

# Chapter 442

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## Health Planning

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442.005 [1955 c.533 §2, 1973 c.754 §1, repealed by 1977 c.717 §23]

442.010 [Amended by 1955 c.533 §3; 1971 c.650 §20; repealed by 1977 c.717 §23]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

nations, 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 "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.

(c) An "ambulatory surgical center" means a health care facility which performs outpatient surgery not routinely or custom-

arily performed in a physician's or dentist's office, and is able to meet health facility licensure requirements.

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

(e) 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 and Developmental Disability Services Division, Senior and Disabled Services Division, Children's Services Division, Department of Corrections or Vocational Rehabilitation Division.

(f) 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) "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) "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.

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

(19) "New hospital" means a facility that did not offer services on a regular basis within the prior 12-month period.

(20) "New skilled nursing or intermediate care service or facility" means a service or facility that did not offer services on a regular basis by or through the facility within the prior 12-month period, rebuilding 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, or the relocation of buildings or the relocation of beds from one licensed health care facility to another.

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

(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.

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

(27) "Total deductions from gross revenue" or "deductions from revenue" means reductions from gross revenue result-

ing from inability to collect payment of charges. Such reductions include bad debts; contractual adjustments; uncompensated care; administrative, courtesy and policy discounts and adjustments and other such revenue deductions. The deduction shall be net of the offset of restricted donations and grants for indigent care. [1977 c 751 §1; 1979 c.697 §2, 1979 c.744 §31; 1981 c.693 §1; 1983 c.482 §1; 1985 c.747 §16; 1987 c 320 §233, 1987 c.660 §4, 1987 c 753 §2; 1989 c.708 §5; 1989 c 1034 §5]

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 (1987 Replacement Part) 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 §5, 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 442.325 to 442.344.

(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]

**442.315 Certificate of need required; enforcement.** (1) Any new hospital or new skilled nursing or intermediate care service or facility not excluded pursuant to ORS 441.065 shall obtain a certificate of need from the state agency prior to an offering or development.

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

(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.

(4) The state agency shall be the decision-making authority for the purpose of certificates of need.

(5)(a) An applicant or any affected person who is dissatisfied with the proposed decision of the 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) 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 the provisions of ORS 183.310 to 183.550 relating to a contested case.

(6) Once a certificate of need has been issued, it may not be revoked or rescinded unless it was acquired by fraud or deceit. However, if the 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 or reconsider the application. A certificate of need is not transferable.

(7) Nothing in this section applies to any hospital, skilled nursing or intermediate care service or facility that seeks to replace equipment that otherwise would be subject to the certificate of need requirement but that was acquired prior to certificate of need requirements.

(8) 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 this section, or any rule or order issued by the state agency under this section, 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. [1989 c.1034 §2]

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

Note: Sections 9 and 10 chapter 1034, Oregon Laws 1989, provide.

(1) Any hospital seeking to add new institutional health services, as defined in ORS 442.015 (16), or any health care facility or person seeking to acquire major medical equipment, as defined in ORS 442.015 (21), shall file a letter of intent. If the annual operating expenses of the new institutional health service exceed \$500,000 or the price of the new major medical equipment exceeds \$1 million, the hospital, facility or person shall obtain a certificate of need from the state agency.

(2) As used in subsection (1) of this section, "new institutional health services" means institutional health services that were not offered by the health care facility on a regular basis within the 12-month period prior to the time such health services are to be offered.

**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 distin-

guished 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 750.095 and statutes incorporated by reference therein.

(5) It is the policy of ORS 244.050, 431.250, 441.015 to 441.087, 442.015 to 442.420, 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]

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

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

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

**442.342 Waiver of requirements.** (1) Notwithstanding any other provision of law,

a hospital licensed under ORS 441.025, in accordance with rules adopted by the state agency, may apply for waiver from the provisions of ORS 442.325, 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 di-

vided 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 442.325, 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 (1987 Replacement Part).

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

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

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

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

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

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

**HEALTH CARE COST REVIEW****442.400 "Health care facility" defined.**

As used in ORS 442.400 to 442.450, 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 deter-

mination, 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 investigation 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 facilities, 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 statewide 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 April 30 of each year, each hospital shall submit to the state agency in such form as established by rule reports of new capital expenditures incurred during the previous calendar year for clinical and nonclinical hospital facilities and medical equipment, whenever the capital expenditure has exceeded \$250,000. [1985 c.747 §22; 1987 c.660 §10; 1989 c.1034 §6]

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

**442.469 Categories for capital expenditures.** In monitoring capital expenditures, the state agency shall categorize reports 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, 1989 c.1034 §7]

### 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;

(c) Type C hospitals are considered rural and have more than 50 beds, but are not a referral center; or

(d) "Rural hospital" of any class does not include a hospital designated by the Federal Government as a rural referral hospital. [1979 c.513 §1; 1987 c.660 §12, 1987 c.918 §5, 1989 c.893 §8a]

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

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

(2) All moneys appropriated for the purposes of ORS 442.470 to 442.505 and all moneys paid to the agency by reason of loans, fees, 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; 1989 c.708 §1]

**442.485 Responsibilities of Office of Rural Health.** The responsibilities of the

Office of Rural Health shall include but not be limited to:

(1) Coordinating 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, interest, expertise or experience in rural areas and health care delivery. The membership of the Rural Health Coordinating Council shall consist of:

(a) One primary care physician who is appointed by the Oregon Medical Association and one primary care physician appointed by the Oregon Osteopathic Association;

(b) One nurse practitioner who is appointed by the Oregon Nursing Association;

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

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

(A) One consumer representative from each of the three health service areas; and

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

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

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

(g) One representative appointed by the Oregon Association for Home Care;

(h) One representative from the Oregon Health Sciences University, appointed by the

President of the Oregon Health Sciences University;

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

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

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

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

(m) One naturopathic physician appointed by the Oregon Association of Naturopathic Physicians.

