Chapter 442

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Health Planning

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ADMINISTRATOR OF THE OFFICE FOR OREGON HEALTH POLICY AND RESEARCH

442.011 Office for Oregon Health Policy and Research created; appointment of administrator. (1) There is created in the Oregon Department of Administrative Services the Office for Oregon Health Policy and Research. The Administrator of the Office for Oregon Health Policy and Research shall be appointed by the Governor and the appointment shall be subject to Senate confirmation in the manner prescribed in ORS 171.562 and 171.565. 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 Oregon Health Plan. Before making the appointment, the Governor must advise the President of the Senate and the Speaker of the House of Representatives of the names of at least three finalists and shall consider their recommendation in appointing the administrator.

(2) In carrying out the responsibilities and duties of the administrator, the administrator shall consult with and be advised by the Oregon Health Policy Commission. [1993 c.725 §33; 1997 c.683 §16; 2001 c.69 §1; 2003 c.784 §5]

ADMINISTRATION

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

(1) "Acquire" or "acquisition" refers to obtaining equipment, supplies, components or facilities by any means, including purchase, capital or operating lease, rental or donation, with intention 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) "Adjusted admission" means the sum of all inpatient admissions divided by the ratio of inpatient revenues to total patient revenues.

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

(4) "Ambulatory surgical center" means a facility that performs outpatient surgery not routinely or customarily performed in a physician's or dentist's office, and is able to meet health facility licensure requirements.

(5) "Audited actual experience" means data contained within financial statements examined by an independent, certified public accountant in accordance with generally accepted auditing standards.

(6) "Budget" means the projections by the hospital for a specified future time period of expenditures and revenues with supporting statistical indicators.

(7) "Case mix" means a calculated index for each hospital, based on financial accounting and case mix data collection as set forth in ORS 442.425, reflecting the relative costliness of that hospital's mix of cases compared to a state or national mix of cases.

(8) "Commission" means the Oregon Health Policy Commission.

(9) "Department" means the Department of Human Services of the State of Oregon.

(10) "Develop" means to undertake those activities which 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.

(11) "Director" means the Director of Human Services.

(12) "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.

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

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

(15) "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.

(16)(a) "Health care facility" means a hospital, a long term care facility, an ambulatory surgical center, a freestanding birthing center or an outpatient renal dialysis facility.

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

(A) An establishment furnishing residential care or treatment not meeting federal intermediate care standards, not following a

primarily medical model of treatment, prohibited from admitting persons requiring 24-hour nursing care and licensed or approved under the rules of the Department of Human Services or the Department of Corrections; or

(B) An establishment furnishing primarily domiciliary care.

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

(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: Usual physician services, hospitalization, laboratory, X-ray, emergency and preventive services, and 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.

(18) "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.

(19) "Hospital" means a facility with an organized medical staff, with permanent facilities that include inpatient beds and with 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, to provide treatment for the mentally ill or to provide treatment in special inpatient care facilities.

(20) "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.

(21) "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.

(22) "Long term care facility" means a facility with permanent facilities that include inpatient beds, providing medical services, including nursing services but excluding surgical procedures except as may be permitted by the rules of the director, to provide treatment for two or more unrelated patients. "Long term care facility" includes skilled nursing facilities and intermediate care facilities but may not be construed to include facilities licensed and operated pursuant to ORS 443.400 to 443.455.

(23) "Major medical equipment" means medical equipment that is used to provide medical and other health services and that costs more than $1 million. "Major medical equipment" does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services, if the clinical laboratory is independent of a physician's office and a hospital and has been determined under Title XVIII of the Social Security Act to meet the requirements of paragraphs (10) and (11) of section 1861(s) of that Act.

(24) "Medically indigent" means a person who has insufficient resources or assets to pay for needed medical care without utilizing resources required to meet basic needs for shelter, food and clothing.

(25) "Net revenue" means gross revenue minus deductions from revenue.

(26) "New hospital" means 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. "New hospital" also includes any replacement of an existing hospital that involves a substantial increase or change in the services offered.

(27) "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. A "new skilled nursing or intermediate care service or facility" also includes the rebuilding of a long term care facility, the relocation of buildings which 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.

(28) "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.

(29) "Operating expenses" means the sum of daily hospital service expenses, ambulatory service expenses, ancillary expenses and other operating expenses, excluding income taxes.

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

(31) "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.

(32) "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 injured, disabled or sick persons.

(33) "Special inpatient care facility" means a facility with permanent inpatient beds and other facilities designed and utilized for special health care purposes, including but not limited to a rehabilitation center, a college infirmary, a chiropractic facility, a facility for the treatment of alcoholism or drug abuse, an inpatient care facility meeting the requirements of ORS 441.065, and any other establishment falling within a classification established by the Department of Human Services, after determination of the need for such classification and the level and kind of health care appropriate for such classification.

(34) "Total deductions from gross revenue" or "deductions from revenue" means reductions from gross revenue resulting from inability to collect payment of charges. Such reductions include bad debts; contractual adjustments; uncompensated care; administrative, courtesy and policy discounts and adjustments and other such revenue deductions. The deduction shall be net of the offset of restricted donations and grants for indigent care. [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]

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 Oregon Health Policy Commission; qualifications; terms; officers; meetings; compensation and expenses. (1)

The Oregon Health Policy Commission is established to serve as the policy-making body responsible for health policy and planning for the state.

