

# Chapter 442

## 1987 REPLACEMENT PART

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442 005 [1955 c 533 §2, 1973 c 754 §1, repealed by 1977 c 717 §23]

442 010 [Amended by 1955 c 533 §3 1971 c 650 §20, repealed by 1977 c 717 §23]

### ADMINISTRATION

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

(1) "Adjusted admission" means the sum of all inpatient admissions divided by the ratio of inpatient revenues to total patient revenues

(2) "Affected persons" has the same meaning as given to 'party' in ORS 183 310 (6)

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

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

(5) "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

(6) "Council" means the Oregon Health Council

(7) "Department" means the Department of Human Resources of the State of Oregon

(8) "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

(9) "Director" means the Director of the Department of Human Resources

(10) "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

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

(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

(13) "Health care facility" means

(a) A "hospital" 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, or to provide treatment for the mentally ill or to provide treatment in special inpatient care facilities A "special inpatient care facility" is a facility with permanent inpatient beds and other facilities designed and utilized for special health care purposes, to include but not limited to Rehabilitation center, college infirmary, chiropractic facility, facility for the treatment of alcoholism or drug abuse, or inpatient care facility meeting the requirements of ORS 441 065, and any other establishment falling within a classification established by the division, after determination of the need for such classification and the level and kind of health care appropriate for such classification

(b) A "hospital associated ambulatory surgery center" means an ambulatory surgical service that is separately identifiable, physically, administratively and financially independent, distinct from other operations of the hospital, and is not located proximate to or adjoining the hospital's campus The hospital associated ambulatory surgery center performs surgery not routinely or customarily performed in the physician's or dentist's office, and is able to meet health facility licensure requirements

(c) A "long term care 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 the terms "skilled nursing facility" and "intermediate care facility," but such definition shall not be construed to include facilities licensed and operated pursuant to ORS 443 400 to 443 455 Such definitions shall include

(A) A "skilled nursing facility" whether an institution or a distinct part of an institution, which is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or

rehabilitation services for the rehabilitation of injured, disabled or sick persons

(B) An "intermediate care facility" which provides, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which 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 which can be made available to them only through institutional facilities

(d) An "ambulatory surgical center" means a health care facility not sponsored by a hospital which 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

(e) An establishment furnishing primarily domiciliary care is not a "health care facility"

(f) A "health care facility" does not mean 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 Mental Health Division, Senior Services Division, Children's Services Division, Department of Corrections or Vocational Rehabilitation Division

(g) A "freestanding birthing center" means a health care facility licensed for the primary purpose of performing low risk deliveries

(14) "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 employes 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

(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

(16) "Hospital performance measurement" means the maximum rate at which a hospital is expected to increase its average gross revenues per adjusted admission for a given period The "hospital performance measurement" is composed of the market basket index which is defined as follows

(a) "Market basket index" means the revised market basket index used to measure the inflation in hospital input prices as employed on January 1, 1985, by the Secretary of the United States Department of Health and Human Services for Medicare reimbursement If the Secretary of the United States Department of Health and Human Services employs a regional index to measure the inflation in hospital input prices for purposes of Medicare reimbursement, the term means such index for the region including Oregon If the measure described in this paragraph ceases to be calculated in this manner, the inflation index shall be the index approved by rule adopted by the agency The methodology used in determining the index approved by rule shall be substantially the same as the methodology employed on January 1, 1985, for determining the inflation in hospital input prices by the Secretary of the United States Department of Health and Human Services for purposes of Medicare reimbursement

(b) "Plus points" means additional percentage points added to the market basket index to adjust for the Oregon specific experience

(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

(18) "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

(19) "Net revenue" means gross revenue minus deductions from revenue

(20) "New health service" has the meaning given the term "institutional health services" in subsection (17) of this section and includes

(a) The construction, development or other establishment of a new health care facility

(b) Any capital expenditure, other than an expenditure for major medical equipment, for

health services by or on behalf of a health care facility which expenditure exceeds the lesser of

(A) \$2 million plus an index factor to reflect construction costs, or

(B) \$500,000, and one-half of one percent of the gross revenues for the last complete fiscal year

(c) "New health service" does not include a capital expenditure for site acquisition or acquisition of a health care facility

(d) An increase in bed capacity of a health care facility which increases the number of beds by more than 10 beds or more than 10 percent of the bed capacity, as defined by the state agency, whichever is less, within a two-year period, or the relocation of beds from one licensed health care facility to another

(e) Health services, except home health services, residential care or treatment of the elderly and residential or outpatient services for alcoholism, drug abuse or mental or emotional disturbances, as specified by state agency rule under ORS 442 320 (2)(a), which were not offered on a regular basis in or through such health care facility either directly or indirectly by contract within the 12-month period prior to the time such health services would be offered, and which could significantly add to the cost of patient care or compromise quality of care

(21) "Major medical equipment" means medical equipment which is used to provide medical and other health services and which 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

