

CHAPTER 50

AN ACT

HB 4020

Relating to health care facilities; creating new provisions; amending ORS 192.660, 441.020, 441.025, 441.030, 441.065, 441.077, 442.015, 442.120, 442.700, 442.837 and 677.515; and declaring an emergency.
Be It Enacted by the People of the State of Oregon:

EXTENDED STAY CENTER LICENSING

SECTION 1. Section 2 of this 2018 Act is added to and made a part of ORS 441.015 to 441.087.

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

- (a) "Extended stay center" means a facility that provides extended stay services.
- (b) "Extended stay services" means post-surgical and post-diagnostic medical and nursing services provided to a patient who is recovering from a surgical procedure performed in an ambulatory surgical center.
- (c) "Local hospital" has the meaning given that term in rules adopted by the Oregon Health Authority that are consistent with federal requirements.
- (d) "Operating room" has the meaning given that term in rules adopted by the authority.
- (2) The authority shall adopt rules and procedures for the licensing of extended stay centers to ensure that each licensed extended stay center:
 - (a) Is affiliated with a facility:
 - (A) That is licensed by the authority as an ambulatory surgical center;
 - (B) Whose license is in good standing with the authority; and
 - (C) That meets the criteria in subsection (3) of this section;
 - (b) Has no more than two recovery beds for each operating room that is in its affiliated ambulatory surgical center and a total of no more than 10 recovery beds;
 - (c) Discharges patients within 48 hours from the time of admission to the ambulatory surgical center;
 - (d)(A) Has an agreement with at least one local hospital that has the capabilities to treat patients requiring medical care that exceeds the capabilities of the extended stay center and the agreement complies with the federal requirements applicable to patient transfer agreements between ambulatory surgical centers and local hospitals; or
 - (B) Is affiliated with an ambulatory surgical center in which all of the physicians performing surgeries have admitting privileges at a local hospital that has the capabilities to treat pa-

tients requiring medical care that exceeds the capabilities of the extended stay center;

- (e) Conforms to all patient safety and facility requirements adopted by the authority by rule;
 - (f) Uses admission criteria based only on the extended stay center's:
 - (A) Medical screening criteria;
 - (B) Evidence-based surgery guidelines; or
 - (C) Patient safety standards;
 - (g) Orally and in writing, clearly notifies patients with Medicare coverage of the services provided by the extended stay center that are not covered by Medicare;
 - (h) Reports data and metrics to the authority as prescribed by the authority by rule, including but not limited to the:
 - (A) Types of procedures performed at the affiliated ambulatory surgical center for which patients are transferred to the extended stay center for recovery;
 - (B) Average duration of patient stays at the extended stay center;
 - (C) Medical acuity of the patients served by the extended stay center;
 - (D) Types of payers that reimburse services provided at the extended stay center and the percentage of each payer type in the total number of payers; and
 - (E) Frequency and cause of patient transfers from the extended stay center to a hospital; and
 - (i) Is located within an urban area as defined by the Office of Rural Health.
 - (3) The ambulatory surgical center that is affiliated with an extended stay center must:
 - (a) Not be affiliated with any other licensed extended stay center;
 - (b) Be physically contiguous with the extended stay center;
 - (c) Have demonstrated safe operating procedures in an outpatient surgery setting for no less than 24 consecutive months;
 - (d) Be certified by the Centers for Medicare and Medicaid Services as participating in the ambulatory surgical center quality reporting program administered by the Centers for Medicare and Medicaid Services; and
 - (e) Be accredited by a national accrediting organization approved by the authority.
 - (4) The authority shall mitigate barriers to and facilitate the reimbursement of extended stay centers with medical assistance funds.
- SECTION 3.** (1) The Health Evidence Review Commission established under ORS 414.688 shall develop evidence-based guidelines regarding the patient characteristics and surgical procedures that may be appropriate for ambulatory surgical centers and extended stay centers. The commission shall provide a report of the timeline and plan for implementing the guidelines to the Legislative Assembly during the 2019 regular session.

(2) No later than December 31, 2022, the Oregon Health Authority shall report to the interim committees of the Legislative Assembly related to health on the implementation of section 2 of this 2018 Act.

SECTION 4. ORS 441.020 is amended to read:

441.020. (1) Licenses for health care facilities, except long term care facilities as defined in ORS 442.015, must be obtained from the Oregon Health Authority.

(2) Licenses for long term care facilities must be obtained from the Department of Human Services.

(3) Applications shall be upon such forms and shall contain such information as the authority or the department may reasonably require, which may include affirmative evidence of ability to comply with such reasonable standards and rules as may lawfully be prescribed under ORS 441.025.

(4)(a) Each application submitted to the Oregon Health Authority must be accompanied by the license fee. If the license is denied, the fee shall be refunded to the applicant. If the license is issued, the fee shall be paid into the State Treasury to the credit of the Oregon Health Authority Fund for the purpose of carrying out the functions of the Oregon Health Authority under ORS 441.015 to [441.063] **441.087** and 441.196; or

(b) Each application submitted to the Department of Human Services must be accompanied by the application fee or the annual renewal fee, as applicable. If the license is denied, the fee shall be refunded to the applicant. If the license is issued, the fee shall be paid into the State Treasury to the credit of the Department of Human Services Account for the purpose of carrying out the functions of the Department of Human Services under ORS 431A.050 to 431A.080, 441.015 to [441.063] **441.087** and 441.196.

