

Chapter 409 Oregon Health Authority, Health Policy and Analytics

DIVISION 1

PROCEDURAL RULES

- 409-001-0000 Notice of Proposed Rules
- 409-001-0005 Model Rules of Procedure

DIVISION 15

HEALTH CARE FACILITY FINANCIAL REPORTING

- 409-015-0005 Definitions
- 409-015-0010 Report Forms
- 409-015-0012 Filing Date
- 409-015-0015 Reports Required
- 409-015-0030 Modification of Reporting Requirements
- 409-015-0035 Civil Penalties

DIVISION 21

ACCESS OF DATA AND FEES FOR DATA SEARCH

- 409-021-0005 Introduction
- 409-021-0010 Definitions
- 409-021-0115 Calculation of Fees
- 409-021-0120 Inspection of Health Data
- 409-021-0130 Requests to Obtain Copies of Public Use Health Data Files
- 409-021-0140 Requests and Requirements to Obtain Restricted Health Data Sets
- 409-021-0150 Denial of Requests to Inspect or Obtain Copies of Health Data

DIVISION 22

REQUIREMENTS FOR SUBMISSION OF HEALTH CARE FACILITY UTILIZATION DATA; AMBULATORY SURGERY

- 409-022-0005 Annual Reports
- 409-022-0010 Definitions
- 409-022-0020 Reporting Source of Ambulatory Surgical Data
- 409-022-0060 Access to Health Data
- 409-022-0070 Limited Data Sets with a Data Use Agreement

DIVISION 23

HOSPITAL REPORTING

- 409-023-0100 Definitions
- 409-023-0105 Reporting

DIVISION 24

CAPITOL PROJECT REPORTING PROGRAM

- 409-024-0000 Definitions
- 409-024-0110 Capital Project Report
- 409-024-0120 Public Comments
- 409-024-0130 Civil Penalties

DIVISION 25

ALL PAYER ALL CLAIMS DATA REPORTING PROGRAM

- 409-025-0100 Definitions
- 409-025-0110 General Reporting Requirements
- 409-025-0120 Data File Layout, Format, and Coding Requirements
- 409-025-0130 Data Submission Requirements
- 409-025-0140 Waivers and Exceptions
- 409-025-0150 Compliance and Enforcement
- 409-025-0160 Data Access and Release
- 409-025-0170 Public Disclosure

DIVISION 26

OREGON HEALTHCARE WORKFORCE DATABASE

- 409-026-0100 Definitions
- 409-026-0110 Data Elements
- 409-026-0120 Reporting Schedule and Format
- 409-026-0130 Fees
- 409-026-0140 Data Access

DIVISION 27

PRIMARY CARE SERVICES REPORTING

- 409-027-0005 Purpose and Scope
- 409-027-0015 Definitions
- 409-027-0025 Coordinated Care Organization (CCO) Reporting Requirements

DIVISION 30

ADMINISTRATIVE REQUIREMENTS FOR HEALTH PROFESSION STUDENT CLINICAL TRAINING

- 409-030-0100 Purpose
- 409-030-0110 Definitions
- 409-030-0120 General applicability
- 409-030-0130 Health Professional Disciplines
- 409-030-0140 Clinical Settings
- 409-030-0150 Exceptions
- 409-030-0160 Regular Review of Clinical Placement Standards
- 409-030-0170 Administrative Requirements for Clinical Placement
- 409-030-0180 Immunization Standards
- 409-030-0190 Screening Standards
- 409-030-0200 Tuberculosis Screening
- 409-030-0210 Drug Testing for Substance Abuse and Misuse
- 409-030-0220 State and Nationwide Criminal Background Checks
- 409-030-0230 Training Standards
- 409-030-0240 Insurance and Liability Coverage
- 409-030-0250 Information Sharing or Use of Data

DIVISION 35

PHYSICIAN VISA WAIVER PROGRAM

- 409-035-0000 Purpose of the Physician Visa Waiver Program
- 409-035-0010 Definitions
- 409-035-0020 Health Care Facility Participation Requirements
- 409-035-0030 Physician Participation Requirements
- 409-035-0040 Application Review Process
- 409-035-0050 Monitoring and Follow-up Requirements
- 409-035-0060 Transfer of J-1 Waiver Physician Obligation

DIVISION 37

MEDICAID PRIMARY CARE LOAN REPAYMENT PROGRAM

- 409-037-0000 Purpose
- 409-037-0010 Definitions
- 409-037-0020 Participation and Application Requirements
- 409-037-0030 Application and Review Process
- 409-037-0040 Maximum Award Amounts
- 409-037-0050 Transfer of Medicaid Loan Repayment Provider Service Obligation
- 409-037-0060 Suspension or Waiver of Minimum Service Obligation
- 409-037-0070 Failure to Comply; Penalties
- 409-037-0080 Monitoring and Follow-up Requirements

Chapter 409 Oregon Health Authority, Health Policy and Analytics

DIVISION 45

HEALTH CARE PRACTITIONER CREDENTIALING

409-045-0025	Definitions
409-045-0030	Oregon Common Credentialing Program
409-045-0035	Oregon Practitioner Credentialing Application
409-045-0040	Credentialing Information Verifications
409-045-0045	Health Care Regulatory Board Participation
409-045-0050	Credentialing Organization Participation
409-045-0055	Health Care Practitioner Participation
409-045-0060	Use of Health Care Practitioner Information
409-045-0065	Common Credentialing Advisory Group
409-045-0070	Imposition of Fees
409-045-0075	Complaints
409-045-0115	General Applicability
409-045-0120	Standard List of Credentialing Documents
409-045-0125	Distant-Site Hospital Agreements
409-045-0130	Hold Harmless Clause
409-045-0135	Information Sharing or Use of Data

DIVISION 50

PAIN MANAGEMENT

409-050-0100	Purpose
409-050-0110	Definitions
409-050-0120	Commission Positions
409-050-0130	Pain Management Education Program Requirements

DIVISION 55

PATIENT-CENTERED PRIMARY CARE HOME PROGRAM

409-055-0000	Purpose and Scope
409-055-0010	Definitions
409-055-0020	Program Administration
409-055-0030	Practice Application and Recognition Process
409-055-0040	Recognition Criteria
409-055-0045	3 STAR Designation
409-055-0050	Data Reporting Requirements for Recognized PCPCHs
409-055-0060	Verification
409-055-0070	Compliance
409-055-0080	Insurance Carrier, Managed Care Plan, and Public Stakeholder Communication
409-055-0090	Reimbursement Objectives

DIVISION 60

HEALTH EVIDENCE REVIEW COMMISSION

409-060-0100	Scope
409-060-0110	Definitions
409-060-0120	Health Evidence Review Commission Process for Evidence-based Reports
409-060-0130	Medical Technology Assessments
409-060-0140	Evidence-based Guidelines
409-060-0150	Coverage Guidances

DIVISION 62

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC PROGRAM

409-062-0000	Purpose and Scope
409-062-0010	Definitions
409-062-0020	Program Administration
409-062-0030	Application and Certification Process
409-062-0040	Certification Criteria
409-062-0050	Level of Readiness Designation
409-062-0060	Variances

DIVISION 90

OFFICE FOR OREGON HEALTH PLAN POLICY AND RESEARCH ADMINISTRATION

409-090-0020	Copy Charges
409-090-0030	Charges for Printed Office for Oregon Health Plan Policy Research Reports

DIVISION 110

HEALTH SYSTEMS PLANNING SAFETY NET CAPACITY GRANT PROGRAM

409-110-0025	Scope
409-110-0030	Definitions
409-110-0035	Program Administration
409-110-0040	Grant Award Process
409-110-0045	Monitoring and Reporting Requirements

DIVISION 1

PROCEDURAL RULES

409-001-0000

Notice of Proposed Rules

The Office for Oregon Health Policy and Research shall issue any rules related to ORS 413.233, 413.248, 413.435, 413.570 through 413.599, 414.211 through 414.227, 414.655, 414.668 through 414.704, 442.011 through 442.210, 442.361, 442.362, 442.400 through 442.468, 442.575 through 442.589, 442.991, 442.993, and 735.721 through 735.727. Prior to the adoption, amendment, or repeal of any permanent rule, the Office for Oregon Health Policy and Research shall give notice of the intended action:

(1) In the Secretary of State's bulletin referred to in ORS 183.360 at least 21 days prior to the effective date of the intended action.

