Chapter 414

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GENERAL PROVISIONS

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, aid to dependent children 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 aid to dependent children except for age and regular attendance in school or in a course of vocational or technical training.

(e) Is a caretaker relative named in ORS 418.035 (1)(c) who cares for a dependent child who would be a dependent child under the program for aid to dependent children except for age and regular attendance in school or in a course of vocational 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 Adult and Family Services Division 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)(c) who cares for a dependent child receiving aid to dependent children, or a child who would be eligible to receive aid to dependent children except for duration of residence requirement; 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 Children's Services Division.

(L) Is a member of a family which received aid to dependent children 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 four calendar months beginning with the month in which such family became ineligible for assistance because of increased hours of employment or increased earnings.

(m) Was receiving Title XIX benefits in the month of December 1973, and for that reason met all conditions of eligibility including financial eligibility for aid to the disabled or blind by criteria for blindness or disability and financial criteria established by the State of Oregon in effect on or before December 1973, had been determined to meet, and for subsequent months met all eligibility requirements.

(n) Is an essential spouse of an individual described in paragraph (m) of this subsection.

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

(p) 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.

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

(r) Is a pregnant woman who would be eligible for aid to families with dependent children including such aid based on the unemployment of a parent, whether or not the woman is eligible for cash assistance.

(s) Would be eligible for aid to families with dependent children pursuant to 42 U.S.C. 607 based upon the unemployment of a parent, whether or not the state provides cash assistance.

(t) 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.

(u) Is not otherwise categorically needy and is not eligible for care under Title XVIII of the federal Social Security Act, but whose family income is less than the federal poverty level.

(3) "Essential spouse" means the husband or wife of a recipient of a category of aid who is needy, is living with the recipient and provides a service that otherwise would have to be provided by some other means.

(4) "Income" means income as defined in ORS 413.005 (3).

(5) "Medical assistance" means so much of the following medical and remedial care and services as may be prescribed by the Adult and Family Services Division 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, 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;

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

(n) 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;

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

(p) 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;

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

(r) 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). [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]

414.030 [Repealed by 1953 c.204 §9]

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]

414.035 [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 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]

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. (1) The Adult and Family Services Division 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 aid to dependent children eligibility, the percent to be set by the division in consultation with the Legislative Assembly. [1985 c.747 §12; 1989 c.31 §1]

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

414.042 Determination of need and amount of aid. (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 Adult and Family Services Division, 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;

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

(d) The conditions existing in each case; and

(e) Except for eligible groups of aged, blind and disabled, or children under ORS 418.001 to 418.034 and 418.187 to 418.970, the report of the Health Services Commission as funded by the Legislative Assembly.

(2) Such amounts of income and resources may be disregarded as the division may prescribe by rules, except that the division 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 or regulation of the division 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 division, 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 as-

sistance program. [1967 c.502 §6; 1971 c.503 §1, 1989 c 836 §20]

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 division. The division 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 division.

(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]

414.050 [1953 c 204 §2, renumbered 414.820 and then 566 320]

414.051 Authorization and payment for dental services. The Adult and Family Services Division of the Department of Human Resources 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]

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 Adult and Family Services Division for a fair hearing. The hearing shall be held at a time and place and shall be conducted in accordance with the rules and regulations of the division. [1965 c 556 §4; 1971 c.734 §45; 1971 c 779 §47]

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 Adult and Family Services Division of the receipt or possession of such property or income, or other change in circumstances. Failure to give the notice shall entitle the Adult and Family Services Division to recover from the recipient the amount of assistance improperly disbursed by reason thereof. [1967 c 502 §8; 1971 c.779 §48]

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 Adult and Family Services Division 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.