(2) The members of the commission shall be residents of the State of Oregon and shall be appointed by the Governor, subject to the following:

(a) The commission shall have 10 public members and shall include at least one member from each congressional district of the state.

(b) The membership of the commission shall broadly represent the geographic, social, economic, occupational, linguistic and racial population of the state and shall include individuals who represent Oregon's rural and urban medically underserved populations.

(c) The commission shall have a majority of members who are not direct providers of health care and shall include individuals who represent Oregon's rural and urban medically underserved populations.

(d) The commission shall have at least one member who is a physician licensed to practice in this state. For the purposes of this paragraph, "physician" has the meaning given that term in ORS 677.010.

(e) Members shall be appointed to three-year terms.

(f) A member may not serve more than two consecutive terms.

(3) Voting members of the commission shall serve at the Governor's pleasure.

(4) Voting members shall select a chairperson and a vice chairperson from among themselves.

(5) The commission shall meet at least quarterly.

(6) Members are entitled to compensation and expenses as provided in ORS 292.495.

(7) Vacancies of voting members on the commission shall be filled by appointments of the Governor for the unexpired term.

(8) In addition to the members appointed to the commission under subsection (2) of this section:

(a) The President of the Senate, in consultation with leadership from the minority party, shall appoint two members of the Senate to the commission, one from the majority party and one from the minority party, who shall be nonvoting, advisory members; and

(b) The Speaker of the House of Representatives, in consultation with leadership from the minority party, shall appoint two members of the House of Representatives to the commission, one from the majority party and one from the minority party, who shall be nonvoting, advisory members. [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]

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

442.045 Commission duties. The Oregon Health Policy Commission shall perform the following functions:

(1) Develop a plan for and monitor the implementation of the state health policy.

(2) Act as the policy-making body for a statewide data clearinghouse established within the Department of Human Services or among other state agencies as appropriate for the acquisition, compilation, correlation and dissemination of data from health care providers, other state and local agencies including the state Medicaid program, third-party payers and other appropriate sources in furtherance of the purpose and intent of the Legislative Assembly as expressed in ORS 442.025.

(3) Review reports provided at least biennially by the Administrator of the Office for Oregon Health Policy and Research on the findings, trends and long-term implications arising from data collected pursuant to ORS 442.120 and 442.400 to 442.463 and by the statewide data clearinghouse authorized by subsection (2) of this section.

(4) Provide a forum for discussion of health policy and health care issues facing the citizens of the State of Oregon.

(5) Identify and analyze significant health policy and health care issues affecting the state and make policy recommendations to the Governor.

(6) Prepare and submit to the Governor and the Legislative Assembly resolutions relating to health policy and health care reform.

(7) Review State Medicaid Plan amendments, modifications in Medicaid operational protocols, applications for waivers to the Centers for Medicare and Medicaid Services proposed by the Department of Human Services and administrative rules for the state's medical assistance program and other health care programs.

(8) Act as the primary advisory committee to the Office for Oregon Health Policy and Research, the Governor and the Legislative Assembly.

(9) Perform all other functions authorized or required by state law. [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]

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 Commission subcommittees and advisory committees. The Oregon Health Policy Commission may establish subcommittees and may appoint advisory committees to advise it in carrying out its duties. Members of advisory committees shall not be eligible for compensation but shall be entitled to receive actual and necessary travel and other expenses incurred in the performance of their official duties. [1977 c.751 §15; 1981 c.693 §5; 2003 c.784 §4]

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. In order to provide data essential for health planning programs:

(1) The Office for Oregon Health Policy and Research may request, by July 1 of each year, each general hospital to file with the office 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 office for developing or evaluating statewide health policy:

(a) Date of birth;

(b) Sex;

(c) Zip code;

(d) Inpatient admission date or outpatient service date;

(e) Inpatient discharge date;

(f) Type of discharge;

(g) Diagnostic related group or diagnosis;

(h) Type of procedure performed;

(i) Expected source of payment, if available;

(j) Hospital identification number; and

(k) Total hospital charges.

(2) By July 1 of each year, the office may request from ambulatory surgery 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 office 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 is not available to the office on an annual and timely basis, the office may establish by rule a fee to be charged each hospital.

(4) Subject to prior approval of the Oregon Department of Administrative Services 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 shall not exceed the cost of abstracting and compiling the records.

(5) The office 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 office.

(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 office 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 office 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 office determines appropriate to

the office'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]

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]

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

CERTIFICATES OF NEED FOR HEALTH SERVICES

442.315 Certificate of need required; 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 shall obtain a certificate of need from the Department of Human Services prior to an offering or development.

(2) The department 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 department on forms provided for this purpose by department 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 Department of Human Services shall prescribe application fees, based on the complexity and scope of the proposed project.

(4) The Department of Human Services shall be the decision-making authority for the purpose of certificates of need.