(2) By mailing a copy of the notice to persons on the Office for Oregon Health Policy and Research's mailing list established pursuant to ORS 183.335(8) at least 28 days before the effective date of the rule.

(3) By mailing or furnishing a copy of the notice at least 28 days before the effective date of the rule to:

- Associated Press;
- Oregon Association of Hospitals and Health Systems;
- Oregon Health Care Association;
- Oregon Medical Association;
- Oregon Association of Homes for the Aging;
- Capitol Building Press Room;
- The section(s) of the Health Division responsible for administering the certificate of need program and health facility construction plans review program; and
- The legislators specified in ORS 183.335(15).

Stat. Auth.: ORS 183.341 & 413.042

Stats. Implemented: ORS 183.341, 413.042, 413.127, 413.233, , 413.248, 413.435, 413.590, 413.599, 414.688 - 414.704, 441.223, 442.120, 442.205, 442.362, 442.420, 442.425, 442.445, 442.463, 442.466, 442.991 & 735.723

Hist.: SHPD 1(Temp), f. & ef. 8-19-77; SHPD 2, f. & ef. 11-2-77; SHPD 1-1982, f. & ef. 5-12-82; SHPD 12-1985, f. & ef. 11-15-85; HP 2-1988, f. & cert. ef. 3-25-88; HP 6-1990, f. & cert. ef. 6-13-90; HP 2-1992, f. & cert. ef. 10-19-92; HP 2-1994, f. & cert. ef. 4-22-94; HP 1-1996, f. & cert. ef. 1-2-96; OHP 1-1997, f. & cert. ef. 8-25-97; OHP 1-2002, f. & cert. ef. 1-2-02

409-001-0005

Model Rules of Procedure

The Office for Oregon Health Policy and Research adopts by reference the Attorney General's Uniform and Model Rules of Procedure in effect as of January 1, 2002, except where these rules conflict with rules adopted in OAR chapter 409.

[ED. NOTE: The full text of the Attorney General's Model Rules of Procedure is available from the Office of the Attorney General or the Office for Oregon Health Policy and Research.]

Stat. Auth.: ORS 183.341 & 413.042

Stats. Implemented: ORS 183.341 & 413.042
 Hist.: SHPD 1(Temp), f. & ef. 8-19-77; SHPD 2, f. & ef. 11-2-77; SHPD 1-1980, f. & ef. 2-19-80; SHPD 8-1981, f. & ef. 11-18-81; SHPD 40-1983, f. & ef. 11-21-83; SHPD 12-1985, f. & ef. 11-15-85; SHPD 1-1987, f. & ef. 2-3-87; HP 2-1988, f. & cert. ef. 3-25-88; HP 6-1990, f. & cert. ef. 6-13-90; HP 1-1992, f. & cert. ef. 6-8-92; HP 1-1994, f. & cert. ef. 4-22-94; HP 1-1996, f. & cert. ef. 1-2-96; OHP 1-1997, f. & cert. ef. 8-25-97; OHP 1-1998, f. & cert. ef. 5-6-98; OHP 1-2002, f. & cert. ef. 1-2-02

DIVISION 15

HEALTH CARE FACILITY FINANCIAL REPORTING

409-015-0005

Definitions

The following definitions apply to OAR 409-015-0005 through 409-015-0040:

- (1) "Authority" means the Oregon Health Authority.
- (2) "Charity care" means the uncollectible value, at the hospital's full established rates, of services provided to financially indigent patients. The uncollectible portion may vary from a very small percentage of the regular charges for some patients, up to 100 percent for other patients.
- (3) "Health care facility" means a hospital, including any special inpatient care facility, and an ambulatory surgical facility. The following facilities are not covered:
 - (a) Institutions providing only domiciliary care;
 - (b) Infirmaries of state institutions, colleges and universities;
 - (c) Federal facilities; and
 - (d) Long-term care facilities, or hospital-based long-term care service.
- (4) "Medicare and Medicaid deductions" means the uncollectible differences between the hospital's full established charges for individual services and the rates paid by Medicare or Medicaid for composite services.
- (5) "Other contractual deductions" means the uncollectible differences between full established charges for individual services and the contractual rates paid by a third-party payer for composite services, usually on a per diem, per discharge or capitation basis.
- (6) "Provision for bad debts" means the estimated amount of accounts receivable expected to result in credit losses.
- (7) "Unreimbursed care" means the sum of the provision for bad debts plus charity service, Medicare deductions, Medicaid deductions and contractual deductions.

Stat. Auth.: ORS 442.400 & 442.420
 Stats. Implemented: ORS 442.400 & 442.420
 Hist.: SHPD 1-1979, f. & ef. 6-1-79; SHPD 6-1981, f. & ef. 10-2-81; SHPD 9-1982(Temp), f. & ef. 12-30-82; SHPD 21-1983, f. & ef. 6-28-83; SHPD 1-1987, f. & ef. 2-3-87; HP 2-1988, f. & cert. ef. 3-25-88; HP 2-1992, f. & cert. ef. 10-19-92; HP 2-1994, f. & cert. ef. 4-22-94; HP 1-1996, f. & cert. ef. 1-2-96; OHP 1-1997, f. & cert. ef. 8-25-97; OHP 1-1999, f. 10-22-99, cert. ef. 10-23-99; OHP 1-2002, f. & cert. ef. 1-2-02; OHP 4-2016, f. & cert. ef. 3-28-16

409-015-0010

Report Forms

- (1) All health care facilities shall file the required reports and data on forms provided or approved by the Authority.
- (2) The Authority adopts and incorporates by reference the Patient Revenue and Unreimbursed Care form, Form FR-3.
- (3) The Authority shall not accept obsolete forms.

[ED. NOTE: Forms referenced are available from the agency.]
 Stat. Auth.: ORS 442.405, 442.420 & 442.425
 Stats. Implemented: ORS 442.425
 Hist.: SHPD 1-1979, f. & ef. 6-1-79; SHPD 6-1981, f. & ef. 10-2-81; SHPD 9-1982(Temp), f. & ef. 12-30-82; SHPD 21-1983, f. & ef. 6-28-83; SHPD 18-1984, f. & ef. 12-20-84; SHPD 12-1986, f. & ef. 7-7-86; HP 2-1988, f. & cert. ef. 3-25-88; HP 2-1990, f. & cert. ef. 2-12-90; HP 2-1992, f. & cert. ef. 10-19-92; HP 2-1994, f. & cert. ef. 4-22-94; HP 1-1996, f. & cert. ef. 1-2-96; OHP 1-1997, f. & cert. ef. 8-25-97; OHP 1-1999, f. 10-22-99, cert. ef. 10-23-99; OHP 1-2002, f. & cert. ef. 1-2-02; OHP 3-2011, f. 2-8-11, cert. ef. 3-1-11; OHP 4-2016, f. & cert. ef. 3-28-16

409-015-0012

Filing Date

The date of filing for the Databank Monthly Data electronically, is the date of receipt by the Oregon Association of Hospitals and

Health Systems. The date of filing for the Patient Revenue and Unreimbursed Care (Form FR-3) is the postmark date.

[ED. NOTE: Forms referenced are available from the agency.]
 Stat. Auth.: ORS 442.405, 442.420 & 442.425
 Stats. Implemented: ORS 442.425
 Hist.: SHPD 9-1982(Temp), f. & ef. 12-30-82; SHPD 21-1983, f. & ef. 6-28-83; SHPD 18-1984, f. & ef. 12-20-84; HP 2-1988, f. & cert. ef. 3-25-88; HP 2-1990, f. & cert. ef. 2-12-90; HP 1-1996, f. & cert. ef. 1-2-96; OHP 1-1999, f. 10-22-99, cert. ef. 10-23-99; OHP 5-2010, f. 9-23-10, cert. ef. 10-1-10

409-015-0015

Reports Required

- (1) Each health care facility shall file with the Authority financial statements, with attached certification of audit, not later than 120 days following the close of each fiscal year. If the financial statements of the facility are a part of the combining of a for-profit or not-for-profit corporation, the combining financial statements and attached certification of audit shall be filed.
- (2) Each health care facility shall file an accurately completed Databank Monthly Data electronically with the Oregon Association of Hospitals and Health Systems (OAHHS) for receipt by OAHHS on or before the 23rd day of each month. This form will transmit data for the preceding month. The Authority may, at its discretion, exempt a special inpatient care facility, ambulatory surgical facility or other health care facility from the requirements of this section. The Authority may, by oral or written notification, require a health care facility to use an express mail service to submit the Databank Monthly Data Input Form to OAHHS.
- (3) The Authority may annually require that each health care facility provide a breakdown of its unreimbursed care into bad debts, charity care, Medicare deductions, Medicaid deductions and other contractual deductions, using Form FR-3.
- (4) Each health care facility may be required to annually submit to the Authority a breakdown of its gross patient service revenue into inpatient revenue and outpatient revenue, and other applicable categories specified by Form FR-3.
- (5) Documents filed with the Authority under these rules are to be addressed to the Oregon Health Authority, Health Systems Research & Data, 500 Summer St. NE E-64, Salem, Oregon 97301-1079.