(5) Except as otherwise provided in subsection (8) of this section, for hospitals with:

(a) Fewer than 26 beds, the annual license fee shall be \$1,250.

(b) Twenty-six beds or more but fewer than 50 beds, the annual license fee shall be \$1,850.

(c) Fifty or more beds but fewer than 100 beds, the annual license fee shall be \$3,800.

(d) One hundred beds or more but fewer than 200 beds, the annual license fee shall be \$6,525.

(e) Two hundred or more beds, but fewer than 500 beds, the annual license fee shall be \$8,500.

(f) Five hundred or more beds, the annual license fee shall be \$12,070.

(6) A hospital shall pay an annual fee of \$750 for each hospital satellite indorsed under its license.

(7) The authority may charge a reduced hospital fee or hospital satellite fee if the authority determines that charging the standard fee constitutes a significant financial burden to the facility.

(8) For long term care facilities with:

(a) One to 15 beds, the application fee shall be \$2,000 and the annual renewal fee shall be \$1,000.

(b) Sixteen to 49 beds, the application fee shall be \$3,000 and the annual renewal fee shall be \$1,500.

(c) Fifty to 99 beds, the application fee shall be \$4,000 and the annual renewal fee shall be \$2,000.

(d) One hundred to 150 beds, the application fee shall be \$5,000 and the annual renewal fee shall be \$2,500.

(e) More than 150 beds, the application fee shall be \$6,000 and the annual renewal fee shall be \$3,000.

(9) For ambulatory surgical centers, the annual license fee shall be:

(a) \$1,750 for certified and high complexity non-certified ambulatory surgical centers with more than two procedure rooms.

(b) \$1,250 for certified and high complexity non-certified ambulatory surgical centers with no more than two procedure rooms.

(c) \$1,000 for moderate complexity noncertified ambulatory surgical centers.

(10) For birthing centers, the annual license fee shall be \$750.

(11) For outpatient renal dialysis facilities, the annual license fee shall be \$2,000.

(12) The authority shall prescribe by rule the fee for licensing an extended stay center, not to exceed:

(a) An application fee of \$25,000; and

(b) An annual renewal fee of \$5,000.

[12] (13) During the time the licenses remain in force, holders are not required to pay inspection fees to any county, city or other municipality.

[13] (14) Any health care facility license may be indorsed to permit operation at more than one location. If so, the applicable license fee shall be the sum of the license fees that would be applicable if each location were separately licensed. The authority may include hospital satellites on a hospital's license in accordance with rules adopted by the authority.

[14] (15) Licenses for health maintenance organizations shall be obtained from the Director of the Department of Consumer and Business Services pursuant to ORS 731.072.

[15] (16) **Notwithstanding subsection (4) of this section, all moneys received for approved applications pursuant to subsection (8) of this section shall be deposited in the Quality Care Fund established in ORS 443.001.**

[16] (17) As used in this section:

(a) "Hospital satellite" has the meaning prescribed by the authority by rule.

(b) "Procedure room" means a room where surgery or invasive procedures are performed.

SECTION 5. ORS 442.015 is amended to read:

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

(1) "Acquire" or "acquisition" means obtaining equipment, supplies, components or facilities by any means, including purchase, capital or operating lease, rental or donation, for the purpose of using such equipment, supplies, components or facilities to provide health services in Oregon. When equipment

or other materials are obtained outside of this state, acquisition is considered to occur when the equipment or other materials begin to be used in Oregon for the provision of health services or when such services are offered for use in Oregon.

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

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

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

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

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

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

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

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

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

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

(9) "Extended stay center" means a facility licensed in accordance with section 2 of this 2018 Act.

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

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

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

[(12)(a)] (13)(a) "Health care facility" means:

- (A) A hospital;
- (B) A long term care facility;
- (C) An ambulatory surgical center;
- (D) A freestanding birthing center; [or]
- (E) An outpatient renal dialysis [center] **facility;**

or

(F) An extended stay center.

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

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

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

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

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

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

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

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

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

- (i) Usual physician services;
- (ii) Hospitalization;
- (iii) Laboratory;
- (iv) X-ray;
- (v) Emergency and preventive services; and
- (vi) Out-of-area coverage;

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

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

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

[(15)] (16) “Hospital” means:

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

- (A) Medical;
- (B) Nursing;
- (C) Laboratory;
- (D) Pharmacy; and
- (E) Dietary; or

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

[(16)] (17) “Institutional health services” means health services provided in or through health care facilities and [includes] the entities in or through which such services are provided.

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

[(18)(a)] (19)(a) “Long term care facility” means a permanent facility with inpatient beds, providing:

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

(B) Treatment for two or more unrelated patients.