(5)(a) An applicant or any affected person who is dissatisfied with the proposed decision of the department 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 department, 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 a department decision under this subsection, the department 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 department finds that a person is offering or developing a project that is not within the scope of the certificate of need, the department 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 department 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 department under this section, the department 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 chap-

ter 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]

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 Department of Human Services 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]

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. (1) Notwithstanding any other provision of law, a hospital licensed under ORS 441.025, in accordance with rules adopted by the Department of Human Services, may apply for waiver from the provisions of ORS 442.325 and section 9, chapter 1034, Oregon Laws 1989, and the department shall grant such 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 shall 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 department 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 which include capital-related expenses or other risk-based payment programs as approved by the department;

(B) Revenue earned pursuant to Title XIX, United States Social Security Act, when such revenue is based on diagnostic related group prices which 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 department 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 department.

(4)(a) The department 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 department 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 or section 9, chapter 1034, Oregon Laws 1989, the department 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]

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]

HEALTH CARE COST REVIEW

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 Office for Oregon Health Policy and Research 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 Administrator of the Office for Oregon Health Policy and Research 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 administrator 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 administrator considers material or relevant in connection with functions of the office 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 necessary in the administrator's judgment for carrying out the functions of the office. [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]

442.425 Authority over reporting systems of facilities. (1) The Administrator of the Office for Oregon Health Policy and Research 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 administrator'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 administrator. The administrator 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 administrator.

(2) Existing systems of reporting used by health care facilities shall be given due consideration by the administrator in carrying out the duty of specifying the systems of reporting required by ORS 442.400 to 442.463. The administrator insofar as reasonably possible shall adopt reporting systems and requirements that will not unreasonably increase the administrative costs of the facility.

(3) The administrator 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 administrator 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 441.055 and 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]

442.430 Investigations; confidentiality of data. (1) Whenever a further investigation is considered necessary or desirable by the Office for Oregon Health Policy and Research to verify the accuracy of the information in the reports made by health care facilities, the office 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 441.055 and 442.400 to 442.463, the office 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 office. [Formerly 441.445; 1995 c.727 §28; 1997 c.683 §24]

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 442.400 to 442.463 and rules of the Office for Oregon Health Policy and Research may be subject to a civil penalty.

(2) The Administrator of the Office for Oregon Health Policy and Research 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 administrator 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]

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 Office for Oregon Health Policy and Research may accept information relating to the utilization and cost of health care services identified by the Administrator of the Office for Oregon Health Policy and Research 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]

442.463 Annual utilization report; contents; approval. (1) Each licensed health facility shall file with the Office for Oregon Health Policy and Research an annual report containing such information related to the facility's utilization as may be required by the Administrator of the Office for Oregon Health Policy and Research, in such form as the administrator prescribes by rule.

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

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]

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

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 316.143.

(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 agency 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 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]

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 boards of 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]

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 Oregon Medical Association and one primary care physician appointed by the Oregon Osteopathic Association;

(b) One nurse practitioner who is appointed by the Oregon Nursing 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 the three health service areas; and

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

(e) One representative appointed by the Conference of Local Health Officials;

(f) One volunteer emergency medical technician from a community of less than 3,500 people appointed by the Oregon State EMT Association;

(g) One representative appointed 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, appointed by the Oregon Association of Hospitals;

(j) One dentist appointed by the Oregon Dental Association;

(k) One optometrist appointed by the Oregon Association of Optometry;

(L) One physician assistant who is appointed by the Oregon Society of Physician Assistants; and

(m) One naturopathic physician appointed 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]

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) To 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]

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 Department of Human Services 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 the mentally ill 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]

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 hospitals defined by the office as rural. The Office of Rural Health shall be primarily responsible for providing:

(1) A recruitment and retention program for physician and other primary care provider manpower 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 the Oregon Association of Hospitals, a report which identifies models that will replace or restructure inefficient health services in rural areas. [1987 c.918 §3]

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 the Oregon Association of Hospitals, 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 the Oregon Association of Hospitals, shall include the following categories:

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

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 Treatment of type B hospitals under medical assistance programs. Except as otherwise provided in section 7, chapter 537, Oregon Laws 1993, type B hospitals, as defined in ORS 442.470, and identified by the Office of Rural Health as rural hospitals, shall be treated the same as type A hospitals for purposes of ORS 414.065 (5). [1989 c.893 §9; 1993 c.765 §50]

Note: 442.525 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.

NURSING SERVICES PROGRAM

442.535 Definitions for ORS 442.540 and 442.545. As used in ORS 442.540 and 442.545:

(1) "Commission" means the Oregon Student Assistance Commission.

(2) "Nurse" means any person who is licensed under ORS 678.010 to 678.410 as a registered nurse.

(3) "Nursing critical shortage area" means a locality or practice specialty identified as such by the Oregon State Board of Nursing, in consultation with the Office of Rural Health, under ORS 442.540.

(4) "Qualifying loan" means any loan made to a nursing student under:

(a) Programs under Title IV, parts B, D and E, of the Higher Education Act of 1965, as amended; or

(b) The Nursing Student Loan and Health Education Assistance Loan programs administered by the United States Department of Health and Human Services. [2001 c.599 §1]

Note: 442.535 to 442.545 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.

