Chapter 442

2015 EDITION

Health Planning

442.005 [1955 c.533 §2; 1973 c.754 §1; repealed by 1977 c.717 §23]

442.010 [Amended by 1955 c.533 §3; 1971 c.650 §20; repealed by 1977 c.717 §23]

ADMINISTRATOR OF THE OFFICE FOR OREGON HEALTH POLICY AND RESEARCH

442.011 Office for Oregon Health Policy and Research created; appointment of administrator. There is created in the Oregon Health Authority the Office for Oregon Health Policy and Research. The Administrator of the Office for Oregon Health Policy and Research shall be appointed by the Director of the Oregon Health Authority. The administrator shall be an individual with demonstrated proficiency in planning and managing programs with complex public policy and fiscal aspects such as those involved in the medical assistance program. [1993 c.725 §33; 1997 c.683 §16; 2001 c.69 §1; 2003 c.784 §5; 2007 c.697 §§14,15; 2009 c.595 §§747,748; 2011 c.720 §197]

ADMINISTRATION

442.015 Definitions. As used in ORS chapter 441 and this chapter, unless the context requires otherwise:

(1) "Acquire" or "acquisition" means obtaining equipment, supplies, components or facilities by any means, including purchase, capital or operating lease, rental or donation, for the purpose of using such equipment, supplies, components or facilities to provide health services in Oregon. When equipment or other materials are obtained outside of this state, acquisition is considered to occur when the equipment or other materials begin to be used in Oregon for the provision of health services or when such services are offered for use in Oregon.

(2) "Affected persons" has the same meaning as given to "party" in ORS 183.310.

(3)(a) "Ambulatory surgical center" means a facility or portion of a facility that operates exclusively for the purpose of providing surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission.

(b) "Ambulatory surgical center" does not mean:

(A) Individual or group practice offices of private physicians or dentists that do not contain a distinct area used for outpatient surgical treatment on a regular and organized basis, or that only provide surgery routinely provided in a physician's or dentist's office using local anesthesia or conscious sedation; or

(B) A portion of a licensed hospital designated for outpatient surgical treatment.

(4) "Delegated credentialing agreement" means a written agreement between an originating-site hospital and a distant-site hospital that provides that the medical staff of the originating-site hospital will rely upon the credentialing and privileging decisions of the distant-site hospital in making recommendations to the governing body of the originating-site hospital as to whether to credential a telemedicine provider, practicing at the distant-site hospital either as an employee or under contract, to provide telemedicine services to patients in the originating-site hospital.

(5) "Develop" means to undertake those activities that on their completion will result in the offer of a new institutional health service or the incurring of a financial obligation, as defined under applicable state law, in relation to the offering of such a health service.

(6) "Distant-site hospital" means the hospital where a telemedicine provider, at the time the telemedicine provider is providing telemedicine services, is practicing as an employee or under contract.

(7) "Essential long term care facility" means an individual long term care facility that serves predominantly rural and frontier communities, as designated by the Office of Rural Health, and meets other criteria established by the Department of Human Services by rule.

(8) "Expenditure" or "capital expenditure" means the actual expenditure, an obligation to an expenditure, lease or similar arrangement in lieu of an expenditure, and the reasonable value of a donation or grant in lieu of an expenditure but not including any interest thereon.

(9) "Freestanding birthing center" means a facility licensed for the primary purpose of performing low risk deliveries.

(10) "Governmental unit" means the state, or any county, municipality or other political subdivision, or any related department, division, board or other agency.

(11) "Gross revenue" means the sum of daily hospital service charges, ambulatory service charges, ancillary service charges and other operating revenue. "Gross revenue" does not include contributions, donations, legacies or bequests made to a hospital without restriction by the donors.

(12)(a) "Health care facility" means:

(A) A hospital;

(B) A long term care facility;

(C) An ambulatory surgical center;

(D) A freestanding birthing center; or

(E) An outpatient renal dialysis center.

(b) "Health care facility" does not mean:

(A) A residential facility licensed by the Department of Human Services or the Oregon Health Authority under ORS 443.415;

(B) An establishment furnishing primarily domiciliary care as described in ORS 443.205;

(C) A residential facility licensed or approved under the rules of the Department of Corrections;

(D) Facilities established by ORS 430.335 for treatment of substance abuse disorders; or

(E) Community mental health programs or community developmental disabilities programs established under ORS 430.620.

(13) "Health maintenance organization" or "HMO" means a public organization or a private organization organized under the laws of any state that:

(a) Is a qualified HMO under section 1310 (d) of the U.S. Public Health Services Act; or

(b)(A) Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services:

(i) Usual physician services;

(ii) Hospitalization;

(iii) Laboratory;

(iv) X-ray;

(v) Emergency and preventive services; and

(vi) Out-of-area coverage;

(B) Is compensated, except for copayments, for the provision of the basic health care services listed in subparagraph (A) of this paragraph to enrolled participants on a predetermined periodic rate basis; and

(C) Provides physicians' services primarily directly through physicians who are either employees or partners of such organization, or through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

(14) "Health services" means clinically related diagnostic, treatment or rehabilitative services, and includes alcohol, drug or controlled substance abuse and mental health services that may be provided either directly or indirectly on an inpatient or ambulatory patient basis.

(15) "Hospital" means:

(a) A facility with an organized medical staff and a permanent building that is capable of providing 24-hour inpatient care to two or more individuals who have an illness or injury and that provides at least the following health services:

(A) Medical;

(B) Nursing;

(C) Laboratory;

(D) Pharmacy; and

(E) Dietary; or

(b) A special inpatient care facility as that term is defined by the authority by rule.

(16) "Institutional health services" means health services provided in or through health care facilities and includes the entities in or through which such services are provided.

(17) "Intermediate care facility" means a facility that provides, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment that a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services above the level of room and board that can be made available to them only through institutional facilities.

(18)(a) "Long term care facility" means a permanent facility with inpatient beds, providing:

(A) Medical services, including nursing services but excluding surgical procedures except as may be permitted by the rules of the Director of Human Services; and

(B) Treatment for two or more unrelated patients.

(b) "Long term care facility" includes skilled nursing facilities and intermediate care facilities but does not include facilities licensed and operated pursuant to ORS 443.400 to 443.455.

(19) "New hospital" means:

(a) A facility that did not offer hospital services on a regular basis within its service area within the prior 12-month period and is initiating or proposing to initiate such services; or

(b) Any replacement of an existing hospital that involves a substantial increase or change in the services offered.

(20) "New skilled nursing or intermediate care service or facility" means a service or facility that did not offer long term care services on a regular basis by or through the facility within the prior 12-month period and is initiating or proposing to initiate such services. "New skilled nursing or intermediate care service or facility" also includes the rebuilding of a long term care facility, the relocation of buildings that are a part of a long term care facility, the relocation of long term care beds from one facility to another

or an increase in the number of beds of more than 10 or 10 percent of the bed capacity, whichever is the lesser, within a two-year period in a facility that applied for a certificate of need between August 1, 2011, and December 1, 2012, or submitted a letter of intent under ORS 442.315 (7) between January 15, 2013, and January 31, 2013.

(21) "Offer" means that the health care facility holds itself out as capable of providing, or as having the means for the provision of, specified health services.

(22) "Originating-site hospital" means a hospital in which a patient is located while receiving telemedicine services.

(23) "Outpatient renal dialysis facility" means a facility that provides renal dialysis services directly to outpatients.

(24) "Person" means an individual, a trust or estate, a partnership, a corporation (including associations, joint stock companies and insurance companies), a state, or a political subdivision or instrumentality, including a municipal corporation, of a state.

(25) "Skilled nursing facility" means a facility or a distinct part of a facility, that is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or an institution that provides rehabilitation services for the rehabilitation of individuals who are injured or sick or who have disabilities.

(26) "Telemedicine" means the provision of health services to patients by physicians and health care practitioners from a distance using electronic communications. [1977 c.751 §1; 1979 c.697 §2; 1979 c.744 §31; 1981 c.693 §1; 1983 c.482 §1; 1985 c.747 §16; 1987 c.320 §233; 1987 c.660 §4; 1987 c.753 §2; 1989 c.708 §5; 1989 c.1034 §5; 1991 c.470 §9; 2001 c.100 §1; 2001 c.104 §181a; 2001 c.900 §179; 2003 c.75 §91; 2003 c.784 §11; 2005 c.22 §300; 2007 c.70 §242; 2009 c.595 §749; 2009 c.792 §63; 2013 c.414 §3; 2013 c.608 §16]

Note: The amendments to 442.015 by section 22, chapter 608, Oregon Laws 2013, become operative June 30, 2020. See section 26, chapter 608, Oregon Laws 2013. The text that is operative on and after June 30, 2020, is set forth for the user's convenience.

442.015. As used in ORS chapter 441 and this chapter, unless the context requires otherwise:

(1) "Acquire" or "acquisition" means obtaining equipment, supplies, components or facilities by any means, including purchase, capital or operating lease, rental or donation, for the purpose of using such equipment, supplies, components or facilities to provide health services in Oregon. When equipment or other materials are obtained outside of this state, acquisition is considered to occur when the equipment or other materials begin to be used in Oregon for the provision of health services or when such services are offered for use in Oregon.

(2) "Affected persons" has the same meaning as given to "party" in ORS 183.310.

(3)(a) "Ambulatory surgical center" means a facility or portion of a facility that operates exclusively for the purpose of providing surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission.

(b) "Ambulatory surgical center" does not mean:

(A) Individual or group practice offices of private physicians or dentists that do not contain a distinct area used for outpatient surgical treatment on a regular and organized basis, or that only provide surgery routinely provided in a physician's or dentist's office using local anesthesia or conscious sedation; or

(B) A portion of a licensed hospital designated for outpatient surgical treatment.

(4) "Delegated credentialing agreement" means a written agreement between an originating-site hospital and a distant-site hospital that provides that the medical staff of the originating-site hospital will rely upon the credentialing and privileging decisions of the distant-site hospital in making recommendations to the governing body of the originating-site hospital as to whether to credential a telemedicine provider, practicing at the distant-site hospital either as an employee or under contract, to provide telemedicine services to patients in the originating-site hospital.

(5) "Develop" means to undertake those activities that on their completion will result in the offer of a new institutional health service or the incurring of a financial obligation, as defined under applicable state law, in relation to the offering of such a health service.

(6) "Distant-site hospital" means the hospital where a telemedicine provider, at the time the telemedicine provider is providing telemedicine services, is practicing as an employee or under contract.

(7) "Expenditure" or "capital expenditure" means the actual expenditure, an obligation to an expenditure, lease or similar arrangement in lieu of an expenditure, and the reasonable value of a donation or grant in lieu of an expenditure but not including any interest thereon.

(8) "Freestanding birthing center" means a facility licensed for the primary purpose of performing low risk deliveries.

(9) "Governmental unit" means the state, or any county, municipality or other political subdivision, or any related department, division, board or other agency.

(10) "Gross revenue" means the sum of daily hospital service charges, ambulatory service charges, ancillary service charges and other operating revenue. "Gross revenue" does not include contributions, donations, legacies or bequests made to a hospital without restriction by the donors.

(11)(a) "Health care facility" means:

(A) A hospital;

(B) A long term care facility;

(C) An ambulatory surgical center;

(D) A freestanding birthing center; or

(E) An outpatient renal dialysis center.

(b) "Health care facility" does not mean:

(A) A residential facility licensed by the Department of Human Services or the Oregon Health Authority under ORS 443.415;

(B) An establishment furnishing primarily domiciliary care as described in ORS 443.205;

(C) A residential facility licensed or approved under the rules of the Department of Corrections;

(D) Facilities established by ORS 430.335 for treatment of substance abuse disorders; or

(E) Community mental health programs or community developmental disabilities programs established under ORS 430.620.

(12) "Health maintenance organization" or "HMO" means a public organization or a private organization organized under the laws of any state that:

(a) Is a qualified HMO under section 1310 (d) of the U.S. Public Health Services Act; or

(b)(A) Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services:

(i) Usual physician services;

(ii) Hospitalization;

(iii) Laboratory;

(iv) X-ray;

(v) Emergency and preventive services; and

(vi) Out-of-area coverage;

(B) Is compensated, except for copayments, for the provision of the basic health care services listed in subparagraph (A) of this paragraph to enrolled participants on a predetermined periodic rate basis; and

(C) Provides physicians' services primarily directly through physicians who are either employees or partners of such organization, or through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

(13) "Health services" means clinically related diagnostic, treatment or rehabilitative services, and includes alcohol, drug or controlled substance abuse and mental health services that may be provided either directly or indirectly on an inpatient or ambulatory patient basis.

(14) "Hospital" means:

(a) A facility with an organized medical staff and a permanent building that is capable of providing 24-hour inpatient care to two or more individuals who have an illness or injury and that provides at least the following health services:

(A) Medical;

(B) Nursing;

(C) Laboratory;

(D) Pharmacy; and

(E) Dietary; or

(b) A special inpatient care facility as that term is defined by the authority by rule.

(15) "Institutional health services" means health services provided in or through health care facilities and includes the entities in or through which such services are provided.

(16) "Intermediate care facility" means a facility that provides, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment that a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services above the level of room and board that can be made available to them only through institutional facilities.

(17)(a) "Long term care facility" means a permanent facility with inpatient beds, providing:

(A) Medical services, including nursing services but excluding surgical procedures except as may be permitted by the rules of the Director of Human Services; and

(B) Treatment for two or more unrelated patients.

(b) "Long term care facility" includes skilled nursing facilities and intermediate care facilities but does not include facilities licensed and operated pursuant to ORS 443.400 to 443.455.

(18) "New hospital" means:

(a) A facility that did not offer hospital services on a regular basis within its service area within the prior 12-month period and is initiating or proposing to initiate such services; or

(b) Any replacement of an existing hospital that involves a substantial increase or change in the services offered.

(19) "New skilled nursing or intermediate care service or facility" means a service or facility that did not offer long term care services on a regular basis by or through the facility within the prior 12-month period and is initiating or proposing to initiate such services. "New skilled nursing or intermediate care service or facility" also includes the rebuilding of a long term care facility, the relocation of buildings that are a part of a long term care facility, the relocation of long term care beds from one facility to another or an increase in the number of beds of more than 10 or 10 percent of the bed capacity, whichever is the lesser, within a two-year period.

(20) "Offer" means that the health care facility holds itself out as capable of providing, or as having the means for the provision of, specified health services.

(21) "Originating-site hospital" means a hospital in which a patient is located while receiving telemedicine services.

(22) "Outpatient renal dialysis facility" means a facility that provides renal dialysis services directly to outpatients.

(23) "Person" means an individual, a trust or estate, a partnership, a corporation (including associations, joint stock companies and insurance companies), a state, or a political subdivision or instrumentality, including a municipal corporation, of a state.

(24) "Skilled nursing facility" means a facility or a distinct part of a facility, that is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or an institution that provides rehabilitation services for the rehabilitation of individuals who are injured or sick or who have disabilities.

(25) "Telemedicine" means the provision of health services to patients by physicians and health care practitioners from a distance using electronic communications.

442.020 [Amended by 1955 c.533 §4; 1973 c.754 §2; repealed by 1977 c.717 §23]

442.025 Findings and policy. (1) The Legislative Assembly finds that the achievement of reasonable access to quality health care at a reasonable cost is a priority of the State of Oregon.

(2) Problems preventing the priority in subsection (1) of this section from being attained include:

(a) The inability of many citizens to pay for necessary health care, being covered neither by private insurance nor by publicly funded programs such as Medicare and Medicaid;

(b) Rising costs of medical care which exceed substantially the general rate of inflation;

(c) Insufficient price competition in the delivery of health care services that would provide a greater cost consciousness among providers, payers and consumers;

(d) Inadequate incentives for the use of less costly and more appropriate alternative levels of health care;

(e) Insufficient or inappropriate use of existing capacity, duplicated services and failure to use less costly alternatives in meeting significant health needs; and

(f) Insufficient primary and emergency medical care services in medically underserved areas of the state.

(3) As a result of rising health care costs and the concern expressed by health care providers, health care users, third-party payers and the general public, there is an urgent need to abate these rising costs so as to place the cost of health care within reach of all Oregonians without affecting the quality of care.

(4) To foster the cooperation of the separate industry forces, there is a need to compile and disseminate accurate and current data, including but not limited to price and utilization data, to meet the needs of the people of Oregon and improve the appropriate usage of health care services.

(5) It is the purpose of this chapter to establish area-wide and state planning for health services, staff and facilities in light of the findings of subsection (1) of this section and in furtherance of health planning policies of this state.