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

[(19)] (20) “New hospital” means:

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

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

[(20)] (21) “New skilled nursing or intermediate care service or facility” means a service or facility that did not offer long term care services on a regular basis by or through the facility within the prior 12-month period and is initiating or proposing to initiate such services. “New skilled nursing or intermediate care service or facility” also includes the rebuilding of a long term care facility, the relocation of buildings that are a part of a long term care facility, the relocation of long term care beds from one facility to another or an increase in the number of beds of more than 10 or 10 percent of the bed capacity, whichever is the lesser, within a two-year period in a facility that applied for a certificate of need between August 1, 2011, and December 1, 2012, or submitted a letter of intent under ORS 442.315 (7) between January 15, 2013, and January 31, 2013.

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

[(22)] (23) “Originating-site hospital” means a hospital in which a patient is located while receiving telemedicine services.

[(23)] (24) “Outpatient renal dialysis facility” means a facility that provides renal dialysis services directly to outpatients.

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

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

[(26)] (27) “Telemedicine” means the provision of health services to patients by physicians and health care practitioners from a distance using electronic communications.

SECTION 6. ORS 442.015, as amended by section 22, chapter 608, Oregon Laws 2013, is amended to read:

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

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

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

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

(b) “Ambulatory surgical center” does not mean:

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

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

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

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

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

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

(8) “Extended stay center” means a facility licensed in accordance with section 2 of this 2018 Act.

[(8)] **(9) “Freestanding birthing center”** means a facility licensed for the primary purpose of performing low risk deliveries.

[(9)] **(10) “Governmental unit”** means the state, or any county, municipality or other political subdivision, or any related department, division, board or other agency.

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

[(11)(a)] **(12)(a) “Health care facility”** means:

- (A) A hospital;
- (B) A long term care facility;
- (C) An ambulatory surgical center;
- (D) A freestanding birthing center; [or]
- (E) An outpatient renal dialysis [center] **facility;**

or

(F) An extended stay center.

(b) “Health care facility” does not mean:

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

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

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

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

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

[(12)] **(13) “Health maintenance organization” or “HMO”** means a public organization or a private organization organized under the laws of any state that:

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

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

- (i) Usual physician services;
- (ii) Hospitalization;
- (iii) Laboratory;
- (iv) X-ray;
- (v) Emergency and preventive services; and
- (vi) Out-of-area coverage;

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

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

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

[(14)] **(15) “Hospital”** means:

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

- (A) Medical;
- (B) Nursing;
- (C) Laboratory;
- (D) Pharmacy; and
- (E) Dietary; or

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

[(15)] **(16) “Institutional health services”** means health services provided in or through health care facilities and [includes] the entities in or through which such services are provided.

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

[(17)(a)] **(18)(a) “Long term care facility”** means a permanent facility with inpatient beds, providing:

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

(B) Treatment for two or more unrelated patients.

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

[(18)] (19) “New hospital” means:

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

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

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

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

[(21)] (22) “Originating-site hospital” means a hospital in which a patient is located while receiving telemedicine services.

[(22)] (23) “Outpatient renal dialysis facility” means a facility that provides renal dialysis services directly to outpatients.

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

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

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

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

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

(a) Date of birth;

(b) Sex;

(c) Race and ethnicity;

(d) Primary language;

(e) Disability;

(f) Zip code;

(g) Inpatient admission date or outpatient service date;

(h) Inpatient discharge date;

(i) Type of discharge;

(j) Diagnostic related group or diagnosis;

(k) Type of procedure performed;

(l) Expected source of payment, if available;

(m) Hospital identification number; and

(n) Total hospital charges.

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

(3) By July 1 of each year, the authority may request from extended stay centers licensed under section 2 of this 2018 Act extended stay center discharge abstract records covering all patients admitted during the preceding year. Extended stay center discharge abstract records must include information prescribed by the authority by rule.

[(3)] (4) In lieu of abstracting and compiling the records itself, the authority may solicit the voluntary submission of *[such data from Oregon hospitals or other sources]* **the data described in subsections (1) to (3) of this section** to enable *[it]* **the authority** to carry out its responsibilities under this section. If such data are not available to the authority on an annual and timely basis, the authority may establish by rule a fee to be charged to each hospital, **ambulatory surgical center or extended stay center**.

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

SECTION 7. ORS 442.120 is amended to read:

[(5)] **(6)** The authority may specify by rule the form in which *[the]* records are to be submitted. If the form adopted by rule requires conversion from the form regularly used by a hospital, **ambulatory surgical center or extended stay center**, reasonable costs of such conversion shall be paid by the authority.

[(6)] **(7)** 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)] **(8)** In addition to the records required in subsection (1) of this section, the authority may obtain abstract records for each patient that identify specific services, classified by International Classification of Disease Code, for special studies on the incidence of specific health problems or diagnostic practices. However, nothing in this subsection shall authorize the publication of specific data in a form that allows identification of individual patients or licensed health care professionals.

[(8)] **(9)** The authority may provide by rule for the submission of records for enrollees in a health maintenance organization from a hospital, **ambulatory surgical center or extended stay center** associated with such an organization in a form the authority determines appropriate to the authority's needs for such data and the organization's record keeping and reporting systems for charges and services.