442.540 Nursing Services Program created; criteria for participation; rules. (1) There is created the Nursing Services Program, to be administered by the Oregon Student Assistance Commission pursuant to rules adopted by the commission. The purpose of the program is to provide loan repayments on behalf of nurses who agree to practice in nursing critical shortage areas.

(2) To be eligible to participate in the program, a nurse or prospective nurse shall submit a letter of interest to the commission. Applicants who are selected for participation according to criteria adopted by the commission under subsection (3) of this section shall sign a letter of agreement stipulating that

the applicant agrees to abide by the terms of the program described in ORS 442.545.

(3) The commission shall by rule adopt, in consultation with the Oregon State Board of Nursing and the Office of Rural Health, criteria for participation in the program.

(4) The Oregon State Board of Nursing by rule shall annually identify, in consultation with the Office of Rural Health, those areas that are considered nursing critical shortage areas.

(5) Amounts paid to the commission as penalties under ORS 442.545 shall be credited and deposited in the Nursing Services Account created under ORS 348.570. The commission, in consultation with the Oregon State Board of Nursing, by rule shall allow waiver of all or part of any fees or penalties owed to the commission due to circumstances that prevent a nurse from fulfilling a service obligation under ORS 442.545. [2001 c.599 §2]

Note: See note under 442.535.

442.545 Conditions of participation in Nursing Services Program. (1) A nurse or prospective nurse applicant who is a graduate of an accredited nursing program with a baccalaureate or associate degree and who wishes to participate in the Nursing Services Program established under ORS 442.540 shall agree that:

(a) For each year of nursing school, the applicant designates an agreed amount, not to exceed $8,800 or the amount determined under subsection (2) of this section, as a qualifying loan for the program.

(b) In the four years following the execution of a Nursing Services Program agreement with the Oregon Student Assistance Commission, a nurse agrees to practice for at least two full years in a nursing critical shortage area in Oregon.

(c) For not less than two nor more than four years that the nurse practices in a nursing critical shortage area, the commission shall annually pay:

(A) For full-time practice, an amount equal to 25 percent of the total of all qualifying loans made to the nurse.

(B) For half-time practice, an amount equal to 12.5 percent of the total of all qualifying loans made to the nurse.

(d) If the nurse does not complete the full service obligation set forth in paragraphs (b) and (c) of this subsection, the commission shall collect 100 percent of any payments made by the commission to the nurse under the Nursing Services Program. In addition, the commission shall assess against the nurse a penalty equal to 50 percent of the qualifying loans and interest paid by the commission.

(2)(a) On July 1 of each year, beginning in 2002 and ending in 2007, the Oregon Student Assistance Commission shall adjust the maximum dollar amount allowed under subsection (1)(a) of this section as a qualifying loan by multiplying the amount by a cost-of-living adjustment as specified in this subsection.

(b) The cost-of-living adjustment applied on July 1 each year by the commission shall be equal to the ratio of the seasonally adjusted United States City Average Consumer Price Index for All Urban Consumers as published by the Bureau of Labor Statistics of the United States Department of Labor for April of the calendar year divided by the value of the same index for April 2001.

(c) Beginning on July 1, 2008, the commission shall use the cost-of-living adjustment calculated for July 1, 2007.

(d) If the value of the dollar amount determined under paragraph (a) of this subsection is not a multiple of $100, the commission shall round the dollar amount to the next lower multiple of $100. [2001 c.599 §3]

Note: See note under 442.535.

RURAL HEALTH SERVICES PROGRAM

442.550 Definitions for ORS 442.550 to 442.570. As used in ORS 442.550 to 442.570:

(1) "Commission" means the Oregon Student Assistance Commission.

(2) "Nurse practitioner" means any person who is licensed under ORS 678.375.

(3) "Physician" means any person licensed to practice medicine under ORS chapter 677.

(4) "Physician assistant" means any such person licensed under ORS 677.495 and 677.505 to 677.525.

(5) "Qualifying loan" means any loan made to a medical student, physician assistant student or nursing student under:

(a) Common School Fund loan program under ORS 348.040 to 348.090;

(b) Programs under Title IV parts B, D and E, of the Higher Education Act of 1965, as amended; and

(c) The Health Professions Student Loan, Nursing Student Loan, Health Education Assistance Loan and Primary Care Loan programs administered by the United States Department of Health and Human Services. [1989 c.893 §16; 1991 c.947 §5; 1999 c.582 §11; 1999 c.704 §23; 2001 c.336 §1]

Note: 442.550 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 leg-

islative action. See Preface to Oregon Revised Statutes for further explanation.

442.555 Rural Health Services Program created; criteria for participation. (1) There is created the Rural Health Services Program, to be administered by the Oregon Student Assistance Commission, pursuant to rules adopted by the commission. The purpose of the program is to provide loan repayments on behalf of physicians, physician assistants and nurse practitioners who agree to practice in a medically underserved rural community in Oregon as determined in subsection (4) of this section.

(2) To be eligible to participate in the program, a prospective physician, physician assistant or nurse practitioner shall submit a letter of interest to the commission. Applicants who are selected for participation according to criteria adopted by the commission in consultation with the Office of Rural Health shall sign a letter of agreement stipulating that the applicant agrees to abide by the terms stated in ORS 442.560.