[ED. NOTE: Forms referenced are available from the agency.]
 Stat. Auth.: ORS 442.405, 442.420 & 442.425
 Stats. Implemented: ORS 442.425
 Hist.: SHPD 1-1979, f. & ef. 6-1-79; SHPD 6-1981, f. & ef. 10-2-81; SHPD 9-1982(Temp), f. & ef. 12-30-82; SHPD 21-1983, f. & ef. 6-28-83; SHPD 18-1984, f. & ef. 12-20-84; SHPD 12-1986, f. & ef. 7-7-86; HP 2-1988, f. & cert. ef. 3-25-88; HP 2-1990, f. & cert. ef. 2-12-90; HP 1-1996, f. & cert. ef. 1-2-96; OHP 1-1999, f. 10-22-99, cert. ef. 10-23-99; OHP 5-2010, f. 9-23-10, cert. ef. 10-1-10; OHP 4-2016, f. & cert. ef. 3-28-16

409-015-0030

Modification of Reporting Requirements

- (1) The Authority, upon request of a health care facility and for good cause, may relieve or modify the reporting requirements provided for in these rules when the reporting requirement is proven to the satisfaction of the Authority to impose an undue hardship.
- (2) Unless otherwise specified by the Authority, any relief or modification granted under section (1) of this rule is restricted to the specific instance or occasion for which relief was sought, and may not be construed to relieve any other reporting requirements of the health care facility.

Stat. Auth.: ORS 442.405, 442.420 & 442.425
 Stats. Implemented: ORS 442.425
 Hist.: SHPD 1-1979, f. & ef. 6-1-79; SHPD 6-1981, f. & ef. 10-2-81; SHPD 9-1982(Temp), f. & ef. 12-30-82; SHPD 21-1983, f. & ef. 6-28-83; HP 2-1988, f. & cert. ef. 3-25-88; OHP 4-2016, f. & cert. ef. 3-28-16

409-015-0035

Civil Penalties

- (1) Pursuant to ORS 442.445, the Authority adopts the following schedule of civil penalties:
 - (a) \$250.00 per day for the first five days of failure to file in accord with ORS 442.425; and

(b) \$500.00 per day from the sixth day until filing in accordance with ORS 442.425 is satisfactorily accomplished.

(2) Any amount of civil penalty imposed by the Authority may not be allowed as a reimbursable cost item and may not be recoverable from any category of payment source or patient.

Stat. Auth.: ORS 442.405, 442.420 & 442.445
Stats. Implemented: ORS 442.445(2)
Hist.: SHPD 1-1979, f. & ef. 6-1-79; SHPD 6-1981, f. & ef. 10-2-81; SHPD 9-1982(Temp), f. & ef. 12-30-82; SHPD 21-1983, f. & ef. 6-28-83; HP 2-1988, f. & cert. ef. 3-25-88; HP 2-1991, f. & cert. ef. 11-8-91; OHP 1-1999, f. 10-22-99, cert. ef. 10-23-99; OHP 4-2016, f. & cert. ef. 3-28-16

DIVISION 21

ACCESS OF DATA AND FEES FOR DATA SEARCH

409-021-0005

Introduction

This division defines the access to the health data collected from various sources and stored at the Office for Oregon Health Policy and Research.

Stat. Auth.: ORS 442.420(3)(d)
Stats. Implemented: ORS 192.410 - 192.440 & 442.420(3)(d)
Hist.: SHPD 5-1986, f. & ef. 1-24-86; HP 2-1988, f. & cert. ef. 3-25-88; HP 2-1992, f. & cert. ef. 10-19-92; HP 2-1994, f. & cert. ef. 4-22-94; HP 1-1996, f. & cert. ef. 1-2-96; OHP 1-1997, f. & cert. ef. 8-25-97; OHP 1-2002, f. & cert. ef. 1-2-02

409-021-0010

Definitions

As used in this division:

(1) "Computer" means a desktop personal computer physically located in the Office.

(2) "Data use agreement" means the terms, conditions, restrictions, and other rules governing the use of health data as specified in Form D-1 (Research Data Request) and in Form D-3 (OHP Data Use Agreement).

(3) "Electronic media" means the consumer media commonly used to store and transport up to 4.7 GB of data. This includes, but is not limited to, floppy diskettes, CDs, DVDs, and other forms of removable storage media.

(4) "Format" means the way health data appears in a display, on electronic media, on printed copy, or in output or data files produced by the Office's computer software.

(5) "Health data" means an electronic or printed copy of a document, book, paper, file, or other materials, regardless of mode received, that is filed or maintained in pursuit of law or in connection with the transaction of public business. Health data reported to the Office from hospitals and other health care facilities may include information that is protected health information when it is maintained at the hospital or health care facility. The Office obtains such information because it is required by law, and because the Office acts in the capacity of a health oversight agency. The Office is not a covered entity or a business associate of a covered entity. Health data may include, but is not limited to:

- (a) The socioeconomic and demographic characteristics of a population;
 - (b) The incidence of specific diseases or injuries;
 - (c) The severity of the diseases and injuries;
 - (d) The supply of health care services;
 - (e) Characteristics of the health care providers;
 - (f) The utilization of health care services; or
 - (g) Determining the need for health care services.
- (6) "HIPAA" means the federal Health Insurance Portability and Accountability Act of 1996 and the regulations published Title 45, Parts 160 and 164, of the Code of Federal Regulations.

(7) "Office" means the Office for Oregon Health Policy and Research.

(8) "Person" means any natural person, corporation, partnership, firm, association or member or committee of the Legislative Assembly.

(9) "Public use health data file" means an aggregation of health data without personal identifiers that are publicly available

for download, available through electronic mail, or available for delivery on electronic media, and at the Office's discretion may require an approved data use agreement.

(10) "Requestor" means the person who:

(a) Requests to inspect health data as provided in OAR 409-021-0120.

(b) Requests one or more copies of one or more public use health data files as provided in OAR 409-021-0130.

(c) Requests one or more copies of one or more limited health data sets as provided in OAR 409-021-0140.

(11) "Restricted health data set" means health data, other than routinely available public use data files, provided exclusively for purposes that are specified in an approved data use agreement. Limited data sets as defined by HIPAA shall be considered restricted health data sets.

(12) "Software" means a proprietary package of written programming language that instructs a computer to perform certain tasks.

(13) "Staff time" means the total time required by staff to complete a data request starting from initial contact to final contact with requestor, including searching for information, summarizing, duplicating, accessing the data, or any other time required by staff to complete the request.

(14) "State" means the State of Oregon.

Stat. Auth.: ORS 192.440 & 442.420(3)(d)
Stats. Implemented: ORS 192.410 - 192.440 & 442.420(3)(d)
Hist.: SHPD 5-1986, f. & ef. 1-24-86; HP 2-1988, f. & cert. ef. 3-25-88; HP 1-1996, f. & cert. ef. 1-2-96; OHP 1-1997, f. & cert. ef. 8-25-97; OHP 1-2002, f. & cert. ef. 1-2-02; OHP 1-2007, f. 1-29-07, cert. ef. 2-1-07

409-021-0115

Calculation of Fees

The Office shall charge fees necessary to fully recover the reasonable costs of responding to data requests and requests to examine health data maintained by the Office.

(1) The costs that the Office shall recover include, but are not limited to:

- (a) Cost of materials and copying as provided in OAR 409-909-0020.
- (b) Cost of staff time necessary to respond to the request.
- (c) Administrative costs necessary to process the request.
- (d) Any reasonable additional costs the Office deems necessary to respond to the request.

(2) Upon receipt of a completed form D-1, the Office shall provide a written estimate of fees within a reasonable period of time, unless the complete fees for the data request are the published fees for obtaining copies of public use health data files.