**PATIENT SAFETY REPORTING
BY EXTENDED STAY CENTERS**

SECTION 8. ORS 442.837 is amended to read:

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

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

- (A) Serious adverse events;
- (B) Root cause analyses of serious adverse events;
- (C) Action plans established to prevent similar serious adverse events; and
- (D) Patient safety plans establishing procedures and protocols.

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

- (A) Statistical analyses;

(B) Recommendations regarding quality improvement techniques;

(C) Recommendations regarding standard protocols; and

(D) Recommendations regarding best patient safety practices.

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

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

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

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

- (A) Feedback to participants; and
- (B) Rewards and recognition to participants.

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

- (A) The types and frequencies of serious adverse events;
- (B) Yearly serious adverse event totals and trends;
- (C) Clusters of serious adverse events;
- (D) Demographics of patients involved in serious adverse events, including the frequency and types of serious adverse events associated with language barriers or ethnicity;
- (E) Systems' factors associated with particular serious adverse events;
- (F) Interventions to prevent frequent or high severity serious adverse events;
- (G) Analyses of statewide patient safety data in Oregon and comparisons of that data to national patient safety data; and
- (H) Appropriate consumer information regarding prevention of serious adverse events.

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

- (a) Hospitals as defined in ORS 442.015;
- (b) Long term care facilities as defined in ORS 442.015;
- (c) Pharmacies licensed under ORS chapter 689;
- (d) Ambulatory surgical centers as defined in ORS 442.015;
- (e) Outpatient renal dialysis facilities as defined in ORS 442.015;
- (f) Freestanding birthing centers as defined in ORS 442.015; *[and]*
- (g) Independent professional health care societies or associations[.]; **and**

(h) Extended stay centers licensed under section 2 of this 2018 Act.

(3) Reports or other information developed and disseminated by the program may not contain or re-

veal the name of or other identifiable information with respect to a particular participant providing information to the commission for the purposes of ORS 442.819 to 442.851, or to any individual identified in the report or information, and upon whose patient safety data, patient safety activities and reports the commission has relied in developing and disseminating information pursuant to this section.

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

(5) The commission shall collaborate with providers of ambulatory health care to develop initiatives to promote patient safety in ambulatory health care.

HOSPITAL FINANCIAL ASSISTANCE POLICIES

SECTION 9. (1) As used in this section:

(a) “Financial assistance policy” means a policy that meets the requirements of section 501(r) of the Internal Revenue Code and implementing regulations.

(b) “Hospital” has the meaning given that term in ORS 442.015.

(2) A hospital shall have a written financial assistance policy that complies with the plain language standards for consumer contracts under ORS 180.545 (1).

(3) A hospital shall:

(a) Provide a paper copy of the financial assistance policy to a patient upon request;

(b) Include on each billing statement notice of:

(A) The availability of financial assistance;
(B) The contact information for the office or department of the hospital that can provide information about obtaining financial assistance; and

(C) The direct Internet address for the financial assistance policy; and

(c) Maintain public displays in locations in the hospital that are accessible to the public that notify and inform patients about the financial assistance policy. Locations that are accessible to the public include but are not limited to the emergency department, if any, and the areas where patient admissions are processed.

(4) No later than January 1, 2020, the Oregon Health Authority shall make available to hospitals and the general public a uniform application for financial assistance, created by a trade association representing hospitals, that may be used in any hospital in this state to request financial assistance.

SECTION 10. Section 9 of this 2018 Act is amended to read:

Sec. 9. (1) As used in this section:

(a) “Financial assistance policy” means a policy that meets the requirements of section 501(r) of the Internal Revenue Code and implementing regulations.

(b) “Hospital” has the meaning given that term in ORS 442.015.

(2) A hospital shall have a written financial assistance policy that complies with the plain language standards for consumer contracts under ORS 180.545 (1).

(3) A hospital shall:

(a) Provide a paper copy of the financial assistance policy to a patient upon request;

(b) Include on each billing statement notice of:

(A) The availability of financial assistance;

(B) The contact information for the office or department of the hospital that can provide information about obtaining financial assistance; and

(C) The direct Internet address for the financial assistance policy; and

(c) Maintain public displays in locations in the hospital that are accessible to the public that notify and inform patients about the financial assistance policy. Locations that are accessible to the public include but are not limited to the emergency department, if any, and the areas where patient admissions are processed.

(4) [No later than January 1, 2020,] The Oregon Health Authority shall make available to hospitals and the general public a uniform application for financial assistance, created by a trade association representing hospitals, that may be used in any hospital in this state to request financial assistance.

CONFORMING AMENDMENTS

SECTION 11. ORS 192.660 is amended to read:

192.660. (1) ORS 192.610 to 192.690 do not prevent the governing body of a public body from holding executive session during a regular, special or emergency meeting, after the presiding officer has identified the authorization under ORS 192.610 to 192.690 for holding the executive session.

(2) The governing body of a public body may hold an executive session:

(a) To consider the employment of a public officer, employee, staff member or individual agent.

(b) To consider the dismissal or disciplining of, or to hear complaints or charges brought against, a public officer, employee, staff member or individual agent who does not request an open hearing.