(3) Subject to available resources, the commission may enter into agreements with not to exceed 10 prospective physicians, 10 prospective physician assistants and 10 prospective nurse practitioners each year.

(4) The Office of Rural Health shall adopt criteria to be applied to determine medically underserved communities for purposes of ORS 316.143, 316.144, 316.146, 353.450, 442.470, 442.503, 442.550 to 442.570 and for the purposes of compliance with federal Public Law 95-210, establishing rural health clinics. [1989 c.893 §17; 1991 c.877 §20; 1991 c.947 §6; 1993 c.765 §52; 1999 c.291 §32; 1999 c.704 §24]

Note: See note under 442.550.

442.560 Conditions of participation in Rural Health Services Program. Prospective physicians, physician assistants and nurse practitioners who wish to participate in the Rural Health Services Program shall agree that:

(1) For each year of medical, physician assistant or graduate school, the applicant designates an agreed amount, not to exceed $25,000, as a qualifying loan subject to ORS 316.143, 316.144, 316.146, 353.450, 442.470, 442.503 and 442.550 to 442.570.

(2) In the five years following the completion of all residency requirements or the five years following the execution of a Rural Health Services agreement with the commission, whichever comes later, a physician agrees to practice for at least three full years in a medically underserved rural community in Oregon.

(3) For not less than three nor more than five years that a physician serves in a medically underserved rural area, the Oregon Student Assistance Commission shall annually pay an amount equal to 20 percent of the total of all qualifying loans made to the physician through the programs described in ORS 442.550.

(4) In the four years following the completion of physician assistant or graduate school or the four years following the execution of a Rural Health Services agreement with the commission, whichever comes later, a physician assistant or nurse practitioner agrees to practice for at least two years in a medically underserved rural community in Oregon.

(5) For not less than two nor more than four years that a physician assistant or nurse practitioner practices in a medically underserved rural area, the commission shall annually pay an amount equal to 25 percent of the total of all qualifying loans made to the physician assistant or nurse practitioner through the programs described in ORS 442.550.

(6) If the participant does not complete the full service obligation set forth in subsection (2) or (4) of this section, the commission shall collect 100 percent of any payments made by the commission to the participant under this program. In addition, a penalty equal to 50 percent of the qualifying loans and interest paid by the commission shall be assessed by the commission, to be credited to and deposited in the Rural Health Services Fund established under ORS 442.570.

(7) The Oregon Student Assistance Commission, in consultation with the Office of Rural Health, shall establish rules to allow waiver of all or part of the fees and penalties owed to the commission due to circumstances that prevent the participant from fulfilling the service obligation. [1989 c.893 §18; 1991 c.877 §21; 1991 c.947 §3; 1993 c.765 §53; 1993 c.813 §13]

Note: See note under 442.550.

442.561 Certifying individuals licensed under ORS chapter 679 for tax credit under ORS 316.144. 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 316.144. 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 316.144. [1995 c.746 §40; 1999 c.291 §33; 1999 c.459 §2]

Note: See note under 442.550.

442.562 Certifying podiatric physicians and surgeons for tax credit under ORS 316.144. The Office of Rural Health shall establish criteria for certifying individuals who are licensed as podiatric physicians and surgeons under ORS chapter 677 as eligible for the tax credit authorized by ORS 316.144. 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 316.144. [1995 c.746 §41; 1999 c.291 §34; 1999 c.459 §3]

Note: See note under 442.550.

442.563 Certifying for tax credit; rules. (1) Subject to ORS 442.560, the Office of Rural Health shall establish criteria for certifying individuals eligible for the tax credit authorized by ORS 316.143, 316.144 or 316.146. Upon application therefor, the office shall certify individuals eligible for the tax credit authorized by ORS 316.143.

(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]

Note: See note under 442.550.

442.564 Certifying optometrists for tax credit under ORS 316.144. The Office of Rural Health shall establish criteria for certifying individuals who are licensed as optometrists under ORS 683.010 to 683.335 as eligible for the tax credit authorized by ORS 316.144. 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 316.144. [1997 c.787 §2; 1999 c.291 §36; 1999 c.459 §5]

Note: See note under 442.550.

442.565 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 areas.

(2) The university shall reserve a number of admissions to each class at the medical school for qualified students who agree to participate in the Rural Health Services Program. The number of admissions under this section is not required to exceed 15 percent of each class, but that figure is a goal consistent with the long term intention of the Legislative Assembly to encourage the availability of medical services in rural areas.

(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. [1989 c.893 §19]

Note: See note under 442.550.

442.570 Rural Health 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 Rural Health Services Fund, for investments as provided by ORS 293.701 to 293.820, for the payment of expenses of the Oregon Student Assistance Commission in carrying out the purposes of ORS 316.143, 316.144, 316.146, 353.450, 442.470, 442.503 and 442.550 to 442.570. Interest earned by the account shall be credited to the account.

(2) The Office of Rural Health shall seek matching funds from communities that benefit from placement of practitioners under ORS 442.550 to 442.570. The office shall establish a program to enroll interested communities in this program and deposit money proceeds from this effort in the Rural Health 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]

Note: See note under 442.550.