(3) The Office reserves the right to discount or waive fees for State agencies or at the discretion of the Administrator of the Office.

(4) The Office may develop contractual agreements for routinely providing data to a person at a discounted fee, upon approval of the Administrator of the Office.

Stat. Auth.: ORS 192.440 & 442.420(3)(d)
Stats. Implemented: ORS 192.410 - 192.440 & 442.420(3)(d)
Hist.: SHPD 5-1986, f. & ef. 1-24-86; HP 2-1988, f. & cert. ef. 3-25-88; HP 1-1996, f. & cert. ef. 1-2-96; Renumbered from 409-021-0025, OHP 1-2007, f. 1-29-07, cert. ef. 2-1-07

409-021-0120

Inspection of Health Data

(1) An inspection of the health data that are maintained at the Office shall be only by appointment during the normal working days and business hours of the Office.

(2) Requests to inspect health data that are maintained by the Office may, at the Office's discretion, require an approved data use agreement as provided in OAR 409-021-0130(1).

(3) The inspection shall take place at the Office; on a case-by-case basis, other reasonable locations may be designated at the sole discretion of the Administrator of the Office.

(4) The inspection of the requested data shall be in a format commonly employed by the Office for maintaining the requested data.

(5) Recovery of fees, if any, shall take place at the time of inspection.

Stat. Auth.: ORS 192.440 & 442.420(3)(d)
 Stats. Implemented: ORS 192.410 - 192.440 & 442.420(3)(d)
 Hist.: SHPD 5-1986, f. & ef. 1-24-86; HP 2-1988, f. & cert. ef. 3-25-88; HP 1-1996, f. & cert. ef. 1-2-96; Renumbered from 409-021-0020, OHP 1-2007, f. 1-29-07, cert. ef. 2-1-07

409-021-0130

Requests to Obtain Copies of Public Use Health Data Files

(1) Any requestor who wishes to obtain copies of public use health data files maintained by the Office shall provide all of the following:

- (a) Form D-1 (Research Data Request).
- (b) Form D-2 (Data Order Form).
- (c) Form D-3 (Data Use Agreement).
- (d) Full payment of fees.

(2) All requests for public use health data files require the written approval of the Research and Data Manager.

(3) Upon approval and receipt of full payment of fees, one copy of the requested public use health data file will be provided to the requestor.

(4) The Office shall respond to public use health data file requests within a reasonable period of time, except that the Office's response may be delayed so that critical operations and activities are not unduly disrupted. The Office shall notify the requestor in writing if an extensive delay is anticipated.

(5) This rule shall not apply to health data that the Office routinely makes available for direct download from the Office's web site.

(6) The public use files may not be used to identify any individual, including but not limited to patients, physicians, and other health care providers. The requestor may not use outside information to attempt to ascertain the identity of particular individuals who are the subject of public use files.

[ED. NOTE: Forms referred are available from the agency.]
 Stat. Auth.: ORS 192.440 & 442.420(3)(d)
 Stats. Implemented: ORS 192.410 - 192.440, 192.496, 192.501 & 442.420(3)(d)
 Hist.: SHPD 5-1986, f. & ef. 1-24-86; HP 2-1988, f. & cert. ef. 3-25-88; HP 2-1992, f. & cert. ef. 10-19-92; HP 2-1994, f. & cert. ef. 4-22-94; HP 1-1996, f. & cert. ef. 1-2-96; OHP 1-1997, f. & cert. ef. 8-25-97; OHP 1-2002, f. & cert. ef. 1-2-02; Renumbered from 409-021-0015, OHP 1-2007, f. 1-29-07, cert. ef. 2-1-07; OHP 1-2013, f. 1-24-13, cert. ef. 2-1-13

409-021-0140

Requests and Requirements to Obtain Restricted Health Data Sets

(1) The Office may authorize the disclosure of health data in accordance with an approved data use agreement entered into by both the Office and a researcher, pursuant to which the Office may disclose a restricted health data set to a researcher for research, public health, or health care operations. The intent of this rule is to generally apply the legal standard established in the HIPAA Privacy Rule applicable to limited data sets, 45 CFR 164.514(e).

(2) Any requestor who wishes to obtain restricted health data sets from the Office shall provide all of the following:

- (a) Form D-1 (Research Data Request)
- (b) Form D-2 (Data Order Form)
- (c) Form D-3 (Data Use Agreement)
- (d) Full payment of fees.

(3) All requests for restricted health data sets require the written approval of the Research and Data Manager.

(4) Upon approval and receipt of full payment of fees, the Office is authorized to provide one copy of the requested restricted health data set to the requestor.

(5) The Office shall respond to restricted health data set requests within a reasonable period of time, except that the Office's response may be delayed so that critical operations and activities are not unduly disrupted. The Office shall notify the requestor in writing if an extensive delay is anticipated.

[ED. NOTE: Forms referred are available from the agency.]
 Stat. Auth.: ORS 192.440 & 442.420(3)(d)
 Stats. Implemented: ORS 192.410 - 192.440 & 442.420(3)(d)
 Hist.: SHPD 5-1986, f. & ef. 1-24-86; HP 2-1988, f. & cert. ef. 3-25-88; HP 2-1992, f. & cert. ef. 10-19-92; HP 2-1994, f. & cert. ef. 4-22-94; HP 1-1996, f. &

cert. ef. 1-2-96; OHP 1-1997, f. & cert. ef. 8-25-97; OHP 1-2002, f. & cert. ef. 1-2-02; Renumbered from 409-021-0030, OHP 1-2007, f. 1-29-07, cert. ef. 2-1-07

409-021-0150

Denial of Requests to Inspect or Obtain Copies of Health Data

The Office shall deny requests to inspect health data, receive copies of public use health data sets, and receive copies of restricted health data sets in order to prevent uses that are not consistent with current agreements, policies, rules, regulations, or statutes.

(1) The Office shall deny requests to examine health data or receive copies of health data for reasons that include, but are not limited to:

- (a) Fulfilling the request violates one or more of the Office's current data use agreements with one or more other persons.
- (b) Fulfilling the request requires unreasonable interference with the Office's regular discharge of duties.
- (c) Fulfilling the request requires disclosures that violate HIPAA privacy rules (45CFR parts 160 and 164).
- (d) Fulfilling the request requires disclosures that are an unreasonable invasion of privacy. If a request is denied for this reason, the burden is on the requestor to provide the Office clear and convincing evidence that fulfilling the data request is not an unreasonable invasion of privacy and that the public interest requires disclosing the requested data.

(2) Nothing in these rules authorizes the Office to disclose health data in a form that allows easy and precise identification of individual patients or individual licensed health care professionals.

Stat. Auth.: ORS 192.440 & 442.420(3)(d)
 Stats. Implemented: ORS 192.410 - 192.440 & 442.420(3)(d)
 Hist.: OHP 1-2007, f. 1-29-07, cert. ef. 2-1-07

DIVISION 22

REQUIREMENTS FOR SUBMISSION OF HEALTH CARE FACILITY UTILIZATION DATA; AMBULATORY SURGERY

409-022-0005

Annual Reports

(1) By December 31 of each year, each licensed health care facility shall file with the Office for Oregon Health Policy and Research an annual report on the facility's utilization. The report will consist of properly completed copies of any of the office's Forms **AR-1** to **AR-3** which relate to services offered by the facility.

(2) Within 15 days of the submission of an annual report by a facility, the office will either acknowledge in writing that the annual report has been completed, or will inform the facility verbally or in writing of any incomplete or incorrectly completed items.

(3) Pursuant to ORS 442.445(2), the office adopts the following schedule of civil penalties:

- (a) \$250.00 per day for the first five days of failure to file in accord with this rule; and
- (b) \$500.00 per day from the sixth day until filing in accord with this rule is satisfactorily accomplished.

(4) Any amount of civil penalty imposed by the office shall not be allowed as a reimbursable cost item and shall not be recoverable from any category of payment source or patient.

[ED. NOTE: Forms referred are available from the agency.]
 Stat. Auth.: ORS 442.420(3)(d), 442.445(2) & 442.463
 Stats. Implemented: ORS 442.445 & 442.463
 Hist.: HP 2-1988, f. & cert. ef. 3-25-88; HP 1-1996, f. & cert. ef. 1-2-96; OHP 1-1997, f. & cert. ef. 8-25-97; OHP 1-1999, f. 10-22-99, cert. ef. 10-23-99; OHP 1-2002, f. & cert. ef. 1-2-02

409-022-0010

Definitions

Pursuant to ORS 442.120, the Oregon Health Authority has established an ambulatory surgical data reporting program. These definitions apply to OAR 409-022-0010 to 409-022-0070.