(22) "Nonclinically related capital expenditures" means an expenditure connected with providing a health service but which does not provide any health service although it will have substantial impact on the cost of health services to the patient

(23) "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

(24) "Office" means the Office of Rural Health, a component of, and contained within, the state agency

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

(26) "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

(27) "Secretary" means the Secretary of the United States Department of Health and Human Services

(28) "State agency" means the office of the Director of the Department of Human Resources

(29) "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]

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, payors 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 payors 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 Council; qualifications; terms; officers; meetings; compensation and expenses.** (1) The Oregon Health Council is established to serve as the policy-making body responsible for health planning pursuant to this chapter

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

(a) The council shall have 16 members appointed by the Governor

(b) The membership of the Oregon Health Council shall broadly represent the geographic, social, economic, occupational, linguistic and racial population of the state and shall include at least one member from each congressional district of the state. Membership on the council shall include individuals who represent Oregon's rural and urban medically underserved populations

(c) The Oregon Health Council 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) Members shall be appointed to three-year terms

(e) No person shall serve more than two consecutive terms

(3) Members of the council shall serve at the Governor's pleasure

(4) Members shall select a chairperson and a vice chairperson from among themselves

(5) The council shall meet at least quarterly

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

(7) Vacancies on the council shall be filled by appointments of the Governor for the unexpired term [1977 c 751 §3, 1979 c 697 §3, 1981 c 693 §3, 1983 c 482 §3, 1985 c 747 §4, 1987 c 660 §1]

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

**442.045 Council duties.** The Oregon Health Council shall perform the following functions

(1) Act as the policy-making body for a state-wide data clearinghouse established within the department 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

(2) Provide a forum for discussion of health care issues facing the citizens of the State of Oregon

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

(4) Annually prepare, review, revise as necessary, and adopt a state health plan which shall be made up of such state agency health plans as the council deems appropriate

(5) Advise the state agency generally on the performance of its functions

(6) Provide members to serve as the Certificate of Need Appeals Board on issues involving certificate of need as provided in ORS 442.320, 442.340 and 442.360 for appeals filed after July 13, 1985

(7) 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]

**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 §6 repealed by 1977 c 717 §23]

**442 055** [1955 c 533 §8, repealed by 1973 c 754 §8]

**442 057 Council subcommittees and advisory committees.** The Oregon Health Council 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]

**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 Duties of director.** The director shall perform the following functions

(1) Administer the health planning activities of the council pursuant to this chapter, and coordinate the health planning activities of state government

(2) Propose revisions to the state health plan

(3) Assist the council in the performance of its functions generally and provide staff services to the council or subcommittees thereof on the conduct of its duties, including routine administrative support under the policy direction of the council

(4) Conduct the administrative and regulatory functions necessary to implement the policies and directives of the council adopted pursuant to state law

(5) Serve as the designated planning agency of the state for purposes of section 1122 of the federal Social Security Act if the state has made an agreement pursuant to that section

(6) Control health care capital expenditures by administering the state certificate of need program pursuant to ORS 442 320 to 442 360

(7) Administer health care cost review programs

(8) Exercise the authority arising out of the policy decisions of the council

(9) Research and analyze critical health care issues leading to the preparation and dissemination of health policy papers for the Governor, Legislative Assembly, state agencies and other entities

(10) Maintain health data systems to assure that accurate and timely information is available to help guide the decisions of health policy makers and planners

(11) Perform other functions required by state law

(12) Adopt rules regarding appropriate construction indexes

(13) Except as otherwise provided by law and in accordance with any applicable provisions of ORS 183 310 to 183 550, the state agency may make such rules as are necessary or proper for the administration or enforcement of the laws the state agency is charged with administering or enforcing

(14) Publish periodically reports of health care charges as directed by the Oregon Health Council [1977 c 751 §6, 1981 c 693 §7, 1983 c 482 §5, 1985 c 747 §7, 1987 c 660 §5]

**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 Hospital discharge abstract records; alternative data.** In order to provide data essential for health planning programs

(1) The state agency may request, by July 1 of each year, each general hospital to file with the state agency hospital discharge abstract records covering all inpatients discharged during the preceding calendar year. The hospital discharge abstract record for each patient shall include at least the following information

(a) Date of birth,

(b) Sex,

(c) Zip code,

(d) Admission date,

(e) Discharge date,

(f) Type of discharge,

(g) Diagnostic related group,

(h) Type of surgical procedure performed,

(i) Expected source of payment, if available,

(j) Hospital identification number, and

## (k) Total hospital charges

(2) In lieu of abstracting and compiling the discharge abstract records itself, the state agency 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 state agency on an annual and timely basis, the state agency may establish by rule a hospital discharge fee to be charged each hospital.

(3) Subject to the review of the Executive Department and the prior approval of the appropriate legislative review agency, the fee established under subsection (2) of this section shall not exceed the cost of abstracting and compiling the discharge abstract records.

