpatient care facilities;

(B) Hospitals that provide only psychiatric care;

(C) Pediatric specialty hospitals providing care to children at no charge; and

(D) Public hospitals other than hospitals created by health districts under ORS 440.315 to 440.410.

(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, 24 and 29, chapter 736, Oregon Laws 2003.

(5) "Type A hospital" has the meaning given that term in ORS 442.470.

(6) "Type B hospital" has the meaning given that term in ORS 442.470. [2003 c.736 §1; 2009 c.792 §34; 2017 c.538 §26]

Note: Operation of the amendments to section 1, chapter 736, Oregon Laws 2003, by section 26, chapter 538, Oregon Laws 2017, is dependent upon federal approval of specified changes to the hospital assessment. If approval is received, the amendments become operative on the later of January 1, 2018, or the date of approval. See section 44, chapter 538, Oregon Laws 2017. The text that is operative until January 1, 2018, until the date of approval or if approval is denied is set forth below.

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.

Sec. 2. (1) An assessment is imposed on the net revenue of each hospital in this state. 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) In addition to the assessment imposed by subsection (1) of this section, an assessment of 0.7 percent is imposed on the net revenue of each hospital in this state that is not a type A hospital or type B hospital.

(3) Each 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 45th 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.

(4)(a) To the extent permitted by federal law, assessments imposed under subsection (1) of this section may not exceed the lesser of:

(A) A rate of 5.3 percent; or

(B) In the aggregate, the total of the following amounts received by the hospitals that are reimbursed by Medicare based on diagnostic related groups:

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

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

(iii) Payments made to the hospitals using a payment methodology established by the authority that advances the goals of the Oregon Integrated and Coordinated Health Care Delivery System described in ORS 414.620 (3).

(b) Notwithstanding paragraph (a) of this subsection, aggregate assessments imposed under subsection (1) of this section on or after July 1, 2015, 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 hospital services under ORS 414.631, 414.651 and 414.688 to 414.745.

(c) The director may impose a lower rate of assessment on type A hospitals and type B hospitals to take into account the hospitals' financial position.

(5) Notwithstanding subsection (4) 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.

(6)(a) The authority shall develop a schedule for collection of the assessment for the calendar quarter ending September 30, 2021, that will result in the collection occurring between December 15, 2021, 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; 2013 c.608 §2; 2015 c.16 §1; 2017 c.538 §§27,28]

Note 1: Operation of the amendments to section 2, chapter 736, Oregon Laws 2003, by section 28, chapter 538, Oregon Laws 2017, is dependent upon federal approval of specified changes to the hospital assessment. If approval is received, the amendments become operative on the later of January 1, 2018, or the date of approval. See section 44, chapter 538, Oregon Laws 2017. The text that, if approval is received, is operative from the later of January 1, 2018, or the date of approval until July 1, 2019, is set forth above. The text that is operative until January 1, 2018, until the date of approval or if approval is denied includes amendments by section 27, chapter 538, Oregon Laws 2017, part of which was referred to the people by referendum petition for their approval or rejection at a special election to be held throughout this state on January 23, 2018. See section 55, chapter 749, Oregon Laws 2017. The part referred to the people is not in effect unless and until voters approve the ballot measure at the special election. If the ballot measure is approved, the referred part, indicated as underlined text below, becomes effective February 22, 2018, unless superseded by the amendments by section 28, chapter 538, Oregon Laws 2017. See Article IV, section 1 (4)(d), of the Oregon Constitution. The text that is operative until January 1, 2018, until the date of approval or if approval is denied is set forth for the user's convenience.

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) In addition to the assessment imposed by subsection (1) of this section, an assessment of 0.7 percent is imposed on the net revenue of each hospital in this state that is not a waivered hospital.

(3) 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 (7) of this section, the hospital shall pay the assessment at the time the hospital files the assessment report. The payment shall accompany the report.