(6) It is further declared that hospital costs should be contained through improved competition between hospitals and improved competition between insurers and through financial incentives on behalf of providers, insurers and consumers to contain costs. As a safety net, it is the intent of the Legislative Assembly to monitor hospital performance. [1977 c.751 §2; 1981 c.693 §2; 1983 c.482 §2; 1985 c.747 §1; 1987 c.660 §3]

442.030 [Amended by 1955 c.533 §5; 1961 c.316 §8; 1967 c.89 §4; repealed by 1977 c.717 §23]

442.035 [1977 c.751 §3; 1979 c.697 §3; 1981 c.693 §3; 1983 c.482 §3; 1985 c.747 §4; 1987 c.660 §1; 1995 c.727 §20; 1997 c.683 §17; 2001 c.280 §1; 2003 c.784 §1; 2005 c.771 §2; repealed by 2009 c.595 §1204]

442.040 [Amended by 1955 c.533 §6; 1973 c.754 §3; repealed by 1977 c.717 §23]

442.045 [1977 c.751 §4; 1981 c.693 §4; 1983 c.482 §4; 1985 c.187 §1; 1985 c.747 §5; 1987 c.660 §2; 1991 c.470 §17; 1995 c.727 §22; 1997 c.683 §18; 1999 c.581 §1; 2003 c.784 §3; repealed by 2009 c.595 §1204]

442.050 [Amended by 1957 c.697 §3; 1969 c.535 §2; 1973 c.754 §4; 1977 c.284 §50; repealed by 1977 c.717 §23]

442.053 [1955 c.533 §7; 1973 c.754 §5; repealed by 1977 c.717 §23]

442.055 [1955 c.533 §8; repealed by 1973 c.754 §8]

442.057 [1977 c.751 §15; 1981 c.693 §5; 2003 c.784 §4; repealed by 2009 c.595 §1204]

442.060 [Amended by 1963 c.92 §1; repealed by 1977 c.717 §23]

442.070 [Amended by 1961 c.316 §9; 1967 c.89 §5; repealed by 1971 c.734 §21]

442.075 [1971 c.734 §58; repealed by 1973 c.754 §6 (442.076 enacted in lieu of 442.075)]

442.076 [1973 c.754 §7 (enacted in lieu of 442.075); repealed by 1977 c.717 §23]

442.080 [Repealed by 1977 c.717 §23]

442.085 [1977 c.751 §5; 1981 c.693 §6; repealed by 1987 c.660 §40]

442.090 [Repealed by 1955 c.533 §10]

442.095 [1977 c.751 §6; 1981 c.693 §7; 1983 c.482 §5; 1985 c.747 §7; 1987 c.660 §5; 1993 c.754 §6; repealed by 1995 c.727 §48]

442.100 [1977 c.751 §7; repealed by 1981 c.693 §31]

442.105 [1977 c.751 §38; 1981 c.693 §8; 1983 c.482 §6; repealed by 1987 c.660 §40]

442.110 [Formerly 431.250 (3), (4); repealed by 1987 c.660 §40]

442.120 Ambulatory surgery and inpatient discharge abstract records; alternative data; rules; fees. In order to provide data essential for health planning programs:

(1) The Oregon Health Authority may request, by July 1 of each year, each general hospital to file with the authority ambulatory surgery and inpatient discharge abstract records covering all patients discharged during the preceding calendar year. The ambulatory surgery and inpatient discharge abstract record for each patient must include the following information, and may include other information deemed necessary by the authority for developing or evaluating statewide health policy:

(a) Date of birth;

(b) Sex;

(c) Race and ethnicity;

(d) Primary language;

(e) Disability;

(f) Zip code;

(g) Inpatient admission date or outpatient service date;

(h) Inpatient discharge date;

(i) Type of discharge;

(j) Diagnostic related group or diagnosis;

(k) Type of procedure performed;

(L) Expected source of payment, if available;

(m) Hospital identification number; and

(n) Total hospital charges.

(2) By July 1 of each year, the authority may request from ambulatory surgical centers licensed under ORS 441.015 ambulatory surgery discharge abstract records covering all patients admitted during the preceding year. Ambulatory surgery discharge abstract records must include information similar to that requested from general hospitals under subsection (1) of this section.

(3) In lieu of abstracting and compiling the records itself, the authority may solicit the voluntary submission of such data from Oregon hospitals or other sources to enable

it to carry out its responsibilities under this section. If such data are not available to the authority on an annual and timely basis, the authority may establish by rule a fee to be charged to each hospital.

(4) Subject to prior approval of the Oregon Health Policy Board and a report to the Emergency Board, if the Legislative Assembly is not in session, prior to adopting the fee, and within the budget authorized by the Legislative Assembly as the budget may be modified by the Emergency Board, the fee established under subsection (3) of this section may not exceed the cost of abstracting and compiling the records.

(5) The authority may specify by rule the form in which the records are to be submitted. If the form adopted by rule requires conversion from the form regularly used by a hospital, reasonable costs of such conversion shall be paid by the authority.

(6) Abstract records must include a patient identifier that allows for the statistical matching of records over time to permit public studies of issues related to clinical practices, health service utilization and health outcomes. Provision of such a patient identifier must not allow for identification of the individual patient.

(7) In addition to the records required in subsection (1) of this section, the authority may obtain abstract records for each patient that identify specific services, classified by International Classification of Disease Code, for special studies on the incidence of specific health problems or diagnostic practices. However, nothing in this subsection shall authorize the publication of specific data in a form that allows identification of individual patients or licensed health care professionals.

(8) The authority may provide by rule for the submission of records for enrollees in a health maintenance organization from a hospital associated with such an organization in a form the authority determines appropriate to the authority's needs for such data and the organization's record keeping and reporting systems for charges and services. [Formerly 442.355; 1991 c.703 §7; 1993 c.754 §7; 1995 c.727 §23; 1997 c.683 §19; 1999 c.581 §2; 2007 c.71 §128; 2009 c.595 §750; 2015 c.318 §6]

442.150 [1977 c.751 §10; repealed by 1987 c.660 §40]

442.155 [1977 c.751 §11; 1983 c.482 §7; 1985 c.747 §6; repealed by 1987 c.660 §40]

442.160 [1977 c.751 §12; repealed by 1987 c.660 §40]

442.165 [1977 c.751 §13; 1981 c.693 §9; repealed by 1983 c.482 §23]

442.170 [1977 c.751 §14; repealed by 1983 c.482 §23]

442.200 Definitions for ORS 442.205. As used in this section and ORS 442.205:

(1) "Charity care" means free or discounted health services provided to persons who cannot afford to pay and from whom a hospital has no expectation of payment. "Charity care" does not include bad debt, contractual allowances or discounts for quick payment.

(2) "Community benefit" means a program or activity that provides treatment or promotes health and healing in response to an identified community need. "Community benefit" includes:

(a) Charity care;

(b) Losses related to Medicaid, Medicare, State Children's Health Insurance Program or other publicly funded health care program shortfalls;

(c) Community health improvement services;

(d) Research;

(e) Financial and in-kind contributions to the community; and

(f) Community building activities affecting health in the community. [2007 c.384 §2]

Note: 442.200 and 442.205 were added to and made a part of ORS chapter 442 by legislative action but were not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

442.205 Community benefit reporting; rules. (1) The Oregon Health Authority shall by rule adopt a cost-based community benefit reporting system for hospitals operating in Oregon that is consistent with established national standards for hospital reporting of community benefits.

(2) Within 90 days of filing a Medicare cost report, a hospital must submit a community benefit report to the authority of the community benefits provided by the hospital, on a form prescribed by the authority.

(3) The authority shall produce an annual report of the information provided under subsections (1) and (2) of this section. The report shall be submitted to the Governor, the President of the Senate and the Speaker of the House of Representatives. The report shall be presented to the Legislative Assembly during each odd-numbered year regular session and shall be made available to the public.

(4) The authority may adopt all rules necessary to carry out the provisions of this section. [2007 c.384 §3; 2011 c.545 §56; 2015 c.318 §28]

Note: See note under 442.200.

442.210 [2009 c.595 §1163; 2015 c.318 §29; 2015 c.798 §8; renumbered 413.259 in 2015]

442.300 [Formerly 441.010; repealed by 1981 c.693 §31]

CERTIFICATES OF NEED FOR HEALTH SERVICES

442.315 Certificate of need; rules; fees; enforcement; exceptions; letter of intent. (1) Any new hospital or new skilled nursing or intermediate care service or facility not excluded pursuant to ORS 441.065, and any long term care facility for which a license was surrendered under section 15, chapter 608, Oregon Laws 2013, shall obtain a certificate of need from the Oregon Health Authority prior to an offering or development.

(2) The authority shall adopt rules specifying criteria and procedures for making decisions as to the need for the new services or facilities.

(3)(a) An applicant for a certificate of need shall apply to the authority on forms provided for this purpose by authority rule.

(b) An applicant shall pay a fee prescribed as provided in this section. Subject to the approval of the Oregon Department of Administrative Services, the authority shall prescribe application fees, based on the complexity and scope of the proposed project.

(4) The authority shall be the decision-making authority for the purpose of certificates of need. The authority may establish an expedited review process for an application for a certificate of need to rebuild a long term care facility, relocate buildings that are part of a long term care facility or relocate long term care facility bed capacity from one long term care facility to another. The authority shall issue a proposed order not later than 120 days after the date a complete application for expedited review is received by the authority.

(5)(a) An applicant or any affected person who is dissatisfied with the proposed decision of the authority is entitled to an informal hearing in the course of review and before a final decision is rendered.

(b) Following a final decision being rendered by the authority, an applicant or any affected person may request a reconsideration hearing pursuant to ORS chapter 183.

(c) In any proceeding brought by an affected person or an applicant challenging an authority decision under this subsection, the authority shall follow procedures consistent with the provisions of ORS chapter 183 relating to a contested case.

(6) Once a certificate of need has been issued, it may not be revoked or rescinded unless it was acquired by fraud or deceit. However, if the authority finds that a person is offering or developing a project that is not within the scope of the certificate of need, the authority may limit the project as specified in the issued certificate of need or reconsider the application. A certificate of need is not transferable.

(7) Nothing in this section applies to any hospital, skilled nursing or intermediate care service or facility that seeks to replace equipment with equipment of similar basic technological function or an upgrade that improves the quality or cost-effectiveness of the service provided. Any person acquiring such replacement or upgrade shall file a letter of intent for the project in accordance with the rules of the authority if the price of the replacement equipment or upgrade exceeds $1 million.

(8) Except as required in subsection (1) of this section for a new hospital or new skilled nursing or intermediate care service or facility not operating as a Medicare swing bed program, nothing in this section requires a rural hospital as defined in ORS 442.470 (5)(a)(A) and (B) to obtain a certificate of need.

(9) Nothing in this section applies to basic health services, but basic health services do not include:

(a) Magnetic resonance imaging scanners;

(b) Positron emission tomography scanners;

(c) Cardiac catheterization equipment;

(d) Megavoltage radiation therapy equipment;

(e) Extracorporeal shock wave lithotriptors;

(f) Neonatal intensive care;

(g) Burn care;

(h) Trauma care;

(i) Inpatient psychiatric services;

(j) Inpatient chemical dependency services;

(k) Inpatient rehabilitation services;

(L) Open heart surgery; or

(m) Organ transplant services.

(10) In addition to any other remedy provided by law, whenever it appears that any person is engaged in, or is about to engage in, any acts that constitute a violation of this section, or any rule or order issued by the authority under this section, the authority may institute proceedings in the circuit courts to enforce obedience to such statute, rule or order by injunction or by other processes, mandatory or otherwise.

(11) As used in this section, "basic health services" means health services offered in or through a hospital licensed under ORS chapter 441, except skilled nursing or intermediate care nursing facilities or services and those services specified in subsection (9) of

this section. [1989 c.1034 §2; 1993 c.722 §3; 1995 c.727 §39; 2001 c.875 §3; 2003 c.14 §258; 2009 c.595 §751; 2013 c.608 §17]

Note: The amendments to 442.315 by section 23, chapter 608, Oregon Laws 2013, become operative June 30, 2020. See section 26, chapter 608, Oregon Laws 2013. The text that is operative on and after June 30, 2020, is set forth for the user's convenience.

442.315. (1) Any new hospital or new skilled nursing or intermediate care service or facility not excluded pursuant to ORS 441.065 shall obtain a certificate of need from the Oregon Health Authority prior to an offering or development.

(2) The authority shall adopt rules specifying criteria and procedures for making decisions as to the need for the new services or facilities.

(3)(a) An applicant for a certificate of need shall apply to the authority on forms provided for this purpose by authority rule.

(b) An applicant shall pay a fee prescribed as provided in this section. Subject to the approval of the Oregon Department of Administrative Services, the authority shall prescribe application fees, based on the complexity and scope of the proposed project.

(4) The authority shall be the decision-making authority for the purpose of certificates of need. The authority may establish an expedited review process for an application for a certificate of need to rebuild a long term care facility, relocate buildings that are part of a long term care facility or relocate long term care facility bed capacity from one long term care facility to another. The authority shall issue a proposed order not later than 120 days after the date a complete application for expedited review is received by the authority.

(5)(a) An applicant or any affected person who is dissatisfied with the proposed decision of the authority is entitled to an informal hearing in the course of review and before a final decision is rendered.

(b) Following a final decision being rendered by the authority, an applicant or any affected person may request a reconsideration hearing pursuant to ORS chapter 183.

(c) In any proceeding brought by an affected person or an applicant challenging an authority decision under this subsection, the authority shall follow procedures consistent with the provisions of ORS chapter 183 relating to a contested case.

(6) Once a certificate of need has been issued, it may not be revoked or rescinded unless it was acquired by fraud or deceit. However, if the authority finds that a person is offering or developing a project that is not within the scope of the certificate of need, the authority may limit the project as specified in the issued certificate of need or reconsider the application. A certificate of need is not transferable.

(7) Nothing in this section applies to any hospital, skilled nursing or intermediate care service or facility that seeks to replace equipment with equipment of similar basic technological function or an upgrade that improves the quality or cost-effectiveness of the service provided. Any person acquiring such replacement or upgrade shall file a letter of intent for the project in accordance with the rules of the authority if the price of the replacement equipment or upgrade exceeds $1 million.

(8) Except as required in subsection (1) of this section for a new hospital or new skilled nursing or intermediate care service or facility not operating as a Medicare swing bed program, nothing in this section requires a rural hospital as defined in ORS 442.470 (5)(a)(A) and (B) to obtain a certificate of need.

(9) Nothing in this section applies to basic health services, but basic health services do not include:

(a) Magnetic resonance imaging scanners;

(b) Positron emission tomography scanners;

(c) Cardiac catheterization equipment;

(d) Megavoltage radiation therapy equipment;

(e) Extracorporeal shock wave lithotriptors;

(f) Neonatal intensive care;

(g) Burn care;

(h) Trauma care;

(i) Inpatient psychiatric services;

(j) Inpatient chemical dependency services;

(k) Inpatient rehabilitation services;

(L) Open heart surgery; or

(m) Organ transplant services.

(10) In addition to any other remedy provided by law, whenever it appears that any person is engaged in, or is about to engage in, any acts that constitute a violation of this section, or any rule or order issued by the authority under this section, the authority may institute proceedings in the circuit courts to enforce obedience to such statute, rule or order by injunction or by other processes, mandatory or otherwise.

(11) As used in this section, "basic health services" means health services offered in or through a hospital licensed under ORS chapter 441, except skilled nursing or intermediate care nursing facilities or services and those services specified in subsection (9) of this section.

(Temporary provisions relating to certificates of need for long term care facilities)

Note: Sections 14, 15 and 27, chapter 608, Oregon Laws 2013, provide:

Sec. 14. Section 15 of this 2013 Act is added to and made a part of ORS chapter 442. [2013 c.608 §14]

Sec. 15. (1) The Legislative Assembly finds that:

(a) A significant amount of public and private funds are expended each year for long term care services provided to Oregonians;

(b) Oregon has established itself as the national leader in providing a choice of noninstitutional care to low income Oregonians in need of long term care services by developing an extensive system of home health care and community-based care; and

(c) Long term care facilities continue to provide critical services to some of Oregon's most frail and vulnerable residents with complex needs. Increasingly, long term care facilities are filling a need for transitional care between hospitals and home settings in a cost-effective manner, reducing the overall costs of long term care.

(2) The Legislative Assembly declares its support for collaboration among state agencies that purchase health services and private health care providers in order to align financial incentives with the goals of achieving better patient care and improved health status while restraining growth in the per capita cost of health care.

(3) It is the goal of the Legislative Assembly that the long term care facility bed capacity in Oregon be reduced by 1,500 beds by December 31, 2015, except for bed capacity in nursing facilities operated by the Department of Veterans' Affairs and facilities that either applied to the Oregon Health Authority for a certificate of need between August 1, 2011, and December 1, 2012, or submitted a letter of intent under ORS 442.315 (7) between January 15, 2013, and January 31, 2013.

(4) In order to reduce the long term care facility bed capacity statewide, the Department of Human Ser-

vices may permit an operator of a long term care facility to purchase another long term care facility's entire bed capacity if:

(a) The long term care facility bed capacity being purchased is not in an essential long term care facility; and

(b) The long term care facility's entire bed capacity is purchased and the seller agrees to surrender the long term care facility's license on the earlier of the date that:

(A) The last resident is transferred from the facility; or

(B) Is 180 days after the date of purchase.

(5) If a long term care facility's entire bed capacity is purchased, the facility may not admit new residents to the facility except in accordance with criteria adopted by the Department of Human Services by rule.

(6) Long term care bed capacity purchased under this section may not be transferred to another long term care facility.

(7) The Department of Human Services may convene meetings with representatives of entities that include, but are not limited to, long term care providers, nonprofit trade associations and state and local governments to collaborate in strategies to reduce long term care facility bed capacity statewide. Participation shall be on a voluntary basis. Meetings shall be held at a time and place that is convenient for the participants.

(8) The Department of Human Services may conduct surveys of entities and individuals specified in subsection (7) of this section concerning current long term care facility bed capacity and strategies for increasing future capacity.

(9) Based on the findings in subsection (1) of this section and the declaration expressed in subsection (2) of this section, the Legislative Assembly declares its intent to exempt from state antitrust laws and provide immunity from federal antitrust laws through the state action doctrine individuals and entities that engage in transactions, meetings or surveys described in subsections (4), (7) and (8) of this section that might otherwise be constrained by such laws.