(1) "Ambulatory surgery data" means the consolidation of complete billing, medical, and personal information describing a patient, the services received, and charges billed for a surgical or diagnostic procedure treatment in a hospital outpatient setting or an ambulatory surgical facility setting into a data record.

(2) "APAC" means the Oregon All-Payer All-Claims Reporting Program as defined in ORS 442.466 and OAR 409-025-0100 to 409-025-0170.

(3) "Authority" means the Oregon Health Authority.

(4) "Hospital" means a facility with an organized medical staff, with permanent facilities that include inpatient beds and with medical services, including physician services and continuous nursing services under the supervision of registered nurses, to provide diagnosis and medical or surgical treatment that is licensed under ORS 441.015.

Stat. Auth.: ORS 442.120
Stats. Implemented: ORS 442.120
Hist.: OHP 3-2006, f. 12-14-06, cert. ef. 1-1-07; OHP 3-2015, f. 6-30-15, cert. ef. 7-1-15

409-022-0020

Reporting Source of Ambulatory Surgical Data

(1) The reporting sources for ambulatory surgery data are the mandatory reporters of the Oregon All-Payer All-Claims Reporting Program (APAC).

(2) The Oregon Health Authority may source discharge abstracts for surgical procedures from the APAC database as authorized by ORS 442.120.

Stat. Auth.: ORS 442.120
Stats. Implemented: ORS 442.120
Hist.: OHP 3-2006, f. 12-14-06, cert. ef. 1-1-07; OHP 3-2015, f. 6-30-15, cert. ef. 7-1-15

409-022-0060

Access to Health Data

(1) An inspection or examination of a Limited Data Set derived from the health data that are filed at the Oregon Health Authority shall be allowed during the normal working days and business hours of the office.

(2) The inspection or examination shall take place at the Authority or other reasonable locations designated by the Authority.

(3) Health data reported to the Authority from hospitals and facilities may include information that is protected health information when it is maintained at the hospital or facility. The Authority obtains such information because it is required by law, and because the Authority acts in the capacity of a health oversight agency. The Authority is not a covered entity or a business associate of a covered entity. The terms used in this rule have the same meaning as those terms in the HIPAA Privacy Rules, 45 CFR Parts 160 and 164.

(4) Except under rules outlined in OAR 409-22-0070 for access to a Limited Data Set, access to health data reported to the Authority will be limited to health data that does not identify any individual patient, or permit the identification of any patient when used alone or in combination with other information, or individual licensed health care professionals.

Stat. Auth.: ORS 442.120
Stats. Implemented: ORS 442.120
Hist.: OHP 3-2006, f. 12-14-06, cert. ef. 1-1-07; OHP 3-2015, f. 6-30-15, cert. ef. 7-1-15

409-022-0070

Limited Data Sets with a Data Use Agreement

(1) The Authority may authorize the disclosure of health data in accordance with a data use agreement entered into by both the Authority and a researcher, pursuant to which the Authority may disclose a limited data set to a researcher for research, public health, or health care operations. The intent of this rule is to generally apply the legal standard established in the HIPAA Privacy Rule applicable to limited data sets, 45 CFR 164.514(e).

(2) A limited data set excludes specified direct identifiers of the individual or of relatives, employers, or household members of the individual. The data use agreement must:

(a) Establish the permitted uses and disclosures of the limited data set by the recipient, consistent with the purposes of the research, and which may not include any use or disclosure that would violate the data use agreement;

(b) Limit who can use or receive the data; and

(c) Require the recipient to agree to the following:

(A) Not to use or disclose the information other than as permitted by the data use agreement or as otherwise required by law;

(B) Use appropriate safeguards to prevent the use or disclosure of the information other than as provided for in the data use agreement;

(C) Report to the covered entity any use or disclosure of the information not provided for by the data use agreement of which the recipient becomes aware;

(D) Ensure that any agents, including a subcontractor, to whom the recipient provides the limited data set agrees to the same restrictions and conditions that apply to the recipient with respect to the limited data set; and

(E) Not to identify the information or contact the individual.

Stat. Auth.: ORS 442.120
Stats. Implemented: ORS 442.120
Hist.: OHP 3-2006, f. 12-14-06, cert. ef. 1-1-07; OHP 3-2015, f. 6-30-15, cert. ef. 7-1-15

DIVISION 23

HOSPITAL REPORTING

409-023-0100

Definitions

The following definitions apply to OAR 409-023-0100 to 409-023-0105:

(1) "Charity care" means free or discounted health services provided to persons who cannot afford to pay and from whom a hospital has no expectation of payment. Charity care does not include bad debt, contractual allowances, or discounts for quick payment. Charity care is reported on the basis of cost, not gross charges by adjusting charges by a ratio of cost to charges (RCC).

(2) "Community" means the geographic service area and patient population that the health care institution serves as defined by the hospital.

(3) "Community benefits" mean programs or activities that provide treatment or promote health and healing as a response to identified community needs. They are not provided primarily for marketing purposes or to increase market share.

(a) Community benefit must meet at least one of the following criteria:

- (A) Generate negative margin;
- (B) Improve access to health services;
- (C) Enhance population health;
- (D) Advance knowledge;
- (E) Demonstrate charitable purpose.

(b) Community benefit activities must be counted in only one of the following categories:

- (A) Charity care;
- (B) Losses related to Medicaid, Medicare, State Children's Health Insurance Program, or other publicly funded health care program shortfalls;
- (C) Community health improvement services;
- (D) Health professionals' education;
- (E) Subsidized health services;
- (F) Research;
- (G) Financial and in-kind contributions to the community;
- (H) Community building activities;
- (I) Community benefit operations.

(4) "Cost" means the total expense incurred by the hospital minus any offsetting revenue (e.g. grants, payments).

(5) "Hospital" has the meaning provided in ORS 442.015.

(6) "Office" means the Office for Oregon Health Policy and Research.

Stat. Auth.: ORS 442.205
Stats. Implemented: ORS 442.205, 442.011, 442.200, 442.425 & 442.445

409-023-0105

Reporting

(1) Hospital reporting required pursuant to this rule shall begin with hospital fiscal years beginning on or after January 1, 2008 and must be consistent with generally accepted accounting principles.

(2) The hospital must submit a community benefit report to the Office within 240 days from the close of the hospital’s fiscal year. The report will be deemed submitted as of the date the report is postmarked or electronically delivered to the Office, whichever is first.

(3) Hospitals may submit an amended report after submission of original report to the Office within 30 days of the report submittal deadline. The amended report must include a written explanation for the reason for the amendment.

(4) Hospitals that are part of a multi-hospital system may submit reports for all system hospitals in one submission, but each hospital must be separately reported and clearly identified in any submission. Nothing in this section removes the requirement that hospitals report their individual community benefit report.

(5) If the ownership of the hospital changes during the reporting year, each hospital owner shall be required to submit a community benefit report for the hospital for the portion of the year owned.

(6) Each hospital must submit, on an annual basis, a community benefit report on form CBR-1 as defined by the Office. The report must be completed in accordance with instructions published in the Community Benefit Reporting Guidelines (CBR-2). The Office shall inform each hospital subject to reporting of any changes for the subsequent year by July 1.

(a) Reporting only includes activities under the direct control and management of hospital management and occurring during the fiscal year of the report.

(b) Hospitals must not include a community benefit cost in more than one category as defined by the Community Benefit Reporting Guidelines (CBR-2). These guidelines shall be posted on the Office web site. The Office must inform each hospital subject to this reporting of any changes in guidelines for the subsequent year by July 1.

(7) A hospital may submit, in addition to the reporting required in section (6), its financial assistance policy or any additional qualitative documents it deems appropriate. Any submission should be clearly identified for explanation of one of the community benefit categories defined in CBR-1.

(8) A parent company or academic health center may submit quantitative and qualitative information about the community benefit provided by the parent company or academic health center and should comply with the definition of community benefit as defined in this rule. Any information provided should clearly identify the hospitals included.

(9) Any information provided to the Office pursuant to this reporting will be publicly available and may be included in the annual report produced by the Office.

