Chapter 414 — Medical Assistance

2001 EDITION

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(Temporary provisions relating to expansion of the Oregon Health Plan are compiled as notes following ORS 414.839)

414.001 [Repealed by 1953 c.378 §2]

414.002 [Repealed by 1953 c.378 §2]

414.003 [Repealed by 1953 c.378 §2]

414.004 [Repealed by 1953 c.378 §2]

414.005 [Repealed by 1953 c.378 §2]

414.006 [Repealed by 1953 c.378 §2]

414.007 [Repealed by 1953 c.378 §2]

414.008 [Repealed by 1953 c.378 §2]

414.009 [Repealed by 1953 c.378 §2]

414.010 [Repealed by 1953 c.378 §2]

414.011 [Repealed by 1953 c.378 §2]

414.012 [Repealed by 1953 c.378 §2]

414.013 [Repealed by 1953 c.378 §2]

414.014 [Repealed by 1953 c.378 §2]

414.015 [Repealed by 1953 c.30 §2]

414.016 [Repealed by 1953 c.30 §2]

414.017 [Repealed by 1953 c.30 §2]

OREGON HEALTH PLAN

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

(2) The Legislative Assembly finds:

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

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

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

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

Note: 414.018 to 414.024 were enacted into law by the Legislative Assembly but were not added to or made a part

of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

414.019 Laws comprising Oregon Health Plan. As used in ORS 414.018 to 414.024, 414.042, 414.107, 414.710, 414.720 and 735.712, as of November 4, 1993, "Oregon Health Plan" means chapter 815, Oregon Laws 1993, and the seven pieces of legislation enacted during the 1987, 1989 and 1991 legislative sessions, the goal of which is to assure Oregonians access to health care coverage, including the high-risk pool created by chapter 838, Oregon Laws 1989, the employer-based coverage reforms contained in chapter 591, Oregon Laws 1987, chapter 381, Oregon Laws 1989, and chapter 916, Oregon Laws 1991, the cost containment and technology assessments contained in chapter 470, Oregon Laws 1991, and the prioritization and medical assistance reforms contained in chapter 836, Oregon Laws 1989, and chapter 753, Oregon Laws 1991. [1993 c.815 §2; 1999 c.547 §4]

Note: See note under 414.018.

414.020 [Repealed by 1953 c.204 §9]

414.021 Duties of administrator; staff; advisory committees; grants. (1) The Administrator of the Office for Oregon Health Policy and Research shall be responsible for analyzing and reporting on the implementation of the elements of the Oregon Health Plan that are assigned to various state agencies, including but not limited to the Department of Human Services and the Department of Consumer and Business Services, and shall administer the Health Services Commission, the Health Resources Commission and the Oregon Health Council. Pursuant to the responsibilities described in this subsection, the administrator may review and monitor the progress of the various activities that comprise Oregon's efforts to reform health care through state-funded and employer-based coverage. Except for administration of the Health Services Commission, the Health Resources Commission and the Oregon Health Council and as specifically authorized in ORS 414.018 to 414.024, 414.042, 414.107, 414.710, 414.720 and 735.712, the administrator shall not be responsible for the day-to-day operations of the Oregon Health Plan, but shall exercise such oversight responsibilities as are necessary to further the Oregon Health Plan's goals.

(2) The administrator shall be responsible for the activities necessary to implement the plans and programs described in sections 4 and 7, chapter 815, Oregon Laws 1993, that are intended to expand voluntary health care coverage to Oregonians.

(3) The administrator shall employ such staff or utilize such state agency personnel as are necessary to fulfill the responsibilities and duties of the administrator. In addition, the administrator may contract with third parties for technical and administrative services necessary to carry out Oregon Health Plan activities where contracting promotes economy, avoids duplication of effort and makes best use of available expertise. The administrator may call upon other state agencies to provide available information as necessary to assist the administrator in meeting the responsibilities under ORS 414.018 to 414.024, 414.042, 414.107, 414.710, 414.720 and 735.712. The information shall be supplied as promptly as circumstances permit.

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

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

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

(7) All health policy advisory committees reporting to the Office for Oregon Health Policy and Research and all advisory task forces on health policy appointed by the administrator shall report directly to the Oregon Health Council. [1993 c.815 §3; 1995 c.727 §19; 1997 c.683 §14; 1999 c.547 §5]

Note: See note under 414.018.

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

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

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

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

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

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

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

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

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

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

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

Note: See note under 414.018.

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

Note: See note under 414.018.

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

Note: See note under 414.018.

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

(1) “Category of aid” means old-age assistance, aid to the blind, aid to the disabled, temporary assistance for needy families or Supplemental Security Income payment of the federal government.

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

(a) Is receiving a category of aid.

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

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

(d) Is under the age of 21 years and would be a dependent child under the program for temporary assistance for needy families except for age and regular attendance in school or in a course of professional or technical training.

(e) Is a caretaker relative named in ORS 418.035 (1)(a)(C) who cares for a dependent child who would be a dependent child under the program for temporary assistance for needy families except for age and regular attendance in school or in a course of professional or technical training; or is the spouse of such caretaker relative and fulfills the requirements of ORS 418.035 (2).

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

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

(h) Is a caretaker relative named in ORS 418.035 (1)(a)(C) who cares for a dependent child receiving temporary assistance for needy families or is the spouse of such caretaker relative and fulfills the requirements of ORS 418.035 (2).

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

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

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

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

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

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

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

(p) Is a pregnant woman who would be eligible for temporary assistance for needy families including such aid based on the unemployment of a parent, whether or not the woman is eligible for cash assistance.

(q) Would be eligible for temporary assistance for needy families pursuant to 42 U.S.C. 607 based upon the unemployment of a parent, whether or not the state provides cash assistance.

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

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

(3) “Income” means income as defined in ORS 413.005 (3).

(4) “Investments and savings” means cash, securities as defined in ORS 59.015, negotiable instruments as defined in ORS 73.0104 and such similar investments or savings as the Department of Human Services may establish by rule

that are available to the applicant or recipient to contribute toward meeting the needs of the applicant or recipient.

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

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

(b) Outpatient hospital services;

(c) Other laboratory and X-ray services;

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

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

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

(g) Home health care services;

(h) Private duty nursing services;

(i) Clinic services;

(j) Dental services;

(k) Physical therapy and related services;

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

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

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

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

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

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

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

(s) Hospice services.

(6) "Medical assistance" includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. "Medical assistance" includes "health services" as defined in ORS 414.705. "Medical assistance" does not include care or services for an inmate in a nonmedical public institution.