(10) The Director of Human Services or the director's designee shall engage in appropriate state supervision necessary to promote state action immunity under state and federal antitrust laws, and may inspect or request additional documentation to verify that the individuals and entities acting pursuant to subsection (4), (7) or (8) of this section are acting in accordance with the legislative intent expressed in this section.

(11) The Director of Human Services or the director's designee, in consultation with the Long Term Care Ombudsman, shall engage in regional planning necessary to promote the safety and dignity of residents living in a long term care facility that surrenders its license under this section. [2013 c.608 §15]

Sec. 27. Section 15 of this 2013 Act is repealed June 30, 2020. [2013 c.608 §27]

442.320 [Formerly 441.090; 1979 c.697 §4; 1981 c.693 §10; 1983 c.482 §8; 1985 c.747 §31; 1987 c.660 §6; 1989 c.708 §6; repealed by 1989 c.1034 §11]

442.325 Certificate for health care facility of health maintenance organization; exempt activities; policy relating to health maintenance organizations. (1) A certificate of need shall be required for the development or establishment of a health care facility of any new health maintenance organization.

(2) Any activity of a health maintenance organization which does not involve the direct delivery of health services, as distinguished from arrangements for indirect delivery of health services through contracts with providers, shall be exempt from certificate of need review.

(3) Nothing in ORS 244.050, 431.250, 441.015 to 441.087, 442.015 to 442.420 and 442.450 applies to any decision of a health maintenance organization involving its organizational structure, its arrangements for financing health services, the terms of its contracts with enrolled beneficiaries or its scope of benefits.

(4) With the exception of certificate of need requirements, when applicable, the licensing and regulation of health maintenance organizations shall be controlled by ORS 750.005 to 750.095 and statutes incorporated by reference therein.

(5) It is the policy of ORS 244.050, 431.250, 441.015 to 441.087, 442.015 to 442.420 and 442.450 to encourage the growth of health maintenance organizations as an alternative delivery system and to provide the facilities for the provision of quality health care to the present and future members who may enroll within their defined service area.

(6)(a) It is also the policy of ORS 244.050, 431.250, 441.015 to 441.087, 442.015 to 442.420 and 442.450 to consider the special needs and circumstances of health maintenance organizations. Such needs and circumstances include the needs of and costs to members and projected members of the health maintenance organization in obtaining health services and the potential for a reduction in the use of inpatient care in the community through an extension of preventive health services and the provision of more systematic and comprehensive health services. The consideration of a new health service proposed by a health maintenance organization shall also address the availability and cost of obtaining the proposed new health service from the existing providers in the area that are not health maintenance organizations.

(b) The Oregon Health Authority shall issue a certificate of need for beds, services or equipment to meet the needs or reasonably anticipated needs of members of health maintenance organizations when beds, services or equipment are not available from nonplan providers. [1977 c.751 §56; 1981 c.693 §11; 1995 c.727 §40; 1999 c.581 §9; 2009 c.595 §752]

442.330 [Formerly 441.092; 1979 c.697 §5; repealed by 1981 c.693 §31]

442.335 [1977 c.751 §8; 1981 c.693 §12; 1983 c.482 §9; 1987 c.660 §7; repealed by 1989 c.1034 §11]

442.340 [Formerly 441.095; 1979 c.174 §1; 1979 c.285 §2; 1979 c.697 §6; 1981 c.693 §13; 1983 c.482 §10; 1985 c.747 §33; 1987 c.660 §8; repealed by 1989 c.1034 §11]

442.342 Waiver of requirements; rules; penalties. (1) Notwithstanding any other provision of law, a hospital licensed under ORS 441.025, in accordance with rules adopted by the Oregon Health Authority, may apply for waiver from the provisions of ORS 442.325, and the authority shall grant the waiver if, for the most recently completed hospital fiscal year preceding the date of application for waiver and each succeeding fiscal year thereafter, the percentage of qualified inpatient revenue is not less than that described in subsection (2) of this section.

(2)(a) The percentage of qualified inpatient revenue for the first year in which a hospital is granted a waiver under subsection (1) of this section may not be less than 60 percent.

(b) The percentage in paragraph (a) of this subsection shall be increased by five percentage points in each succeeding hospital fiscal year until the percentage of qualified inpatient revenue equals or exceeds 75 percent.

(3) As used in this section:

(a) "Qualified inpatient revenue" means revenue earned from public and private payers for inpatient hospital services approved by the authority pursuant to rules, including:

(A) Revenue earned pursuant to Title XVIII, United States Social Security Act, when such revenue is based on diagnostic related group prices that include capital-related expenses or other risk-based payment programs as approved by the authority;

(B) Revenue earned pursuant to Title XIX, United States Social Security Act, when such revenue is based on diagnostic related group prices that include capital-related expenses;

(C) Revenue earned under negotiated arrangements with public or private payers based on all-inclusive per diem rates for one or more hospital service categories;

(D) Revenue earned under negotiated arrangements with public or private payers based on all-inclusive per discharge or per admission rates related to diagnostic related groups or other service or intensity-related measures;

(E) Revenue earned under arrangements with one or more health maintenance organizations; or

(F) Other prospectively determined forms of inpatient hospital reimbursement approved in advance by the authority in accordance with rules.

(b) "Percentage of qualified inpatient revenue" means qualified inpatient revenue divided by total gross inpatient revenue as defined by administrative rule of the authority.

(4)(a) The authority shall hold a hearing to determine the cause if any hospital granted a waiver pursuant to subsection (1) of this section fails to reach the applicable percentage of qualified inpatient revenue in any subsequent fiscal year of the hospital.

(b) If the authority finds that the failure was without just cause and that the hospital has undertaken projects that, except for the provisions of this section, would have been subject to ORS 442.325, the authority shall impose one of the penalties outlined in paragraph (c) of this subsection.

(c)(A) A one-time civil penalty of not less than $25,000 or more than $250,000; or

(B) An annual civil penalty equal to an amount not to exceed 110 percent of the net profit derived from such project or projects for a period not to exceed five years.

(5) Nothing in this section shall be construed to permit a hospital to develop a new inpatient hospital facility or provide new services authorized by facilities defined as "long term care facility" under ORS 442.015 under a waiver granted pursuant to subsection (1) of this section. [1985 c.747 §35; 1987 c.660 §9; 1991 c.470 §18; 1995 c.727 §41; 2009 c.595 §753; 2013 c.1 §65]

Note: 442.342 was enacted into law by the Legislative Assembly and added to or made a part of ORS chapter 442 by legislative action but not to any series therein. See Preface to Oregon Revised Statutes for further explanation.

442.344 Exemptions from requirements. In furtherance of the purpose and intent of the Legislative Assembly as expressed in ORS 442.025 to achieve reasonable access to quality health care at a reasonable cost, the requirements of ORS 442.325 shall not apply to ambulatory surgical centers performing only ophthalmic surgery. [1987 c.723 §1]

Note: 442.344 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 442 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

442.345 [1977 c.751 §33; 1981 c.693 §14; 1985 c.747 §36; repealed by 1989 c.1034 §11]

442.347 Rural hospital required to report certain actions. A rural hospital exempted from the certificate of need requirement by ORS 442.315 (8) shall report any action taken by the hospital that would have required a certificate of need if the exemption did not exist. [1993 c.722 §4]

Note: 442.347 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 442 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

442.350 [Formerly 441.140; repealed by 1989 c.1034 §11]

442.355 [1983 c.482 §12; 1985 c.747 §14; renumbered 442.120]

442.360 [1977 c.751 §9; 1979 c.697 §7; 1981 c.693 §25; 1985 c.747 §37; repealed by 1989 c.1034 §11]

442.361 Definitions for ORS 442.361, 442.362 and 442.991. As used in this section and ORS 442.362 and 442.991:

(1)(a) "Capital project" means:

(A) The construction, development, purchase, renovation or any construction expenditure by or on behalf of a reporting entity, for which the cost:

(i) For type A hospitals, exceeds five percent of gross revenue.

(ii) For type B hospitals, exceeds five percent of gross revenue.

(iii) For DRG hospitals, exceeds 1.75 percent of gross revenue.

(iv) For ambulatory surgery centers, exceeds $2 million.

(B) The purchase or lease of, or other comparable arrangement for, a single piece of diagnostic or therapeutic equipment for which the cost or, in the case of a donation, the value exceeds $1 million. The acquisition of two or more pieces of diagnostic or therapeutic equipment that are necessarily interdependent in the performance of ordinary functions shall be combined in calculating the cost or value of the transaction.

(b) "Capital project" does not include a project financed entirely through charitable fundraising.

(2) "DRG hospital" means a hospital that is not a type A or type B hospital and that receives Medicare reimbursement based upon diagnostic related groups.

(3) "Gross revenue" has the meaning given that term in ORS 442.015.

(4) "Reporting entity" includes the following if licensed pursuant to ORS 441.015:

(a) A type A hospital as described in ORS 442.470.

(b) A type B hospital as described in ORS 442.470.

(c) A DRG hospital.

(d) An ambulatory surgical center as defined in ORS 442.015. [2009 c.595 §1197]

Note: 442.361 and 442.362 were added to and made a part of ORS chapter 442 by legislative action but were not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

442.362 Reporting of proposed capital projects by hospitals and ambulatory surgical centers. The Oregon Health Authority may adopt rules requiring reporting entities within the state to publicly report proposed capital projects. Rules adopted under this section must:

(1) Require a reporting entity to establish on the home page of its website a prominently labeled link to information about proposed or pending capital projects. The information posted must include but is not limited to a report of the community benefit for the project, its estimated cost and a means for interested persons to submit comments. When a reporting entity posts the information required under this subsection, the reporting entity must notify the authority of the posting in the manner prescribed by the authority.

(2) If a reporting entity does not have a website, require the reporting entity to publish notice of the proposed capital project in a major newspaper or online equivalent serving the region in which the proposed capital project will be located. The notice must include but is not limited to a report of the community benefit for the project, its estimated cost and a means for interested persons to submit comments. When a reporting entity publishes the information required under this subsection, the reporting entity must notify the authority of the publication in the manner prescribed by the authority.

(3) Establish a publicly available resource for information collected under this section. [2009 c.595 §1198; 2015 c.318 §30]

Note: See note under 442.361.

HEALTH CARE COSTS

(Standardized Payment Methodologies)

442.392 Uniform payment methodology for hospital and ambulatory surgical center services; rules. (1) The Oregon Health Authority shall prescribe by rule a uniform payment methodology for hospital and ambulatory surgical center services that:

(a) Incorporates the most recent Medicare payment methodologies established by the Centers for Medicare and Medicaid Services, or similar payment methodologies, for hospital and ambulatory surgical center services;

(b) Includes payment methodologies for services and equipment that are not fully addressed by Medicare payment methodologies; and

(c) Allows for the use of alternative payment methodologies, including but not limited to pay-for-performance, bundled payments and capitation.

(2) In developing the payment methodologies described in this section, the authority shall convene and be advised by a work group consisting of providers, insurers and consumers of the types of health care ser-

vices that are subject to the methodologies. [2011 c.418 §3]

Note: 442.392 to 442.396 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 442 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

442.394 Acceptance by facilities as payment in full. (1) A hospital or ambulatory surgical center shall bill and accept as payment in full an amount determined in accordance with the payment methodology prescribed by the Oregon Health Authority under ORS 442.392.

(2) This section does not apply to type A or type B hospitals as described in ORS 442.470 or rural critical access hospitals as defined in ORS 315.613. [2011 c.418 §4]

Note: See note under 442.392.

442.396 Attestation of compliance by insurers; rules. An insurer, as defined in ORS 731.106, that contracts with the Oregon Health Authority, including with the Public Employees' Benefit Board and the Oregon Educators Benefit Board, to provide health insurance coverage for state employees, educators or medical assistance recipients must annually attest, on a form and in a manner prescribed by the authority, to its compliance with ORS 243.256, 243.879, 442.392 and 442.394. A contract with an insurer subject to the requirements of this section may not be renewed without the attestation required by this section. [2011 c.418 §9]

Note: See note under 442.392.

Note: Sections 2 to 5, chapter 575, Oregon Laws 2015, provide:

Sec. 2. (1) As used in this section:

(a) "Carrier" means an insurer that offers a health benefit plan, as defined in ORS 743B.005.

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

(c) "Primary care" means family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics or general psychiatry.

(d) "Primary care provider" includes:

(A) A physician, naturopath, nurse practitioner, physician assistant or other health professional licensed or certified in this state, whose clinical practice is in the area of primary care.

(B) A health care team or clinic that has been certified by the Oregon Health Authority as a patient centered primary care home.

(2) The Oregon Health Authority shall convene a primary care payment reform collaborative to advise and assist the authority in developing a Primary Care Transformation Initiative to develop and share best practices in technical assistance and methods of reimbursement that direct greater health care resources and investments toward supporting and facilitating health care innovation and care improvement in primary care. The collaborative is a governing body, as defined in ORS 192.610.

(3) The authority shall invite representatives from all of the following to participate in the primary care payment reform collaborative:

(a) Primary care providers;

(b) Health care consumers;

(c) Experts in primary care contracting and reimbursement;

(d) Independent practice associations;

(e) Behavioral health treatment providers;

(f) Third party administrators;

(g) Employers that offer self-insured health benefit plans;

(h) The Department of Consumer and Business Services;

(i) Carriers;

(j) A statewide organization for mental health professionals who provide primary care;

(k) A statewide organization representing federally qualified health centers;

(L) A statewide organization representing hospitals and health systems;

(m) A statewide professional association for family physicians;

(n) A statewide professional association for physicians;

(o) A statewide professional association for nurses; and

(p) The Centers for Medicare and Medicaid Services.

(4) The authority shall convene the primary care payment reform collaborative no later than October 1, 2015.

(5) A coordinated care organization shall report to the authority, no later than December 31, 2015, the proportion of the organization's total medical costs that are allocated to primary care.

(6) The authority, in collaboration with the Department of Consumer and Business Services, shall adopt rules prescribing the primary care services for which costs must be reported under subsection (5) of this section. [2015 c.575 §2]

Sec. 3. No later than February 1, 2016, the Oregon Health Authority and the Department of Consumer and Business Services shall report to the Legislative Assembly, in the manner provided in ORS 192.245:

(1) The percentage of the medical expenses of carriers, coordinated care organizations, the Public Employees' Benefit Board and the Oregon Educators Benefit Board that is allocated to primary care; and

(2) How carriers, coordinated care organizations, the Public Employees' Benefit Board and the Oregon Educators Benefit Board pay for primary care. [2015 c.575 §3]

Sec. 4. (1) The Legislative Assembly declares that collaboration among insurers, purchasers and providers of health care to coordinate service delivery systems and develop innovative reimbursement methods in support of integrated and coordinated health care delivery is in the best interest of the public. The Legislative Assembly therefore declares its intent to exempt from state antitrust laws, and to provide immunity from federal antitrust laws through the state action doctrine, the activities specified in section 2 (2) of this 2015 Act, of the participants in the primary care payment reform collaborative, that might otherwise be constrained by such laws.

(2) The Director of the Oregon Health Authority or the director's designee shall engage in state supervision of the primary care payment reform collaborative to ensure that the activities and discussions of the participants in the collaborative are limited to the activities described in section 2 (2) of this 2015 Act.

(3) Groups that include, but are not limited to, health insurance companies, health care centers, hospitals, health service organizations, employers, health care providers, health care facilities, state and local governmental entities and consumers may meet to facilitate the development, implementation and operation of the Primary Care Transformation Initiative in accordance with section 2 of this 2015 Act.

(4) The Oregon Health Authority may conduct a survey of the entities and individuals specified in subsection (3) of this section to assist in the evaluation of the Primary Care Transformation Initiative.

(5) A survey or meeting under subsection (3) or (4) of this section is not a violation of state antitrust laws and shall be considered state action for purposes of federal antitrust laws through the state action doctrine. [2015 c.575 §4]

Sec. 5. Sections 1 to 4 of this 2015 Act are repealed on December 31, 2018. [2015 c.575 §5]

(Cost Reporting by Health Care Facilities)

442.400 "Health care facility" defined. As used in ORS 442.400 to 442.463, unless the context requires otherwise, "health care facility" or "facility" means such facility as defined by ORS 442.015, exclusive of a long term care facility, and includes all publicly and privately owned and operated health care facilities, but does not include facilities described in ORS 441.065. [Formerly 441.415; 1979 c.697 §8; 1981 c.693 §15]

442.405 Legislative findings and policy. The Legislative Assembly finds that rising costs and charges of health care facilities are a matter of vital concern to the people of this state. The Legislative Assembly finds and declares that it is the policy of this state:

(1) To require health care facilities to file for public disclosure reports that will enable both private and public purchasers of services from such facilities to make informed decisions in purchasing such services; and

(2) To encourage development of programs of research and innovation in the methods of delivery of institutional health care services of high quality with costs and charges reasonably related to the nature and quality of the services rendered. [Formerly 441.420; 1999 c.581 §3]

442.410 [1977 c.751 §45; 1981 c.693 §16; 1983 c.482 §13; 1985 c.747 §38; 1995 c.727 §24; 1997 c.683 §20; repealed by 1999 c.581 §11]

442.415 [1977 c.751 §46; 1983 c.482 §14; 1995 c.727 §25; 1997 c.683 §21; repealed by 1999 c.581 §11]

442.420 Application for financial assistance; financial analysis and investigation authority; rules. (1) The Oregon Health Authority may apply for, receive and accept grants, gifts, payments and other funds and advances, appropriations, properties and services from the United States, the State of Oregon or any governmental body, agency or agencies or from any other public or private corporation or person, and enter into agreements with respect thereto, including the undertaking of studies, plans, demonstrations or projects.