(10) The Office shall produce and publicly report, by hospital, an annual report of the community benefit information submitted to the Office.

(11) A hospital that fails to report as required in these rules may be subject to a civil penalty not to exceed \$500 per day.

Stat. Auth.: ORS 442.205

Stats. Implemented: ORS 442.205, 442.011, 442.200, 442.425 & 442.445

Hist.: OHP 2-2008, f. & cert. ef. 7-1-08

DIVISION 24

CAPITOL PROJECT REPORTING PROGRAM

409-024-0000

Definitions

The following definitions apply to OAR 409-024-0000 to 409-024-0130:

(1) “Authority” means the Oregon Health Authority.

(2) "Capital project" has the meaning described in ORS 442.361.

(3) "Community benefits" mean programs or activities that provide treatment or promote health and healing as a response to identified community needs and are not provided primarily for marketing purposes or to increase market share.

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

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

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

(c) A diagnostic-related group (DRG) hospital as described in ORS 442.361.

(d) An ambulatory surgical center as defined in ORS 442.015.

(e) Any Type A, Type B, or DRG hospital as defined in (4)(a) through (c) above that is certified as a Critical Access Hospital by the Centers for Medicare and Medicaid Services.

Stat. Auth.: ORS 442.362

Stats. Implemented: ORS 442.361 & 442.362

Hist.: OHP 3-2010, f. 6-24-10, cert. ef. 7-1-10; OHP 7-2015, f. & cert. ef. 9-24-15

409-024-0110

Capital Project Report

(1) Each reporting entity must submit to the Authority a report of pending or proposed capital projects using a Capital Project Reporting Form CPR-1 as defined by the Authority. The report must be completed in accordance with instructions in the capital project reporting guidelines published on the Authority's website.

(2) The Capital Project Reporting Form CPR-1 shall include but is not limited to:

(a) A summary of the information posted by the reporting entity under ORS 442.362.

(b) The procedure that the reporting entity used to collect public comment.

(c) A summary of expected community benefits for the project.

(d) The estimated cost of the project.

(3) Capital project reports must be submitted to the Authority no later than 30 days after financing for a project that has been approved for ambulatory surgical centers or within 30 days after the project has been approved by the hospital's board of directors or other governing body for hospitals. The report shall be considered submitted on the date the report is postmarked or electronically delivered to the Authority, whichever is first.

(4) The Authority shall maintain on its website a publicly available resource to enable interested parties to view capital project reports filed with the Authority.

Stat. Auth.: ORS 442.362

Stats. Implemented: ORS 442.361 & 442.362

Hist.: OHP 3-2010, f. 6-24-10, cert. ef. 7-1-10; OHP 7-2015, f. & cert. ef. 9-24-15

409-024-0120

Public Comments

(1) Each reporting entity must make available a means for interested persons to submit public comments on the capital project either on their website or by posting public notice in a major newspaper for a period of no less than seven days. Comments must be collected for a period of no less than 30 days and made available for public review.

(2) The hospital or ambulatory care center shall then notify the Authority after the 30 day public comment if the hospital or ambulatory care center chooses to complete the project as is or if the project has changed and an expected completion date. The Authority shall post this update on its website for 30 days.

Stat. Auth.: ORS 442.362

Stats. Implemented: ORS 442.361 & 442.362

Hist.: OHP 3-2010, f. 6-24-10, cert. ef. 7-1-10; OHP 7-2015, f. & cert. ef. 9-24-15

409-024-0130

Civil Penalties

(1) If the Authority learns that any reporting entity has failed to file a capital project report, the Authority shall contact the

reporting entity by certified mail requesting the unfiled report. If the reporting entity fails to reply within 30 calendar days or continues to be non-compliant with the reporting requirements, the Authority shall assess a civil penalty pursuant to the following schedule:

(a) \$250 per day for the first five days of failure to file in accordance with ORS 442.991; and

(b) \$500 per day from the sixth day until filing in accordance with ORS 442.991 is completed.

(2) Any amount of civil penalty assessed by the Authority may not be allowed as a reimbursable cost item and may not be recoverable from any category of payment source or patient.

Stat. Auth.: ORS 442.362

Stats. Implemented: ORS 442.361, 442.362 & 442.991

Hist.: OHP 3-2010, f. 6-24-10, cert. ef. 7-1-10; OHP 7-2015, f. & cert. ef. 9-24-15

DIVISION 25

ALL PAYER ALL CLAIMS DATA REPORTING PROGRAM

409-025-0100

Definitions

The following definitions apply to OAR 409-025-0100 to 409-025-0170:

(1) "Accident policy" means an insurance policy that provides benefits only for a loss due to accidental bodily injury.

(2) "Allowed amount" means the actual amount of charges for healthcare services, equipment, or supplies that are covered expenses under the terms of an insurance policy or health benefits plan.

(3) "Annual supplemental provider level APM summary file" means a data set composed of total and primary care-related dollars disbursed, by payment arrangement and line of business, to billing providers and organizations with a place of business in Oregon.

(4) "APAC" means all payer all claims.

(5) "APM" means alternative payment method.

(6) "Association" means any organization, including a labor union, that has an active existence for at least one year, that has a constitution and bylaws and that has been organized and is maintained in good faith primarily for purposes other than that of obtaining insurance.

(7) "Attending provider" means the individual health care provider who delivered the health care services, equipment, or supplies specified on a health care claim.

(8) "Authority" means the Oregon Health Authority.

(9) "Billing provider" means the individual or entity that submits claims for health care services, equipment, or supplies delivered by an attending provider.

(10) "Capitated services" means services rendered by a provider through a contract in which payments are based upon a fixed dollar amount for each enrolled member on a monthly basis.

(11) "Carrier" shall have the meaning given that term in ORS 743.730.

(12) "Certificate of authority" shall have the meaning given that term in ORS 731.072.

(13) "Charges" means the actual dollar amount charged on the claim.

(14) "Claim" means an encounter or request for payment under the terms of an insurance policy, health benefits plan, Medicare, or Medicaid.

(15) "Co-insurance" means the percentage an enrolled member pays toward the cost of a covered service.

(16) "Coordinated Care Organization (CCO)" shall have the meaning given that term in ORS 414.025.

(17) "Co-payment" means the fixed dollar amount an enrolled member pays to a health care provider at the time a covered service is provided or the full cost of a service when that is less than the fixed dollar amount.

(18) "Data file" means electronic health information including medical claims files, eligibility files, medical provider files, phar-

macy claims files, control totals files, subscriber-billed premiums files, APM files and any other related information specified in these rules.

(19) "Data set" means a collection of individual data records, whether in electronic or manual files.

(20) "DCBS" means the Oregon Department of Consumer and Business Services.

(21) "Deductible" means the total dollar amount an enrolled member pays toward the cost of covered services over an established period of time before the carrier or third-party administrator makes any payments under an insurance policy or health benefit plan.

(22) "De-identified health information" means health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

(23) "Direct personal identifier" means information relating to an individual patient or enrolled member that contains primary or obvious identifiers, including:

(a) Names;

(b) Business names when that name would serve to identify a person;

(c) Postal address information other than town or city, state, and 5-digit zip code;

(d) Specific latitude and longitude or other geographic information that would be used to derive postal address;

(e) Telephone and fax numbers;

(f) Electronic mail addresses;

(g) Social security numbers;

(h) Vehicle identifiers and serial numbers, including license plate numbers;

(i) Medical record numbers;

(j) Health plan beneficiary numbers;

(k) Certificate and license numbers;

(l) Internet protocol (IP) addresses and uniform resource locators (URL) that identify a business that would serve to identify a person;

(m) Biometric identifiers, including finger and voice prints; and

(n) Personal photographic images.

(24) "Disability policy" means an insurance policy that provides benefits for losses due to a covered illness or disability.

(25) "Disclosure" means the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

(26) "DRC" means Data Review Committee.

(27) "Dual eligible special needs plan" means a special needs plan that enrolls beneficiaries entitled to both Medicare and Medicaid.

(28) "Eligibility file" means a data set containing demographic information for each individual enrolled member eligible for medical benefits for one or more days of coverage at any time during a calendar month for an Oregon resident as defined in ORS 803.355, a non-Oregon resident who is a member of a PEBB or OEBB group health insurance plan, or services provided in Oregon.

(29) "Eligible employee" shall have the meaning given that term in ORS 743.730.