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

(8) "Resources" means resources as defined in ORS 413.005 (4). For eligibility purposes, "resources" shall not include charitable contributions raised by a community to assist with medical expenses. [1965 c.556 §2; 1967 c.502 §3; 1969 c.507 §1; 1971 c.488 §1; 1973 c.651 §10; 1974 s.s. 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]

MEDICAL ASSISTANCE FOR CERTAIN INMATES AND PATIENTS

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

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

(3) Upon notification that a pregnant woman described under subsection (1) of this section is no longer an inmate residing in a public institution, the department shall reinstate medical assistance under the plan if the woman is otherwise eligible for medical assistance. [2001 c.980 §2]

414.027 Conditions for coverage for pregnant women who are incarcerated. ORS 414.026 does not extend eligibility to an otherwise ineligible individual or extend medical assistance to an individual if matching federal funds are not available to pay for medical assistance. [2001 c.980 §3]

414.028 Payment of cost of medical care for institutionalized persons. The Department of Human Services is hereby authorized to pay the cost of care for patients in institutions operated under ORS 179.321 under the medical assistance program established by ORS chapter 414. [Formerly 414.305]

Note: 414.028 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.

414.030 [Repealed by 1953 c.204 §9]

MISCELLANEOUS PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

PROCEDURE TO OBTAIN MEDICAL ASSISTANCE

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

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

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

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

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

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

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

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

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

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

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

(d) The report of the Health Services Commission as funded by the Legislative Assembly and such other programs as the Legislative Assembly may authorize. However, medical assistance, including health services, shall not be provided to persons described in ORS 414.025 (2)(s) unless the Legislative Assembly specifically appropriates funds to provide such assistance.

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

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

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

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

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

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

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

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

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

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

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

EXTENT AND COVERAGE OF MEDICAL ASSISTANCE

414.065 Standards for medical assistance; effect of payment; extent of medical benefits; reimbursement of rural hospitals. (1) With respect to medical and remedial care and services to be provided in medical assistance during any period, and within the limits of funds available therefor, the Department of Human Services shall determine, subject to such revisions as it may make from time to time and with respect to the "health services" defined in ORS 414.705, subject to legislative funding in response to the report of the Health Services Commission:

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

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

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

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

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

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

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

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

(4) Medical benefits, standards and limits established pursuant to subsection (1)(a), (b) and (c) of this section for the eligible medically needy, except for the aged served under ORS chapter 413 and for the blind and disabled served under ORS chapter 412, may be less but shall not exceed medical benefits, standards and limits established for the eligible categorically needy, except that, in the case of a research and demonstration project entered into under ORS 411.135, medical benefits, standards and limits for the eligible medically needy may exceed those established for specific eligible groups of the categorically needy.

(5) Notwithstanding the provisions of this section, the department shall cause Type A hospitals, Type B hospitals and rural critical access hospitals, as described in ORS 442.470, identified by the Office of Rural Health as rural hospitals to be reimbursed for the cost of covered services as follows:

(a) For services provided to persons entitled to receive medical assistance, based on the Medicare determination of reasonable cost as derived from the Hospital and Hospital Health Care Complex Cost Report, referred to as the Medicare Report.

(b) In accordance with the terms of the agreement for services provided to persons whose medical assistance benefits are administered by the contracting health care provider under an agreement between the hospital and a health care provider contracting with the Department of Human Services under ORS 414.725 (1) for reimbursement other than that specified by ORS 414.727 (1). Hospitals reimbursed under the terms of this paragraph are entitled to no additional reimbursement for services provided.

(c) Hospitals that have been reimbursed by health care providers contracting with the Department of Human Services under ORS 414.725 (1) in accordance with ORS 414.727 (1), are entitled to full reimbursement from the department for the cost of covered services provided to persons whose medical assistance benefits are administered by the contracting health care provider according to paragraph (a) of this subsection. [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]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

414.105 Recovery of certain medical assistance; certain transfers of property voidable; legal burden. (1) The Department of Human Services may recover from any person the amounts of medical assistance incorrectly paid on behalf of such person.

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

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

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

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

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

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

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

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

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

INSURANCE AND SERVICE CONTRACTS

414.115 Medical assistance by insurance or service contracts. (1) In lieu of providing one or more of the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

STATE AND LOCAL PUBLIC HEALTH PARTNERSHIP

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

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

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

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

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

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

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

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

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

Note: See note under 414.150.

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

Note: See note under 414.150.

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

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

(a) Immunizations;

(b) Sexually transmitted diseases; and

(c) Other communicable diseases;

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

(a) Family planning services;

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

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

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

(a) Maternity case management;

(b) Well-child care;

(c) Prenatal care;

(d) School-based clinics;
(e) Health services for children provided through schools and Head Start programs; and
(f) Screening services to provide early detection of health care problems among low income women and children, migrant workers and other special population groups; and
(4) Recognize the social value of partnerships between county health departments and other publicly supported programs and other health providers, and take appropriate measures to involve publicly supported health care and service programs in the development and implementation of managed health care programs in their areas of responsibility. [1991 c.337 §4; 1993 c.592 §1]

Note: See note under 414.150.

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

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

ADVISORY COMMITTEES

414.211 Medicaid Advisory Committee. (1) There is established a Medicaid Advisory Committee consisting of not more than 15 members appointed by the Governor.
(2) The committee shall be composed of:
(a) A physician licensed under ORS chapter 677;
(b) Two members of health care consumer groups that include Medicaid recipients;
(c) Two Medicaid recipients, one of whom shall be a disabled person;
(d) The Director of Human Services or designee;
(e) Health care providers;
(f) Persons associated with health care organizations, including but not limited to managed care plans under contract to the Medicaid program; and
(g) Members of the general public.
(3) In making appointments, the Governor shall consult with appropriate professional and other interested organizations. All members appointed to the committee shall be familiar with the medical needs of low income persons.
(4) The term of office for each member shall be two years, but each member shall serve at the pleasure of the Governor.
(5) Members of the committee shall receive no compensation for their services but, subject to any applicable state law, shall be allowed actual and necessary travel expenses incurred in the performance of their duties from the Public Welfare Account. [1995 c.727 §43]

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 Department 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]

Note: See note under 414.211.

414.225 Department to consult with and assist committee. (1) The Department of Human Services shall consult

with the Medicaid Advisory Committee concerning the determinations required under ORS 414.065.

(2) The department shall provide secretarial services to the Medicaid Advisory Committee. [1967 c.502 §20; 1991 c.66 §22; 1995 c.727 §46]

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

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

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

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

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

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

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

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

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

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

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

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

PRESCRIPTION DRUGS

(Generally)

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

(2) A licensed practitioner may prescribe such drugs under this chapter as the practitioner in the exercise of professional judgment considers appropriate for the diagnosis or treatment of the patient in the practitioner's care and within the scope of practice. Prescriptions shall be dispensed in the generic form pursuant to ORS 689.515, 689.854 and 689.857 and pursuant to rules of the Department of Human Services unless the practitioner prescribes otherwise and an exception is granted by the department.