(4) The state agency may specify by rule the form in which the hospital discharge abstract 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 state agency.

(5) No patient identifier shall be included with the hospital discharge abstract record to insure that patient confidentiality is maintained.

(6) In addition to the records required in subsection (1) of this section, the state agency may obtain hospital discharge abstract records for each patient which 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 such specific data with patient, physician or hospital identifiers.

(7) The state agency 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 such form as the agency determines appropriate to the agency's needs for such data and the organization's record keeping and reporting systems for charges and services. [Formerly 442 355]

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]

## CERTIFICATES OF NEED FOR HEALTH SERVICES

442 300 [Formerly 441 010, repealed by 1981 c 693 §31]

**442.320 When certificate required; application; fee; review.** (1)(a) The following shall obtain a certificate of need from the state agency prior to an offering or development:

(A) Any person not excluded pursuant to ORS 441 065 and 442 340 (6) and any health care facilities of any health maintenance organization proposing to offer or develop a new health service.

(B) Any person acquiring or making or obligating an expenditure for major medical equipment not excluded pursuant to ORS 441 065. Any person who acquired, made or obligated an expenditure prior to July 13, 1985, to serve outpatients only and who did not apply for and receive a certificate of need, may not serve inpatients without first applying for and receiving a certificate of need.

(b) The following do not require a certificate of need:

(A) Reducing capacity of a health care facility;

(B) Separate projects for remodeling or renovating of existing facilities or space,

(C) Construction necessitated by health, safety or fire requirements, or

(D) For a rural hospital identified by the Office of Rural Health as a rural hospital, when the capital project or new medical service is consistent with the criteria developed by the Office of Rural Health by rule.

(2)(a) The state agency shall adopt rules specifying criteria and procedures for making decisions as to the need for new health services.

(b) The state agency shall adopt rules providing for accelerated review or waiver of review of a proposed expenditure for repairs or replacement of plant or equipment, or when the offering or development of a new health service is of a nonsubstantive nature or for other capital projects or service as determined by the agency.

(c) The state agency shall adopt rules for substitute review procedures as may be necessary.

(d) A series of projects having a health service related linkage, which in the aggregate exceeds the limits described in ORS 442 015 (16) over the whole project period, shall not be offered or developed without a certificate of need having first been obtained.

(3)(a) An applicant for a certificate of need shall apply to the state agency on forms provided for this purpose which forms shall be established by state agency rule.

(b) An applicant shall pay a fee prescribed as provided in this section. Subject to the approval

of the Executive Department, the state agency shall prescribe application fees, based on the complexity and scope of the proposed project, not to exceed \$12,000

(c) In the event a public hearing is held pursuant to ORS 183 310 to 183 550, 442 340 and this section, the state agency may impose a fee equally on the parties to the hearing. In no case shall the fees assessed pursuant to this paragraph exceed the costs of the public hearing incurred by the state agency, except as provided in paragraph (d) of this subsection.

(d) Notwithstanding the provisions of paragraphs (b) and (c) of this subsection, the state agency and the parties to the hearing held pursuant to ORS 183 310 to 183 550, 442 340 and this section shall share equally in the cost of preparation of a transcript of record, if any.

(e) Fees derived under this section shall be continuously appropriated to the state agency and may be expended by the state agency for the administration of this section and ORS 442 340.

(4) The state agency shall adopt rules governing the reporting, by all persons not excluded pursuant to ORS 441 065 and 442 340 (6), of their intent to offer or develop a new health service during the succeeding 12 months, and the general nature of such new health service. Such a report shall be submitted to the state agency.

(5) To assist it in carrying out its responsibility to control unwarranted capital expenditures through the certificate of need program, the state agency may, in order to consider an application with other applications concerning health services, facilities or equipment for the same area, delay consideration of an application for a reasonable time not to exceed 180 days [Formerly 441 090, 1979 c 697 §4, 1981 c 693 §10, 1983 c 482 §8, 1985 c 747 §31, 1987 c 660 §6].

Note Section 11a, chapter 660, Oregon Laws 1987, provides

Sec 11a The requirements of ORS 442 320 to 442 340, as they apply to hospital associated ambulatory surgical centers, or to ambulatory surgical centers shall not apply to such centers after June 30, 1989 [1987 c 660 §11a]

**442.325 Health care facility or health maintenance organization certificates; exempt activities; certain activities subject to insurance laws; policy to encourage 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, 442 435 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 750 065 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, 442 435 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, 442 435 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 agency 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].

Note See note under 442 320

442 330 [Formerly 441 092, 1979 c 697 §5, repealed by 1981 c 693 §31]

**442.335 Applications; time for review; notice.** (1) The state agency shall be the decision-making authority for the purposes of certificates of need.