(c) To consider matters pertaining to the function of the medical staff of a public hospital licensed pursuant to ORS 441.015 to [441.063] **441.087** and 441.196 including, but not limited to, all clinical committees, executive, credentials, utilization review, peer review committees and all other matters relating to medical competency in the hospital.

(d) To conduct deliberations with persons designated by the governing body to carry on labor negotiations.

(e) To conduct deliberations with persons designated by the governing body to negotiate real property transactions.

(f) To consider information or records that are exempt by law from public inspection.

(g) To consider preliminary negotiations involving matters of trade or commerce in which the governing body is in competition with governing bodies in other states or nations.

(h) To consult with counsel concerning the legal rights and duties of a public body with regard to current litigation or litigation likely to be filed.

(i) To review and evaluate the employment-related performance of the chief executive officer of any public body, a public officer, employee or staff member who does not request an open hearing.

(j) To carry on negotiations under ORS chapter 293 with private persons or businesses regarding proposed acquisition, exchange or liquidation of public investments.

(k) To consider matters relating to school safety or a plan that responds to safety threats made toward a school.

(L) If the governing body is a health professional regulatory board, to consider information obtained as part of an investigation of licensee or applicant conduct.

(m) If the governing body is the State Landscape Architect Board, or an advisory committee to the board, to consider information obtained as part of an investigation of registrant or applicant conduct.

(n) To discuss information about review or approval of programs relating to the security of any of the following:

(A) A nuclear-powered thermal power plant or nuclear installation.

(B) Transportation of radioactive material derived from or destined for a nuclear-fueled thermal power plant or nuclear installation.

(C) Generation, storage or conveyance of:

(i) Electricity;

(ii) Gas in liquefied or gaseous form;

(iii) Hazardous substances as defined in ORS 453.005 (7)(a), (b) and (d);

(iv) Petroleum products;

(v) Sewage; or

(vi) Water.

(D) Telecommunication systems, including cellular, wireless or radio systems.

(E) Data transmissions by whatever means provided.

(3) Labor negotiations shall be conducted in open meetings unless negotiators for both sides request that negotiations be conducted in executive session. Labor negotiations conducted in executive session are not subject to the notification requirements of ORS 192.640.

(4) Representatives of the news media shall be allowed to attend executive sessions other than those held under subsection (2)(d) of this section relating to labor negotiations or executive session held pursuant to ORS 332.061 (2) but the governing body

may require that specified information be undisclosed.

(5) When a governing body convenes an executive session under subsection (2)(h) of this section relating to conferring with counsel on current litigation or litigation likely to be filed, the governing body shall bar any member of the news media from attending the executive session if the member of the news media is a party to the litigation or is an employee, agent or contractor of a news media organization that is a party to the litigation.

(6) No executive session may be held for the purpose of taking any final action or making any final decision.

(7) The exception granted by subsection (2)(a) of this section does not apply to:

(a) The filling of a vacancy in an elective office.

(b) The filling of a vacancy on any public committee, commission or other advisory group.

(c) The consideration of general employment policies.

(d) The employment of the chief executive officer, other public officers, employees and staff members of a public body unless:

(A) The public body has advertised the vacancy;

(B) The public body has adopted regular hiring procedures;

(C) In the case of an officer, the public has had the opportunity to comment on the employment of the officer; and

(D) In the case of a chief executive officer, the governing body has adopted hiring standards, criteria and policy directives in meetings open to the public in which the public has had the opportunity to comment on the standards, criteria and policy directives.

(8) A governing body may not use an executive session for purposes of evaluating a chief executive officer or other officer, employee or staff member to conduct a general evaluation of an agency goal, objective or operation or any directive to personnel concerning agency goals, objectives, operations or programs.

(9) Notwithstanding subsections (2) and (6) of this section and ORS 192.650:

(a) ORS 676.175 governs the public disclosure of minutes, transcripts or recordings relating to the substance and disposition of licensee or applicant conduct investigated by a health professional regulatory board.

(b) ORS 671.338 governs the public disclosure of minutes, transcripts or recordings relating to the substance and disposition of registrant or applicant conduct investigated by the State Landscape Architect Board or an advisory committee to the board.

(10) Notwithstanding ORS 244.290, the Oregon Government Ethics Commission may not adopt rules that establish what entities are considered representatives of the news media that are entitled to attend executive sessions under subsection (4) of this section.

SECTION 12. ORS 441.025 is amended to read:

441.025. (1)(a) Upon receipt of a license fee and an application to operate a health care facility other than a long term care facility, the Oregon Health Authority shall review the application and conduct an on-site inspection of the health care facility. The authority shall issue a license if it finds that the applicant and health care facility comply with ORS 441.015 to [441.063] 441.087 and 441.196 and the rules of the authority provided that the authority does not receive within the time specified a certificate of noncompliance issued by the State Fire Marshal, deputy, or approved authority pursuant to ORS 479.215.

(b) The authority shall, following payment of the fee, annually renew each license issued under this subsection unless:

(A) The health care facility's license has been suspended or revoked; or

(B) The State Fire Marshal, a deputy or an approved authority has issued a certificate of noncompliance pursuant to ORS 479.215.