(4)(a) To the extent permitted by federal law, assessments imposed under subsection (1) of this section may not exceed the lesser of:

(A) A rate of 5.3 percent; or

(B) In the aggregate, the total of the following amounts received by the hospitals that are reimbursed by Medicare based on diagnostic related groups:

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

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

(iii) Payments made to the hospitals using a payment methodology established by the authority that advances the goals of the Oregon Integrated and Coordinated Health Care Delivery System described in ORS 414.620 (3).

(b) Notwithstanding paragraph (a) of this subsection, aggregate assessments imposed under subsection (1) of this section on or after July 1, 2015, 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 hospital services under ORS 414.631, 414.651 and 414.688 to 414.745.

(5) Notwithstanding subsection (4) 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.

(6) 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.

(7)(a) The authority shall develop a schedule for collection of the assessment for the calendar quarter ending September 30, 2019, that will result in the collection occurring between December 15, 2019, 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.

Note 2: Operation of the amendments to section 2, chapter 736, Oregon Laws 2003, by section 29, chapter 538, Oregon Laws 2017, is dependent upon federal approval of specified changes to the hospital assessment. If approval is received, the amendments become operative July 1, 2019. See section 44, chapter 538, Oregon Laws 2017. The text that, if approval is received, is operative on and after July 1, 2019, is set forth below.

Sec. 2. (1) An assessment is imposed on the net revenue of each hospital in this state. 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) Each 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 45th day following the end of the calendar quarter for which the assessment is being reported. Except as provided in subsection (5) 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) 30 percent of payments made to the hospitals on a fee-for-service basis by the authority for inpatient hospital services;

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

(C) Payments made to the hospitals using a payment methodology established by the authority that advances the goals of the Oregon Integrated and Coordinated Health Care Delivery System described in ORS 414.620 (3).

(b) Notwithstanding paragraph (a) of this subsection, aggregate assessments imposed under this section on or after July 1, 2015, 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 hospital services under ORS 414.631, 414.651 and 414.688 to 414.745.

(c) The director may impose a lower rate of assessment on type A hospitals and type B hospitals to take into account the hospitals' financial position.

(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)(a) The authority shall develop a schedule for collection of the assessment for the calendar quarter ending September 30, 2021, that will result in the collection occurring between December 15, 2021, 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.

Sec. 3. Notwithstanding section 2, chapter 736, Oregon Laws 2003, the Director of the Oregon Health Authority shall reduce the rate of assessment imposed under section 2 (1), chapter 736, Oregon Laws 2003, to the maximum rate allowed under federal law if the reduction is required to comply with federal law. [2003 c.736 §3; 2013 c.608 §3; 2017 c.538 §30]

Note: Operation of the amendments to section 3, chapter 736, Oregon Laws 2003, by section 30, chapter 538, Oregon Laws 2017, is dependent upon federal approval of specified changes to the hospital assessment. If approval is received, the amendments become operative July 1, 2018. See section 44, chapter 538, Oregon Laws 2017. The text that is operative until July 1, 2018, or if approval is denied is set forth below.

Sec. 3. (1) Notwithstanding section 2, chapter 736, Oregon Laws 2003, the Director of the Oregon Health Authority shall reduce the rate of assessment imposed under section 2, chapter 736, Oregon Laws 2003, to the maximum rate allowed under federal law if the reduction is required to comply with federal law.

(2) If federal law requires a reduction in the rate of assessments, the director shall, after consulting with representatives of the hospitals that are subject to the assessments, first reduce the distribution of moneys described in section 9 (2)(d), chapter 736, Oregon Laws 2003, by a corresponding amount.

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 ORS 413.101.

(3) Penalties paid under this section are in addition to and not in lieu of any assessment imposed under section 2, chapter 736, Oregon Laws 2003. [2003 c.736 §5; 2009 c.828 §52; 2009 c.867 §18; 2017 c.538 §31]

Sec. 6. (1) Any hospital that has paid an amount that is not required under sections 1 to 9, chapter 736, Oregon Laws 2003, may file a claim for refund with the Oregon Health Authority.