(2)(a) Except as provided in paragraph (b) of this subsection and ORS 442 320 (5), no more than 90 days shall elapse from the time an application for a certificate of need is declared complete by the state agency to the time when the state agency makes its proposed decision

(b) The state agency with written agreement of the applicant for a certificate of need may extend the time period specified in paragraph (a) of this subsection

(3) At the same time that the state agency notifies the applicant for a certificate of need of its decision, it shall notify the council [1977 c 751 §8 1981 c 693 §12, 1983 c 482 §9, 1987 c 660 §7]

Note See note under 442 320

**442.340 Issuance, criteria; hearing; reconsideration and review of determinations; revocation or rescission; application of statutes** (1) The state agency shall issue a certificate of need for all or part of the new health services applied for in the application if the need is confirmed by an evaluation of the criteria in subsection (2) of this section

(2) In making determinations regarding an application for a certificate of need, the state agency shall make specific findings regarding

(a) The need for the proposed project, including

(A) The service area population's need for the proposed project

(B) Significant functional inefficiency, obsolescence or structural problems which the facility has which seriously compromise the effective delivery of health care to patients

(C) The effect of the proposed project on patients' reasonable access to services

(D) The effect of travel on a patient's health condition or outcome if the proposed health services, beds or equipment are not available in the area served or to be served

(E) The special service area populations and health care utilization rates of the following

(i) Health maintenance organizations

(ii) Health care facilities or services which provide a substantial portion of their health services to individuals residing more than 50 miles away from the facility by road

(iii) Health care facilities established or operated by a religious body or denomination to provide for the care and treatment of members of the religious body or denomination in accordance with their religious or ethical convictions, when these religious or ethical convictions demonstra-

bly preclude use of established health care facilities in the area

(b) The relationship of the project being reviewed and its conformance to such of the following plans as are in existence at the time of the review

(A) State health plan as approved by the council

(B) Long-range development plan of the project proponent

(c) The availability of resources for the provision of necessary health services and the availability of alternative uses for such resources for the provision of other health services, including

(A) The availability of allopathic and osteopathic facilities and services to protect the freedom of choice of the patient in the area served

(B) The relationship of the proposed project being reviewed to the efficiency and utilization of the existing health care system of the area in which health services are provided or proposed to be provided

(C) The conformity to state standards of both the proposed project and existing health services or major medical equipment which are currently serving the area

(D) The availability of adequate less costly alternatives or more effective methods of meeting the identified needs in the area

(E) Demonstration that the proposed project is the most appropriate way to use the resources which are proposed to be allocated to it

(F) Availability of qualified personnel to support the proposed project, adequacy of land to develop the proposed project and capacity to provide or secure funding for the proposed project if a certificate of need is issued

(G) The ability of the institution to maintain its status as a training facility for general and family practice physicians

(d) The immediate and long-term financial impact of the proposed project on the institution and the community, including

(A) The financial condition of the applicant and the impact of the proposed project on the institution Levels of profitability, patient charges and staffing may be considered with respect to the proposed project, the health care facility as a whole, or both

(B) The impact of the proposed project on the cost of health care to the patient including consideration of travel costs to the patient

(C) The relationship of the expense of providing the proposed service to its proposed or actual charges to patients, compared to other similar services in the area

(3) In any case in which the specifically enumerated criteria are not judged pertinent by the state agency, the state agency shall so state and give the reasons therefor

(4)(a) An applicant or any affected person who is dissatisfied with the proposed decision of the state agency, 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 state agency, an applicant or any affected person may request a reconsideration hearing pursuant to ORS 183 310 to 183.550

(c) An appeal before the appeals board pursuant to ORS 442 360, whose decision, based upon substantial evidence and made by not fewer than three members, shall be final subject to judicial review pursuant to ORS 183.310 to 183 550

(d) A request for a hearing pursuant to paragraph (a) of this subsection must be received by the state agency within 10 days after service of the proposed decision of the state agency

(e) A request for a hearing pursuant to paragraph (b) of this subsection must be received by the state agency within 30 days after service of the final decision

(f) In any proceeding brought by an affected person, an applicant challenging a state agency decision under this subsection, the state agency shall follow procedures consistent with ORS 442 015 to 442 345 and the provisions of ORS 183 310 to 183 550 relating to a contested case

(g) An applicant or any affected person may exercise its right to either paragraph (b) or (c) of this subsection or both or neither. Failure to exercise paragraph (b) or (c) of this subsection shall not prejudice an applicant or affected person's right to judicial review pursuant to ORS 183 310 to 183 550

(h) Procedures under paragraphs (b) and (c) of this subsection shall be consistent with the contested case hearing as defined in ORS 183.413 to 183 470 and shall include admission of oral direct evidence. The hearings officer or board may limit the issues and may exclude irrelevant or redundant evidence. The director, hearings officer and board have power to issue notices and subpoenas in the name of the state agency, compel the attendance of witnesses and the production of evidence, administer oaths, hold hearings and

perform such other acts as are reasonably necessary to carry out their duties under this section