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

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

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

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

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

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

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

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

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

**442.500 Technical and financial assistance to rural communities.** (1) The office 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]

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

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

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

(1) A recruitment and retention program for physician and other primary care provider manpower in rural areas.

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

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

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

(5) In conjunction with the Oregon Association of Hospitals, a report which identifies models that will replace or restructure inefficient health services in rural areas. [1987 c.918 §3]

**442.515 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 phys-

ical 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]

### RURAL HEALTH SERVICES PROGRAM

**442.550 Definitions for ORS 442.550 to 442.565.** As used in ORS 442.550 to 442.565:

(1) "Commission" means the State Scholarship Commission.

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

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

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

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

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

(c) Health professions student loan program. [1989 c.893 §16]

**Note:** 442.550 to 442.570 were enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 442 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

**442.555. Rural Health Services Program created.** (1) There is created the Rural Health Services Program, to be administered by the State Scholarship Commission, pursuant to rules adopted by the commission. The purpose of the program is to provide loan forgiveness to physicians and nurse practitioners who agree to practice in a medically underserved rural community in Oregon as determined in subsection (4) of this section.

(2) To be eligible to participate in the program, a prospective physician or nurse practitioner shall submit a letter of interest to the commission while attending medical school or graduate school. During the final year of school or the first year of residency, applicants shall sign a letter of agreement stipulating that the applicant agrees to abide by the terms stated in ORS 442.560.

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

(4) The Office of Rural Health by rule shall adopt criteria to be applied to determine medically underserved communities for purposes of ORS 316.143 to 316.146, 317.142, 352.095, 442.470, 442.503 and 442.550 to 442.570. [1989 c 893 §17]

**Note:** See note under 442.550

**442.560 Effect of participation in Rural Health Services Program.** Prospective physicians and nurse practitioners who wish to participate in the Rural Health Services Program shall agree that:

(1) For each year of medical or graduate school, the applicant designates an agreed amount, not to exceed \$7,500, as a qualifying loan subject to ORS 316.143 to 316.146, 317.142, 352.095, 442.470, 442.503 and 442.550 to 442.570.

(2) In the five years following the completion of all residency requirements, a physician agrees to practice for at least three full years in a medically underserved rural community in Oregon.

(3) For not less than three nor more than five years that a physician serves in a medically underserved rural area, the commission shall annually pay an amount equal to one year of qualifying loans and the interest accrued on those loans to the physician through the programs described in ORS 442.550.

(4) In the four years following the completion of graduate school, a nurse practitioner agrees to practice for at least two years in a medically underserved rural community in Oregon.

(5) For not less than two nor more than four years that a nurse practitioner practices in a medically underserved rural area, the commission shall annually pay an amount equal to one year of qualifying loans and the interest accrued on those loans made to the nurse practitioner through the programs described in ORS 442.550.

(6) If the participant does not complete the full service obligation set forth in subsection (2) or (4) of this section, the commission shall collect 100 percent of any payments made by the commission to the participant under this program. In addition, a penalty equal to 25 percent of the qualifying loans and interest paid by the commission shall be assessed by the commission, to be credited to and deposited in the Rural Health Services Fund established under ORS 442.570.

(7) The State Scholarship Commission shall establish rules to allow waiver of all or part of the fees and penalties owed to the commission due to circumstances that prevent the participant from fulfilling the service obligation.

(8) The tax credit available under ORS 316.143 to 316.146 or 317.142 shall not be available to a person otherwise eligible until the person has fulfilled the practice requirements in subsection (2) of this section. [1989 c.893 §18]

**Note:** See note under 442.550.

**Note:** Section 7, chapter 893, Oregon Laws 1989 provides: (1) Subject to subsection (8) of section 18 of this Act [ORS 442.560], the Office of Rural Health shall establish by rule criteria for certifying persons eligible for the tax credit authorized by this Act. Upon application therefor, filed on or before December 31, 1993, the office shall certify persons eligible for the tax credit authorized by this Act. The tax credit authorized under this Act applies to tax years beginning on and after January 1, 1990, and ending December 31, 1993.

(2) The classification of rural hospitals for purposes of determining eligibility under this section shall be the classification of the hospital in effect on January 1, 1989. [1989 c.893 §7]

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

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

the Legislative Assembly to encourage the availability of medical services in rural areas.

(3) In the event that the university is unable to recruit the number of qualified students required under subsection (2) of this section, after having made a reasonable effort to do so, the university is authorized to fill the remaining positions with other eligible candidates. [1989 c.893 §19]

**Note:** See note under 442.550.

**442.570 Rural Health Services Fund.** There is established in the State Treasury a fund, separate and distinct from the General Fund, to be known as the Rural Health Services Fund, for investments as provided by ORS 293.701 to 293.776, 293.810 and 293.820 for the payment of expenses of the State Scholarship Commission in carrying out the purposes of ORS 316.143 to 316.144, 317.142, 352.095, 442.470, 442.503 and 442.550 to 442.570. [1989 c.893 §21]

**Note:** See note under 442.550

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