(2) The authority shall conduct or cause to have conducted such analyses and studies relating to costs of health care facilities as considered desirable, including but not limited to methods of reducing such costs, utilization review of services of health care facilities, peer review, quality control, financial status of any facility subject to ORS 442.400 to 442.463 and sources of public and private financing of financial requirements of such facilities.

(3) The authority may also:

(a) Hold public hearings, conduct investigations and require the filing of information relating to any matter affecting the costs of and charges for services in all health care facilities;

(b) Subpoena witnesses, papers, records and documents the authority considers material or relevant in connection with functions of the authority subject to the provisions of ORS chapter 183;

(c) Exercise, subject to the limitations and restrictions imposed by ORS 442.400 to 442.463, all other powers which are reasonably necessary or essential to carry out the express objectives and purposes of ORS 442.400 to 442.463; and

(d) Adopt rules in accordance with ORS chapter 183 for carrying out the functions of the authority. [Formerly 441.435; 1981 c.693 §17; 1983 c.482 §15; 1985 c.747 §39; 1995 c.727 §26; 1997 c.683 §22; 1999 c.581 §4; 2015 c.318 §31]

442.425 Financial reporting systems. (1) The Oregon Health Authority by rule may specify one or more uniform systems of financial reporting necessary to meet the requirements of ORS 442.400 to 442.463. Such systems shall include such cost allocation methods as may be prescribed and such records and reports of revenues, expenses, other income and other outlays, assets and liabilities, and units of service as may be prescribed. Each facility under the authority's jurisdiction shall adopt such systems for its fiscal period starting on or after the effective date of such system and shall make the required reports on such forms as may be required by the authority. The authority may extend the period by which compliance is required upon timely application and for good cause. Filings of such records and reports shall be made at such times as may be reasonably required by the authority.

(2) Existing systems of reporting used by health care facilities shall be given due consideration by the authority in carrying out the duty of specifying the systems of reporting required by ORS 442.400 to 442.463. The

authority insofar as reasonably possible shall adopt reporting systems and requirements that will not unreasonably increase the administrative costs of the facility.

(3) The authority may allow and provide for modifications in the reporting systems in order to correctly reflect differences in the scope or type of services and financial structure between the various categories, sizes or types of health care facilities and in a manner consistent with the purposes of ORS 442.400 to 442.463.

(4) The authority may establish specific annual reporting provisions for facilities that receive a preponderance of their revenue from associated comprehensive group-practice prepayment health care service plans. Notwithstanding any other provisions of ORS 442.400 to 442.463, such facilities shall be authorized to utilize established accounting systems and to report costs and revenues in a manner consistent with the operating principles of such plans and with generally accepted accounting principles. When such facilities are operated as units of a coordinated group of health facilities under common ownership, the facilities shall be authorized to report as a group rather than as individual institutions, and as a group shall submit a consolidated balance sheet, income and expense statement and statement of source and application of funds for such group of health facilities. [Formerly 441.440; 1981 c.693 §18; 1995 c.727 §27; 1997 c.683 §23; 1999 c.581 §5; 2009 c.792 §40; 2015 c.318 §32]

442.430 Investigations; confidentiality of data. (1) Whenever a further investigation is considered necessary or desirable by the Oregon Health Authority to verify the accuracy of the information in the reports made by health care facilities, the authority may make any necessary further examination of the facility's records and accounts. Such further examinations include, but are not limited to, requiring a full or partial audit of all such records and accounts.

(2) In carrying out the duties prescribed by ORS 442.400 to 442.463, the authority may utilize its own staff or may contract with any appropriate, independent, qualified third party. No such contractor shall release or publish or otherwise use any information made available to it under its contractual responsibility unless such permission is specifically granted by the authority. [Formerly 441.445; 1995 c.727 §28; 1997 c.683 §24; 2009 c.792 §41; 2015 c.318 §33]

442.435 [Formerly 441.460; 1983 c.482 §16; 1987 c.660 §27; 1995 c.727 §29; 1997 c.683 §25; repealed by 1999 c.581 §11]

442.440 [Formerly 441.465; 1983 c.482 §17; 1983 c.740 §161; repealed by 1987 c.660 §40]

442.442 [1979 c.697 §10; repealed by 1981 c.693 §31]

442.445 Civil penalty for failure to perform. (1) Any health care facility that fails to perform as required in ORS 442.205 and 442.400 to 442.463 or section 3, chapter 838, Oregon Laws 2007, and rules of the Oregon Health Authority may be subject to a civil penalty.

(2) The Oregon Health Authority shall adopt a schedule of penalties not to exceed $500 per day of violation, determined by the severity of the violation.

(3) Civil penalties under this section shall be imposed as provided in ORS 183.745.

(4) Civil penalties imposed under this section may be remitted or mitigated upon such terms and conditions as the authority considers proper and consistent with the public health and safety.

(5) Civil penalties incurred under any law of this state are not allowable as costs for the purpose of rate determination or for reimbursement by a third-party payer. [Formerly 441.480; 1981 c.693 §19; 1983 c.482 §18; 1983 c.696 §21; 1991 c.734 §24; 1993 c.18 §110; 1995 c.727 §30; 1997 c.683 §26; 1999 c.581 §6; 2007 c.384 §4; 2007 c.838 §7; 2013 c.61 §2b]

Note: The amendments to 442.445 by section 8, chapter 838, Oregon Laws 2007, become operative January 2, 2018. See section 9, chapter 838, Oregon Laws 2007. The text that is operative on and after January 2, 2018, including amendments by section 2c, chapter 61, Oregon Laws 2013, is set forth for the user's convenience.

442.445. (1) Any health care facility that fails to perform as required in ORS 442.205 and 442.400 to 442.463 and rules of the Oregon Health Authority may be subject to a civil penalty.

(2) The Oregon Health Authority shall adopt a schedule of penalties not to exceed $500 per day of violation, determined by the severity of the violation.

(3) Civil penalties under this section shall be imposed as provided in ORS 183.745.

(4) Civil penalties imposed under this section may be remitted or mitigated upon such terms and conditions as the authority considers proper and consistent with the public health and safety.

(5) Civil penalties incurred under any law of this state are not allowable as costs for the purpose of rate determination or for reimbursement by a third-party payer.

442.450 Exemption from cost review regulations. The following are not subject to ORS 442.400 to 442.463:

(1) Physicians in private practice, solo or in a group or partnership, who are not employed by, or hold ownership or part ownership in, a health care facility; or

(2) Health care facilities described in ORS 441.065. [1977 c.751 §55]

442.460 Information about utilization and cost of health care services. In order to obtain regional or statewide data about the utilization and cost of health care services, the Oregon Health Authority may accept information relating to the utilization and cost of health care services identified by

the authority from physicians, insurers or other third-party payers or employers or other purchasers of health care. [1985 c.747 §15; 1995 c.727 §31; 1997 c.683 §27; 1999 c.581 §7; 2015 c.318 §34]

442.463 Annual utilization report; contents; approval; rules. (1) Each licensed health facility shall file with the Oregon Health Authority an annual report containing such information related to the facility's utilization as may be required by the authority, in such form as the authority prescribes by rule.

(2) The annual report shall contain such information as may be required by rule of the authority and must be approved by the authority. [1985 c.747 §§18,19; 1995 c.727 §32; 1997 c.683 §28; 1999 c.581 §8; 2015 c.318 §35]

HEALTH CARE DATA REPORTING

442.464 Definitions for ORS 442.464 and 442.466. As used in this section and ORS 442.466, "reporting entity" means:

(1) An insurer as defined in ORS 731.106 or fraternal benefit society as described in ORS 748.106 required to have a certificate of authority to transact health insurance business in this state.

(2) A health care service contractor as defined in ORS 750.005 that issues medical insurance in this state.

(3) A third party administrator required to obtain a license under ORS 744.702.

(4) A pharmacy benefit manager or fiscal intermediary, or other person that is by statute, contract or agreement legally responsible for payment of a claim for a health care item or service.

(5) A coordinated care organization as defined in ORS 414.025.

(6) An insurer providing coverage funded under Part A, Part B or Part D of Title XVIII of the Social Security Act, subject to approval by the United States Department of Health and Human Services. [2009 c.595 §1200; 2011 c.602 §54]

Note: 442.464 and 442.466 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 442 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

442.465 [1985 c.747 §22; 1987 c.660 §10; 1989 c.1034 §6; 1995 c.727 §33; 1997 c.683 §29; repealed by 1999 c.581 §11]

442.466 Health care data reporting by health insurers. (1) The Oregon Health Authority shall establish and maintain a program that requires reporting entities to report health care data for the following purposes:

(a) Determining the maximum capacity and distribution of existing resources allocated to health care.

(b) Identifying the demands for health care.

(c) Allowing health care policymakers to make informed choices.

(d) Evaluating the effectiveness of intervention programs in improving health outcomes.

(e) Comparing the costs and effectiveness of various treatment settings and approaches.

(f) Providing information to consumers and purchasers of health care.

(g) Improving the quality and affordability of health care and health care coverage.

(h) Assisting the authority in furthering the health policies expressed by the Legislative Assembly in ORS 442.025.

(i) Evaluating health disparities, including but not limited to disparities related to race and ethnicity.

(2) The authority shall prescribe by rule standards that are consistent with standards adopted by the Accredited Standards Committee X12 of the American National Standards Institute, the Centers for Medicare and Medicaid Services and the National Council for Prescription Drug Programs that:

(a) Establish the time, place, form and manner of reporting data under this section, including but not limited to:

(A) Requiring the use of unique patient and provider identifiers;

(B) Specifying a uniform coding system that reflects all health care utilization and costs for health care services provided to Oregon residents in other states; and

(C) Establishing enrollment thresholds below which reporting will not be required.

(b) Establish the types of data to be reported under this section, including but not limited to:

(A) Health care claims and enrollment data used by reporting entities and paid health care claims data;

(B) Reports, schedules, statistics or other data relating to health care costs, prices, quality, utilization or resources determined by the authority to be necessary to carry out the purposes of this section; and

(C) Data related to race, ethnicity and primary language collected in a manner consistent with established national standards.

(3) Any third party administrator that is not required to obtain a license under ORS 744.702 and that is legally responsible for payment of a claim for a health care item or

service provided to an Oregon resident may report to the authority the health care data described in subsection (2) of this section.

(4) The authority shall adopt rules establishing requirements for reporting entities to train providers on protocols for collecting race, ethnicity and primary language data in a culturally competent manner.

(5)(a) The authority shall use data collected under this section to provide information to consumers of health care to empower the consumers to make economically sound and medically appropriate decisions. The information must include, but not be limited to, the prices and quality of health care services.

(b) The authority shall, using only data collected under this section from reporting entities described in ORS 442.464 (1) to (3), post to its website health care price information including the median prices paid by the reporting entities to hospitals and hospital outpatient clinics for, at a minimum, the 50 most common inpatient procedures and the 100 most common outpatient procedures.

(c) The health care price information posted to the website must be:

(A) Displayed in a consumer friendly format;

(B) Easily accessible by consumers; and

(C) Updated at least annually to reflect the most recent data available.

(d) The authority shall apply for and receive donations, gifts and grants from any public or private source to pay the cost of posting health care price information to its website in accordance with this subsection. Moneys received shall be deposited to the Oregon Health Authority Fund.

(e) The obligation of the authority to post health care price information to its website as required by this subsection is limited to the extent of any moneys specifically appropriated for that purpose or available from donations, gifts and grants from private or public sources.

(6) The authority may contract with a third party to collect and process the health care data reported under this section. The contract must prohibit the collection of Social Security numbers and must prohibit the disclosure or use of the data for any purpose other than those specifically authorized by the contract. The contract must require the third party to transmit all data collected and processed under the contract to the authority.

(7) The authority shall facilitate a collaboration between the Department of Human Services, the authority, the Department of Consumer and Business Services and interested stakeholders to develop a comprehensive health care information system using the data reported under this section and collected by the authority under ORS 442.120 and 442.400 to 442.463. The authority, in consultation with interested stakeholders, shall:

(a) Formulate the data sets that will be included in the system;

(b) Establish the criteria and procedures for the development of limited use data sets;

(c) Establish the criteria and procedures to ensure that limited use data sets are accessible and compliant with federal and state privacy laws; and

(d) Establish a time frame for the creation of the comprehensive health care information system.

(8) Information disclosed through the comprehensive health care information system described in subsection (7) of this section:

(a) Shall be available, when disclosed in a form and manner that ensures the privacy and security of personal health information as required by state and federal laws, as a resource to insurers, employers, providers, purchasers of health care and state agencies to allow for continuous review of health care utilization, expenditures and performance in this state;

(b) Shall be available to Oregon programs for quality in health care for use in improving health care in Oregon, subject to rules prescribed by the authority conforming to state and federal privacy laws or limiting access to limited use data sets;

(c) Shall be presented to allow for comparisons of geographic, demographic and economic factors and institutional size; and

(d) May not disclose trade secrets of reporting entities.

(9) The collection, storage and release of health care data and other information under this section is subject to the requirements of the federal Health Insurance Portability and Accountability Act. [2009 c.595 §1201; 2015 c.318 §36; 2015 c.845 §1]

Note: The amendments to 442.466 by section 1, chapter 845, Oregon Laws 2015, become operative July 1, 2016. See section 4, chapter 845, Oregon Laws 2015. The text that is operative until July 1, 2016, including amendments by section 36, chapter 318, Oregon Laws 2015, is set forth for the user's convenience.

442.466. (1) The Oregon Health Authority shall establish and maintain a program that requires reporting entities to report health care data for the following purposes:

(a) Determining the maximum capacity and distribution of existing resources allocated to health care.

(b) Identifying the demands for health care.

(c) Allowing health care policymakers to make informed choices.

(d) Evaluating the effectiveness of intervention programs in improving health outcomes.

(e) Comparing the costs and effectiveness of various treatment settings and approaches.

(f) Providing information to consumers and purchasers of health care.

(g) Improving the quality and affordability of health care and health care coverage.

(h) Assisting the authority in furthering the health policies expressed by the Legislative Assembly in ORS 442.025.

(i) Evaluating health disparities, including but not limited to disparities related to race and ethnicity.

(2) The authority shall prescribe by rule standards that are consistent with standards adopted by the Accredited Standards Committee X12 of the American National Standards Institute, the Centers for Medicare and Medicaid Services and the National Council for Prescription Drug Programs that:

(a) Establish the time, place, form and manner of reporting data under this section, including but not limited to:

(A) Requiring the use of unique patient and provider identifiers;

(B) Specifying a uniform coding system that reflects all health care utilization and costs for health care services provided to Oregon residents in other states; and

(C) Establishing enrollment thresholds below which reporting will not be required.

(b) Establish the types of data to be reported under this section, including but not limited to:

(A) Health care claims and enrollment data used by reporting entities and paid health care claims data;

(B) Reports, schedules, statistics or other data relating to health care costs, prices, quality, utilization or resources determined by the authority to be necessary to carry out the purposes of this section; and

(C) Data related to race, ethnicity and primary language collected in a manner consistent with established national standards.

(3) Any third party administrator that is not required to obtain a license under ORS 744.702 and that is legally responsible for payment of a claim for a health care item or service provided to an Oregon resident may report to the authority the health care data described in subsection (2) of this section.

(4) The authority shall adopt rules establishing requirements for reporting entities to train providers on protocols for collecting race, ethnicity and primary language data in a culturally competent manner.

(5) The authority shall use data collected under this section to provide information to consumers of health care to empower the consumers to make economically sound and medically appropriate decisions. The information must include, but not be limited to, the prices and quality of health care services.

(6) The authority may contract with a third party to collect and process the health care data reported under this section. The contract must prohibit the collection of Social Security numbers and must prohibit the disclosure or use of the data for any purpose other than those specifically authorized by the contract. The contract must require the third party to transmit all data collected and processed under the contract to the authority.

(7) The authority shall facilitate a collaboration between the Department of Human Services, the authority, the Department of Consumer and Business Services and interested stakeholders to develop a comprehensive health care information system using the data reported under this section and collected by the authority under ORS 442.120 and 442.400 to 442.463. The authority, in consultation with interested stakeholders, shall:

(a) Formulate the data sets that will be included in the system;

(b) Establish the criteria and procedures for the development of limited use data sets;

(c) Establish the criteria and procedures to ensure that limited use data sets are accessible and compliant with federal and state privacy laws; and

(d) Establish a time frame for the creation of the comprehensive health care information system.

(8) Information disclosed through the comprehensive health care information system described in subsection (7) of this section:

(a) Shall be available, when disclosed in a form and manner that ensures the privacy and security of personal health information as required by state and federal laws, as a resource to insurers, employers, providers, purchasers of health care and state agencies to allow for continuous review of health care utilization, expenditures and performance in this state;

(b) Shall be available to Oregon programs for quality in health care for use in improving health care in Oregon, subject to rules prescribed by the authority conforming to state and federal privacy laws or limiting access to limited use data sets;

(c) Shall be presented to allow for comparisons of geographic, demographic and economic factors and institutional size; and

(d) May not disclose trade secrets of reporting entities.

(9) The collection, storage and release of health care data and other information under this section is subject to the requirements of the federal Health Insurance Portability and Accountability Act.