(5) 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 state agency finds that a person is offering or developing a project that is not within the scope of the certificate of need, the state agency may limit the project as specified in the issued certificate of need, reconsider the application, or take action as provided in ORS 442 345

(6)(a) The provisions of ORS 442 320 and this section do not apply to

(A) A sole or group medical practice that is not within the definitions of "health care facility," "new health service," or "health maintenance organization" in ORS 442 015 unless a capital expenditure for major medical equipment is proposed

(B) A low volume freestanding birthing center which has been excluded by agency rule

(C) An applicant for licensure as a freestanding birthing center which provided such care prior to July 13, 1985

(b) A hospital is not required to apply for a certificate of need if it is not the purchaser of the major medical equipment and the equipment is not located in the hospital

(7)(a) A certificate of need issued pursuant to this section shall be automatically canceled 12 months from its effective date unless

(A) Extended pursuant to paragraph (c) of this subsection, or

(B) The project covered by such certificate is substantially implemented

(b) The expiration date of a substantially implemented certificate of need shall coincide with completion of the project for which it was issued

(c) For good cause shown, the state agency may grant two extensions of time, not to exceed six months each, if the project for which the certificate was issued has not been substantially implemented. An additional extension may be granted due to unusual and unforeseen circumstances which prevent substantial implementation within the period of the second extension

(8) The state agency may with respect to any approved certificate of need, impose such reporting requirements as are necessary to monitor for substantial implementation and to determine that the project conforms to the approved application. When a project is found to have substantially exceeded the scope of an approved

certificate of need and the state agency has not approved the project changes or cost overrun, or both, the state agency may require full or accelerated certificate of need review

(9) A certificate of need shall not be bought, sold nor transferred either on its own or as part of a facility or health service purchase, sale or transfer [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]

Note See note under 442 320

**442.342 Waiver of requirements of ORS 442.320 to 442.340.** (1) Notwithstanding any other provision of law, a hospital licensed under ORS 441 025, in accordance with rules adopted by the state agency, may apply for waiver from the provisions of ORS 442 320 to 442 340, and the agency 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 agency 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 state agency,

(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 state agency 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 state agency

(4)(a) The state agency 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 agency 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 442 320 to 442 340, the state agency 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

(d) The decision of the agency may be appealed to the Certificate of Need Appeals Board pursuant to ORS 442 320 and 442 340

(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]

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 of ORS 442.320 to 442.340.** 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 442.320 to 442 340 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.

**Note** Section 2, chapter 723 Oregon Laws 1987, provides

**Sec 2** The Director of the Department of Human Resources shall report to the Sixty-fifth Legislative Assembly on the effect of section 1 of this Act [ORS 442 344] on the access to quality health care and the costs thereto at ambulatory surgical centers performing only ophthalmic surgery [1987 c 723 §2]

**442.345 Injunctive relief; investigation.** (1) 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 which constitute a violation of ORS 442 320, 442 340, or any rule or order issued by the state agency, the state agency 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

(2) Whenever there is reasonable cause for the state agency to believe that any person is engaged in, or is about to engage in, any acts which constitute a violation of ORS 442 320, 442 340 or any rule or order issued by the state agency, the state agency may institute an investigation into the matter. The director may administer oaths and affirmations, subpoena witnesses, compel their attendance, take evidence and require the production or inspection of books, papers, correspondence, memoranda, agreements, accounts and other documents or records which the director considers relevant or material to the inquiry [1977 c 751 §33, 1981 c 693 §14, 1985 c 747 §36]

**442.350 Federal aid, disposition of funds received.** (1) The state agency may apply for and receive from the secretary, or from the Treasury of the United States as directed by the secretary, such sums as are available for the purposes of ORS 442 320, 442 340 and this section, implementing the federal law, and functions set forth in agreements between the state agency and the secretary

(2) Any sums appropriated by the secretary, or by the Treasury of the United States, for the purpose of constructing or remodeling health care facilities shall be deposited by the state agency with the State Treasurer. These funds shall be credited to the Health Resources and Development Account which is hereby created, are continuously appropriated and shall be used solely for the purpose of making grants pursuant to Title XVI of the Federal Act

(3) Expenditures for purposes of this section shall be confined solely to such funds as may be made available by the secretary [Formerly 441 140]

**442 355** [1983 c.482 §12, 1985 c 747 §14, renumbered 442 120]

**442.360 Certificate of Need Appeals Board; members, terms, officers, compensation and expenses.** (1) The Certificate of Need Appeals Board is established. The board shall serve as the appeals body on issues involving certificates of need as provided in ORS 442 320 and 442 340

(2) The board shall consist of five members of the Oregon Health Council knowledgeable about health care matters appointed as follows

(a) Three consumer members appointed by the chairperson of the Oregon Health Council with regard to geographic representation

(b) Two direct providers appointed by the chairperson of the Oregon Health Council with regard to geographic representation