(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 division 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 division 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 paragraphs (a), (b) and (c) of subsection (1) of this section for the eligible medically needy 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 division shall cause Type A hospitals, as defined in ORS 442.470, identified by the Office of Rural Health as rural hospitals to be reimbursed fully for the cost of covered services 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, provided by the hospital to a person entitled to receive medical assistance. [1965 c 556 §5; 1967 c 502 §12, 1975 c 509 §5, 1981 c 825 §4, 1987 c 918 §4; 1989 c 836 §21]

Note: Section 9, chapter 893, Oregon Laws 1989, provides:

Sec. 9. Subject to funds made available for this purpose, for the biennium ending June 30, 1991, type B hospitals, as defined in ORS 442.470, and identified by the Office of Rural Health as rural hospitals, shall be treated the same as type A hospitals for purposes of ORS 414 065 (5) if the type B hospital met the definition of type B rural hospital under ORS 442 470, as amended by section 8a of this Act, as of January 1, 1989

414.070 [1953 c.204 §4, renumbered 414.840 and then 566 340]

414.073 Information on all healing arts to be made available. When giving information concerning medical assistance, the Adult and Family Services Division 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]

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 Adult and Family Services Division 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 division 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]

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 ORS 411.405 and this chapter is subject to execution, levy, attachment, garnishment or other legal process. [1965 c 556 §11, 1967 c 502 §14]

414.105 Recovery of certain medical assistance; certain transfers of property voidable. (1) The Adult and Family Services Division may recover from any person the amounts of medical assistance incorrectly paid on behalf of such person.

(2) Medical assistance pursuant to ORS 411.405 and this chapter paid on behalf of an individual who was 65 years of age or older when the individual received such assistance may be recovered from the estate, or if there be no estate the estate of the surviving spouse, if any, shall be charged for such aid paid to either or both; provided, however, that 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 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) Except where there is a surviving spouse, or a surviving child who is under 21 years of age or is blind or permanently and totally disabled, the amount of any medical assistance paid under this chapter is a claim against the estate in any guardianship or conservatorship proceedings and may be paid pursuant to ORS 126.353.

(4) 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. [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]

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 Adult and Family Services Division 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 division; 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 division, 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 division as may be required by the division for its records, reports and audits. [1967 c.502 §9, 1975 c.401 §1, 1981 c.825 §5]

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 Adult and Family Services Division 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]

414.135 Contracts with direct providers of care and services. The Adult and Family Services Division 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 division pursuant to the number of days and the fees, charges and costs established under ORS 414.065. The contractor must guarantee the division 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 division as may be required by the division. [1967 c 502 §11]

414.145 Implementation of ORS 414.115 to 414.135. (1) The provisions of ORS 414.115, 414.125 or 414.135 shall be implemented whenever it appears to the Adult and Family Services Division that such implementation will provide comparable benefits at equal or less cost than provision thereof by direct payments by the division 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 division 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]

MEDICAL ADVISORY COMMITTEE

414.205 Medical advisory committee. (1) A medical advisory committee is established, consisting of not more than 15 members to be appointed by the Governor from among persons in the health professions, providers of medical and remedial care and services, including but not limited to physicians, hospital administrators, ambulance operators, pharmacists and dentists, and the general public. In making the appointment, the Governor shall consult with appropriate professional and other interested organizations.

(2) Members shall serve at the pleasure of the Governor.

(3) Members of the advisory 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. [1967 c.502 §18, 1981 c.825 §1]

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

414.215 Duties of committee. The medical advisory committee shall advise the Adult and Family Services Division on:

(1) Health and medical care and services to be provided pursuant to this chapter.

(2) Matters referred to it for study by the division. [1967 c 502 §19]

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

414.225 Division to consult with and assist committee. (1) The Adult and Family Services Division shall consult with the medical advisory committee concerning the determinations required under ORS 414.065.

(2) The division shall provide secretarial services to the medical advisory committee. [1967 c.502 §20]

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]

MISCELLANEOUS

414.305 Payment of cost of medical care for institutionalized persons. (1) The Adult and Family Services Division is hereby authorized to pay the cost of care for patients within Mental Health and Developmental Disability Services Division institutions under the medical assistance program established by this chapter.

(2) All moneys received by the Mental Health and Developmental Disability Services Division from the Adult and Family Services Division for the cost of care of patients shall be accounted for separately and deposited daily for credit to the Mental Health and Developmental Disability Services Account. [1969 c.507 §3, 1971 c.33 §1; 1977 c.384 §5]

Note: 414.305 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 414 by legislative action. See Preface to Oregon Revised Statutes for further explanation

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

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

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

(3) Except as provided in subsections (4) and (5) of this section, the division shall place no limit on the type of legend drug that may be prescribed by a practitioner, but shall

pay only for drugs in the generic form unless an exception has been granted by the division.