Note: See note under 442.464.

Note: Sections 1 and 16, chapter 389, Oregon Laws 2015, provide:

Sec. 1. (1) The Oregon Health Policy Board, in consultation with the Public Employees' Benefit Board, the Oregon Educators Benefit Board, the Oregon Health Authority and the Department of Consumer and Business Services shall develop a statewide strategic plan for the collection and use of health care data. The plan must:

(a) Include clear objectives for how health care data will be used, and what types of data are needed, in state health care programs to support health system transformation efforts and promote value;

(b) Allow for alignment of performance metrics across state health care programs;

(c) Ensure that the state's efforts in the collection and use of health care data encourage integrated and coordinated care, promote improved quality, health outcomes and patient satisfaction and help reduce costs;

(d) Include strategies to ensure that the state's collection, use and measurement of health care data advance payment reform and allow for alternative payment methodologies;

(e) To the extent practicable, allow for alternative reporting and measurement mechanisms that are not claims-based or that are for payers and providers who are moving away from fee-for-service based reimbursement;

(f) Identify appropriate and inappropriate uses of health care data, including safeguards to ensure privacy and ensure that data is not used for marketing or other inappropriate purposes; and

(g) Outline a five-year vision including implementation timelines in sufficient detail that health care

stakeholders can plan for expected new data reporting requirements and uses.

(2) The Oregon Health Policy Board shall submit the plan developed under subsection (1) of this section to the interim committees of the Legislative Assembly related to health care no later than September 1, 2016.

(3) The performance measures developed by the Health Plan Quality Metrics Committee established under ORS 413.017 (4) must be aligned with the statewide strategic plan adopted under this section. [2015 c.389 §1]

Sec. 16. Section 1 of this 2015 Act is repealed on January 2, 2021. [2015 c.389 §16]

442.467 [1985 c.747 §23; repealed by 1989 c.1034 §11]

442.468 [2009 c.595 §1174; 2011 c.602 §30; repealed by 2015 c.380 §2]

442.469 [1985 c.747 §24; 1987 c.660 §11; 1989 c.1034 §7; 1995 c.727 §34; 1997 c.683 §30; repealed by 1999 c.581 §11]

RURAL HEALTH

442.470 Definitions for ORS 442.470 to 442.507. As used in ORS 442.470 to 442.507:

(1) "Acute inpatient care facility" means a licensed hospital with an organized medical staff, with permanent facilities that include inpatient beds, and with comprehensive medical services, including physician services and continuous nursing services under the supervision of registered nurses, to provide diagnosis and medical or surgical treatment primarily for but not limited to acutely ill patients and accident victims.

(2) "Council" means the Rural Health Coordinating Council.

(3) "Office" means the Office of Rural Health.

(4) "Primary care physician" means a doctor licensed under ORS chapter 677 whose specialty is family practice, general practice, internal medicine, pediatrics or obstetrics and gynecology.

(5)(a) "Rural hospital" means a hospital characterized as one of the following:

(A) A type A hospital, which is a small and remote hospital that has 50 or fewer beds and is more than 30 miles from another acute inpatient care facility;

(B) A type B hospital, which is a small and rural hospital that has 50 or fewer beds and is 30 miles or less from another acute inpatient care facility;

(C) A type C hospital, which is considered to be a rural hospital and has more than 50 beds, but is not a referral center; or

(D) A rural critical access hospital as defined in ORS 315.613.

(b) "Rural hospital" does not include a hospital of any class that was designated by the federal government as a rural referral hospital before January 1, 1989. [1979 c.513 §1; 1987 c.660 §12; 1987 c.918 §5; 1989 c.893 §8a; 1991 c.947 §1; 2001 c.875 §2]

442.475 Office of Rural Health. There is created the Office of Rural Health in the Oregon Health and Science University. [1979 c.513 §2; 1987 c.660 §13; 1989 c.708 §4]

442.480 Rural Health Care Revolving Account. (1) There is established the Rural Health Care Revolving Account in the General Fund.

(2) All moneys appropriated for the purposes of ORS 442.470 to 442.507 and all moneys paid to the Office of Rural Health by reason of loans, fees, gifts or grants for the purposes of ORS 442.470 to 442.507 shall be credited to the Rural Health Care Revolving Account.

(3) All moneys contained in the Rural Health Care Revolving Account are continuously appropriated to the Oregon Department of Administrative Services for the Office of Rural Health and shall be used for the purposes of ORS 442.470 to 442.507. [1979 c.513 §3; 1987 c.660 §14; 1989 c.708 §1; 2005 c.755 §37]

442.485 Responsibilities of Office of Rural Health. The responsibilities of the Office of Rural Health shall include but not be limited to:

(1) Coordinating statewide efforts for providing health care in rural areas.

(2) Accepting and processing applications from communities interested in developing health care delivery systems. Application forms shall be developed by the agency.

(3) Through the agency, applying for grants and accepting gifts and grants from other governmental or private sources for the research and development of rural health care programs and facilities.

(4) Serving as a clearinghouse for information on health care delivery systems in rural areas.

(5) Helping local health care delivery systems develop ongoing funding sources.

(6) Developing enabling legislation to facilitate further development of rural health care delivery systems. [1979 c.513 §4; 1983 c.482 §19; 1987 c.660 §15; 2015 c.736 §89]

442.490 Rural Health Coordinating Council; membership; terms; officers; compensation and expenses. (1) In carrying out its responsibilities, the Office of Rural Health shall be advised by the Rural Health Coordinating Council. All members of the Rural Health Coordinating Council shall have knowledge, interest, expertise or experience in rural areas and health care delivery. The membership of the Rural Health Coordinating Council shall consist of:

(a) One primary care physician who is appointed by the office from a list of physicians recommended by the Oregon Medical Association and one primary care physician

appointed by the office from a list of physicians recommended by the Osteopathic Physicians and Surgeons of Oregon;

(b) One nurse practitioner who is appointed by the office from a list of nurse practitioners recommended by the Oregon Nurses Association;

(c) One pharmacist who is appointed by the State Board of Pharmacy;

(d) Five consumers who are appointed by the Governor as follows:

(A) One consumer representative from each of three rural health service areas as defined by the office; and

(B) Two consumer representatives at large from communities of less than 3,500 people;

(e) One representative appointed by the office from a list of individuals recommended by the Conference of Local Health Officials;

(f) One volunteer emergency medical services provider from a community of less than 3,500 people appointed by office from a list of providers recommended by the Oregon EMS Association;

(g) One representative appointed by the office from a list of individuals recommended by the Oregon Association for Home Care;

(h) One representative from the Oregon Health and Science University, appointed by the president of the Oregon Health and Science University;

(i) One representative from the Oregon Association of Hospitals and Health Systems, appointed by the office from a list of individuals recommended by the Oregon Association of Hospitals and Health Systems;

(j) One dentist appointed by the office from a list of dentists recommended by the Oregon Dental Association;

(k) One optometrist appointed by the office from a list of optometrists recommended by the Oregon Optometric Physicians Association;

(L) One physician assistant who is appointed by the office from a list of physician assistants recommended by the Oregon Society of Physician Assistants; and

(m) One naturopathic physician appointed by the office from a list of physicians recommended by the Oregon Association of Naturopathic Physicians.

(2) The Rural Health Coordinating Council shall elect a chairperson and vice chairperson.

(3) A member of the council is entitled to compensation and expenses as provided in ORS 292.495.

(4) The chairperson may appoint nonvoting, advisory members of the Rural Health Coordinating Council. However, advisory members without voting rights are not entitled to compensation or reimbursement as provided in ORS 292.495.

(5) Members shall serve for two-year terms.

(6) The Rural Health Coordinating Council shall report its findings to the Office of Rural Health. [1979 c.513 §5; 1981 c.693 §20; 1983 c.482 §19a; 1989 c.708 §2; 2011 c.703 §40; 2015 c.70 §14]

442.495 Responsibilities of council. The responsibilities of the Rural Health Coordinating Council shall be to:

(1) Advise the Office of Rural Health on matters related to the health care services and needs of rural communities;

(2) Develop general recommendations to meet the identified needs of rural communities; and

(3) View applications and recommend to the office which communities should receive assistance, how much money should be granted or loaned and the ability of the community to repay a loan. [1979 c.513 §6; 1981 c.693 §21; 1983 c.482 §20; 2007 c.71 §129]

442.500 Technical and financial assistance to rural communities. (1) The Office of Rural Health shall provide technical assistance to rural communities interested in developing health care delivery systems.

(2) Communities shall make application for this technical assistance on forms developed by the office for this purpose.

(3) The office shall make the final decision concerning which communities receive the money and whether a loan is made or a grant is given.

(4) The office may make grants or loans to rural communities for the purpose of establishing or maintaining medical care services.

(5) The office shall provide technical assistance and coordination of rural health activities through staff services which include monitoring, evaluation, community needs analysis, information gathering and disseminating, guidance, linkages and research. [1979 c.513 §8; 1981 c.693 §22; 1983 c.482 §21]

442.502 Determination of size of rural hospital. (1) For purposes of determining the size of a rural hospital, beds certified by the Oregon Health Authority on the license of the hospital as special inpatient care beds shall not be included.

(2) As used in this section, "special inpatient care beds" means beds that:

(a) Are used for the treatment of patients with mental illness or for the treatment of

alcoholism or drug abuse, or are located in a rehabilitation center, a college infirmary, a chiropractic facility, a freestanding hospice facility, an infirmary for the homeless or an inpatient care facility described in ORS 441.065;

(b) Are physically separate from acute inpatient care beds, at least by being located on separate floors or wings of the same building;

(c) Are never used for acute patient care;

(d) Are staffed by dedicated direct care personnel for whom separate employment records are maintained;

(e) Have separate medical directors; and

(f) Maintain separate admission, discharge and patient records. [1993 c.765 §55; 2007 c.70 §243; 2009 c.595 §754]

442.503 Eligibility for economic development grants. In addition to any other authorized uses of funds for economic development available from the Administrative Services Economic Development Fund, economic development grants may be made for the purpose of constructing, equipping, refurbishing, modernizing and making other capital improvements for type A and B rural hospitals, as defined under ORS 442.470. [1989 c.893 §10]

Note: 442.503 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 442 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

442.505 Technical assistance to rural hospitals. The Office of Rural Health shall institute a program to provide technical assistance to rural hospitals. The Office of Rural Health shall be primarily responsible for providing:

(1) A recruitment and retention program for physicians and other primary care providers in rural areas.

(2) An informational link between rural hospitals and state and federal policies regarding regulations and payment sources.

(3) A system for effectively networking rural hospitals and providers so that they may compete or negotiate with urban based health maintenance organizations.

(4) Assistance to rural hospitals in identifying strengths, weaknesses, opportunities and threats.

(5) In conjunction with a trade association representing hospitals and health systems in Oregon, a report that identifies models that will replace or restructure inefficient health services in rural areas. [1987 c.918 §3; 2005 c.22 §301; 2015 c.70 §15]

442.507 Assistance to rural emergency medical service systems. (1) With the moneys transferred to the Office of Rural Health by ORS 442.625, the office shall establish a dedicated grant program for the purpose of providing assistance to rural communities to enhance emergency medical service systems.

(2) Communities, as well as nonprofit or governmental agencies serving those communities, may apply to the office for grants on forms developed by the office.

(3) The office shall make the final decision concerning which entities receive grants, but the office may seek advice from the Rural Health Coordinating Council, the State Emergency Medical Service Committee and other appropriate individuals experienced with emergency medical services.

(4) The office may make grants to entities for the purchase of equipment, the establishment of new rural emergency medical service systems or the improvement of existing rural emergency medical service systems.

(5) With the exception of printing and mailing expenses associated with the grant program, the Office of Rural Health shall pay for administrative costs of the program with funds other than those transferred under ORS 442.625. [1999 c.1056 §5]

442.515 Rural hospitals; findings. The Legislative Assembly finds that Oregon rural hospitals are an integral part of the communities and geographic area where they are located. Their impact on the economic well-being and health status of the citizens is vast. The problems faced by rural hospitals include a general decline in rural economies, the age of the rural populations, older physical plants, lack of physicians and other health care providers and a poor financial outlook. The Legislative Assembly recognizes that the loss of essential hospital services is imminent in many communities. [1987 c.918 §1]

442.520 Risk assessment formula; relative risk of rural hospitals. (1) Subject to the formula set out in subsection (2) of this section, the Office of Rural Health, in consultation with a trade association representing hospitals and health systems in Oregon, shall establish a risk assessment formula to identify the relative risk of a rural hospital, as defined in ORS 442.470.

(2) To assess the degree of risk faced by each rural hospital, the risk assessment formula developed by the Office of Rural Health, in consultation with a trade association representing hospitals and health systems in Oregon, shall include the following categories:

(a) Organizational risk: The financial situation of each facility, as measured by a na-

tionally accepted formula that identifies the hospital's current and future financial viability;

(b) Population risk: The impact that a hospital closure would have on the health care needs of the citizens of each hospital's respective service area, as measured by an index that includes medically underserved, distance and target population components; and

(c) Economic risk: The direct and indirect economic contribution made to the communities of each hospital's respective service area, as measured by an index that measures the overall economic benefit added to the service area community by the hospital. [1991 c.947 §20; 2015 c.70 §16]

Note: 442.520 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 442 by legislative action. See Preface to Oregon Revised Statutes for further explanation.

442.525 [1989 c.893 §9; 1993 c.765 §50; repealed by 2005 c.806 §5]

442.535 [2001 c.599 §1; 2011 c.637 §272; repealed by 2015 c.829 §8]

442.540 [2001 c.599 §2; 2011 c.637 §273; 2013 c.747 §162; 2015 c.513 §21; repealed by 2015 c.829 §8]

442.545 [2001 c.599 §3; 2011 c.637 §274; 2013 c.747 §163; repealed by 2015 c.829 §8]

442.550 [1989 c.893 §16; 1991 c.947 §5; 1999 c.582 §11; 1999 c.704 §23; 2001 c.336 §1; 2005 c.357 §3; 2007 c.485 §1; 2010 c.42 §1; repealed by 2013 c.177 §4]

442.555 [1989 c.893 §17; 1991 c.877 §20; 1991 c.947 §6; 1993 c.765 §52; 1999 c.291 §32; 1999 c.704 §24; 2005 c.357 §1; 2007 c.485 §2; 2010 c.42 §2; repealed by 2013 c.177 §4]

442.560 [1989 c.893 §18; 1991 c.877 §21; 1991 c.947 §3; 1993 c.765 §53; 1993 c.813 §13; 2005 c.357 §2; 2007 c.485 §3; 2010 c.42 §3; repealed by 2013 c.177 §4]

PRIMARY CARE SERVICES PROGRAM

442.561 Certifying individuals licensed under ORS chapter 679 for tax credit. The Office of Rural Health shall establish criteria for certifying individuals who are licensed under ORS chapter 679 as eligible for the tax credit authorized by ORS 315.616. Upon application therefor and upon a finding that the applicant is or will be providing dental services to one or more rural communities and otherwise meets the eligibility criteria established by the office, the office shall certify individuals eligible for the tax credit authorized by ORS 315.616. [1995 c.746 §40; 1999 c.291 §33; 1999 c.459 §2]

Note: 442.561 to 442.570 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 442 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

442.562 Certifying podiatrists for tax credit. The Office of Rural Health shall establish criteria for certifying individuals who are licensed to practice podiatry under ORS chapter 677 as eligible for the tax credit authorized by ORS 315.616. Upon application therefor and upon a finding that the applicant is or will be providing podiatric services to one or more rural communities and otherwise meets the eligibility criteria established by the office, the office shall certify individuals eligible for the tax credit authorized by ORS 315.616. [1995 c.746 §41; 1999 c.291 §34; 1999 c.459 §3; 2013 c.129 §31]

Note: See note under 442.561.

442.563 Certifying certain individuals providing rural health care for tax credit. (1) The Office of Rural Health shall establish criteria for certifying individuals eligible for the tax credit authorized by ORS 315.613, 315.616 or 315.619. Upon application therefor, the office shall certify individuals eligible for the tax credit authorized by ORS 315.613.

(2) The classification of rural hospitals for purposes of determining eligibility under this section shall be the classification of the hospital in effect on January 1, 1991. [1989 c.893 §7; 1991 c.877 §19; 1995 c.746 §35; 1999 c.291 §35; 1999 c.459 §4; 2013 c.177 §5]

Note: See note under 442.561.

442.564 Certifying optometrists for tax credit. The Office of Rural Health shall establish criteria for certifying individuals who are licensed as optometrists under ORS 683.010 to 683.340 as eligible for the tax credit authorized by ORS 315.616. Upon application therefor and upon a finding that the applicant is or will be providing optometry services to one or more rural communities and otherwise meets the eligibility criteria established by the office, the office shall certify individuals eligible for the tax credit authorized by ORS 315.616. [1997 c.787 §2; 1999 c.291 §36; 1999 c.459 §5]

Note: See note under 442.561.

442.565 [1989 c.893 §19; renumbered 442.568 in 2005]

442.566 Certifying emergency medical services providers for tax credit. The Office of Rural Health shall establish criteria for certifying individuals who are licensed as emergency medical services providers under ORS chapter 682 as eligible for the tax credit authorized by ORS 315.622. Upon application for the credit and upon a finding that the applicant will be providing emergency medical services in one or more rural areas and otherwise meets the eligibility criteria established by the office, the office shall certify the individual as eligible for the tax credit authorized by ORS 315.622. [2005 c.832 §65; 2011 c.703 §41]

Note: See note under 442.561.