(3) Members shall serve the term established by their council membership, and are eligible for reappointment. Any vacancy shall be filled in the same manner as the original appointment as described in subsection (2) of this section

(4) Members are entitled to compensation and expenses as provided in ORS 292 495

(5) Members shall select a chairperson and vice chairperson with such functions as the board may determine. The board shall meet on the call of the chairperson as necessary to hear appeals [1977 c 751 §9, 1979 c 697 §7, 1981 c 693 §25, 1985 c 747 §37]

## HEALTH CARE COST REVIEW

**442.400 "Health care facility" defined.** As used in ORS 442 400 to 442 450, 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) That cost containment programs be established and implemented by health care facilities in such manner as to both enable and motivate such facilities to control rapidly increasing costs,

(2) To require health care facilities to file for public disclosure such reports under systems of

accounting as will enable both private and public purchasers of services from such facilities to make informed decisions in purchasing such services, and

(3) 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]

**442.410 Facilities required to file budget and rate documents; effective date of rate increases; effect of failure to file increase; public inspection of rate schedules.** (1) Health care facilities shall file with the state agency in such form or forms as the state agency may require by rule

(a) Prospective budgets for fiscal years of such facilities beginning on and after the operative date of this section, and

(b) A list of all rates required by rule of the state agency that are in effect as of January 1 each year

(2) Changes in previously filed rates or unfiled rates, for which filing is required, new rate charges for existing services and rates for new services, supplies or facilities not provided for at the time of the original filing, may be made by the health care facility by filing such amendment or addition with the state agency. No increase in rates becomes effective until the 30th day after having been filed with the state agency. Rates for new services or new facilities not previously offered or for which filing was not previously required may become effective immediately upon filing. There shall be filed with any increase or addition in filed rates, justification for such increase or addition in such form as the state agency by rule may require.

(3) For the purpose of public information, the state agency shall notify the appropriate health systems agency of the filing of changed or new rates by hospitals in the health service area

(4) Upon notice being given by the state agency, the state agency may order any rates which are put into effect in violation of subsection (2) of this section to revert to the previously filed rates until subsection (2) of this section has been complied with. Upon notice being given by the state agency, all amounts or some proportion of the amounts as determined by the state agency at its discretion that are obtained by a facility in violation of subsection (2) of this section may at the discretion of the state agency either

(a) Be refunded to those persons overcharged,

or

(b) Offset against future charges in lieu of refunding

(5) Each facility shall make a copy of its current filed rates available, during ordinary business hours, for inspection by any person on demand [1977 c 751 §45, 1981 c 693 §16, 1983 c 482 §13, 1985 c 747 §38]

**442.415 Effect of service reductions on rates; markup on supplies and services; penalties not allowable in determining rates.** In connection with the filing of rates as required under ORS 442 410, 442 450 and this section

(1) A finding by the state agency that any health care facility has reduced the content of a service without a compensating reduction in rates shall be considered as if such reduction in content of such service were an increase in rates subject to ORS 442 325, 442 410, 442 450, section 47, chapter 751, Oregon Laws 1977, and this section

(2) Costs of supplies, materials or services furnished to and separately charged to patients of hospitals on the basis of a set percentage markup or a set professional fee need not be filed as a rate, but the percentage markup or set professional fee shall be so filed. Any change in such percentage markup or set professional fee shall be considered as a change in rate. The state agency shall provide by rule for the filing of such percentage markup or set professional fee

(3) Amounts incurred as civil penalties under any law of this state shall not be allowable as costs for purposes of rate determination, nor for reimbursement by a third party payor [1977 c 751 §46, 1983 c 482 §14]

**442.420 Application for financial assistance; financial analysis and investment authority; rules** (1) The state agency 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) In cooperation with the appropriate health systems agency and the appropriate professional review organizations, the state agency shall conduct or cause to have conducted such analyses and studies relating to costs of health care facilities as it considers desirable, including but not limited to methods of reducing such costs, utilization review of services of health care facili-

ties, peer review, quality control, financial status of any facility subject to ORS 442 400 to 442 450 and sources of public and private financing of financial requirements of such facilities

(3) The state agency 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 state agency considers material or relevant in connection with functions of the state agency subject to the provisions of ORS 183 310 to 183 550,

(c) Exercise, subject to the limitations and restrictions imposed by ORS 442 400 to 442 450, all other powers which are reasonably necessary or essential to carry out the express objectives and purposes of ORS 442 400 to 442 450, and

(d) Adopt rules in accordance with ORS 183 310 to 183 550 necessary in the state agency's judgment for carrying out the functions of the state agency [Formerly 441 435 1981 c 693 §17 1983 c 482 §15, 1985 c 747 §39]

**442.425 Authority over accounting and reporting systems of facilities.** (1) The state agency by rule may specify one or more uniform systems of accounting and financial reporting, necessary to meet the requirements of ORS 442 400 to 442 450. 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 state agency'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 state agency. The state agency 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 state agency.