(3) The department shall pay only for drugs in the generic form if the federal Food and Drug Administration has approved a generic version of a particular brand name drug that is chemically identical to the brand name drug according to federal Food and Drug Administration rating standards, unless an exception has been granted by the department.

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

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

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

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

(6) Notwithstanding subsection (3) of this section, the department may not limit legend drugs when used as

approved by the federal Food and Drug Administration to treat mental illness, HIV and AIDS, and cancer. [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]

Note: The amendments to 414.325 by section 6, chapter 897, Oregon Laws 2001, become operative January 2, 2007. See section 7, chapter 897, Oregon Laws 2001. The text that is operative on and after January 2, 2007, is set forth for the user's convenience.

414.325. (1) As used in this section, "legend drug" means any drug requiring a prescription by a practitioner, as defined in ORS 689.005.

(2) A licensed practitioner may prescribe such drugs under this chapter as the practitioner in the exercise of professional judgment considers appropriate for the diagnosis or treatment of the patient in the practitioner's care and within the scope of practice. Prescriptions shall be dispensed in the generic form pursuant to ORS 689.515, 689.854 and 689.857 and pursuant to rules of the Department of Human Services unless the practitioner prescribes otherwise and an exception is granted by the department.

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

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

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

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

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

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

(A) Asthma;

(B) Sinusitis;

(C) Rhinitis; or

(D) Allergies.

414.327 Electronically transmitted prescriptions; federal waiver; rules. (1) The Department of Human Services shall seek a waiver from the federal Health Care Financing Administration to allow the Office of Medical Assistance Programs to communicate prescription drug orders by electronic means from a practitioner authorized to prescribe drugs directly to the dispensing pharmacist.

(2) The Department of Human Services and the Office of Medical Assistance Programs shall adopt rules permitting the Office of Medical Assistance Programs to communicate prescription drug orders by electronic means from a practitioner authorized to prescribe drugs directly to the dispensing pharmacist. [2001 c.623 §8]

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.

(Practitioner-Managed Prescription Drug Plan)

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

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

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

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

Note: 414.330 to 414.334 were enacted into law by the Legislative Assembly but were not added to or made a part

of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

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

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

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

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

Note: See note under 414.330.

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

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

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

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

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

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

Note: See note under 414.330.

Note: Section 4, chapter 897, Oregon Laws 2001, provides:

Sec. 4. The President of the Senate and the Speaker of the House of Representatives shall designate an appropriate interim legislative committee or legislative commission to:

(1) Receive regular reports on the development and implementation of the Practitioner-Managed Prescription Drug Plan;

(2) Review the impact of the implementation of the Practitioner-Managed Prescription Drug Plan, including but not limited to a review of whether the program realizes any savings, whether there is an increase in physician and hospital costs for individuals receiving medical assistance, and whether there is an impact on the ability of an individual receiving medical assistance to obtain prescribed drugs; and

(3) Report its findings and recommendations periodically to the Emergency Board and to the Seventy-second Legislative Assembly. [2001 c.897 §4]

(Patient Prescription Drug Assistance Program)

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

(2) The program shall:

(a) Provide information on:

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

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

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

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

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

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

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

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

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

(Senior Prescription Drug Assistance Program)

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

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

(a) Is 65 years of age or older;

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

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

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

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

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

(4) "Income" has the meaning given that term in ORS 413.005.

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

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

Note: See note under 414.338.

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

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

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

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

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

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

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

(8) Subject to funds available, the Department of Human Services may adjust the Senior Prescription Drug Assistance Program price to subsidize up to 50 percent of the Medicaid price of the prescription drug, using a sliding scale based on the income and resources of an enrollee.

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

(A) Identify critical access pharmacies; and

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

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

Note: See note under 414.338.

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

Note: See note under 414.338.

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

Note: See note under 414.338.

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

Note: See note under 414.338.

DRUG USE REVIEW BOARD

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

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

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

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

(a) The American Hospital Formulary Services drug information.

(b) The United States Pharmacopeia drug information.

(c) The American Medical Association drug evaluations.

(d) The peer-reviewed medical literature.

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

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

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

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

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

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

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

(8) "Drug use review" means the programs designed to measure and assess on a retrospective and a prospective basis, through an evaluation of claims data, the proper utilization, quantity, appropriateness as therapy and medical necessity of prescribed medication in the medical assistance program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Drug use review, evaluation and intervention.

(d) Medical quality assurance.

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

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

Note: See note under 414.350.

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

(1) Adoption of rules to implement ORS 414.350 to 414.415 in accordance with the provisions of ORS chapter 183.

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

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

(a) Therapeutic appropriateness.

(b) Overutilization or underutilization.

(c) Therapeutic duplication.

(d) Drug-disease contraindications.

(e) Drug-drug interactions.

(f) Incorrect drug dosage or drug treatment duration.

(g) Clinical abuse or misuse.

(h) Drug allergies.

(4) Development, selection and application of and assessment for interventions for medical assistance program prescribers, dispensers and patients that are educational and not punitive in nature. [1993 c.578 §6]

Note: See note under 414.350.

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

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

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

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

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

(c) Therapeutic appropriateness.

(d) Overutilization or underutilization.

(e) Appropriate use of generic products.

(f) Therapeutic duplication.

(g) Drug-disease contraindications.

(h) Drug-drug interactions.

(i) Drug allergy interactions.

(j) Clinical abuse and misuse.

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

Note: See note under 414.350.

414.370 Authorized intervention procedures. In appropriate instances, interventions developed under ORS 414.360 (4) may include the following:

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

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

(3) Face-to-face discussions between experts in drug therapy and the prescriber or pharmacist who has been targeted for educational intervention.

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

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

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

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

Note: See note under 414.350.

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

(1) Therapeutic duplication.

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

(3) Incorrect dosage and duration of treatment.

(4) Drug-allergy interactions.

(5) Clinical abuse and misuse.

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

Note: See note under 414.350.

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

must:

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

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

(a) Therapeutic appropriateness.

(b) Overutilization or underutilization.

(c) Fraud and abuse.

(d) Therapeutic duplication.

(e) Drug-disease contraindications.

(f) Drug-drug interactions.

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

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

Note: See note under 414.350.

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

Note: See note under 414.350.

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

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

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

Note: See note under 414.350.

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

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

Note: See note under 414.350.

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

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

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

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

Note: See note under 414.350.

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

Note: See note under 414.350.

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

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

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

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

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

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

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

Note: See note under 414.350.