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

(5) Notwithstanding subsections (1) to (4) of this section, the division 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 which the division has determined should be limited to those conditions generally recognized as appropriate by the medical profession. [1977 c 818 §§2, 3; 1979 c 777 §45, 1979 c 785 §3, 1983 c 608 §2]

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 or any series therein 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 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 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

414.555 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 state-wide 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 Adult and Family Services Division 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 414.650, instrumentalities and political subdivisions of the state are authorized to enter into prepaid capitated health service contracts with the Adult and Family Services Division 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 division 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]

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

(2) The division 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 division 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 414.650. [1983 c 590 §4]

414.650 Oregon Health Care Cost Containment System Advisory Committee; members; duties; staff. (1) There is created an Oregon Health Care Cost Containment System Advisory Committee. The advisory committee shall be appointed by the Governor and composed of:

(a) One representative from the Oregon Medical Professional Review Organization;

(b) One representative of the Health Division;

(c) One member of the public with professional experience in health care economics;

(d) One representative of the Adult and Family Services Division;

(e) One member of the private sector with professional experience in capitated health care;

(f) Two consumer representatives;

(g) One representative from a health maintenance organization under contract with the Adult and Family Services Division;

(h) Two representatives from different physician care organizations under contract with the Adult and Family Services Division;

(i) One registered nurse licensed by the Oregon State Board of Nursing and practicing in a managed care organization; and

(j) One mental health practitioner licensed by the state to provide mental health services.

(2) The advisory committee shall be staffed by the office of the Director of Human Resources.

(3) The advisory committee shall evaluate and monitor the design and implementation of the Oregon Health Care Cost Containment System. Such evaluation and monitoring shall include, but not be limited to, the following aspects of the system:

(a) Contracting standards, criteria, procedures and processes;

(b) Client enrollment procedures;

(c) Administrative and fiscal impacts of the system on Adult and Family Services Division and contractors;

(d) The impact of the system on reasonable access to and quality of care for Adult and Family Services Division beneficiaries; and

(e) Overall fiscal ramifications of the system to the State of Oregon.

(4) The advisory committee shall serve as a consulting body to the Adult and Family Services Division regarding future changes in the system.

(5) The advisory committee shall report on a periodic basis to the Emergency Board or the Joint Committee on Ways and Means, whichever is appropriate.

(6) The members of the advisory committee shall serve without compensation or reimbursement of expenses. [1983 c.590 §7, 1987 c.660 §19; 1989 c.513 §1]

414.660 Demonstration projects for medical service contracts. The Adult and Family Services Division 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 division the reimbursement flexibility necessary to implement a prospective reimbursement system for hospital care. [1983 c.590 §5, 1985 c.747 §3]

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 Adult and Family Services Division is directed to phase eligible clients into the newly formed systems as rapidly as possible. [1983 c.590 §6, 1985 c.747 §3a]

DETERMINATION OF AND PAYMENT FOR ADDITIONAL HEALTH SERVICES

Note: Section 9, chapter 836, Oregon Laws 1989, provides.

Sec. 9. The prerequisites for implementation of this Act [ORS 414.025, 414.036, 414.042, 414.065 and 414.705 to 414.750] are:

(1) The Adult and Family Services Division shall obtain the necessary agreement from the Federal Government; and

(2) The Emergency Board must vote affirmatively to authorize the release of the appropriation for the second year of the 1989-1991 biennium. [1989 c.836 §9]

414.705 Definitions for ORS 414.705 to 414.750. As used in ORS 414.025, 414.036, 414.042, 414.065 and 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]

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

414.710 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):

(1) Nursing facilities and home- and community-based waivered services funded through the Senior and Disabled Services Division;

(2) Medical assistance for the aged, the blind and the disabled or medical care provided to children under ORS 418.001 to 418.034 and 418.187 to 418.970;

(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 Children's Services Division by order of the juvenile court and services to children and families for health care or mental health care through the division. [1989 c.836 §3]

Note: See note under 414.705.