(2) Existing systems of accounting and reporting used by health care facilities shall be given due consideration by the state agency in carrying out its duty of specifying the systems of accounting and uniform reporting required by ORS 442 400 to 442 450. The state agency insofar as reasonably possible shall adopt accounting and reporting systems and requirements which will not unreasonably increase the administrative costs of the facility.

(3) The state agency may allow and provide for modifications in the accounting and reporting

system 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 442 450.

(4) The state agency 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 442 450, such facilities shall be authorized to utilize established accounting systems and to report costs and revenues in a manner which is 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, they 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].

**442.430 Investigations; confidentiality of data.** (1) Whenever a further investigation is considered necessary or desirable by the state agency to verify the accuracy of the information in the reports made by health care facilities, the state agency 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 442 450, the state agency 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 state agency [Formerly 441 445].

**442.435 Investigation of facility financial status; cost review determinations; judicial review.** (1) The state agency may conduct such investigations as to determine to the satisfaction of the state agency that

(a) The total operating revenues and costs of each facility are reasonably related to the total services offered by the facility,

(b) The facility's gross revenues are reasonably related to the facility's gross costs,

(c) Rates and charges are set equitably among all purchasers or classes of purchasers of services without unjust discrimination or preference, and

(d) Rates and charges meet the agency's rate increase guidelines and standards of performance

(2) In establishing by rule rate increase guidelines and standards of performance, the agency is encouraged to consult with national, regional or local experts on health care finance and economics

(3) The state agency may review the reasonableness of rates for particular services, supplies or materials established by any health care facility

(4) When the state agency finds that rates charged by a facility are excessive because of underutilization of a service or unnecessary duplication of a service, it shall report its findings to the facility and to the Oregon Health Council

(5) If the state agency determines that rates charged by a facility or to be charged by a facility exceed the agency's guidelines for reasonableness which may be adopted by rule, and the rates are judged unreasonable, the state agency shall cause such facility to be given written notice of such determination and provide for publication of such determination in such manner and in such media as the state agency considers necessary to give the public notice of such determination

(6) A determination by the state agency that a rate or charge is unreasonable may be appealed as a contested case under ORS 183 480 [Formerly 441 460 1983 c 482 §16, 1987 c 660 §27]

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 442 500 and 442 120 and rules of the state agency may be subject to a civil penalty.

(2) The state agency shall adopt a schedule of penalties which shall not exceed \$100 per day of violation determined by the severity of the violation

(3) Any penalty imposed under this section shall become due and payable when the facility incurring the penalty receives a notice in writing from the director of the state agency The notice shall be sent by registered or certified mail and shall include a reference to the statute violated, a statement of the violation, a statement of the amount of the penalty imposed and a statement

of the facility's right to request a hearing The facility to whom the notice is addressed shall have 20 days from the date of mailing the notice to make written application for a hearing All hearings shall be conducted as provided in ORS 183.310 to 183 550 for a contested case

(4) Unless the amount of the penalty is paid within 10 days after the order of the state agency becomes final, the order shall constitute a judgment and may be recorded with the county clerk in the county where the facility is located The clerk shall thereupon record the name of the facility incurring the penalty and the amount of the penalty in the County Clerk Lien Record The penalty provided in the order so recorded shall become a lien upon the title of the real property held by the facility Execution may be issued upon the order in the same manner as execution upon a judgment of a court of record

(5) The penalty imposed under this section may be remitted or mitigated upon such terms and conditions as the state agency considers proper and consistent with the public health and safety [Formerly 441 480, 1981 c 693 §19, 1983 c 482 §18, 1983 c 696 §21]

**442.450 Exemption from cost review regulations.** The following are not subject to ORS 442 400 to 442 450

(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 physician charges on certain diagnosis-related groups.** In order to obtain regional or state-wide data about physician charges for nonhospital-based services, the state agency shall request information about physician charges for the 25 major diagnosis-related groups identified by the state agency from physicians, insurers or other third-party payers Compliance with the request is voluntary on the part of such physicians, insurers and payers [1985 c 747 §15]

**442.463 Annual utilization report; effect of failure to file report.** (1) By December 31 of each year, each licensed health facility shall file with the state agency an annual report containing such information related to the facility's utilization as may be required by the state agency, in such form as the state agency prescribes by rule

(2) The Department of Human Resources shall withhold medical assistance payments not

to exceed 10 percent of such payments from any licensed health facility upon notice from the state agency that the facility has failed to submit an annual report until the report is filed or if the report is filed after it is disapproved

(3) The annual report shall contain such information as may be required by rule of the state agency and must be approved by the state agency [1985 c 747 §§18, 19]

**442.465 Capital expenditure report.** Not later than December 31 of each year, each hospital shall submit to the state agency in such form as established by rule preliminary applications for new capital expenditures on clinical and nonclinical hospital facilities and major medical equipment anticipated during the next year, whenever the capital expenditure is expected to exceed \$250,000 [1985 c 747 §22, 1987 c 660 §10]