MEDICAL ASSISTANCE FOR PERSONS WITH HEMOPHILIA

414.500 Policy. 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 for ORS 414.500 to 414.530. (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. 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.

MEDICAL ASSISTANCE FOR PERSONS WITH BREAST OR 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 743.801. [2001 c.902 §1]

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

414.534 Treatment for breast or cervical cancer; eligibility criteria for medical assistance. (1) The Department of Human Services shall provide medical assistance to a woman who:
(a) Is screened for breast or cervical cancer through the Oregon Breast and Cervical Cancer Program operated by the department;
(b) As a result of a screening in accordance with paragraph (a) of this subsection, is found by a provider to be in need of treatment for breast or cervical cancer;
(c) Does not otherwise have creditable coverage, as defined in 42 U.S.C. 300gg(c); and
(d) Is 64 years of age or younger.
(2) The period of time a woman can receive medical assistance based on the eligibility criteria of subsection (1) of this section:
(a) Begins:
(A) On the date the department makes a formal determination that the woman is eligible for medical assistance in accordance with subsection (1) of this section; or
(B) Up to three months prior to the month in which the woman applied for medical assistance if on the earlier date the woman met the eligibility criteria of subsection (1) of this section.
(b) Ends when:
(A) The woman is no longer in need of treatment; or
(B) The department determines the woman no longer meets the eligibility criteria of subsection (1) of this section. [2001 c.902 §2]

Note: See note under 414.532.

414.536 Presumptive eligibility for medical assistance for treatment of breast or cervical cancer. (1) The Department of Human Services shall provide medical assistance to a woman whom the department determines is presumptively eligible for medical assistance. As used in this section, a woman is "presumptively eligible for medical assistance" if the department determines that the woman likely is eligible for medical assistance under ORS 414.534.
(2) The period of time a woman may receive medical assistance based on presumptive eligibility is limited. The period of time:
(a) Begins on the date that the department determines the woman likely meets the eligibility criteria under ORS 414.534; and
(b) Ends on the earlier of the following dates:
(A) If the woman applies for medical assistance following the determination by the department that the woman is presumptively eligible for medical assistance, the date on which a formal determination on eligibility is made by the department in accordance with ORS 414.534; or
(B) If the woman does not apply for medical assistance following the determination by the department that the woman is presumptively eligible for medical assistance, the last day of the month following the month in which presumptive eligibility begins. [2001 c.902 §3]

Note: See note under 414.532.

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

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

Note: See note under 414.532.

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

Note: See note under 414.532.

MEDICAL ASSISTANCE FOR PERSONS WITH 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 physicians' fees, X-rays and necessary clinical tests to insure proper ongoing monitoring and maintenance of the patient's health.

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

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

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

Note: See note under 414.550.

OREGON HEALTH CARE COST CONTAINMENT SYSTEM

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

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

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

(2) For purposes of ORS 279.015, 279.712, 414.145 and 414.610 to 414.640, instrumentalities and political subdivisions of the state are authorized to enter into prepaid capitated health service contracts with the Department of Human Services and shall not thereby be considered to be transacting insurance.

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

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

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

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

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

(4) Actions taken by providers, potential providers, contractors and bidders in specific accordance with this chapter in forming consortiums or in otherwise entering into contracts to provide medical care shall be considered to be conducted at the direction of this state, shall be considered to be lawful trade practices and shall not be considered to be the transaction of insurance for purposes of ORS 279.015, 279.712, 414.145 and 414.610 to 414.640. [1983 c.590 §4; 1991 c.66 §25]

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

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

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

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

(3) Limiting the choice of eligible persons to those providers affiliated with a participating health plan;
(4) Allowing primary care providers access to data concerning clients' utilization of service from other providers; and
(5) Allowing the department the reimbursement flexibility necessary to implement a prospective reimbursement system for hospital care. [1983 c.590 §5; 1985 c.747 §3; 1991 c.66 §27]

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

DETERMINATION OF AND PAYMENT FOR ADDITIONAL HEALTH SERVICES

414.705 Definitions for ORS 414.705 to 414.750. As used in ORS 414.705 to 414.750, "health services" means at least so much of each of the following as are approved and funded by the Legislative Assembly:
(1) Provider services and supplies;
(2) Outpatient services;
(3) Inpatient hospital services; and
(4) Health promotion and disease prevention services. [1989 c.836 §2; 1991 c.753 §4]

Note: 414.705 to 414.715 and 414.725 to 414.750 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

414.710 Services available to eligible persons. The following services are available to persons eligible for services under ORS 414.025, 414.036, 414.042, 414.065 and 414.705 to 414.750 but such services are not subject to ORS 414.720:
(1) Nursing facilities and home- and community-based waivered services funded through the Department of Human Services;
(2) Medical assistance to eligible persons who are aged and described in ORS chapter 413 or who are blind or disabled and described in ORS chapter 412 or to children described in ORS 414.025 (2)(f), (i), (j), (k) and (m), 418.001 to 418.034, 418.187 to 418.970 and 657A.020 to 657A.460;
(3) Institutional, home- and community-based waivered services or community mental health program care for the mentally retarded or developmentally disabled, for the chronically mentally ill or emotionally disturbed and for the treatment of alcohol and drug dependent persons; and
(4) Services to children who are wards of the Department of Human Services by order of the juvenile court and services to children and families for health care or mental health care through the department. [1989 c.836 §3; 1991 c.67 §107; 1991 c.753 §5; 1993 c.815 §17; 1997 c.581 §25]

Note: The amendments to 414.710 by section 52, chapter 1084, Oregon Laws 1999, become operative July 1, 2001, contingent on the events specified in section 48, chapter 1084, Oregon Laws 1999 (note under 418.187). See sections 48 and 74, chapter 1084, Oregon Laws 1999. The text of 414.710, as amended by section 52, chapter 1084, Oregon Laws 1999, is set forth for the user's convenience.

414.710. The following services are available to persons eligible for services under ORS 414.025, 414.036, 414.042, 414.065 and 414.705 to 414.750 but such services are not subject to ORS 414.720:
(1) Nursing facilities and home- and community-based waivered services funded through the Department of Human Services;
(2) Medical assistance to eligible persons who are aged and described in ORS chapter 413 or who are blind or disabled and described in ORS chapter 412 or to children described in ORS 414.025 (2)(f), (i), (j), (k) and (m), 418.001 to 418.034, 418.189 to 418.970 and 657A.020 to 657A.460;
(3) Institutional, home- and community-based waivered services or community mental health program care for the mentally retarded or developmentally disabled, for the chronically mentally ill or emotionally disturbed and for the treatment of alcohol and drug dependent persons; and
(4) Services to children who are wards of the Department of Human Services by order of the juvenile court and

services to children and families for health care or mental health care through the department.