(2) Any hospital that is aggrieved by an action of the authority or by an action of the Director of the Oregon Health 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. [2003 c.736 §6; 2013 c.608 §4]

Sec. 7. The Oregon Health Authority may audit the records of any hospital in this state to determine compliance with sections 1 to 9, chapter 736, Oregon Laws 2003. The authority 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, chapter 736, Oregon Laws 2003. [2003 c.736 §7; 2013 c.608 §5; 2017 c.538 §32]

Note: Operation of the amendments to section 7, chapter 736, Oregon Laws 2003, by section 32, chapter 538, Oregon Laws 2017, is dependent upon federal approval of specified changes to the hospital assessment. If approval is received, the amendments become operative July 1, 2018. See section 44, chapter 538, Oregon Laws 2017. The text that is operative until July 1, 2018, or if approval is denied is set forth below.

Sec. 7. The Oregon Health Authority may audit the records of any hospital in this state to determine compliance with sections 1 to 9, chapter 736, Oregon Laws 2003, and section 1 of this 2013 Act [section 1, chapter 608, Oregon Laws 2013]. The authority 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, chapter 736, Oregon Laws 2003.

Sec. 8. Amounts collected by the Oregon Health Authority 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; 2013 c.608 §6]

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:

(a) Paying refunds due under section 6, chapter 736, Oregon Laws 2003;

(b) Funding services under ORS 414.631, 414.651 and 414.688 to 414.745, including but not limited to increasing reimbursement rates for inpatient and outpatient hospital services under ORS 414.631, 414.651 and 414.688 to 414.745;

(c) Making payments described in section 2 (4)(a)(B)(iii), chapter 736, Oregon Laws 2003;

(d) Making payments to coordinated care organizations to be used to provide additional reimbursement to type A hospitals and type B hospitals to improve and expand access to services for medical assistance recipients, to the extent permitted by federal requirements; and

(e) 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 (4)(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; 2011 c.602 §59; 2013 c.608 §7; 2017 c.538 §§33,34,35]

Note 1: Operation of the amendments to section 9, chapter 736, Oregon Laws 2003, by sections 34, 35 and 36, chapter 538, Oregon Laws 2017, is dependent upon federal approval of specified changes to the hospital assessment. If approval is received, the amendments become operative in stages. See section 44, chapter 538, Oregon Laws 2017. The text that, if approval is received, is operative from July 1, 2018, until July 1, 2019, is set forth above. The text that, if approval is received, is operative from the later of January 1, 2018, or the date of approval until July 1, 2018, is set forth below.

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:

(a) Paying refunds due under section 6, chapter 736, Oregon Laws 2003;

(b) Funding services under ORS 414.631, 414.651 and 414.688 to 414.745, including but not limited to increasing reimbursement rates for inpatient and outpatient hospital services under ORS 414.631, 414.651 and 414.688 to 414.745;

(c) Making payments described in section 2 (4)(a)(B)(iii), chapter 736, Oregon Laws 2003;

(d) Making distributions, as described in section 1 (4), chapter 608, Oregon Laws 2013, of an amount of moneys equal to the federal financial participation received from one percentage point of the rate assessed under section 2 (1), chapter 736, Oregon Laws 2003;

(e) Making payments to coordinated care organizations to be used to provide additional reimbursement to type A hospitals and type B hospitals to improve and expand access to services for medical assistance recipients, to the extent permitted by federal requirements; and

(f) Paying administrative costs incurred by the authority to administer section 1, chapter 608, Oregon Laws 2013, and the assessments imposed under section 2, chapter 736, Oregon Laws 2003.

(3) Except for assessments imposed pursuant to section 2 (4)(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.

Note 2: Operation of the amendments to section 9, chapter 736, Oregon Laws 2003, by sections 34, 35 and 36, chapter 538, Oregon Laws 2017, is dependent upon federal approval of specified changes to the hospital assessment. See section 44, chapter 538, Oregon Laws 2017. The text that is operative until either the later of January 1, 2018, or the date of approval (if approval is received) or July 1, 2018 (if approval is denied), is set forth below.