442.568 Oregon Health and Science University to recruit persons interested in rural practice. (1) The Oregon Health and Science University shall develop and implement a program to focus recruitment efforts on students who reside in or who are

interested in practicing in rural or medically underserved areas of this state.

(2) The university shall reserve a number of admissions to each class at the medical school for qualified students who demonstrate an interest in practicing medicine in rural or medically underserved areas of this state. Once the students are admitted, the university shall support them with resources such as clinical rotations in rural or medically underserved areas, programs that allow a student to complete a clerkship in family medicine and rural and community health in a single rural Oregon community and technical assistance with accessing education loan and assistance programs. Not more than 15 percent of the students in each class shall be admitted under this section, consistent with the intent of the Legislative Assembly to encourage the availability of medical services in rural and medically underserved areas of this state.

(3) In the event that the university is unable to recruit the number of qualified students required under subsection (2) of this section, after having made a reasonable effort to do so, the university is authorized to fill the remaining positions with other eligible candidates. [Formerly 442.565; 2010 c.42 §4; 2013 c.177 §6]

Note: See note under 442.561.

442.570 Primary Care Services Fund; matching funds. (1) There is established in the State Treasury a fund, separate and distinct from the General Fund, to be known as the Primary Care Services Fund. Moneys in the Primary Care Services Fund are continuously appropriated to the Oregon Department of Administrative Services for allocation to the Office of Rural Health for investments as provided by ORS 293.701 to 293.857, for expenses and payments by the office in carrying out the purposes of ORS 315.613, 315.616, 315.619, 353.450, 442.470, 442.503 and 442.561 to 442.570. Interest earned by the fund shall be credited to the fund.

(2) The office shall seek matching funds from the federal government and from communities that benefit from placement of participants under ORS 442.561 to 442.570. The office shall establish a program to enroll interested communities in this program and deposit moneys from the matching funds in the Primary Care Services Fund. In addition, the office shall explore other funding sources including federal grant programs. [1989 c.893 §21; 1991 c.877 §22; 1991 c.947 §4; 2010 c.42 §5; 2013 c.177 §7]

Note: See note under 442.561.

PRIMARY HEALTH CARE LOAN FORGIVENESS PROGRAM

442.573 Fund established. The Primary Health Care Loan Forgiveness Program Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Primary Health Care Loan Forgiveness Program Fund shall be credited to the fund. Moneys in the fund are continuously appropriated to the Oregon Department of Administrative Services for distribution to the Office of Rural Health for the purposes of carrying out the provisions of ORS 442.574. [2011 c.651 §2]

Note: 442.573 is repealed January 2, 2018. See sections 9 and 12, chapter 829, Oregon Laws 2015.

Note: 442.573 and 442.574 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 442 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

442.574 Eligibility; requirements; rules. (1) As used in this section:

(a) "Participant" means a person who has been selected by the Office of Rural Health to receive a loan under subsection (4) of this section.

(b) "Primary care practitioner" means a:

(A) Physician licensed under ORS chapter 677;

(B) Physician assistant licensed under ORS 677.505 to 677.525; or

(C) Nurse practitioner licensed under ORS 678.375.

(c) "Prospective primary care practitioner" means a person who is enrolled in a medical education program that meets the educational requirements for licensure as a physician, physician assistant or nurse practitioner.

(d) "Service agreement" means the agreement executed by a prospective primary care practitioner under subsection (3) of this section.

(2) There is created the Primary Health Care Loan Forgiveness Program, to be administered by the office pursuant to rules adopted by the office.

(3) A prospective primary care practitioner who wishes to participate in the program shall submit an application to the office in accordance with rules adopted by the office. To be eligible to be a participant in the program, a prospective primary care practitioner must:

(a) Have completed the first year of the prospective primary care practitioner's medical education;

(b) Be enrolled in a medical education program in Oregon that emphasizes training

rural health care practitioners and is approved by the office;

(c) Execute a service agreement stating that, immediately upon the prospective primary care practitioner's completion of residency or training as established by the office by rule, the prospective primary care practitioner will practice as a primary care practitioner in a rural setting in this state approved by the office for at least as many years as the number of years for which the practitioner received loans from the Primary Health Care Loan Forgiveness Program; and

(d) Meet other requirements established by the office by rule.

(4) The office may select participants from among the prospective primary care practitioners who submit applications as provided in subsection (3) of this section. The office shall give preference to a prospective primary care practitioner who agrees to practice in a community that agrees to contribute funds to the Primary Health Care Loan Forgiveness Program Fund established in ORS 442.573.

(5) The office shall provide an annual loan of up to $35,000 to each participant to cover expenses related to the participant's medical education, on terms established by the office by rule. The loan must be evidenced by a written obligation but no additional security may be required.

(6) Repayment of loans provided under subsection (5) of this section is deferred while a participant is in compliance with the service agreement.

(7) At the end of each full year that a participant complies with the service agreement, the office shall forgive one annual loan provided to the participant under subsection (5) of this section.

(8)(a) A person receiving a loan under subsection (5) of this section who fails to complete the residency or training as required by the office by rule shall repay the amount received to the Primary Health Care Loan Forgiveness Program plus 10 percent interest on the unpaid balance, accrued from the date the loan was granted.

(b) A person receiving a loan under subsection (5) of this section who completes the residency or training required by the office by rule but fails to fulfill the obligations required by the service agreement shall repay the amount received to the Primary Health Care Loan Forgiveness Program plus 10 percent interest on the unpaid balance, accrued from the date the loan was granted. Additionally, a penalty fee equal to 25 percent of the amount received shall be assessed against the person. No interest accrues on the penalty. The office shall establish rules to allow waiver of all or part of the penalty owed to the program due to circumstances that prevent the participant from fulfilling the service obligation.

(9) Payments on loans provided under subsection (5) of this section shall be deposited in the Primary Health Care Loan Forgiveness Program Fund established in ORS 442.573.

(10) If a participant defaults on a loan provided under section (5) of this section:

(a) Any amounts due may be collected by the Collections Unit in the Department of Revenue under ORS 293.250; or

(b) The Oregon Health and Science University may contract with a collections agency to collect any amounts due.

(11) Any amounts collected under subsection (10) of this section shall be deposited in the Primary Health Care Loan Forgiveness Program Fund established in ORS 442.573.

(12) The office may accept funds from any public or private source for the purposes of carrying out the provisions of this section. [2011 c.651 §1]

Note: 442.574 is repealed January 2, 2018. See sections 9 and 12, chapter 829, Oregon Laws 2015.

Note: Section 13, chapter 829, Oregon Laws 2015, provides:

Sec. 13. (1) Service agreements under ORS 442.574 and 348.303 that are in effect on the operative date of this section [January 1, 2018] shall remain in effect for the term specified in the agreement.

(2) Individuals participating in the primary care provider loan repayment program on the operative date of this section shall continue to participate for the duration of the term of the individual's commitment made pursuant to ORS 413.233.

(3) Nothing in the repeal of ORS 348.303, 413.233 and 442.574 relieves a person of a liability, duty or obligation accruing under or with respect to ORS 348.303, 413.233 and 442.574. Payments made by participants to discharge an obligation arising under ORS 348.303 (6) or (7), 413.233 (2)(e) or 442.574 shall be deposited to the Health Care Provider Incentive Fund established in section 1 of this 2015 Act [676.450].

(4) The duties, rights and obligations of the Office of Rural Health under ORS 442.574 are transferred to the Oregon Health Authority.

(5) Any unexpended balances of moneys in the Primary Health Care Loan Forgiveness Program Fund are transferred to the Health Care Provider Incentive Fund established under section 1 of this 2015 Act and shall be used by the Oregon Health Authority to carry out section 2 of this 2015 Act [676.460] and to administer the service agreements entered into pursuant to ORS 442.574 that remain in effect under subsection (1) of this section. [2015 c.829 §13]

Note: See note under 442.573.

442.575 [1993 c.754 §3; repealed by 2011 c.720 §228]

442.580 [1991 c.470 §2; 2001 c.238 §1; 2009 c.326 §9; repealed by 2011 c.720 §228]

442.581 [1991 c.470 §4; 1995 c.727 §37; 1997 c.683 §31; repealed by 2011 c.720 §228]

442.582 [1991 c.470 §5; repealed by 1993 c.754 §4 (442.583 enacted in lieu of 442.582)]

442.583 [1993 c.754 §5 (enacted in lieu of 442.582); repealed by 2011 c.720 §228]

442.584 [1991 c.470 §§7,22; 2009 c.595 §1180; repealed by 2011 c.720 §228]

442.586 [1991 c.470 §8; repealed by 1995 c.727 §48]

442.588 [1993 c.754 §10; 1995 c.727 §47; repealed by 2011 c.720 §228]

442.589 [2009 c.595 §1179; repealed by 2011 c.720 §228]

MISCELLANEOUS

442.600 Policy on maternity care. The Legislative Assembly finds and declares that:

(1) Maternity care is the cornerstone of health care delivery in the state. It provides a proven, cost-effective foundation for improving the health of all Oregonians, and a healthy start in life allows our future citizens to achieve their full potential.

(2) Although great strides have been made to improve maternity care, barriers continue to exist as indicated by high rates of inadequate prenatal care and lack of coordination between prenatal and delivery services.

(3) Individual communities have unique combinations of barriers and resources. Therefore, planning and solutions must be developed at the local level whenever possible, with the state providing guidelines, standards and support.

(4) Local resources are strained and communities need a structure and technical assistance to assure development of access to a coordinated system of maternity care.

(5) There is a need for a system to assure coordination of all maternity service providers to develop a comprehensive service system for Oregon that addresses all barriers to guide the state's action in this area.

(6)(a) Therefore, it is the intent of this state that there shall be a comprehensive system of maternity care based on the plan that includes prenatal, delivery and postpartum care and that meets the unique needs of the individual pregnant woman, available to all pregnant women in this state.

(b) As used in this subsection, "plan" means the Maternity Care Access Planning Commission's comprehensive statewide plan for a maternity care system dated March 1993 and titled "Comprehensive Perinatal Health Services: A Strategy Toward Universal Access to Care in Oregon." [1991 c.760 §1; 1993 c.514 §1]

Note: 442.600 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 442 by legislative action. See Preface to Oregon Revised Statutes for further explanation.

442.625 Emergency Medical Services Enhancement Account; distribution of moneys in account. (1) The Emergency Medical Services Enhancement Account is established separate and distinct from the General Fund. Interest earned on moneys in the account shall accrue to the account. All moneys deposited in the account are continuously appropriated to the Department of Revenue for the purposes of this section.

(2) The Department of Revenue shall distribute moneys in the Emergency Medical Services Enhancement Account in the following manner:

(a) 35 percent of the moneys in the account shall be transferred to the Office of Rural Health established under ORS 442.475 for the purpose of enhancing emergency medical services in rural areas as specified in ORS 442.507.

(b) 25 percent of the moneys in the account shall be transferred to the Emergency Medical Services and Trauma Systems Program established under ORS 431A.085.

(c) 35 percent of the moneys in the account shall be transferred to the Area Health Education Center program established under ORS 353.450.

(d) 5 percent of the moneys in the account shall be transferred to the Oregon Poison Center referred to in ORS 431A.313. [1999 c.1056 §3]

Note: 442.625 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 442 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

COOPERATIVE PROGRAM ON HEART AND KIDNEY TRANSPLANTS

442.700 Definitions for ORS 442.700 to 442.760. As used in ORS 442.700 to 442.760:

(1) "Board of governors" means the governors of a cooperative program as described in ORS 442.720.

(2) "Cooperative program" means a program among two or more health care providers for the purpose of providing heart and kidney transplant services including, but not limited to, the sharing, allocation and referral of physicians, patients, personnel, instructional programs, support services, facilities, medical, diagnostic, laboratory or therapeutic services, equipment, devices or supplies, and other services traditionally offered by health care providers.

(3) "Health care provider" means a hospital, physician or entity, a significant part of whose activities consist of providing hospital or physician services in this state. For purposes of the immunities provided by ORS 442.700 to 442.760 and 646.740, "health care

provider" includes any officer, director, trustee, employee, or agent of, or any entity under common ownership and control with, a health care provider.

(4) "Hospital" means a hospital, a long term care facility or an ambulatory surgical center, as those terms are defined in ORS 442.015, that is licensed under ORS 441.015 to 441.089. "Hospital" includes community health programs established under ORS 430.610 to 430.695.

(5) "Order" means a decision issued by the Director of the Oregon Health Authority under ORS 442.710 either approving or denying an application for a cooperative program and includes modifications of an original order under ORS 442.730 (3)(b) and ORS 442.740 (1) and (4).

(6) "Party to a cooperative program agreement" or "party" means an entity that enters into the principal agreement to establish a cooperative program and applies for approval under ORS 442.700 to 442.760 and 646.740 and any other entity that, with the approval of the director, becomes a member of a cooperative program.

(7) "Physician" means a physician licensed under ORS chapter 677. [1993 c.769 §3; 2001 c.104 §182; 2007 c.70 §244; 2009 c.595 §755; 2009 c.792 §42; 2011 c.720 §198; 2013 c.129 §32]

442.705 Legislative findings; goals. (1) The Legislative Assembly finds that direct competition among health care providers in the field of heart and kidney transplant services may not result in the most cost efficient and least expensive transplant services for the citizens of this state and that it is in the public interest to allow cooperative programs among health care providers providing heart and kidney transplant services.

(2) The Legislative Assembly declares that, to the extent provided in ORS 442.700 to 442.760, it is the policy and intent of this state to displace competition among health care providers providing heart and kidney transplant services by allowing health care providers to enter into cooperative programs governing the provision of heart and kidney transplant services in order to achieve in each instance the following goals:

(a) Reduction of, or protection against, rising costs of heart and kidney transplant services;

(b) Reduction of, or protection against, rising prices for heart and kidney transplant services;

(c) Improvement or maintenance of the quality of heart and kidney transplant services provided in this state;

(d) Reduction of, or protection against, duplication of resources including, without limitation, expensive medical specialists, medical equipment and sites of service;

(e) Improvement or maintenance of efficiency in the delivery of heart and kidney transplant services;

(f) Improvement or maintenance of public access to heart and kidney transplant services;

(g) Increase in donations of organs for transplantation; and

(h) Improvement in the continuity of patient care.

(3) The Legislative Assembly further declares that the goals identified in subsection (2) of this section represent the policies of this state.

(4) The Legislative Assembly further declares that once a cooperative program is approved under ORS 442.700 to 442.760, there is an interest in insuring stability in the provision of health care services by a cooperative program, to the extent stability is consistent with achieving the goals identified in subsection (2) of this section.

(5) The Director of the Oregon Health Authority shall actively supervise the cooperative program in accordance with authority under ORS 442.700 to 442.760 and 646.740. [1993 c.769 §1; 2009 c.595 §756]

442.710 Application for approval of cooperative program; form; content; review; modification; order. (1) The Oregon Health and Science University and one or more entities, each of which operates at least three hospitals in a single urban area in this state, may apply to the Director of the Oregon Health Authority for approval of a cooperative program. The application shall include an executed written copy of all agreements for the cooperative program.

(2) An application for approval of a cooperative program shall be made in the form and manner and shall set forth any information regarding the proposed cooperative program that the director may prescribe. The information shall include, but not be limited to:

(a) A list of the names of all health care providers who propose to provide heart and kidney transplant services under the cooperative program, together with appropriate evidence of compliance with any licensing or certification requirements for those health care providers to practice in this state. In the case of employed physicians, the list and the information to be submitted may be limited to the employer or organizational unit of the employer;

(b) A description of the activities to be conducted by the cooperative program;

(c) A description of proposed anticompetitive practices listed in ORS 442.715, any practices that the parties anticipate will have significant anticompetitive effects and a description of practices of the cooperative program affecting costs, prices, personnel positions, capital expenditures and allocation of resources;

(d) A list of the goals identified in ORS 442.705 (2) that the cooperative program expects to achieve;

(e) A description of the proposed places and manner of providing heart and kidney transplant services and services related to heart and kidney transplants under the cooperative program;

(f) A proposed budget for operating the cooperative program;

(g) Satisfactory evidence of financial ability to deliver heart and kidney transplant services in accordance with the cooperative program;

(h) The agreement that establishes the cooperative program and policies that shall govern it; and

(i) Other information the director believes will assist in determining whether the cooperative program will likely achieve the goals listed in ORS 442.705 (2).

(3) The director shall review the application in accordance with the provisions of this section and shall grant, deny or request modification of the application within 90 days of the date the application is filed. The director shall hold one or more public hearings on the application, which shall conclude no later than 80 days after the date the application is filed. The decision of the director on an application shall be considered an order in a contested case for the purposes of ORS chapter 183.

(4) The director shall approve an application made under subsection (2) of this section after:

(a) The applicants have demonstrated they will achieve at least six of the goals of ORS 442.700 to 442.760 and 646.740, including at least the goals identified in ORS 442.705 (2)(a) to (d); and

(b) The director has reviewed and approved the specifics of the anticompetitive activity expected to be conducted by the cooperative program.

(5) In evaluating the application, the director shall consider whether a cooperative program will contribute to or detract from achieving the goals listed in ORS 442.705 (2). The director may weigh goals relating to circumstances that are likely to occur without the cooperative program, and relating to existing circumstances. The director may also consider whether any alternative arrangements would be less restrictive of competition while achieving the same goals.

(6) An order approving a cooperative program shall identify and define the limits of the permitted activities for purposes of granting antitrust immunity under ORS 442.700 to 442.760.