Note: See note under 414.705.

414.712 Medical assistance for aged, blind, disabled and certain children. Within six months after obtaining the necessary federal waivers or January 1, 1995, whichever is later, the Department of Human Services shall provide medical assistance under ORS 414.705 to 414.750 to eligible persons who are aged and described in ORS chapter 413 or who are blind or disabled and described in ORS chapter 412 and to children described in ORS 414.025 (2)(f), (i), (j), (k) and (m), 418.001 to 418.034, 418.187 to 418.970 and 657A.020 to 657A.460 and those mental health and chemical dependency services recommended according to standards of medical assistance set pursuant to chapter 836, Oregon Laws 1989, and according to the schedule of implementation established by the Legislative Assembly. In providing medical assistance services described in ORS 414.018 to 414.024, 414.042, 414.107, 414.710, 414.720 and 735.712, the Department of Human Services shall also provide the following:

(1) Ombudsman services for eligible persons who are aged and described in ORS chapter 413 or who are blind or disabled and described in ORS chapter 412. An ombudsman shall serve as a patient's advocate whenever the patient or a physician or other medical personnel serving the patient is reasonably concerned about access to, quality of or limitations on the care being provided by a health care provider. Patients shall be informed of the availability of an ombudsman.

(2) Case management services in each health care provider organization for those eligible persons who are aged and described in ORS chapter 413 or who are blind or disabled and described in ORS chapter 412. Case managers shall be trained in and shall exhibit skills in communication with and sensitivity to the unique health care needs of people who are elderly and those with disabilities. Case managers shall be reasonably available to assist patients served by the organization with the coordination of the patient's health care services at the reasonable request of the patient or a physician or other medical personnel serving the patient. Patients shall be informed of the availability of case managers.

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

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

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

Note: The amendments to 414.712 by section 53, chapter 1084, Oregon Laws 1999, become operative July 1, 2001, contingent on the events specified in section 48, chapter 1084, Oregon Laws 1999 (note under 418.187). See sections 48 and 74, chapter 1084, Oregon Laws 1999. The text of 414.712, as amended by section 53, chapter 1084, Oregon Laws 1999, and including amendments by section 7, chapter 547, Oregon Laws 1999, is set forth for the user's convenience.

414.712. Within six months after obtaining the necessary federal waivers or January 1, 1995, whichever is later, the Department of Human Services shall provide medical assistance under ORS 414.705 to 414.750 to eligible persons who are aged and described in ORS chapter 413 or who are blind or disabled and described in ORS chapter 412 and to children described in ORS 414.025 (2)(f), (i), (j), (k) and (m), 418.001 to 418.034, 418.189 to 418.970 and 657A.020 to 657A.460 and those mental health and chemical dependency services recommended according to standards of medical assistance set pursuant to chapter 836, Oregon Laws 1989, and according to the schedule of implementation established by the Legislative Assembly. In providing medical assistance services described in ORS 414.018 to 414.024, 414.042, 414.107, 414.710, 414.720 and 735.712, the Department of Human Services shall also provide the following:

(1) Ombudsman services for eligible persons who are aged and described in ORS chapter 413 or who are blind or disabled and described in ORS chapter 412. An ombudsman shall serve as a patient's advocate whenever the patient or a physician or other medical personnel serving the patient is reasonably concerned about access to, quality of or limitations on the care being provided by a health care provider. Patients shall be informed of the availability of an ombudsman.

(2) Case management services in each health care provider organization for those eligible persons who are aged and described in ORS chapter 413 or who are blind or disabled and described in ORS chapter 412. Case managers

shall be trained in and shall exhibit skills in communication with and sensitivity to the unique health care needs of people who are elderly and those with disabilities. Case managers shall be reasonably available to assist patients served by the organization with the coordination of the patient's health care services at the reasonable request of the patient or a physician or other medical personnel serving the patient. Patients shall be informed of the availability of case managers.

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

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

(5) Due process procedures for any individual whose request for medical assistance coverage for any treatment or service is denied or is not acted upon with reasonable promptness. These procedures shall include an expedited process for cases in which a patient's medical needs require swift resolution of a dispute.

Note: See note under 414.705.

Note: The Health Care Financing Administration has informed the Legislative Counsel that the waiver referenced in ORS 414.712 was obtained on September 28, 1994.

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

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

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

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

Note: See note under 414.705.

414.720 Public hearings; public involvement; biennial reports on health services priorities; funding. (1) The Health Services Commission shall conduct public hearings prior to making the report described in subsection (3) of this section. The commission shall solicit testimony and information from advocates for seniors; handicapped persons; mental health services consumers; low-income Oregonians; and providers of health care, including but not limited to physicians licensed to practice medicine, dentists, oral surgeons, chiropractors, naturopaths, hospitals, clinics, pharmacists, nurses and allied health professionals.

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

(3) The commission shall report to the Governor a list of health services, including health care services of the aged, blind and disabled pursuant to section 14, chapter 753, Oregon Laws 1991, including one list into which those mental health and chemical dependency services recommended pursuant to ORS 414.730 are integrated, ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the entire population to be served. The report shall be accompanied by a report of an independent actuary retained for the commission to determine rates necessary to cover the costs of the services. Until federal waiver approval is obtained and funding authorized for the integrated list including mental health and chemical dependency services, the coverage for mental health and chemical dependency services shall not be considered to be mandated. The list submitted by the commission pursuant to this subsection is not subject to alteration by any other state agency. The recommendation may include practice guidelines reviewed and adopted by the commission pursuant to subsection (4) of this section.

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

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

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

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

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

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

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

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

414.725 Prepaid managed care health services contracts; case management systems; expenditure limitation; state supervision; notice to patient. Upon meeting the requirements of section 9, chapter 836, Oregon Laws 1989:

(1) Pursuant to rules adopted by the Department of Human Services, the department shall execute prepaid managed care health services contracts for the health services funded pursuant to section 9, chapter 836, Oregon Laws 1989. The contract must require that all services are provided to the extent and scope of the Health Services Commission's report for each service provided under the contract. Such contracts are not subject to ORS 279.011 to 279.063. It is the intent of ORS 414.705 to 414.750 that the state move toward utilizing full service managed care health service providers for providing health services under ORS 414.705 to 414.750. The department shall solicit qualified providers or plans to be reimbursed at rates which cover the costs of providing the covered services. Such contracts may be with hospitals and medical organizations, health maintenance organizations, managed health care plans and any other qualified public or private entities. The department shall not discriminate against any contractors which offer services within their providers' lawful scopes of practice.