414.715 Health Services Commission; confirmation; qualifications; terms; expenses; subcommittees. (1) The Health Services Commission is established, consisting of 11 members appointed by the Governor and confirmed by the Senate. Five members shall be physicians licensed to practice medicine in this state who have clinical expertise in the general areas of obstetrics, perinatal, pediatrics, adult medicine, 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]

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 consult with the Joint Legislative Committee on Health Care and 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) In conjunction with the Joint Legislative Committee on Health Care, the commission shall actively solicit public involvement in a community meeting process to build a consensus on the values to be used to guide health resource allocation decisions.

(3) The commission shall report to the Governor a list of health services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the entire population to be served. The recommendation 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.

(4) 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 Joint Legislative Committee on Health Care.

(5) The Joint Legislative Committee on Health Care shall determine whether or not to recommend funding of the Health Services Commission's report to the Legislative Assembly and shall advise the Governor of its recommendations. After considering the recommendations of the Joint Legislative Committee on Health Care, the Legislative Assembly shall fund the report to the extent that funds are available to do so. [1989 c 836 §4a]

Note: See note under 414 705

Note: Section 5, chapter 836, Oregon Laws 1989, provides.

Sec. 5. For the purpose of this Act [414 025, 414 036, 414 042, 414 065 and 414 705 to 414 750], and for the 1989-1991 biennium only

(1) The Health Services Commission shall make its report to the Governor and to the Joint Legislative Committee on Health Care no later than March 1, 1990.

(2) The committee shall make its recommendations to the Emergency Board

(3) After consideration of the recommendations of the committee, the Emergency Board shall fund the report to the extent that funds are available to do so

(4) The Joint Legislative Committee on Health Care and the Emergency Board are not authorized to alter the report of the Health Services Commission. [1989 c 836 §5]

414.725 Prepaid managed care health services contracts; case management systems; expenditure limitation; state

supervision; notice to patient. Upon meeting the requirements of ORS 414.740:

(1) Pursuant to rules adopted by the Adult and Family Services Division, the division shall execute prepaid managed care health services contracts for the health services funded pursuant to ORS 414.740. 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 414.025, 414.036, 414.042, 414.065 and 414.705 to 414.750 that the state move toward utilizing full service managed care health service providers for providing health services under ORS 414.025, 414.036, 414.042, 414.065 and 414.705 to 414.750. The division 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 division shall not discriminate against any contractors which offer services within their providers' lawful scopes of practice.

(2) The initial contract period shall begin on or after July 1, 1990.

(3) Except for special circumstances recognized in rules of the division, all subsequent contracts shall be for one-year periods starting on July 1, 1991.

(4) 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 division 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 414.025, 414.036, 414.042, 414.065 and 414.705 to 414.750. In addition, the division 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.

(5) As provided in subsections (1) and (4) of this section, the aggregate expenditures by the Adult and Family Services Division for health services provided pursuant to ORS 414.025, 414.036, 414.042, 414.065 and 414.705 to 414.750 shall not exceed the total dollars appropriated for health services under ORS 414.025, 414.036, 414.042, 414.065 and 414.705 to 414.750.

(6) Actions taken by providers, potential providers, contractors and bidders in specific accordance with ORS 414.025, 414.036, 414.042, 414.065 and 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.

(7) Health care providers contracting to provide services under ORS 414.025, 414.036, 414.042, 414.065 and 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]

Note: See note under 414.705.

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 that shall be reported to the Sixty-sixth Legislative Assembly. 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]

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 414.025, 414.036, 414.042, 414.065 and 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]

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 414.025, 414.036, 414.042, 414.065 and 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]

Note: See note under 414.705

414.750 Authority of Legislative Assembly to authorize services for other persons. Nothing in ORS 414.025, 414.036, 414.042, 414.065 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]

Note: See note under 414.705.

414.810 [Formerly 414.040; renumbered 566.310]

414.820 [Formerly 414.050, renumbered 566.320]

414.830 [Formerly 414.060, renumbered 566.330]

414.840 [Formerly 414.070; renumbered 566.340]

414.850 [Formerly 414.080, renumbered 566.350]

414.860 [Formerly 414.090, renumbered 566.360]