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:

(a) Paying refunds due under section 6, chapter 736, Oregon Laws 2003;

(b) Funding services under ORS 414.631, 414.651 and 414.688 to 414.745, including but not limited to increasing reimbursement rates for inpatient and outpatient hospital services under ORS 414.631, 414.651 and 414.688 to 414.745;

(c) Making payments described in section 2 (4)(a)(B)(iii), chapter 736, Oregon Laws 2003;

(d) Making distributions, as described in section 1 (4), chapter 608, Oregon Laws 2013, of an amount of moneys equal to the federal financial participation received from one percentage point of the rate assessed under section 2 (1), chapter 736, Oregon Laws 2003; and

(e) Paying administrative costs incurred by the authority to administer section 1, chapter 608, Oregon Laws 2013, and the assessments imposed under section 2, chapter 736, Oregon Laws 2003.

(3) Except for assessments imposed pursuant to section 2 (4)(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.

Note 3: Operation of the amendments to section 9, chapter 736, Oregon Laws 2003, by sections 34, 35 and 36, chapter 538, Oregon Laws 2017, is dependent upon federal approval of specified changes to the hospital assessment. If approval is received, the amendments become operative in stages. See section 44, chapter 538, Oregon Laws 2017. The text that, if approval is received, is operative on and after July 1, 2019, is set forth below.

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:

(a) Paying refunds due under section 6, chapter 736, Oregon Laws 2003;

(b) Funding services under ORS 414.631, 414.651 and 414.688 to 414.745, including but not limited to increasing reimbursement rates for inpatient and outpatient hospital services under ORS 414.631, 414.651 and 414.688 to 414.745;

(c) Making payments described in section 2 (3)(a)(C), chapter 736, Oregon Laws 2003;

(d) Making payments to coordinated care organizations to be used to provide additional reimbursement to type A hospitals and type B hospitals to improve and expand access to services for medical assistance recipients, to the extent permitted by federal requirements; and

(e) 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.

Note 4: Operation of the amendments to section 9, chapter 736, Oregon Laws 2003, by sections 34, 35 and 36, chapter 538, Oregon Laws 2017, is dependent upon federal approval of specified changes to the hospital assessment. If approval is denied, the amendments to section 9, chapter 736, Oregon Laws 2003, by section 37, chapter 538, Oregon Laws 2017, become operative July 1, 2018. See section 44, chapter 538, Oregon Laws 2017. The text that, if approval is denied, is operative on and after July 1, 2018, is set forth below.

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:

(a) Paying refunds due under section 6, chapter 736, Oregon Laws 2003;

(b) Funding services under ORS 414.631, 414.651 and 414.688 to 414.745, including but not limited to increasing reimbursement rates for inpatient and outpatient hospital services under ORS 414.631, 414.651 and 414.688 to 414.745;

(c) Making payments described in section 2 (4)(a)(B)(iii), chapter 736, Oregon Laws 2003; 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 (4)(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.

Sec. 10. Sections 1 to 9, chapter 736, Oregon Laws 2003, apply to net revenues earned by hospitals during a period beginning October 1, 2015, and ending the earlier of September 30, 2021, or the date on which the assessment no longer qualifies for federal financial participation under Title XIX or XXI of the Social Security Act. [2003 c.736 §10; 2007 c.780 §3; 2009 c.867 §20; 2013 c.608 §8; 2015 c.16 §2; 2017 c.538 §37a]

Sec. 12. (1) Sections 1 to 9, chapter 736, Oregon Laws 2003, are repealed on January 2, 2026.

(2) Section 1, chapter 608, Oregon Laws 2013, is repealed on July 1, 2018. [2003 c.736 §12; 2007 c.780 §4; 2009 c.867 §21; 2013 c.608 §9; 2015 c.16 §3; 2017 c.538 §38]

Sec. 13. Nothing in the repeal of sections 1 to 9, chapter 736, Oregon Laws 2003, and section 1, chapter 608, Oregon Laws 2013, 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, 2021. [2003 c.736 §13; 2007 c.780 §5; 2009 c.867 §22; 2013 c.608 §10; 2015 c.16 §4; 2017 c.538 §39]

Sec. 14. Any moneys remaining in the Hospital Quality Assurance Fund on December 31, 2025, are transferred to the General Fund. [2003 c.736 §14; 2007 c.780 §6; 2009 c.867 §23; 2015 c.16 §5; 2017 c.538 §40]

Note: Sections 9 to 12, chapter 538, Oregon Laws 2017, provide:

Sec. 9. (1) As used in this section and sections 10 and 11 of this 2017 Act:

(a) "Managed care organization" means:

(A) A coordinated care organization as defined in ORS 414.025; and

(B) A prepaid managed care health services organization as defined in ORS 414.025.