(2) In the event that there is an insufficient number of qualified entities to provide for prepaid managed health services contracts in certain areas of the state, the department may institute a fee-for-service case management system where possible or may continue a fee-for-service payment system for those areas that pay for the same services provided under the health services contracts for persons eligible for health services under ORS 414.705 to 414.750. In addition, the department may make other special arrangements as necessary to increase the interest of providers in participation in the state's managed care system, including but not limited to the provision of stop-loss insurance for providers wishing to limit the amount of risk they wish to underwrite.

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

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

(5) Health care providers contracting to provide services under ORS 414.705 to 414.750 shall advise a patient of any service, treatment or test that is medically necessary but not covered under the contract if an ordinarily careful practitioner in the same or similar community would do so under the same or similar circumstances. [1989 c.836 §6; 1991 c.753 §8]

Note: See note under 414.705.

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

(2) Nothing in this section shall be construed to prohibit a health care provider and hospital from mutually agreeing to reimbursement other than the reimbursement specified in subsection (1) of this section. [1997 c.642 §2; 1999 c.546 §2]

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

Note: See note under 414.705.

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

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

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

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

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

Note: See note under 414.705.

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

Note: See note under 414.705.

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

Note: See note under 414.705.

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

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

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

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

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

(e) Representatives of the Department of Human Services.

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

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

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

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

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

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

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

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

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

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

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

(4) As used in this section:

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

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

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

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

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

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

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

(2) After the injured person is incarcerated and throughout the period of incarceration, the Department of Human Services shall continue to pay, out of the Law Enforcement Medical Liability Account, charges and expenses for

injuries related to law enforcement activities as provided in subsection (1) of this section. Upon release of the injured person from actual physical custody, the Law Enforcement Medical Liability Account is no longer liable for the payment of medical expenses of the injured person.

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

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

(a) Providers of medical services as repayment;

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

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

(5) As used in this section:

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

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

Note: See note under 414.805.

414.810 [Formerly 414.040; renumbered 566.310]

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

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

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

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

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

Note: See note under 414.805.

414.820 [Formerly 414.050; renumbered 566.320]

EXPANSION OF OREGON HEALTH PLAN

Note: The leadlines for 414.821 to 414.839 and sections 9, 12, 13, 14, 15 and 16, chapter 898, Oregon Laws 2001, were enacted as part of chapter 898, Oregon Laws 2001.

414.821 Preamble. It is the primary goal of ORS 414.821 to 414.839 to increase access by Oregon's low-income, uninsured children and families to affordable health care coverage. [2001 c.898 §1]

Note: 414.821 to 414.839 were enacted into law by the Legislative Assembly but were not added to or made a part

of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

414.823 Findings. The Legislative Assembly finds that:

(1) The Oregon Health Plan has provided access to health care services to over one million Oregonians who would otherwise not have been able to afford health care services.

(2) The Oregon Health Plan has improved health outcomes by expanding access to timely preventive services and primary health care services.

(3) In spite of the Oregon Health Plan's important achievements, thousands of Oregonians still do not have health insurance coverage, often seeking health care services through the emergency department late in the course of their illness when costs are higher and outcomes are less favorable.

(4) The costs incurred by the health care delivery system by providing health care services through emergency departments are shifted to patients with health insurance coverage, driving up the costs of health care services and health insurance for all Oregonians.

(5) The lack of flexibility in current federal Medicaid policy forces the state into "one-size-fits-all" benefit packages and "all-or-nothing" coverage decisions, preventing the state from using federal resources to develop a system of subsidies for public and private insurance coverage based on the relative medical need and financial vulnerability of those being served.

(6) The lack of adequate reimbursement rates creates unwanted cost-shifting and barriers to health care providers at all levels in providing health care services to enrollees of the Oregon Health Plan.

(7) The current trends in increases in health care costs create concern for:

(a) The future sustainability of the Oregon Health Plan and the private insurance market;

(b) The State of Oregon in administering benefit plans for its employees;

(c) Individuals unable to pay for all or part of the costs of their health care;

(d) Employers providing health care coverage for their workers and their dependents;

(e) Health care providers providing services; and

(f) Insurers and other organizations providing health care coverage.

(8) Complex factors affect the balance between public and private health care programs and need to be better understood in order to establish policies that result in necessary access to health care. These factors include, but are not limited to:

(a) Whether the current structure of Medicare, Medicaid and the private insurance market is cost-sustainable;

(b) The reasons behind general health care cost trends;

(c) Appropriate reimbursement methods that reduce cost-shifting and optimize access to providers and plan choices;

(d) Whether public programs for low-income Oregonians that ensure adequate coverage are cost-effective and provide a realistic transition to private coverage; and

(e) Whether private coverage that is affordable offers sufficient benefit choices and is based on a market-based system.

(9) Employer-sponsored health coverage:

(a) Provides coverage for a majority of all Oregonians; and

(b) Must be supported by public policies that remove barriers to obtaining private health insurance coverage. [2001 c.898 §2]

Note: See note under 414.821.

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

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

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

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

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

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

Note: See note under 414.821.

414.827 Increased access for uninsured individuals. In order to carry out the policy established in ORS 414.825, subject to funds available, the State of Oregon shall increase access to basic health care services provided through Medicaid, the Children's Health Insurance Program or private insurance for uninsured Oregonians with an income of up to 185 percent of the federal poverty guidelines. [2001 c.898 §4]

Note: See note under 414.821.

414.829 Waiver for private insurance coverage. (1)(a) In order to make progress toward the goal set forth in ORS 414.821, the Department of Human Services shall apply to the Centers for Medicare and Medicaid Services for waivers to obtain federal matching dollars for public subsidies for low-income, working Oregonians for the purpose of making private health insurance more accessible and affordable.

(b) Prior to the submission of the waiver application, the department shall comply with ORS 291.375 (1) and (2).

(2) The waiver application shall provide for the establishment of a basic benchmark health benefit plan or plans, or approved equivalent, for subsidized employer-sponsored coverage that is comparable to coverage common in the small employer health insurance market. Consideration shall be given to the appropriate inclusion of preventive services for children and innovative means of ensuring access to such coverage. Options in the development of the benchmark health benefit plan may include, but are not limited to, provision of supplemental coverage for preventive services.

(3) The Insurance Pool Governing Board, in consultation with the Health Insurance Reform Advisory Committee, shall identify and recommend to the Waiver Application Steering Committee created under section 13, chapter 898, Oregon Laws 2001, and the Leadership Commission on Health Care Costs and Trends created under section 14, chapter 898, Oregon Laws 2001, a basic benchmark health benefit plan or plans that qualify for a subsidy under the waiver program, taking into account employer-sponsored health benefit plans currently in the market.

(4) The waiver application shall be based on a consideration of various models to maximize subsidies for employer-sponsored coverage with special attention given to creative means of increasing dependent coverage under the employer-sponsored health benefit plans.