HEALTH RESOURCES COMMISSION

442.575 Definitions for ORS 442.575 to 442.584. As used in ORS 442.575 to 442.584:

(1) "Commission" means the Health Resources Commission established pursuant to ORS 442.580.

(2) "Established medical technology" means a medical technology that is in widespread use and considered by practitioners as accepted or standard practice for addressing a specific clinical condition.

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

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

(5) "New and emerging medical technology" means a medical technology that is not in widespread use or does not constitute

standard practice for a particular clinical condition. [1993 c.754 §3]

442.580 Health Resources Commission; membership; terms. (1) There is created the Health Resources Commission, consisting of eleven members appointed by the Governor.

(2) The commission shall include:

(a) Four physicians, one of whom engages in family practice, and each of whom shall be licensed to practice in this state and experienced in health research and the evaluation of medical technologies and clinical outcomes;

(b) One representative of hospitals;

(c) One insurance industry representative;

(d) One business representative;

(e) One representative of labor organizations;

(f) One consumer representative; and

(g) Two pharmacists engaged in the practice of pharmacy, one of whom engages in the practice of pharmacy at a retail drug outlet. For the purposes of this paragraph:

(A) "Pharmacist" has the meaning given that term in ORS 689.005;

(B) "Practice of pharmacy" has the meaning given that term in ORS 689.015; and

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

(3) The term of office of each member of the commission is three years. Each member serves at the pleasure of the Governor. Before the expiration of the term of a member, the Governor shall appoint a successor whose term begins on July 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

(4) The consumer representative on the commission shall be entitled to compensation and expenses as provided in ORS 292.495. The other members shall not be entitled to compensation or expenses. [1991 c.470 §2; 2001 c.238 §1]

442.581 Officers; quorum; meetings; staffing. (1) The Health Resources Commission shall select one of its members as chairperson and another as vice chairperson, for such terms and with duties and powers as the commission determines necessary for the performance of the functions of such offices.

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

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

(4) The commission may use advisory committees or subcommittees, the members to be appointed by the chairperson of the commission subject to approval by a majority of the members of the commission.

(5) The Office for Oregon Health Policy and Research shall provide the commission such staff and support services as it requires. [1991 c.470 §4; 1995 c.727 §37; 1997 c.683 §31]

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

442.583 Medical technology assessment program; content; advisory committee. (1)(a) The Health Resources Commission shall develop a medical technology assessment program that addresses the introduction, diffusion and utilization of medical technologies and their associated services and shall make recommendations regarding the program's implementation.

(b) The assessment program developed pursuant to paragraph (a) of this subsection shall include the results of at least two medical technology assessments to be selected by the commission. The commission shall select one new and emerging medical technology and one established medical technology to be assessed.

(c) The program shall include criteria for selection of the medical technologies to be assessed.

(d) The commission shall appoint and work with an advisory committee whose members shall have the appropriate expertise to develop a medical technology assessment program. The advisory committee shall present its recommendations to the commission at a public hearing. The commission shall conduct public hearings to solicit testimony and information from health care consumers prior to making the report described in subsection (2) of this section. The commission shall give strong consideration to the recommendations of the advisory committee and public testimony in developing its report.

(2)(a) The commission shall present its findings and recommendations in a report to the Governor and the appropriate interim legislative committees on or before April 1, 1994. The report shall include, in addition to at least two medical technology assessments, a determination of the supply and distribution of medical technology and associated services that are required to meet the need

for medical technology in the five years following the completion of the assessment.

(b) The report also shall identify strategies and contain recommendations:

(A) Regarding the program's implementation, including which agency should implement the program;

(B) To promote compliance with the program regarding the introduction, diffusion and utilization of those medical technologies assessed;

(C) Regarding whether the state should have a regulatory function and, if so, which agency should carry out that function; and

(D) Regarding the collection, storage and dissemination of data required for a technology assessment program.

(3) To insure that confidentiality is maintained, no identification of a patient or a person licensed to provide health services shall be included with the data submitted under this section, and the commission shall release such data only in aggregate statistical form. All findings and conclusions, interviews, reports, studies, communications and statements procured by or furnished to the commission in connection with obtaining the data necessary to perform its functions shall be confidential pursuant to ORS 192.501 to 192.505.

(4) All data and information collected, analyzed and summarized by professional and trade associations conducting quality assurance and improvement programs shall be considered confidential and shall not be admissible in any legal proceeding or used to create a legal standard of care. However, such data and information may be submitted to the commission on request and shall remain confidential and inadmissible. [1993 c.754 §5 (enacted in lieu of 442.582)]

442.584 Application for certificate of need. (1) All applicants for a certificate of need for any of the technologies or services under study by the Health Resources Commission shall provide the information specified in paragraphs (a) to (f) of this subsection. This information may be utilized by the commission in performing its functions under ORS 442.583. The information shall include:

(a) The estimated number of patients needing the service or procedure who are not currently being served and who cannot be served by existing programs in the service area.

(b) The anticipated number of procedures to be performed per year for a five-year period commencing on the date the service is started or the technology is acquired.