(b) "Premium equivalent" means the payments made to the managed care organization by the Oregon Health Authority for providing health services under ORS chapter 414.

(2) No later than 45 days following the end of a calendar quarter, a managed care organization shall pay an assessment at a rate of 1.5 percent of the gross amount of premium equivalents received during that calendar quarter.

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

(4) Assessments received by the authority under this section shall be paid into the State Treasury and credited to the Health System Fund established under section 2 of this 2017 Act.

(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 managed care organization. [2017 c.538 §9]

Note: Parts of section 9, chapter 538, Oregon Laws 2017, were referred to the people by referendum petition for their approval or rejection at a special election to be held throughout this state on January 23, 2018. See section 55, chapter 749, Oregon Laws 2017. The parts referred to the people are not in effect unless and until voters approve the ballot measure at the special election. If the ballot measure is approved, the referred parts, indicated as underlined text above, become effective February 22, 2018. See Article IV, section 1 (4)(d), of the Oregon Constitution.

Sec. 10. (1) If a managed care organization fails to timely pay an assessment under section 9 of this 2017

Act, the Oregon Health Authority shall impose a penalty on the managed care organization 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 2017 Act.

(3) Penalties received by the authority under this section shall be paid into the State Treasury and credited to the Health System Fund established under section 2 of this 2017 Act. [2017 c.538 §10]

Sec. 11. (1) A managed care organization that has paid an amount that is not required under section 9 of this 2017 Act may file a claim for refund with the Oregon Health Authority.

(2) Any 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. [2017 c.538 §11]

Sec. 12. Sections 9, 10 and 11 of this 2017 Act apply to any payments made to a managed care organization by the Oregon Health Authority for the period beginning January 1, 2018, and ending December 31, 2019. [2017 c.538 §12]

Note: Section 1, chapter 608, Oregon Laws 2013, provides:

Sec. 1. (1) As used in this section:

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

(b) "Hospital" means a hospital that is subject to the assessment imposed under section 2, chapter 736, Oregon Laws 2003.

(c) "Metrics and scoring subcommittee" means the subcommittee created in ORS 414.638.

(2) In consultation with the President of the Senate and the Speaker of the House of Representatives, the Director of the Oregon Health Authority shall appoint a hospital performance metrics advisory committee consisting of nine members, including:

(a) Four members who represent hospitals;

(b) Three members who have expertise in measuring health outcomes; and

(c) Two members who represent coordinated care organizations.

(3) The hospital performance metrics advisory committee shall recommend three to five performance standards that are consistent with state and national quality standards.

(4) The Oregon Health Authority shall adopt by rule the procedures for distributing to hospitals the moneys described in section 9 (2)(d), chapter 736, Oregon Laws 2003, to ensure that such moneys are distributed as follows:

(a) The authority shall distribute 50 percent of the moneys based upon each hospital's:

(A) Compliance with data submission requirements; and

(B) Achievement of the performance standards recommended by the hospital performance metrics advisory committee under subsection (3) of this section.

(b) The authority shall annually distribute the remainder of the moneys to coordinated care organizations based upon recommendations made by the metrics and scoring subcommittee. [2013 c.608 §1; 2015 c.16 §6; 2015 c.389 §13]

Note: Section 12 (2), chapter 736, Oregon Laws 2003, provides:

Sec. 12. (2) Section 1, chapter 608, Oregon Laws 2013, is repealed on July 1, 2018. [2003 c.736 §12; 2007 c.780 §4; 2009 c.867 §21; 2013 c.608 §9; 2015 c.16 §3; 2017 c.538 §38 (2)]