(7) An order approving a cooperative program shall include:

(a) Approval of specific activities listed in ORS 442.715;

(b) Approval of activities the director anticipates will have substantial anticompetitive effects;

(c) Approval of the proposed budget of the cooperative program;

(d) The goals listed in ORS 442.705 (2) that the cooperative program is expected to achieve; and

(e) Approval of the cooperative program as described in the application and a finding that the cooperative program is in the public interest.

(8) An order denying the application for a cooperative program shall identify the findings of fact and reasons supporting denial.

(9) Either the director or all the parties to the cooperative program may request a modification of an application made under this section. A request for a modification shall result in one extension of 30 days after submission of the modified application. The director shall issue an order under this section within 30 days after submission of the modified application. [1993 c.769 §14; 2009 c.595 §757]

442.715 Authorized practices under approved cooperative program. (1) To the extent permitted by an order issued under ORS 442.710, health care providers providing heart and kidney transplant services through a cooperative program approved under ORS 442.700 to 442.760 may engage in the following practices in order to achieve the goals described in ORS 442.705 (2):

(a) Set prices for heart and kidney transplants and all services directly related to heart and kidney transplants;

(b) Refuse to deal with competitors in the heart and kidney transplant market;

(c) Allocate product, service, geographic and patient markets directly relating to heart and kidney transplants;

(d) Acquire and maintain a monopoly in heart and kidney transplant services; and

(e) Engage in other activities that might give rise to liability under ORS 646.705 to 646.836 or federal antitrust laws.

(2) To the extent permitted by an order issued under ORS 442.710 and in addition to the provisions of subsection (1) of this section, physicians participating in a cooperative program may agree among themselves on referrals of nontransplant cardiac surgeries to the extent necessary to achieve redistribution of the cardiac surgery cases among participating surgeons.

(3) The Legislative Assembly intends that all persons arranging or participating in a cooperative program approved and conducted in accordance with an order issued under ORS 442.710 and all persons participating in good faith negotiations conducted pursuant to ORS 442.750 shall:

(a) Not be subject to the provisions of ORS 646.705 to 646.836 so long as the activities of the cooperative program are regulated, lawful and approved in accordance with ORS 442.700 to 442.760 and 646.740; and

(b) Receive the full benefit of state action immunity under federal antitrust laws. [1993 c.769 §2]

442.720 Board of governors for cooperative program. (1) If the Director of the Oregon Health Authority issues an order approving an application for a cooperative program under ORS 442.710, the director shall establish a board of governors to govern the cooperative program. The board of governors shall not constitute, for any purpose, a governmental agency.

(2) The board of governors shall consist of the president or other chief executive officer of each health care provider that is a party to the cooperative program agreement and the director or a designee of the director. The designee shall serve at the pleasure of the director. The designee shall not have any economic or other interest in any of the health care providers associated with the cooperative program.

(3) In governing the cooperative program, the board of governors shall develop policy and approve budgets for the implementation of the cooperative program.

(4) The director or designee of the director may reject any operating or capital budget of the cooperative program upon a finding by the director that the budget is not consistent with the goals listed in ORS 442.705 (2) that the cooperative program is expected to achieve. [1993 c.769 §5; 2009 c.595 §758]

442.725 Annual report of board of governors. Not later than 60 days following each anniversary date of the approval of a cooperative program by the Director of the Oregon Health Authority, the board of governors of the cooperative program shall deliver an annual report to the director. The report shall specifically describe:

(1) How heart and kidney transplant services and related services of the cooperative program are being provided in accordance with the order;

(2) Which of the goals identified in the order are being achieved and to what extent; and

(3) Any substantial changes in the cooperative program. [1993 c.769 §6; 2009 c.595 §759]

442.730 Review and evaluation of report; modification or revocation of order of approval. (1) The Director of the Oregon Health Authority shall review and evaluate the annual report delivered under ORS 442.725. The director shall:

(a) Determine the extent to which the cooperative program is achieving the goals identified in the order;

(b) Review the activities being conducted to achieve the goals; and

(c) Determine whether each of the activities is still necessary and appropriate to achieve the goals.

(2) If the director determines that additional information is needed for the review described in subsection (1) of this section, the director may order the board of governors to provide the information within a specified time.

(3) Within 60 days after receiving the annual report or any additional information ordered under subsection (2) of this section, the director shall:

(a) Approve the report if the director determines that the cooperative program is operating in accordance with the order and that the goals identified in the order are being adequately achieved by the cooperative program;

(b) Modify the order as appropriate to adjust to changes in the cooperative program approved by the director and approve the report as provided in paragraph (a) of this subsection;

(c) Order the board of governors to make remedial changes in anticompetitive activities not in compliance with the order and request the board of governors to report on progress not later than a deadline specified by the director;

(d) Revoke approval of the cooperative program; or

(e) Take any of the actions set forth in ORS 442.740. [1993 c.769 §7; 2009 c.595 §760]

442.735 Complaint procedure. (1) Any person may file a complaint with the Director of the Oregon Health Authority requesting that a specific decision or action of a cooperative program supervised by the director be reversed or modified, or that approval

for all or part of the activities permitted by the order be suspended or terminated. The complaint shall allege the reasons for the requested action and shall include any evidence relating to the complaint.

(2) The director on the director's own initiative may at any time request information from the board of governors concerning the activities of the cooperative program to determine whether the cooperative program is in compliance with the order. [1993 c.769 §8; 2009 c.595 §761]

442.740 Powers of director over action under cooperative program. (1) During the review of the annual report described in ORS 442.730, after receiving a complaint under ORS 442.735, or on the director's own initiative, the Director of the Oregon Health Authority may take one or more of the following actions:

(a) If the director determines that a particular decision or action is not in accordance with the order, or that the parties are engaging in anticompetitive activity not permitted by the order, the director may direct the board of governors to identify and implement corrective action to insure compliance with the order or may modify the order.

(b) If the director determines that the cooperative program is engaging in unlawful activity not permitted by the order or is not complying with the directive given under paragraph (a) of this subsection, the director may serve on the cooperative program a proposed order directing the cooperative program to:

(A) Conform with the directive under paragraph (a) of this subsection; or

(B) Cease and desist from engaging in the activity.

(2) The cooperative program shall have up to 30 days to comply with a proposed order under subsection (1)(b) of this section unless the board of governors demonstrates additional time is needed for compliance.

(3) If the director determines that the participants in the cooperative program are in substantial noncompliance with the cease and desist directive, the director may seek an appropriate injunction in the circuit courts of Marion or Multnomah Counties.

(4) If the director determines that a sufficient number of the goals set forth in ORS 442.705 (2) are not being achieved or that the cooperative program is engaging in activity not permitted by the order, the director may suspend or terminate approval for all or part of the activities approved and permitted by the order.

(5) A proposed order to be entered under subsection (1)(b) or (4) of this section may be served upon the cooperative program without prior notice. The cooperative program may contest the proposed order by filing a written request for a contested case hearing with the director not later than 20 days following the date of the proposed order. The proposed order shall become final if no request for a hearing is received. Unless inconsistent with this subsection, the provisions of ORS chapter 183, as applicable, shall govern the hearing procedure and any judicial review.

(6) The only effect of an order suspending or terminating approval under ORS 442.700 to 442.760 shall be to withdraw the immunities granted under ORS 442.715 (3) for anticompetitive activity permitted by the order and taken after the effective date of the order. [1993 c.769 §9; 2009 c.595 §762]

442.745 Disclosure of confidential information not waiver of right to protect information. If parties to a cooperative program agreement provide the Director of the Oregon Health Authority with written or oral information that is confidential or otherwise protected from disclosure under Oregon law, the disclosures shall not be considered a waiver of any right to protect the information from disclosure in other proceedings. [1993 c.769 §10; 2009 c.595 §763]

442.750 Status of actions under cooperative program; effect on other liability. (1) Notwithstanding the provisions of ORS 646.705 to 646.836:

(a) A cooperative program for which approval has been granted under ORS 442.700 to 442.760 and 646.740 is a lawful program to the extent it engages in activities permitted by the order and supervised by the Director of the Oregon Health Authority and is in compliance with the order; and

(b) If the parties to a cooperative program apply to the director as provided in ORS 442.710, the conduct of the parties and all other participants in negotiating or entering into a cooperative program is lawful conduct.

(2) Subsection (1)(b) of this section does not apply to persons negotiating a cooperative program if it can be demonstrated, by a preponderance of the evidence, that the persons do not or did not intend to enter into a cooperative agreement.

(3) Nothing in ORS 442.700 to 442.760 and 646.740 shall be construed to immunize any person from liability or impose liability where none would otherwise exist under federal or state antitrust laws for conduct in negotiating and entering into a cooperative program for which no application was filed with the director. [1993 c.769 §11; 2009 c.595 §764]

442.755 Rules; costs; fees. (1) The Director of the Oregon Health Authority shall adopt rules as may be necessary to carry out the provisions of ORS 442.700 to 442.760.

(2) The costs of program approval and supervision shall be paid by the parties to a cooperative program agreement and the director shall set fees for application, annual review and supervision as necessary to fund the director's supervision of the program. [1993 c.769 §12; 2009 c.595 §765]

442.760 Status to contest order. Notwithstanding the provisions of ORS 183.310 (7) and 183.480, only a party to a cooperative program agreement or the Director of the Oregon Health Authority shall be entitled to a contested case hearing or judicial review of an order issued pursuant to ORS 442.700 to 442.760 and 646.740. [1993 c.769 §13; 2003 c.75 §92; 2009 c.595 §766]

442.800 [1999 c.494 §1; 2009 c.595 §767; renumbered 441.221 in 2013]

442.805 [1999 c.494 §3; renumbered 441.222 in 2013]

442.807 [1999 c.494 §4; 2001 c.900 §180; 2009 c.595 §768; 2013 c.414 §4; renumbered 441.223 in 2013]

OREGON PATIENT SAFETY COMMISSION

442.819 Definitions for ORS 442.819 to 442.851. As used in ORS 442.819 to 442.851:

(1) "Participant" means an entity that reports patient safety data to the Oregon Patient Safety Reporting Program, and any agent, employee, consultant, representative, volunteer or medical staff member of the entity.

(2) "Patient safety activities" includes but is not limited to:

(a) The collection and analysis of patient safety data by a participant;

(b) The collection and analysis of patient safety data by the Oregon Patient Safety Commission established in ORS 442.820;

(c) The utilization of patient safety data by participants;

(d) The utilization of patient safety data by the Oregon Patient Safety Commission to improve the quality of care with respect to patient safety and to provide assistance to health care providers to minimize patient risk; and

(e) Oral and written communication regarding patient safety data among two or more participants with the intent of making a disclosure to or preparing a report to be submitted to the patient safety reporting program.

(3) "Patient safety data" means oral communication or written reports, data, records, memoranda, analyses, deliberative work, statements, root cause analyses or action plans that are collected or developed to improve patient safety or health care quality that:

(a) Are prepared by a participant for the purpose of reporting patient safety data voluntarily to the patient safety reporting program, or that are communicated among two or more participants with the intent of making a disclosure to or preparing a report to be submitted to the patient safety reporting program;

(b) Are collected or prepared by a patient safety organization certified by the United States Department of Health and Human Services under 42 U.S.C. 299b-24; or

(c) Are created by or at the direction of the patient safety reporting program, including communication, reports, notes or records created in the course of an investigation undertaken at the direction of the Oregon Patient Safety Commission.

(4) "Patient safety reporting program" means the Oregon Patient Safety Reporting Program created in ORS 442.837.

(5) "Serious adverse event" means an objective and definable negative consequence of patient care, or the risk thereof, that is unanticipated, usually preventable and results in, or presents a significant risk of, patient death or serious physical injury. [2003 c.686 §1; 2009 c.436 §3]

Note: 442.819 to 442.851 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 442 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

442.820 Oregon Patient Safety Commission. (1) The Oregon Patient Safety Commission is established as a semi-independent state agency subject to ORS 182.456 to 182.472. The commission shall exercise and carry out all powers, rights and privileges that are expressly conferred upon it, are implied by law or are incident to such powers.

(2) The mission of the commission is to improve patient safety by reducing the risk of serious adverse events occurring in Oregon's health care system and by encouraging a culture of patient safety in Oregon. To accomplish this mission, the commission shall:

(a) Establish a confidential, voluntary serious adverse event reporting system to identify serious adverse events;

(b) Establish quality improvement techniques to reduce systems' errors contributing to serious adverse events; and

(c) Disseminate evidence-based prevention practices to improve patient outcomes.

(3) ORS 192.410 to 192.505 do not apply to public records created or maintained by the commission that contain patient safety data or to reports obtained by the program.

(4) ORS 192.610 to 192.690 do not apply to portions of a meeting of the Oregon Patient Safety Commission Board of Directors, or subcommittees or advisory committees established by the board, to consider information that identifies a participant or patient and the written minutes of that portion of the meeting.

(5) Notwithstanding ORS 182.460, ORS 293.250 applies to the commission for the purpose of collecting unpaid fees established under ORS 442.850 that are owed to the commission and are past due. [2003 c.686 §2; 2009 c.436 §4]

Note: See note under 442.819.

442.825 Funds received by commission. The Oregon Patient Safety 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 not inconsistent with the purposes of the commission. All funds received by the commission shall be deposited in the account established pursuant to ORS 182.470. The commission may apply for grants and foundation support and may compete for contracts consistent with the mission and goals of the commission. [2003 c.686 §3]

Note: See note under 442.819.

442.830 Oregon Patient Safety Commission Board of Directors. (1) There is established the Oregon Patient Safety Commission Board of Directors consisting of 17 members, including the Public Health Officer and 16 directors who shall be appointed by the Governor and who shall be confirmed by the Senate in the manner prescribed in ORS 171.562 and 171.565.

(2) Membership on the board shall reflect the diversity of facilities, providers, insurers, purchasers and consumers that are involved in patient safety. Directors shall demonstrate interest, knowledge or experience in the area of patient safety.

(3) The membership of the board shall be as follows:

(a) The Public Health Officer or the officer's designee;

(b) One faculty member, who is not involved in the direct delivery of health care, of a public university listed in ORS 352.002 or a private Oregon university;

(c) Two representatives of group purchasers of health care, one of whom shall be employed by a state or other governmental entity and neither of whom may provide direct health care services or have an immediate family member who is involved in the delivery of health care;

(d) Two representatives of health care consumers, neither of whom may provide direct health care services or have an immediate family member who is involved in the delivery of health care;

(e) Two representatives of health insurers, including a representative of a domestic not-for-profit health care service contractor, a representative of a domestic insurance company licensed to transact health insurance or a representative of a health maintenance organization;

(f) One representative of a statewide or national labor organization;

(g) Two physicians licensed under ORS chapter 677 who are in active practice;

(h) Two hospital administrators or their designees;

(i) One pharmacist licensed under ORS chapter 689;

(j) One representative of an ambulatory surgical center or an outpatient renal dialysis facility;

(k) One nurse licensed under ORS chapter 678 who is in active clinical practice; and

(L) One nursing home administrator licensed under ORS chapter 678 or one nursing home director of nursing services.

(4) The term of office of each director appointed by the Governor is four years. Before the expiration of the term of a director, the Governor shall appoint a successor whose term begins on July 2 next following. A director is eligible for reappointment for an additional term. If there is a vacancy for any cause, the Governor shall make an appointment to become effective immediately for the unexpired term. The board shall nominate a slate of candidates whenever a vacancy occurs or is announced and shall forward the recommended candidates to the Governor for consideration.

(5) The board shall select one of its members as chairperson and another as vice chairperson for the terms and with the duties and powers as the board considers necessary for performance of the functions of those offices. The board shall adopt bylaws as necessary for the efficient and effective operation of the commission.

(6) The Governor may remove any member of the board at any time at the pleasure of the Governor, but not more than eight directors shall be removed within a period of four years, unless it is for corrupt conduct in office. The board may remove a director as specified in the commission bylaws.

(7) The board may appoint subcommittees and advisory groups as needed to assist the board, including but not limited to one or more consumer advisory groups and technical advisory groups. The technical advisory groups shall include physicians, nurses and other licensed or certified professionals with specialty knowledge and experience as necessary to assist the board.

(8) No voting member of the board may be an employee of the commission. [2003 c.686 §7; 2007 c.71 §130; 2007 c.476 §5; 2011 c.272 §3; 2013 c.768 §143a; 2015 c.767 §174]

Note: See note under 442.819.

442.831 Powers of board relating to Oregon Patient Safety Reporting Program; rules; confidentiality of patient safety data. (1) Except as otherwise provided in ORS 442.819 to 442.851, the Oregon Patient Safety Commission Board of Directors, or officials of the Oregon Patient Safety Commission acting under the authority of the board, shall exercise all the powers of the commission and shall govern the commission. The board shall adopt rules necessary for the implementation of the Oregon Patient Safety Reporting Program, including but not limited to:

(a) Developing a list of objective and definable serious adverse events to be reported by participants. In developing this list, the board shall consider similar lists developed in other states and nationally. The board may change the list from time to time.

(b) Developing a budget.

(c) Establishing a process to seek grants and other funding from federal and other sources.

(d) Establishing a method to determine participant fees, if necessary.

(e) Establishing auditing and oversight procedures, including a process to:

(A) Assess completeness of reports from participants;

(B) Assess credibility and thoroughness of root cause analyses submitted to the program;

(C) Assess the acceptability of action plans and participant follow-up on the action plan; and

(D) Obtain certification by the Public Health Officer on the completeness, credibility, thoroughness and acceptability of participant reports, root cause analyses and action plans.