(2)(a) Upon receipt of a license fee and an application to operate a long term care facility, the Department of Human Services shall review the application and conduct an on-site inspection of the long term care facility. The department shall issue a license if the department finds that the applicant and long term care facility comply with ORS 441.015 to [441.063,] 441.087 and 441.196 and the rules of the department provided that it does not receive within the time specified a certificate of noncompliance issued by the State Fire Marshal, deputy, or approved authority pursuant to ORS 479.215.

(b) The department shall, following an on-site inspection and payment of the fee, annually renew each license issued under this subsection unless:

(A) The long term care facility's license has been suspended or revoked;

(B) The long term care facility is found not to be in substantial compliance following the on-site inspection; or

(C) The State Fire Marshal, a deputy or an approved authority has issued a certificate of noncompliance pursuant to ORS 479.215.

(3) Each license shall be issued only for the premises and persons or governmental units named in the application and shall not be transferable or assignable.

(4) Licenses shall be posted in a conspicuous place on the licensed premises as prescribed by rule of the authority or the department.

(5) No license shall be issued or renewed for any health care facility or health maintenance organization that is required to obtain a certificate of need under ORS 442.315 until a certificate of need has been granted. An ambulatory surgical center is not subject to the certificate of need requirements in ORS 442.315.

(6) No license shall be issued or renewed for any skilled nursing facility or intermediate care facility, unless the applicant has included in the application the name and such other information as may be necessary to establish the identity and financial in-

terests of any person who has incidents of ownership in the facility representing an interest of 10 percent or more thereof. If the person having such interest is a corporation, the name of any stockholder holding stock representing an interest in the facility of 10 percent or more shall also be included in the application. If the person having such interest is any other entity, the name of any member thereof having incidents of ownership representing an interest of 10 percent or more in the facility shall also be included in the application.

(7) A license may be denied to any applicant for a license or renewal thereof or any stockholder of any such applicant who has incidents of ownership in the health care facility representing an interest of 10 percent or more thereof, or an interest of 10 percent or more of a lease agreement for the facility, if during the five years prior to the application the applicant or any stockholder of the applicant had an interest of 10 percent or more in the facility or of a lease for the facility and has divested that interest after receiving from the authority or the department written notice that the authority or the department intends to suspend or revoke the license or to decertify the facility from eligibility to receive payments for services provided under this section.

(8) The Department of Human Services may not issue or renew a license for a long term care facility, unless the applicant has included in the application the identity of any person who has incident of ownership in the long term care facility who also has a financial interest in any pharmacy, as defined in ORS 689.005.

(9) The authority shall adopt rules for each type of health care facility, except long term care facilities, to carry out the purposes of ORS 441.015 to 441.087 including, but not limited to:

(a) Establishing classifications and descriptions for the different types of health care facilities that are licensed under ORS 441.015 to 441.087; and

(b) Standards for patient care and safety, adequate professional staff organizations, training of staff for whom no other state regulation exists, suitable delineation of professional privileges and adequate staff analyses of clinical records.

(10) The department shall adopt rules for each type of long term care facility to carry out the purposes of ORS 441.015 to 441.087 including, but not limited to:

(a) Establishing classifications and descriptions for the different types of long term care facilities that are licensed under ORS 441.015 to 441.087; and

(b) Standards for patient care and safety, adequate professional staff organizations, training of staff for whom no other state regulation exists, suitable delineation of professional privileges and adequate staff analyses of clinical records.

(11) The authority or department may not adopt a rule requiring a health care facility to serve a specific food as long as the necessary nutritional food elements are present in the food that is served.

(12) A health care facility licensed by the authority or department may not:

(a) Offer or provide services beyond the scope of the license classification assigned by the authority or department; or

(b) Assume a descriptive title or represent itself under a descriptive title other than the classification assigned by the authority or department.

(13) A health care facility must reapply for licensure to change the classification assigned or the type of license issued by the authority or department.

SECTION 13. ORS 441.030 is amended to read:

441.030. (1) The Oregon Health Authority or the Department of Human Services may assess a civil penalty and, pursuant to ORS 479.215, shall deny, suspend or revoke a license, in any case where the State Fire Marshal, or the representative of the State Fire Marshal, certifies that there is a failure to comply with all applicable laws, lawful ordinances and rules relating to safety from fire.

(2) The authority may:

(a) Assess a civil penalty or deny, suspend or revoke a license of a health care facility other than a long term care facility in any case where it finds that there has been a substantial failure to comply with ORS 441.015 to [441.063] **441.087** and 441.196 or the rules or minimum standards adopted under ORS 441.015 to [441.063] **441.087** and 441.196.

(b) Assess a civil penalty or suspend or revoke a license issued under ORS 441.025 for failure to comply with an authority order arising from a health care facility's substantial lack of compliance with the provisions of ORS 441.015 to [441.063] **441.087**, 441.152 to 441.177 or 441.196 or the rules adopted under ORS 441.015 to [441.063] **441.087**, 441.152 to 441.177 or 441.196.

(c) Suspend or revoke a license issued under ORS 441.025 for failure to pay a civil penalty imposed under ORS 441.175.