(c) The anticipated number of patients to be served by the applicant, based on the incidence in the population to be served or the conditions for which the technology or service will be used.

(d) Clinical indications for ordering use of the technology or service, with appropriate references to relevant literature.

(e) An estimate of the treatment decisions likely to result from use of the technology or service.

(f) A proposed method for collecting data on the patients served, costs engendered directly or indirectly and the health outcomes resulting from use of the technology or service.

(2) An application shall be decided in accordance with the statutes and rules in effect at the time of filing of a completed letter of intent for that application. [1991 c.470 §§7,22]

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

442.588 Employees. Nothing in ORS 414.720, 431.120, 442.120, 442.575, 442.583 and 442.588 is intended to limit the authority of the Health Resources Commission and Health Services Commission to appoint their own employees. [1993 c.754 §10; 1995 c.727 §47]

Note: 442.588 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.

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 sys-

tem 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 431.623.

(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 431.890. [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) "Director" means the Director of Human Services.

(4) "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.

(5) "Hospital" means a hospital, as defined in ORS 442.015 (19), or 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.

(6) "Order" means a decision issued by the director 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).

(7) "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.

(8) "Physician" means a physician defined in ORS 677.010 (12) and licensed under ORS chapter 677. [1993 c.769 §3; 2001 c.104 §182]

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 Human Services shall actively supervise the cooperative program in accordance with authority under ORS 442.700 to 442.760 and 646.740. [1993 c.769 §1]

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 Human Services 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 ap-

plication 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]

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 Human Services 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]

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 Human Services, 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]

442.730 Review and evaluation of report; modification or revocation of order of approval. (1) The Director of Human Services 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]

442.735 Complaint procedure. (1) Any person may file a complaint with the Director of Human Services 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]

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 Human Services 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]

442.745 Disclosure of confidential information not waiver of right to protect information. If parties to a cooperative program agreement provide the Director of Human Services 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]

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 Human Services 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]

442.755 Rules; costs; fees. (1) The Director of Human Services 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]

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 Human Services 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]

ADVISORY COMMITTEE ON PHYSICIAN CREDENTIALING INFORMATION

442.800 Advisory Committee on Physician Credentialing Information; membership; terms. (1) The Advisory Committee on Physician Credentialing Information is established within the Office for Oregon Health Policy and Research. The committee consists of nine members appointed by the Administrator of the Office for Oregon Health Policy and Research as follows:

(a) Three members who are physicians licensed by the Board of Medical Examiners for the State of Oregon or representatives of physician organizations doing business within the State of Oregon;

(b) Three representatives of hospitals licensed by the Department of Human Services; and

(c) Three representatives of health care service contractors that have been issued a certificate of authority to transact health insurance in this state by the Department of Consumer and Business Services.

(2) All members appointed pursuant to subsection (1) of this section shall be knowledgeable about national standards relating to physician credentialing.

(3) The term of appointment for each member of the committee is three years. If, during a member's term of appointment, the member no longer qualifies to serve as designated by the criteria of subsection (1) of this section, the member must resign. If there is a vacancy for any cause, the administrator shall make an appointment to become immediately effective for the unexpired term.

(4) Members of the committee are not entitled to compensation or reimbursement of expenses. [1999 c.494 §1]

Note: 442.800 to 442.807 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.

442.805 Committee recommendations. (1) The Advisory Committee on Physician Credentialing Information shall develop and submit recommendations to the Administrator of the Office for Oregon Health Policy and Research for the collection of uniform information necessary for hospitals and health plans to credential physicians seeking membership on a hospital medical staff or designation as a participating provider for a health plan. The recommendations must specify:

(a) The content and format of a credentialing application form; and

(b) The content and format of a recredentialing application form.

(2) The committee shall meet at least once every calendar year to review the uniform credentialing information and to assure the administrator that the information complies with credentialing standards developed by national accreditation organizations and applicable regulations of the federal government.

(3) The Office for Oregon Health Policy and Research shall provide the support staff necessary for the committee to accomplish its duties. [1999 c.494 §3]

Note: See note under 442.800.

442.807 Implementation of recommendations; rules. (1) Within 30 days of receiving the recommendations of the Advisory Committee on Physician Credentialing Information, the Administrator of the Office for Oregon Health Policy and Research shall forward the recommendations to the Director of the Department of Consumer and Business Services and to the Director of Human Services. The administrator shall request that the Department of Consumer and Business Services and the Department of Human Services adopt rules to carry out the efficient implementation and enforcement of the recommendations of the committee.

(2) The Department of Consumer and Business Services and the Department of Human Services shall:

(a) Adopt administrative rules in a timely manner, as required by the Administrative Procedures Act, for the purpose of effectuating the provisions of ORS 442.800 to 442.807; and

(b) Consult with each other and with the administrator to ensure that the rules adopted by the Department of Consumer and Business Services and the Department of Human Services are identical and are consistent with the recommendations developed pursuant to ORS 442.805 for affected hospitals and health care service contractors.