(5) The waiver application shall ensure that:

(a) Coverage under the proposed program does not reduce employer-sponsored coverage presently available; and

(b) The risk distribution of the current population covered by the state's Medicaid program is not adversely affected.

(6) The waiver application shall strive to minimize administrative complexities for enrollees, employers, providers, health insurance plans and public agencies that participate in the proposed program.

(7) Prior to its submission for legislative review under subsection (1) of this section, the department shall submit the waiver application to the Leadership Commission on Health Care Costs and Trends for review. [2001 c.898 §5]

Note: See note under 414.821.

414.830 [Formerly 414.060; renumbered 566.330]

414.831 Family Health Insurance Assistance Program. Upon receipt of the waiver, the Insurance Pool Governing Board shall focus on expanding group coverage provided by the Family Health Insurance Assistance Program, with the goal of having available funds equally distributed between providing group coverage and individual coverage. [2001 c.898 §5a]

Note: See note under 414.821.

414.833 Levels of coverage for Medicaid. In the Medicaid portion of the Oregon Health Plan, the state shall

provide levels of benefit packages of health care services as described in ORS 414.834 and 414.835. One level shall provide a basic benefit package of health care services and be called “OHP Standard.” The second level shall provide a benefit package of health care services for persons with greater medical needs and be called “OHP Plus.” [2001 c.898 §6]

Note: 414.833 becomes operative the day after the date the Department of Human Services receives the necessary waivers from the Centers for Medicare and Medicaid Services. See section 16, chapter 898, Oregon Laws 2001.

Note: See note under 414.821.

414.834 Basic benefit package. (1) The Health Services Commission, in consultation with the legislative committees with oversight of health care issues, shall develop a basic benefit package of health care services for the Medicaid portion of the Oregon Health Plan, the cost of which shall be actuarially equivalent to the minimum level of care mandated by the current federal Medicaid law.

(2)(a) In addition to the basic benefit package of health care services developed under subsection (1) of this section, the commission shall develop and rank in priority order additional benefit packages of health care services that may be provided to the extent the Legislative Assembly has provided funds for additional benefit packages.

(b) When developing the benefit packages of health care services to be provided, the commission shall consider that those benefit packages of health care services may be provided through managed care organizations with contracts to provide services to enrollees of the Oregon Health Plan as well as commercial carriers.

(3) The commission shall obtain from an independent actuary the costs of providing the benefit packages of health care services identified in subsections (1) and (2) of this section.

(4) The commission shall recommend whether Oregonians receiving subsidies for OHP Standard be required to pay premiums and copayments based on the individual’s ability to pay and how to structure the copayments and premiums in a manner that encourages the use of preventive services.

(5) The commission shall submit its report on benefit packages for health care services by July 1 of the year preceding each regular session of the Legislative Assembly to the Governor, the Speaker of the House of Representatives and the President of the Senate. [2001 c.898 §7]

Note: See note under 414.821.

414.835 Prioritized list. The Health Services Commission shall continue to develop and report to the Legislative Assembly the prioritized list of health care services required in ORS 414.720. The list shall be used to establish the OHP Plus benefit package of health care services to be provided to Oregonians who are categorically eligible for medical assistance as defined by rule by the Department of Human Services and persons receiving general assistance as defined in ORS 411.010. [2001 c.898 §8]

Note: See note under 414.821.

414.837 Funding by Legislative Assembly. (1) The Legislative Assembly shall determine the health care services provided under the Medicaid portion of Oregon Health Plan by funding:

(a) OHP Standard, which shall be the combination of the basic benefit package of health care services developed in ORS 414.834 (1) and any additional benefit packages, added in priority order, from the packages developed under ORS 414.834 (2).

(b) OHP Plus, which shall be the benefit package developed in ORS 414.835.

(2) The cost of the benefit package of health care services provided under OHP Standard may not exceed the cost of the benefit package of health care services provided under OHP Plus. [2001 c.898 §10]

Note: 414.837 becomes operative the day after the date the Department of Human Services receives the necessary waivers from the Centers for Medicare and Medicaid Services. See section 16, chapter 898, Oregon Laws 2001.

Note: See note under 414.821.

414.839 Subsidies for health insurance coverage. (1) Subject to funds available, the waiver program described by

ORS 414.829 shall provide public subsidies for the purchase of health insurance coverage provided by public programs or private insurance, including but not limited to the Family Health Insurance Assistance Program, for currently uninsured individuals based on incomes up to 185 percent of the federal poverty level. The objective is to create a transition from dependence on public programs to privately financed health insurance.

(2) Public subsidies shall apply only to the cost of the basic benchmark health benefit plan or the approved equivalent established in ORS 414.829.

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

(4) Cost-sharing shall be based on an individual's ability to pay and may not exceed the cost of purchasing a plan approved as provided under subsection (2) of this section.

(5) The state may pay a portion of the cost of the subsidy, based on the individual's income and other resources. [2001 c.898 §11]

Note: 414.839 becomes operative the day after the date the Department of Human Services receives the necessary waivers from the Centers for Medicare and Medicaid Services. See section 16, chapter 898, Oregon Laws 2001.

Note: See note under 414.821.

(Temporary provisions relating to expansion of the Oregon Health Plan)

Note: Sections 9, 12, 13, 14, 15 and 16, chapter 898, Oregon Laws 2001, provide:

Sec. 9. Written report of costs. (1) For the biennium beginning July 1, 2001, and no later than November 1, 2001, the Health Services Commission shall prepare and give to the interim legislative committee with oversight of health care issues, the chairpersons of the Emergency Board and the Waiver Application Steering Committee created under section 13 of this 2001 Act a written report of the costs developed by the actuary under section 7 of this 2001 Act [414.834] of a basic benefit package of health care services and the additional benefit packages of health care services in priority order.

(2) The Waiver Application Steering Committee shall recommend the level of benefits to be included in the waiver application for the OHP Standard benefit package. [2001 c.898 §9]

Sec. 12. Rates. (1) The Department of Human Services shall recommend to the Seventy-second Legislative Assembly an alternative method of determining the capitation rate paid to fully capitated health plans, mental health organizations, dental organizations and other managed care entities providing services to enrollees of the Oregon Health Plan.

(2) Rates recommended under subsection (3) of this section shall:

(a) Be sufficient to provide appropriate access to services covered by the Oregon Health Plan; and

(b) Ensure that the current health care delivery system of fully capitated health plans, mental health organizations and dental care organizations used to deliver health care services to enrollees of the Oregon Health Plan is maintained and enhanced as needed to provide appropriate access to covered health care services for all enrollees of the Oregon Health Plan.