(3) The department may:

(a) Assess a civil penalty or deny, suspend or revoke a long term care facility's license in any case where it finds that there has been a substantial failure to comply with ORS 441.015 to [441.063,] 441.087 or 441.196 or the rules or minimum standards adopted under ORS 441.015 to [441.063,] 441.087 or 441.196.

(b) Assess a civil penalty or suspend or revoke a long term care facility's license issued under ORS 441.025 for failure to comply with a department order arising from a long term care facility's substantial lack of compliance with the provisions of ORS 441.015 to [441.063, 441.084,] 441.087 or 441.196 or the rules adopted under ORS 441.015 to [441.063, 441.084,] 441.087 or 441.196.

(c) Suspend or revoke a license issued under ORS 441.025 for failure to pay a civil penalty imposed under ORS 441.710.

(d) Order a long term care facility licensed under ORS 441.025 to restrict the admission of patients when the department finds an immediate threat to patient health and safety arising from failure of the long term care facility to be in compliance with ORS

441.015 to [441.063, 441.084,] 441.087 or 441.196 and the rules adopted under ORS 441.015 to [441.063, 441.084,] 441.087 or 441.196.

(4) Any long term care facility that has been ordered to restrict the admission of patients pursuant to subsection (3)(d) of this section shall post a notice of the restriction, provided by the department, on all doors providing ingress to and egress from the facility, for the duration of the restriction.

SECTION 14. ORS 441.065 is amended to read:

441.065. (1) ORS 441.015 to [441.063] **441.087** and 441.196 or the rules adopted pursuant thereto do not authorize the supervision, regulation or control of the remedial care or treatment of residents or patients in any home or institution that is described under subsection (2) of this section and is conducted for those who rely upon treatment solely by prayer or spiritual means, except as to the sanitary and safe conditions of the premises, cleanliness of operation and its physical equipment. This section does not exempt such a home or institution from the licensing requirements of ORS 441.015 to 441.087, 441.525 to 441.595, 441.815, 441.820, 441.990, 442.342[,] and 442.344 [and 442.400 to 442.463].

(2) To qualify under subsection (1) of this section, a home or institution must:

(a) Be owned by an entity that is registered with the Secretary of State as a nonprofit corporation and that does not own, hold a financial interest in, control or operate any facility, wherever located, of a type providing medical health care and services; and

(b) Provide 24 hour a day availability of non-medical care and services.

(3) As used in this section:

(a) "Medical health care and services" means medical screening, examination, diagnosis, prognosis, treatment and drug administration. "Medical health care and services" does not include counseling or the provision of social services or dietary services.

(b) "Nonmedical care and services" means assistance or services, other than medical health care and services, provided by attendants for the physical, mental, emotional or spiritual comfort and well being of residents or patients.

SECTION 15. ORS 441.077 is amended to read:

441.077. (1) If the governing body of a health care facility or health maintenance organization excludes or expels a person licensed under ORS chapter 677 from staff membership, or limits in any way the professional privilege of the person in the health care facility or health maintenance organization solely because of the school of medicine to which the person belongs, the license of the health care facility shall be subject to revocation in the manner provided in ORS [441.015 to 441.065] **441.030**. A health maintenance organization which violates this section shall be subject to penalties provided in ORS 731.988 and 731.992.

(2) Nothing in this section is intended to limit the authority of the governing body of a health care facility or health maintenance organization with re-

spect to a person who has violated the reasonable rules and regulations of the health care facility or health maintenance organization or who has violated the provisions of ORS chapter 677 if the governing body has reported the violation of ORS chapter 677 to the Oregon Medical Board in writing.

SECTION 16. ORS 442.700 is amended to read: 442.700. As used in ORS 442.700 to 442.760:

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

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

(3) "Health care provider" means a hospital, physician or entity, a significant part of whose activities consist of providing hospital or physician services in this state. For purposes of the immunities provided by ORS 442.700 to 442.760 and 646.740, "health care provider" includes any officer, director, trustee, employee, or agent of, or any entity under common ownership and control with, a health care provider.

(4) "Hospital" means a hospital, a long term care facility or an ambulatory surgical center, as those terms are defined in ORS 442.015, that is licensed under ORS 441.015 to [441.089] **441.087**. "Hospital" includes community health programs established under ORS 430.610 to 430.695.

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

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

(7) "Physician" means a physician licensed under ORS chapter 677.

SECTION 17. ORS 677.515 is amended to read:

677.515. (1) A physician assistant licensed under ORS 677.512 may provide any medical service, including prescribing and administering controlled substances in Schedules II through V under the federal Controlled Substances Act:

(a) That is delegated by the physician assistant's supervising physician or supervising physician organization;

(b) That is within the scope of practice of the physician assistant;

(c) That is within the scope of practice of the supervising physician or supervising physician organization;

(d) That is provided under the supervision of the supervising physician or supervising physician organization;

(e) That is generally described in and in compliance with the practice agreement; and

(f) For which the physician assistant has obtained informed consent as provided in ORS 677.097, if informed consent is required.

(2) This chapter does not prohibit a student enrolled in a program for educating physician assistants approved by the board from rendering medical services if the services are rendered in the course of the program.

(3) The degree of independent judgment that a physician assistant may exercise shall be determined by the supervising physician, or supervising physician organization, and the physician assistant in accordance with the practice agreement.