(30) "Employee" shall have the meaning given that term in ORS 654.005.

(31) "Employer" shall have the meaning given that term in ORS 654.005.

(32) "Encrypted identifier" means a code or other means of identification to allow individual patients or enrolled members to be tracked across data sets without revealing their identity.

(33) "Encryption" means a method by which the true value of data has been disguised in order to prevent the identification of individual patients or enrolled members and does not provide the means for recovering the true value of the data.

(34) "Enrolled member" means enrollee as defined in ORS 743.730.

(35) "ERISA" means the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001

(36) "Facility" means a health care facility as defined in ORS 442.015.

(37) "Genetic test" shall have the meaning given that term in ORS 192.531.

(38) "Group health insurance" shall have the meaning given that term in ORS 731.098.

(39) "Health benefit plan" shall have the meaning given that term in ORS 743.730.

(40) "Health care" shall have the meaning given that term in ORS 192.556.

(41) "Health care operations" means certain administrative, financial, legal, and quality improvement activities that are necessary to run programs including, but not limited to, conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, case management and care coordination, evaluating practitioner, provider, or health plan performance, and underwriting, enrollment, premium rating and other activities related to creation, renewal, or replacement of a health insurance contract.

(42) "Health care provider" shall have the meaning given that term in ORS 192.556.

(43) "Health information" shall have the meaning given that term in ORS 192.556.

(44) "Health insurance exchange" shall have the meaning given that term in ORS 741.300.

(45) "Healthcare Common Procedure Coding System (HCPCS)" means a medical code set, maintained by the United States Department of Health and Human Services, that identifies health care procedures, equipment, and supplies for claim submission purposes.

(46) "HIPAA" means Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d, et seq. and the federal regulations adopted to implement the Act.

(47) "Hospital indemnity policy" means an insurance policy that provides benefits only for covered hospital stays.

(48) "Indirect personal identifier" means information relating to an individual patient or enrolled member that a person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods could apply to render such information individually identifiable by using such information alone or in combination with other reasonably available information.

(49) "Individual", when used in a list of required lines of business, means individual health benefit plans.

(50) "Individually identifiable health information" shall have the meaning given that term in ORS 192.556.

(51) "Insurance" shall have the meaning given that term in ORS 731.102.

(52) "Labor union" means any organization which is constituted for the purpose, in whole or in part, of collective bargaining or dealing with employers concerning grievances, terms or conditions of employment or of other mutual aid or protection in connection with employees.

(53) "Large group" means health benefit plans for employers with more than 50 employees.

(54) "Limited data set" means protected health information that excludes direct personal identifiers and is disclosed for research, health care operations, or to a public health authority for public health purposes.

(55) "Long-term care insurance" shall have the meaning given that term in ORS 743.652.

(56) "Managed care organization" (MCO) means a prepaid managed care health services organization as defined in ORS 414.736.

(57) "Mandatory reporter" means any reporting entity defined as a mandatory reporter in OAR 409-025-0110.

Chapter 409 Oregon Health Authority, Health Policy and Analytics

(58) “Medicaid” means medical assistance provided under 42 U.S.C. section 1396a (section 1902 of the Social Security Act), as administered by the Division of Medical Assistance Programs.

(59) “Medicaid fee-for-service”(Medicaid FFS) means that portion of Medicaid where a health care provider is paid a fee for each covered health care service delivered to an eligible Medicaid patient.

(60) “Medical claims file” means a data set composed of health care service level remittance information for all adjudicated claims for each billed service including but not limited to member demographics, provider information, charge and payment information, and clinical diagnosis and procedure codes for an Oregon resident as defined in ORS 803.355, a non-Oregon resident who is a member of a PEBB or OEGB group health insurance plan, or services provided in Oregon.

(61) “Medical provider file” means a data set containing information about health care providers providing health care services, equipment, or supplies to enrolled members during the reporting period.

(62) “Medicare” means coverage under Part A, Part B, Part C, or Part D of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., as amended.

(63) “Medicare Modernization Act” means the Medicare Prescription Drug, Improvement, and Modernization Act of 2003(Public Law 108-173) and the federal regulations adopted to implement the Act.

(64) “OEGB” means the Oregon Educators Benefit Board.

(65) “OMIP” means the Oregon Medical Insurance Pool.

(66) “Patient” means any person in the data set who is the subject of the activities of the claim performed by the health care provider.

(67) “Paid amount” means the actual dollar amount paid for claims.

(68) “PEBB” means the Oregon Public Employees’ Benefit Board.

(69) “Person” shall have the meaning given that term in ORS 731.116.

(70) “Pharmacy benefit manager (PBM)” means a person or entity that performs pharmacy benefit management, including a person or entity in a contractual or employment relationship with a person or entity performing pharmacy benefit management for a health benefits plan.

(71) “Pharmacy claims file” means a data set containing service level remittance information from all adjudicated claims including, but not limited to, enrolled member demographics, provider information, charge and payment information, and national drug codes for an Oregon resident as defined in ORS 803.355, a non-Oregon resident who is a member of a PEBB or OEGB group health insurance plan, or services provided in Oregon.

(72) “Pharmacy eligibility file” means a data set containing demographic information for each individual enrolled member eligible for pharmacy benefits for one or more days of coverage at any time during a calendar month for an Oregon resident as defined in ORS 803.355, a non-Oregon resident who is a member of a PEBB or OEGB group health insurance plan, or services provided in Oregon.

(73) “Policy” shall have the meaning given that term in ORS 731.122.

(74) “Prepaid amount” means the fee for the service equivalent that would have been paid for a specific service if the service had not been capitated.

(75) “Premium” shall have the meaning given that term in ORS 743.730.

(76) “Principal investigator (PI)” means the person in charge of a research project that makes use of limited data sets. The PI is the custodian of the data and shall comply with all state and federal restrictions, limitations, and conditions of use associated with the data release.

(77) “Protected health information” shall have the meaning given that term in ORS 192.519.

(78) “Public health authority” means the Public Health Division of the Authority or local public health authority as defined in ORS 431.260.

(79) “Public health purposes” means the activities of a public health authority for the purpose of preventing or controlling disease, injury, or disability including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, investigations, and interventions.

(80) “Public use data set” means a publicly available data set of de-identified health information containing only the data elements specified by the Authority for inclusion.

(81) “Registered entity” means any person required to register with DCBS under ORS 744.714.

(82) “Reporting entity” means:

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

(b) A health care service contractor as defined in ORS 750.005 that issues medical insurance in Oregon.

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

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

(e) A prepaid managed care health services organization as defined in ORS 414.736.

(f) An insurer providing coverage funded under Part A, Part B, or Part D of Title XVIII of the Social Security Act, subject to approval by the United States Department of Health and Human Services.

(83) “Research” means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalized knowledge.

(84) “Self-insured plan” means any plan, program, contract, or any other arrangement under which one or more employers, unions, or other organizations provide health care services or benefits to their employees or members in this state, either directly or indirectly through a trust or third-party administrator.

(85) “Small employer health insurance” means health benefit plans for employers whose workforce consists of at least two but not more than 50 eligible employees.

(86) “Special Needs Plan” means a Medicare health benefit plan created by the Medicare Modernization Act that is specifically designed to provide targeted care to individuals with special needs.

(87) “Specific disease policy” means an insurance policy that provides benefits only for a loss due to a covered disease.

(88) “Strongly-encrypted” means an encryption method that uses a cryptographic key with a large number of random keyboard characters.

(89) “Subscriber” means the individual responsible for payment of premiums or whose employment is the basis for eligibility for membership in a health benefit plan.

(90) “Summarized data” means data aggregated by one or more categories. Summarized data created from protected health information may not contain direct or indirect identifiers.

(91) “Third-party administrator (TPA)” means any person who directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums from, or adjusts or settles claims on, residents of Oregon or residents of another state from offices in Oregon, in connection with life insurance or health insurance coverage; or any person or entity who must otherwise be licensed under ORS 744.702.

(92) “Transact insurance” shall have the meaning given that term in ORS 731.146.

(93) “Trust” means a fund established by two or more employers in the same or related industry or by one or more labor unions or by one or more employers and one or more labor unions or by an association.

(94) “Vision policy” means a health benefits plan covering only vision health care.

(95) "Voluntary reporter" means any registered or reporting entity, other than a mandatory reporter, that voluntarily elects to comply with the reporting requirements in OAR 409-025-0100 to 409-025-0170.