**442.467 Monitoring expenditure targets.** The state agency shall monitor the expenditure target imposed by ORS 442 465 by conducting necessary physical plant surveys and examination of facility plans in carrying out its duties under ORS 442 320 to 442 360 [1985 c 747 §23]

**442.469 Categories for capital expenditures.** In monitoring capital expenditures, the state agency shall categorize preliminary applications for capital expenditures based on the following factors

(1) Projects shall be divided into two groups

(a) Projects for upgrading or changing services or capacity for acute care services, or

(b) Projects for modernizing or replacing the physical plant or equipment

(2) For each project included in paragraph (a) of subsection (1) of this section, the state agency shall determine which of the following categories applies to the project

(a) Category A, which includes projects to reduce excess acute care capacity according to institution-specific recommendations or projects to develop alternative programs in place of inpatient acute care services

(b) Category B, which includes projects to increase acute care capacity in a service area in an amount not exceeding 95 percent of the minimum bed need established by the state agency

(c) Category C, which includes projects to increase capacity in a service area between 95 percent and 100 percent of the minimum bed need established by the state agency or to upgrade equipment which has exceeded its useful life and whose replacement is consistent with the requirements for obtaining a certificate of need under this chapter

(d) Category D, which includes projects to increase acute care capacity, services or equipment by single providers which could be provided more efficiently through multi-facility projects or to upgrade equipment within its useful life and whose replacement is consistent with the requirements for obtaining a certificate of need under this chapter

(e) Category E, which includes all other projects to increase acute care services or capacity

(3) For each project included in paragraph (b) of subsection (1) of this section, the state agency shall determine which of the following categories apply to the project

(a) Category A, which includes projects to address an imminent threat to life, safety or continuity of service

(b) Category B, which includes projects to address life safety requirements which are not waivable for the applicant, projects to address direct patient care of infection control requirements which are not waivable for the applicant or projects to address energy conservation or management systems, including computer or telephone systems, for which the capital cost is not greater than the projected operational cost savings expected from such systems within a five-year period

(c) Category C, which includes projects to address basic needs for direct patient care and infection control, projects to address structural or mechanical requirements which are not waivable for the applicant, projects to address indirect patient care basic treatment and diagnostic needs not required by any applicable health and safety code, projects to address preventative maintenance based on expected useful life of the facility or equipment, projects to address indirect patient care basic needs other than treatment and diagnostic services not required by any applicable health and safety code or projects to address life safety items not required by any applicable health and safety code

(d) Category D, which includes projects to address direct patient care and infection control improvements, projects to address staff and administrative amenities or projects to address the marketability of a facility or its appearance

(e) Category E, which includes all modernization or replacement projects not otherwise included in this subsection [1985 c 747 §24, 1987 c 660 §11]

## RURAL HEALTH

**442.470 Definitions for ORS 442.470 to 442.505.** As used in ORS 442 470 to 442.505

(1) "Council" means the Rural Health Coordinating Council

(2) "Office" means the Office of Rural Health

(3) "Primary care physician" means a doctor of family practice, general practice, internal medicine, pediatrics and obstetrics and gynecology

(4) "Rural hospital" means a hospital characterized by one of the following

(a) Type A hospitals are small and remote and have fewer than 50 beds, and are greater than 30 miles to another acute inpatient care facility,

(b) Type B hospitals are small and rural and have fewer than 50 beds, and are less than 30 miles to another acute inpatient care facility, or

(c) Type C hospitals are considered rural and have more than 50 beds, but are not a referral center [1979 c 513 §1, 1987 c 660 §12, 1987 c 918 §5]

**442.475 Office of Rural Health created.** There is created the Office of Rural Health in the agency [1979 c 513 §2, 1987 c 660 §13]

**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 442 505 and all moneys paid to the agency by reason of loans, gifts or grants for the purposes of ORS 442 470 to 442 505, 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 442 505 [1979 c 513 §3, 1987 c 660 §14]

**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 state-wide 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, 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) Two consumers who are appointed by the Governor,

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

(f) One consumer representative from the Western Oregon Health Systems Agency, appointed by the Western Oregon Health Systems Agency,

(g) One consumer representative from the Eastern Oregon Health Systems Agency, appointed by the Eastern Oregon Health Systems Agency,

(h) One consumer representative from the Northwest Oregon Health Systems, appointed by the Northwest Oregon Health Systems,

(i) One representative from the Oregon Health Sciences University, appointed by the President of the Oregon Health Sciences University,

(j) One representative from the Oregon Association of Hospitals, appointed by the Oregon Association of Hospitals,

(k) One dentist appointed by the Oregon Dental Association,

(L) One optometrist appointed by the Oregon Association of Optometry,

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

(n) 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]

**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 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]

**442.505 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]

**442.515 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]

**442 990** [Amended by 1955 c 533 §9 repealed by 1977 c 717 §23]