(4) A supervising physician, upon the approval of the board and in accordance with the rules established by the board, may delegate to the physician assistant the authority to administer and prescribe medications pursuant to this section and ORS 677.535. The board may not limit the privilege of administering, dispensing and prescribing to population groups federally designated as underserved, or to geographic areas of the state that are federally designated health professional shortage areas, federally designated medically underserved areas or areas designated as medically disadvantaged and in need of primary health care providers by the Director of the Oregon Health Authority or the Office of Rural Health. All prescriptions written pursuant to this subsection must bear the name, office address and telephone number of the supervising physician.

(5) This chapter does not require or prohibit a physician assistant from practicing in a hospital licensed pursuant to ORS 441.015 to [441.089] **441.087**.

(6) Prescriptions for medications prescribed by a physician assistant in accordance with this section and ORS 475.005, 677.010, 677.500, 677.510 and 677.535 and dispensed by a licensed pharmacist may be filled by the pharmacist according to the terms of the prescription, and the filling of such a prescription does not constitute evidence of negligence on the part of the pharmacist if the prescription was dispensed within the reasonable and prudent practice of pharmacy.

IMPLEMENTATION

SECTION 18. The Oregon Health Authority shall adopt all rules necessary to carry out section 2 of this 2018 Act no later than 180 days after the effective date of this 2018 Act.

SECTION 19. (1) No later than January 1, 2019, the Oregon Health Authority shall apply to the Centers for Medicare and Medicaid Ser-

VICES for approval of a demonstration project or other authorization to permit the state to receive federal financial participation in the costs of extended stay services and to permit extended stay centers and ambulatory surgical centers to operate under a single license.

(2) The authority shall report to the interim committees of the Legislative Assembly related to health no later than July 1, 2019, on the status of the application described in subsection (1) of this section.

SECTION 20. ORS 441.086 is added to and made a part of ORS 441.015 to 441.087.

SECTION 21. (1) Sections 2 and 9 of this 2018 Act and the amendments to ORS 441.020, 442.015, 442.120 and 442.837 by sections 4 to 8 of this 2018 Act become operative on January 1, 2019.

(2) The amendments to section 9 of this 2018 Act by section 10 of this 2018 Act become operative on January 2, 2020.

SECTION 22. Section 3 of this 2018 Act is repealed on January 2, 2023.

FINANCE

SECTION 23. (1) Notwithstanding any other provision of law, the General Fund appropriation made to the Oregon Health Authority by section 1 (1), chapter 545, Oregon Laws 2017, for the biennium ending June 30, 2019, for programs, is increased by \$245,991 for the purpose of carrying out the provisions of sections 2 and 3 of this 2018 Act.

(2) Notwithstanding any other law limiting expenditures, the limitation on expenditures established by section 2 (1), chapter 545, Oregon Laws 2017, for the biennium ending June 30, 2019, as the maximum limit for payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts, tobacco tax receipts, recreational marijuana tax receipts, provider taxes, Medicare receipts and federal funds for indirect cost recovery, Supplemental Security Income recoveries, Women, Infants and Children Program food rebates, the Coordinated School Health Program, the Edward Byrne Memorial State and Local Law Enforcement Assistance Grant Program and emergency preparedness and response services, but excluding lottery funds and federal funds not described in section 2, chapter 545, Oregon Laws 2017, collected or received by the Oregon Health Authority, for programs, is increased by \$106,583

for the purpose of carrying out the provisions of sections 2 and 3 of this 2018 Act.

(3) Notwithstanding any other law limiting expenditures, the limitation on expenditures established by section 2 (3), chapter 545, Oregon Laws 2017, for the biennium ending June 30, 2019, as the maximum limit for payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts, tobacco tax receipts, recreational marijuana tax receipts, provider taxes, Medicare receipts and federal funds for indirect cost recovery, Supplemental Security Income recoveries, Women, Infants and Children Program food rebates, the Coordinated School Health Program, the Edward Byrne Memorial State and Local Law Enforcement Assistance Grant Program and emergency preparedness and response services, but excluding lottery funds and federal funds not described in section 2, chapter 545, Oregon Laws 2017, collected or received by the Oregon Health Authority, for shared administrative services, is increased by \$100,045 for the purpose of carrying out the provisions of sections 2 and 3 of this 2018 Act.

(4) Notwithstanding any other law limiting expenditures, the limitation on expenditures established by section 4 (1), chapter 545, Oregon Laws 2017, for the biennium ending June 30, 2019, as the maximum limit for payment of expenses from federal funds, excluding federal funds described in section 2, chapter 545, Oregon Laws 2017, collected or received by the Oregon Health Authority, for programs, is increased by \$45,946 for the purpose of carrying out the provisions of sections 2 and 3 of this 2018 Act.

CAPTIONS

SECTION 24. The unit captions used in this 2018 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2018 Act.

EMERGENCY CLAUSE

SECTION 25. This 2018 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2018 Act takes effect on its passage.

Approved by the Governor April 3, 2018
Filed in the office of Secretary of State April 3, 2018
Effective date April 3, 2018