(f) Establishing criteria for terminating a participant from the program. Incomplete reporting, failure to comply with ORS 442.837 (4) or failure to adequately implement an action plan are grounds for termination from the program.

(2) The board may not use or disclose patient safety data reported, collected or developed pursuant to ORS 442.819 to 442.851 for purposes of any enforcement or regulatory action in relation to a participant.

(3) The board shall maintain the confidentiality of all patient safety data that identifies or could be reasonably used to identify a participant or an individual who is receiving or has received health care from the participant. [2003 c.686 §9; 2011 c.30 §3]

Note: See note under 442.819.

442.835 Appointment of administrator. The Oregon Patient Safety Commission Board of Directors shall appoint an administrator of the Oregon Patient Safety Commission. Subject to the supervision of the board, the administrator has authority to direct the affairs of the commission. The administrator may not be a voting member of the board. [2003 c.686 §11]

Note: See note under 442.819.

442.837 Oregon Patient Safety Reporting Program. (1) The Oregon Patient Safety Reporting Program is created in the Oregon Patient Safety Commission to develop a serious adverse event reporting system. The program shall include but is not limited to:

(a) Reporting by participants, in a timely manner and in the form determined by the Oregon Patient Safety Commission Board of Directors established in ORS 442.830, of the following:

(A) Serious adverse events;

(B) Root cause analyses of serious adverse events;

(C) Action plans established to prevent similar serious adverse events; and

(D) Patient safety plans establishing procedures and protocols.

(b) Analyzing reported serious adverse events, root cause analyses and action plans to develop and disseminate information to improve the quality of care with respect to patient safety. This information shall be made available to participants and shall include but is not limited to:

(A) Statistical analyses;

(B) Recommendations regarding quality improvement techniques;

(C) Recommendations regarding standard protocols; and

(D) Recommendations regarding best patient safety practices.

(c) Providing technical assistance to participants, including but not limited to recommendations and advice regarding methodology, communication, dissemination of information, data collection, security and confidentiality.

(d) Auditing participant reporting to assess the level of reporting of serious adverse events, root cause analyses and action plans.

(e) Overseeing action plans to assess whether participants are taking sufficient steps to prevent the occurrence of serious adverse events.

(f) Creating incentives to improve and reward participation, including but not limited to providing:

(A) Feedback to participants; and

(B) Rewards and recognition to participants.

(g) Distributing written reports using aggregate, deidentified data from the program to describe statewide serious adverse event patterns and maintaining a website to facilitate public access to reports, as well as a list of names of participants. The reports shall include but are not limited to:

(A) The types and frequencies of serious adverse events;

(B) Yearly serious adverse event totals and trends;

(C) Clusters of serious adverse events;

(D) Demographics of patients involved in serious adverse events, including the frequency and types of serious adverse events associated with language barriers or ethnicity;

(E) Systems' factors associated with particular serious adverse events;

(F) Interventions to prevent frequent or high severity serious adverse events;

(G) Analyses of statewide patient safety data in Oregon and comparisons of that data to national patient safety data; and

(H) Appropriate consumer information regarding prevention of serious adverse events.

(2) Participation in the program is voluntary. The following entities are eligible to participate:

(a) Hospitals as defined in ORS 442.015;

(b) Long term care facilities as defined in ORS 442.015;

(c) Pharmacies licensed under ORS chapter 689;

(d) Ambulatory surgical centers as defined in ORS 442.015;

(e) Outpatient renal dialysis facilities as defined in ORS 442.015;

(f) Freestanding birthing centers as defined in ORS 442.015; and

(g) Independent professional health care societies or associations.

(3) Reports or other information developed and disseminated by the program may not contain or reveal the name of or other identifiable information with respect to a particular participant providing information to the commission for the purposes of ORS 442.819 to 442.851, or to any individual identified in the report or information, and upon whose patient safety data, patient safety activities and reports the commission has relied in developing and disseminating information pursuant to this section.

(4) After a serious adverse event occurs, a participant must provide written notification in a timely manner to each patient served by the participant who is affected by the event. Notice provided under this subsection may not be construed as an admission of liability in a civil action.

(5) The commission shall collaborate with providers of ambulatory health care to develop initiatives to promote patient safety in ambulatory health care. [2003 c.686 §4; 2009 c.436 §5; 2011 c.30 §4]

Note: See note under 442.819.

442.839 Commission as central patient safety organization. (1) The Oregon Patient Safety Commission is the central agency in Oregon responsible for the collection of data and analyses produced by all entities in Oregon that are certified by the United States Department of Health and Human Services under 42 U.S.C. 299b-24 as patient safety organizations.

(2) The commission shall incorporate the data and analyses collected under this section in the preparation of reports required by ORS 442.837. [2009 c.436 §2]

Note: See note under 442.819.

442.844 Patient safety data; use; disclosure. (1) Patient safety data reported to the Oregon Patient Safety Commission and information developed pursuant to the auditing and oversight described in ORS 442.837 (1) may not be disclosed to, subject to subpoena by or used by any state agency for purposes of any enforcement or regulatory action in relation to a participant.

(2) Nothing in ORS 442.819 to 442.851 may be construed to limit the regulatory or enforcement authority of any state agency and, except for patient safety data, state agencies have the same authority to access participant records or other information in the same manner and to the same extent as if ORS 442.819 to 442.851 were not enacted.

(3) As used in this section, "state agency" has the meaning given that term in ORS 183.750. [2003 c.686 §5]

Note: See note under 442.819.

442.846 Patient safety data not admissible in civil actions. (1) Patient safety data and reports obtained by a patient safety reporting program from participants are confidential and privileged and are not admissible in evidence in any civil action, including but not limited to a judicial, administrative, arbitration or mediation proceeding. Patient safety data, patient safety activities and reports are not subject to:

(a) Civil or administrative subpoena;

(b) Discovery in connection with a civil action, including but not limited to a judicial, administrative, arbitration or mediation proceeding; or

(c) Disclosure under state public records law pursuant to ORS 442.820 (3) and, if permissible, federal public records laws.

(2) The privilege established under this section does not apply to records of a patient's medical diagnosis and treatment and to records of a participant created in the ordinary course of business.

(3) Patient safety data, collected or developed for the purpose of and with the intent to communicate with or to make a disclosure or report to the patient safety reporting program, that are contained in the business records of the participant are confidential and not subject to civil or administrative subpoena or to discovery in a civil action, including but not limited to a judicial, administrative, arbitration or mediation proceeding.

(4) The following persons are not subject to an action for civil damages for affirmative actions taken, acts of omission or statements made in good faith:

(a) A person serving on the Oregon Patient Safety Commission Board of Directors;

(b) A person serving on a committee established by the board;

(c) A person communicating information to the Oregon Patient Safety Reporting Program; or

(d) A person conducting a study or investigation on behalf of the program.

(5) A participant or a representative of the Oregon Patient Safety Reporting Program may not be examined in any civil action, including but not limited to a judicial, administrative, arbitration or mediation proceeding, as to whether a communication of any kind, including oral and written communication, has been made or shared with another participant or with the program regarding patient safety data, patient safety activities, reports, records, memoranda, analyses, deliberative work, statements or root cause analyses, provided the communication was made with the intent of making a disclosure to or preparing a report to be submitted to the Oregon Patient Safety Commission.

(6) Nothing in this section may be construed to:

(a) Limit or discourage patient safety activities of or among participants or the voluntary reporting of patient safety data by one or more participants, individually or jointly, to a patient safety reporting program;

(b) Affect other privileges that are available under federal or state laws that provide greater peer review or confidentiality protections than do the protections afforded under ORS 442.819 to 442.851;

(c) Preempt or otherwise affect mandatory reporting requirements under Oregon law or licensing or certification requirements of state or federal law; or

(d) Diminish obligations of participants to comply with state and federal laws pertaining to quality assurance, personnel management and infection control requirements.

(7) Reporting or sharing of patient safety data by a participant is not a waiver of any privilege or protection established under ORS 442.819 to 442.851 or other Oregon law. [2003 c.686 §12]

Note: See note under 442.819.

442.850 Fees. The Oregon Patient Safety Commission may assess fees on the entities described in ORS 442.837 (2)(a) to (f) as determined by the Oregon Patient Safety Commission Board of Directors to fund the operating costs of the Oregon Patient Safety Reporting Program. [2003 c.686 §6; 2007 c.476 §2]

Note: See note under 442.819.

442.851 Limit on amounts collected to fund Oregon Patient Safety Reporting Program. (1) Amounts collected by the Oregon Patient Safety Commission under ORS 442.850 may not exceed $1.5 million for the fiscal year beginning on July 1, 2007, and ending on June 30, 2008.

(2) The dollar amount specified in subsection (1) of this section shall be adjusted annually by the commission based upon the change in the Consumer Price Index as defined in ORS 327.006 for every fiscal year beginning on or after July 1, 2008. [2007 c.476 §3]

Note: See note under 442.819.

HEALTH CARE ACQUIRED INFECTIONS

(Temporary provisions relating to health care acquired infections)

Note: Sections 1 to 4, 6 and 12, chapter 838, Oregon Laws 2007, provide:

Sec. 1. The Legislative Assembly finds that Oregonians should be free from infections acquired during

the delivery of health care. Action taken in this state to prevent health care acquired infections should be trustworthy, effective, transparent and reliable. [2007 c.838 §1]

Sec. 2. As used in sections 1 to 6 of this 2007 Act:

(1) "Health care facility" has the meaning given that term in ORS 442.015.

(2) "Health care acquired infection" means a localized or systemic condition that:

(a) Results from an adverse reaction to the presence of an infectious agent or its toxin; and

(b) Was not present or incubating at the time of admission to the health care facility.

(3) "Risk-adjusted methodology" means a standardized method used to ensure that intrinsic and extrinsic risk factors for a health care acquired infection are considered in the calculation of health care acquired infection rates. [2007 c.838 §2]

Sec. 3. (1) There is established in the Oregon Health Authority the Oregon Health Care Acquired Infection Reporting Program. The program shall:

(a) Provide useful and credible infection measures, specific to each health care facility, to consumers;

(b) Promote quality improvement in health care facilities; and

(c) Utilize existing quality improvement efforts to the extent practicable.

(2) The authority shall adopt rules to:

(a) Require health care facilities to report to the authority health care acquired infection measures, including but not limited to health care acquired infection rates;

(b) Specify the health care acquired infection measures that health care facilities must report; and

(c) Prescribe the form, manner and frequency of reports of health care acquired infection measures by health care facilities.

(3) In prescribing the form, manner and frequency of reports of health care acquired infection measures by health care facilities, to the extent practicable and appropriate to avoid unnecessary duplication of reporting by facilities, the authority shall align the requirements with the requirements for health care facilities to report similar data to the Department of Human Services and to the Centers for Medicare and Medicaid Services.

(4) The authority shall utilize, to the extent practicable and appropriate, a credible and reliable risk-adjusted methodology in analyzing the health care acquired infection measures reported by health care facilities.

(5) The authority shall provide health care acquired infection measures and related information to health care facilities in a manner that promotes quality improvement in the health care facilities.

(6) The authority shall adopt rules prescribing the form, manner and frequency for public disclosure of reported health care acquired infection measures. The authority shall disclose updated information to the public no less frequently than every calendar quarter.

(7) Individually identifiable health information submitted to the authority by health care facilities pursuant to this section may not be disclosed to, made subject to subpoena by or used by any state agency for purposes of any enforcement or regulatory action in relation to a participating health care facility. [2007 c.838 §3; 2009 c.595 §1157; 2013 c.61 §6]

Sec. 4. (1) There is established the Health Care Acquired Infection Advisory Committee to advise the Director of the Oregon Health Authority regarding the Oregon Health Care Acquired Infection Reporting Program. The advisory committee shall consist of 16 members appointed by the director as follows:

(a) Seven of the members shall be health care providers or their designees, including:

(A) A hospital administrator who has expertise in infection control and who represents a hospital that contains fewer than 100 beds;

(B) A hospital administrator who has expertise in infection control and who represents a hospital that contains 100 or more beds;

(C) A long term care administrator;

(D) A hospital quality director;

(E) A physician with expertise in infectious disease;

(F) A registered nurse with interest and involvement in infection control; and

(G) A physician who practices in an ambulatory surgical center and who has interest and involvement in infection control.

(b) Nine of the members shall be individuals who do not represent health care providers, including:

(A) A consumer representative;

(B) A labor representative;

(C) An academic researcher;

(D) A health care purchasing representative;

(E) A representative of the Department of Human Services;

(F) A representative of the business community;

(G) A representative of the Oregon Patient Safety Commission who does not represent a health care provider on the commission;

(H) The state epidemiologist; and

(I) A health insurer representative.

(2) The Director of the Oregon Health Authority and the advisory committee shall evaluate on a regular basis the quality and accuracy of the data collected and reported by health care facilities under section 3, chapter 838, Oregon Laws 2007, and the methodologies of the Oregon Health Authority for data collection, analysis and public disclosure.

(3) Members of the advisory committee are not entitled to compensation and shall serve as volunteers on the advisory committee.

(4) Each member of the advisory committee shall serve a term of two years.

(5) The advisory committee shall make recommendations to the director regarding:

(a) The health care acquired infection measures that health care facilities must report, which may include but are not limited to:

(A) Surgical site infections;

(B) Central line related bloodstream infections;

(C) Urinary tract infections; and

(D) Health care facility process measures designed to ensure quality and to reduce health care acquired infections;

(b) Methods for evaluating and quantifying health care acquired infection measures that align with other data collection and reporting methodologies of health care facilities and that support participation in other quality interventions;

(c) Requiring different reportable health care acquired infection measures for differently situated health care facilities as appropriate;

(d) A method to ensure that infections present upon admission to the health care facility are excluded from the rates of health care acquired infection disclosed to the public for the health care facility under sections 3 and 6, chapter 838, Oregon Laws 2007;

(e) Establishing a process for evaluating the health care acquired infection measures reported under section 3, chapter 838, Oregon Laws 2007, and for modifying the reporting requirements over time as appropriate;

(f) Establishing a timetable to phase in the reporting and public disclosure of health care acquired infection measures; and

(g) Procedures to protect the confidentiality of patients, health care professionals and health care facility employees. [2007 c.838 §4; 2009 c.595 §1158; 2013 c.61 §7]

Sec. 6. (1) In addition to any report required pursuant to section 3, chapter 838, Oregon Laws 2007, on or before April 30 of each year, the Oregon Health Authority shall prepare an annual report summarizing the health care facility reports submitted pursuant to section 3, chapter 838, Oregon Laws 2007. The authority shall make the reports available to the public in the manner provided in ORS 192.243 and to the Legislative Assembly in the manner provided in ORS 192.245.

(2) The annual report shall, for each health care facility in the state, compare the health care acquired infection measures reported under section 3, chapter 838, Oregon Laws 2007. The authority, in consultation with the Health Care Acquired Infection Advisory Committee, shall provide the information in the report in a format that is as easily comprehensible as possible.

(3) The annual report may include findings, conclusions and trends concerning the health care acquired infection measures reported under section 3, chapter 838, Oregon Laws 2007, a comparison to the health care acquired infection measures reported in prior years and any policy recommendations.

(4) The authority shall publicize the annual report and its availability to interested persons, including providers, media organizations, health insurers, health maintenance organizations, purchasers of health insurance, organized labor, consumer and patient advocacy groups and individual consumers.

(5) The annual report and quarterly reports under this section and section 3, chapter 838, Oregon Laws 2007, may not contain information that identifies a patient, a licensed health care professional or an employee of a health care facility in connection with a specific infection incident. [2007 c.838 §6; 2013 c.61 §8]

Sec. 12. Sections 1 to 6 of this 2007 Act are repealed on January 2, 2018. [2007 c.838 §12]

442.990 [Amended by 1955 c.533 §9; repealed by 1977 c.717 §23]

PENALTIES

442.991 Civil penalties for failure to report proposed capital projects. (1) Any reporting entity that fails to report as required by rules of the Oregon Health Authority adopted pursuant to ORS 442.362 may be subject to a civil penalty.

(2) The authority shall adopt a schedule of penalties, not to exceed $500 per day of violation, that are based on the severity of the violation.

(3) Civil penalties imposed under this section shall be imposed as provided in ORS 183.745.

(4) Civil penalties imposed under this section may be remitted or mitigated upon such terms and conditions as the authority considers proper and consistent with the public health and safety.

(5) Civil penalties incurred under any law of this state are not allowable as costs for the purpose of rate determination or for reimbursement by a third-party payer. [2009 c.595 §1199; 2015 c.318 §38]

442.993 Civil penalties for failure to report health care data of health insurers. (1) Any reporting entity that fails to report as required in ORS 442.466 or rules of the Oregon Health Authority adopted pursuant to ORS 442.466 may be subject to a civil penalty.

(2) The authority shall adopt a schedule of penalties not to exceed $500 per day of violation, determined by the severity of the violation.

(3) Civil penalties under this section shall be imposed as provided in ORS 183.745.

(4) Civil penalties imposed under this section may be remitted or mitigated upon such terms and conditions as the authority considers proper and consistent with the public health and safety.

(5) Civil penalties incurred under any law of this state are not allowable as costs for the purpose of rate determination or for reimbursement by a third-party payer. [2009 c.595 §1202; 2015 c.318 §39; 2015 c.845 §2]

Note: 442.993 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 442 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.