(3) The recommendation regarding the capitation rate shall:

(a) Provide for the rate to be constructed in a manner that allows providers, patients and policymakers to easily understand how the rate is developed and the components that are used to develop the rate;

(b) Use nationally recognized comparators for constructing the rate including but not limited to:

(A) The Medicare Resource Based Relative Value conversion factor for physician services;

(B) The Medicare hospital reimbursement principles; and

(C) Medical inflation rates used by the Centers for Medicare and Medicaid Services;

(c) Seek to equitably reimburse the different providers at rates necessary to provide appropriate access to services covered by the Oregon Health Plan; and

(d) Consider reasonable estimates of health care service utilization based on an actuarially appropriate model for projecting such utilization. [2001 c.898 §12]

Sec. 13. Waiver Application Steering Committee. (1) The Department of Human Services shall establish a Waiver Application Steering Committee to assist and advise the department in the preparation of the application for federal waivers from the Centers for Medicare and Medicaid Services necessary to carry out sections 1 to 11 of this 2001 Act [414.821 to 414.839]. The committee shall ensure that the concerns and views of Oregonians interested in

the Oregon Health Plan are fully considered in the preparation of the waiver application.

(2) The committee shall consist of, but not be limited to, the following:

(a) Two members of the House of Representatives appointed by the Speaker of the House of Representatives, one of whom shall be a member of the Emergency Board;

(b) Two members of the Senate appointed by the President of the Senate, one of whom shall be a member of the Emergency Board;

(c) A representative of a statewide association representing hospitals and health systems;

(d) A representative of a statewide association representing physicians licensed under ORS chapter 677 to practice medicine in this state;

(e) A representative of community-based health plans with contracts to provide health care services under the Oregon Health Plan;

(f) A representative of dental care organizations with contracts to provide health care services under the Oregon Health Plan;

(g) A representative of commercial carriers;

(h) A representative of safety net clinics;

(i) Advocates for health care consumers and persons without health insurance;

(j) Advocates for persons with mental illness;

(k) One representative each of small and large businesses;

(L) A representative of insurance agents; and

(m) A representative of organized labor.

(3)(a) When preparing the waiver application, the Department of Human Services and the Waiver Application Steering Committee shall carefully consider the connection between the coverage provided through the state Medicaid program and coverage provided through private insurance.

(b) The waiver application shall set forth the circumstances under which persons covered under the waivers may use coverage provided through the state Medicaid program and when they may use coverage provided by private insurance. These circumstances shall ensure that the viability of the community-based health plans currently with contracts to provide health care services under the Oregon Health Plan will be maintained.

(c) The department and the committee shall consider the following factors when setting forth the circumstances described in paragraph (b) of this subsection:

(A) Personal choice;

(B) The ability of a family to obtain employer-sponsored group coverage;

(C) The cost to a family to obtain employer-sponsored group coverage;

(D) The cost to the department to obtain or supplement employer-sponsored group coverage for a person and the person’s family; and

(E) The medical needs of the person and the person’s family. [2001 c.898 §13]

Sec. 14. Leadership Commission on Health Care Costs and Trends. (1) In order to provide a sound basis for future consideration of strategies to improve access to an adequate level of high quality health care at an affordable cost for all Oregonians, the Leadership Commission on Health Care Costs and Trends is created, consisting of eight members. The commission shall consist of:

(a) The President of the Senate or a member of the Senate designated by the President;

(b) The Speaker of the House of Representatives or a member of the House of Representatives designated by the Speaker;

(c) Two members of the Senate appointed by the President of the Senate, one of whom shall be a member of the Emergency Board;

(d) Two members of the House of Representatives appointed by the Speaker of the House of Representatives, one of whom shall be a member of the Emergency Board; and

(e) One member each appointed by the minority leadership of the Senate and the House of Representatives.

(2) The commission shall develop an Oregon Health Care Cost Index. The index shall categorize health care cost components and health care trends to inform future policymakers about potential implications of trends in health care programs provided by public and private programs.

(3) The commission shall review the health care cost trends that are reducing the affordability and availability of private coverage and thereby increasing dependence on publicly funded health care services.

(4) The commission shall monitor developments of possible federal health benefit tax credit programs and determine ways to maximize opportunities to expand health insurance coverage through a state income tax credit.

(5) The commission may contract with a private entity to develop the index.

(6) The commission shall recommend to the Seventy-second Legislative Assembly methods to:

(a) Update and distribute the index annually; and

(b) Report to policymakers and the public on potential implications for health care coverage available in Oregon.

(7) Except as provided in this section, the commission is subject to the provisions of ORS 171.605 to 171.635 and has the authority contained in ORS 171.505 and 171.510.

(8) The President of the Senate and the Speaker of the House of Representatives shall develop a work plan for the commission. The work plan shall be filed with the Legislative Administrator.

(9) The Legislative Administrator, in cooperation with the President of the Senate and the Speaker of the House of Representatives, shall provide staff necessary to the performance of the functions of the commission.

(10) Members of the Legislative Assembly who serve on the commission shall be entitled to an allowance as authorized by ORS 171.072. Claims for expenses incurred in performing functions of the commission shall be paid out of funds appropriated for that purpose.

(11) Subject to approval of the Emergency Board, the commission may accept contributions of funds and assistance from the United States Government or its agencies, or from any other source, public or private, and agree to conditions thereon not inconsistent with the purposes of the commission. All such funds are to aid in financing the functions of the commission and shall be deposited in the General Fund of the State Treasury to the credit of separate accounts for the commission and shall be disbursed for the purpose for which contributed in the same manner as funds appropriated for the commission.

(12) Official action taken by the commission shall require the approval of the majority of the members of the commission. All legislation recommended by official action of the commission must indicate that it is introduced at the request of the commission. Such legislation shall be prepared in time for presession filing pursuant to ORS 171.130. [2001 c.898 §14]

Sec. 15. Benefit packages for 2001-2003 biennium. For the 2001-2003 biennium, the benefit package of health care services provided to individuals currently receiving services under the Oregon Health Plan shall be the benefit package funded by the Seventy-first Legislative Assembly until sections 6 and 11 of this 2001 Act [414.833 and 414.839] become operative. [2001 c.898 §15]

Sec. 16. Operative date. (1) Sections 6, 10 and 11 of this 2001 Act [414.833, 414.837 and 414.839] become operative the day after the date of receipt by the Department of Human Services of the necessary waivers from the Centers for Medicare and Medicaid Services.

(2) The Director of Human Services shall notify the President of the Senate, the Speaker of the House of Representatives and the Legislative Counsel upon receipt of the waivers or denial of the waiver request. [2001 c.898 §16]

414.840 [Formerly 414.070; renumbered 566.340]

414.850 [Formerly 414.080; renumbered 566.350]

414.860 [Formerly 414.090; renumbered 566.360]