(3) The uniform credentialing information required pursuant to the administrative rules of the Department of Consumer and Business Services and the Department of Human Services represent the minimum uniform credentialing information required by the affected hospitals and health care service contractors. Nothing in ORS 442.800 to 442.807 shall be interpreted to prevent an affected hospital or health care service contractor from requesting additional credentialing information from a licensed physician for the purpose of completing physician credentialing procedures used by the affected hospital or health care service contractor. [1999 c.494 §4; 2001 c.900 §180]

Note: See note under 442.800.

OREGON PATIENT SAFETY COMMISSION

Note: Section 1, chapter 686, Oregon Laws 2003, provides:

Sec. 1. Definitions. As used in sections 1 to 12 of this 2003 Act [442.820 to 442.835 and sections 1, 4 to 6, 8 to 10 and 12, chapter 686, Oregon Laws 2003]:

(1) "Participant" means an entity that reports patient safety data to a 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 section 2 of this 2003 Act [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 a 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 a 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 a patient safety reporting program; or

(b) 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" includes but is not limited to the Oregon Patient Safety Reporting Program created in section 4 of this 2003 Act and any other patient safety reporting program established to improve the safety and quality of patient care.

(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]

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. [2003 c.686 §2]

Note: 442.820 to 442.835 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.

442.825 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 442.820.

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;

(b) One faculty member, who is not involved in the direct delivery of health care, of the Oregon University System 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 immedi-

ate 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 services 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 October 1 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 professional 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]

Note: See note under 442.820.

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 442.820.

Note: Sections 4 to 6, 8 to 10, 12 and 16, chapter 686, Oregon Laws 2003, provide:

Sec. 4. Oregon Patient Safety Reporting Program; participants; reports. (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 section 7 of this 2003 Act [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, de-identified 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; and

(G) 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 sections 1 to 12 of this 2003 Act [442.820 to 442.835 and sections 1, 4 to 6, 8 to 10 and 12, chapter 686, Oregon Laws 2003], 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. [2003 c.686 §4]

Sec. 5. 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 section 4 (1) of this 2003 Act 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 sections 1 to 12 of this 2003 Act [442.820 to 442.835 and sections 1, 4 to 6, 8 to 10 and 12, chapter 686, Oregon Laws 2003] 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 sections 1 to 12 of this 2003 Act 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]

Sec. 6. Fees; exemption. (1) Except as provided in subsection (2) of this section, the Oregon Patient Safety Commission may assess fees on the participating entities described in section 4 (2) of this 2003 Act as determined by the Oregon Patient Safety Commission Board of Directors to fund the Oregon Patient Safety Reporting Program.

(2) Independent professional health care societies or associations are exempt from fees assessed by the commission. [2003 c.686 §6]

Sec. 8. Term of office of board. Notwithstanding the term of office specified by section 7 of this 2003 Act [442.830], of the directors first appointed to the Oregon Patient Safety Commission Board of Directors under section 7 of this 2003 Act:

(1) Four shall serve for terms ending July 1, 2004;

(2) Four shall serve for terms ending July 1, 2005;

(3) Four shall serve for terms ending July 1, 2006; and

(4) Four shall serve for terms ending July 1, 2007. [2003 c.686 §8]

Sec. 9. Powers of board relating to Oregon Patient Safety Reporting Program; rules; confidentiality of patient safety data. (1) Except as otherwise provided in sections 1 to 12 of this 2003 Act [442.820 to 442.835 and sections 1, 4 to 6, 8 to 10 and 12, chapter 686, Oregon Laws 2003], 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. The first list developed by the board shall focus on serious adverse events that caused death or serious physical injury. Later lists may include, in the discretion of the board, serious adverse events that did not cause death or serious physical injury but posed a significant risk of death or a risk of significant physical injury.

(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 section 4 (4) of this 2003 Act 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 sections 1 to 12 of this 2003 Act 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]

Sec. 10. Reports by board. The Oregon Patient Safety Commission Board of Directors shall report:

(1) No later than September 30, 2004, to an interim committee of the Seventy-second Legislative Assembly on the implementation of the Oregon Patient Safety Commission and the serious adverse event reporting system developed by the Oregon Patient Safety Reporting Program;

(2) No later than September 30, 2005, to an interim committee of the Seventy-third Legislative Assembly on preliminary results of a facility-based serious adverse event reporting system;

(3) No later than September 30, 2006, to an interim committee of the Seventy-third Legislative Assembly on the implementation of a retail pharmacy serious adverse event reporting system; and

(4) No later than September 30, 2007, to an interim committee of the Seventy-fourth Legislative Assembly regarding reporting results and whether performance goals have been met. The board shall offer recommendations for any changes to the system, including possible implementation of a mandatory serious adverse event reporting system. [2003 c.686 §10]

Sec. 12. 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 section 2 (3) of this 2003 Act [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 sections 1 to 12 of this 2003 Act [442.820 to 442.835 and sections 1, 4 to 6, 8 to 10 and 12, chapter 686, Oregon Laws 2003];

(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 sections 1 to 12 of this 2003 Act or other Oregon law. [2003 c.686 §12]

Sec. 16. Sections 1, 4, 5, 6, 9, 10 and 12 of this 2003 Act are repealed on January 2, 2010. [2003 c.686 §16]

442.990 [Amended by 1955 c.533 §9; repealed by 1977 c.717 §23]