Stat. Auth.: ORS 442.466
Stats. Implemented: ORS 442.464 & 442.466
Hist.: OHP 1-2010, f. 2-26-10, cert. ef. 3-1-10; OHP 4-2012, f. 5-23-12, cert. ef. 6-1-12; OHP 5-2012(Temp), f. 6-23-12, cert. ef. 6-1-12 thru 11-15-12; OHP 6-2012, f. 6-26-12, cert. ef. 7-9-12; OHP 1-2016, f. & cert. ef. 1-5-16; OHP 10-2016, f. 6-22-16, cert. ef. 1-1-17

409-025-0110

General Reporting Requirements

(1) Definition of "mandatory reporter"

(a) For carriers and licensed third-party administrators, the Authority shall identify mandatory reporters using information collected by DCBS including, but not limited to, data from the Health Insurance Member Enrollment Report.

(A) The Authority shall aggregate the most recent four quarters of data.

(B) The Authority shall calculate the mean total lives for each carrier and licensed third-party administrator.

(C) All carriers and licensed third-party administrators with calculated mean total lives of 5,000 or higher shall be mandatory reporters.

(b) All PBMs shall be mandatory reporters.

(c) All MCOs shall be mandatory reporters.

(d) All CCOs shall be mandatory reporters.

(e) All reporting entities with Dual Eligible Special Needs Plans in Oregon shall be mandatory reporters.

(f) All insurers providing coverage funded under Part A, Part B or Part D of Title XVIII of the Social Security Act, subject to approval by the United States Department of Health and Human Services.

(g) All insurers offering a health benefits plan in Oregon's health insurance exchange shall be mandatory reporters.

(2) Voluntary reporters may elect to participate by notifying the Authority in writing.

(3) Mandatory and voluntary reporters shall submit data files for all required lines of business. They may submit data files for the voluntary lines of business and may not submit data files for any excluded lines of business.

(a) Required lines of business include:

- (A) Medicare (parts C and D);
- (B) Medicaid;
- (C) Individual;
- (D) Small employer health insurance;
- (E) Large group;
- (F) Associations and trusts;
- (G) PEBB and OEGB group health insurance plans; and
- (H) Self-insured plans not subject to ERISA.

(b) Voluntary lines of business include self-insured plans subject to ERISA.

(c) Excluded lines of business include:

- (A) Accident policy;
- (B) Dental insurance;
- (C) Disability policy;
- (D) Hospital indemnity policy;
- (E) Long-term care insurance;
- (F) Medicare supplemental insurance;
- (G) Specific disease policy;
- (H) Stop-loss plans;
- (I) Student health policy;
- (J) Vision-only insurance; and
- (K) Workers compensation.

(4) Mandatory and voluntary reporters shall comply with data file layout, format, and coding requirements in OAR 409-025-0120.

(5) Mandatory and voluntary reporters shall comply with data submission requirements in OAR 409-025-0130.

(6) Unless otherwise required by state or federal rules, regulations or statutes, mandatory and voluntary reporters may not

submit claims subject to stricter disclosure limits imposed by state or federal rules, regulations, or statutes.

(7) The Authority shall provide written notification by July 1 of each year to all mandatory reporters subject to the reporting requirements of OAR 409-025-0100 to 409-025-0170 for the following calendar year.

Stat. Auth.: ORS 442.466
Stats. Implemented: ORS 442.464 & 442.466
Hist.: OHP 1-2010, f. 2-26-10, cert. ef. 3-1-10; OHP 4-2012, f. 5-23-12, cert. ef. 6-1-12; OHP 5-2012(Temp), f. 6-23-12, cert. ef. 6-1-12 thru 11-15-12; OHP 6-2012, f. 6-26-12, cert. ef. 7-9-12; OHP 1-2016, f. & cert. ef. 1-5-16; OHP 10-2016, f. 6-22-16, cert. ef. 1-1-17

409-025-0120

Data File Layout, Format, and Coding Requirements

(1) All data files shall include:

- (a) Medical claims;
- (b) Eligibility;
- (c) Medical provider;
- (d) Pharmacy claims;
- (e) Control totals;
- (f) Subscriber billed premiums;
- (g) Annual supplemental provider level APM summary; and
- (h) Control totals for annual supplemental provider level APM summary.

(2) The medical claims file shall be submitted using the approved layout, format, and coding described in Appendix A.

(3) The eligibility file shall be submitted using the approved layout, format, and coding described in Appendix B.

(a) Mandatory reporters shall report race and ethnicity data as outlined in Appendix B. This layout aligns with the Office of Management and Budget's (OMB) Federal Register Notice of October 30, 1997 (62 FR 58782-58790).

(b) Mandatory reporters shall report primary language in accordance with ANSI/NISO guidance using the three-character string outlined in Codes for the Representation of Languages for Information Interchange.

(c) Race, ethnicity and primary language data shall be collected in a manner that aligns with the following principles:

(A) To the greatest extent practicable, race, ethnicity, and preferred language shall be self-reported.

(i) Collectors of race, ethnicity and primary language data may not assume or judge ethnic and racial identity or preferred signed, written and spoken language, without asking the individual.

(ii) If an individual is unable to self-report and a family member, advocate, or authorized representative is unable to report on his or her behalf, the information shall be recorded as unknown.

(B) When an individual declines to identify race, ethnicity or preferred language, the information shall be reported as refused.

(4) The medical provider file shall be submitted using the approved layout, format, and coding described in Appendix C.

(5) The pharmacy claims file shall be submitted using the approved layout, format, and coding described in Appendix D.

(6) The control totals file shall be submitted using the approved layout, format, and coding described in Appendix E.

(7) The subscriber billed premium file shall be submitted using the approved layout, format, and coding described in Appendix F.

(8) The annual supplemental provider level APM summary file shall be submitted using the approved layout, format, and coding described in Appendix G.

(9) The control totals for annual supplemental provider level APM summary file shall be submitted using the approved layout, format, and coding described in Appendix H.

(10) All data elements are required unless specified as optional or situational.

(11) All required data files shall be submitted as delimited ASCII files.

(12) Numeric data are positive integers unless otherwise specified.

(a) Negative values are allowed for revenue codes, quantities, charges, payment, co-payment, co-insurance, deductible, and prepaid amount.

(b) Negative values shall be preceded by a minus sign.

(13) The Authority shall convene a technical advisory group to advise the Authority and associated contractors on submission specifications including but not limited to Appendices A-H, Schedule A and any additional data submission requirements. The advisory group shall include, but is not limited to representatives from:

- (a) Mandatory reporters;
- (b) Providers;
- (c) Researchers, and;
- (d) Other stakeholders and interested parties.

(14) All data files shall pass edit checks and validations implemented by the Authority or the data vendor.

(a) Data vendors may perform quality and edit checks on data file submissions. If data files do not pass data vendor edit checks or validation, mandatory reporters must make corrections and resubmit data. Mandatory reporters must submit corrected data or an exception request within 14 calendar days of notification of error.

(b) Mandatory reporters must participate in efforts to validate and check the quality of current and historic APAC data, as prescribed and requested by the Authority.

(A) The Authority may request from mandatory reporters information from their internal records that is reasonably necessary to validate and check the quality of APAC data. This information may include, but is not limited to, aggregated number of enrolled members, number of claims and claim lines, charges, allowed amounts, paid amounts, co-insurance, co-payments, premiums, number of visits to primary care, emergency department, inpatient, and other health care treatment settings, and number of prescriptions.

(B) Mandatory reporters shall provide the aggregated information within 30 days of the Authority's request.

(C) If the Authority finds errors through edit checks or validation, mandatory reporters must make corrections and resubmit data or submit an exception request within 30 days or at the next regularly scheduled submission due date.

[ED. NOTE: Appendices and Schedules referenced are available from the agency.]

Stat. Auth.: ORS 442.466
 Stats. Implemented: ORS 442.464 & 442.466
 Hist.: OHP 1-2010, f. 2-26-10, cert. ef. 3-1-10; OHP 4-2012, f. 5-23-12, cert. ef. 6-1-12; OHP 1-2016, f. & cert. ef. 1-5-16; OHP 10-2016, f. 6-22-16, cert. ef. 1-1-17; OHP 13-2016, f. & cert. ef. 9-13-16

**409-025-0130
 Data Submission Requirements**

(1) Mandatory reporters shall submit data files as specified in Schedule A. Voluntary reporters may consult with the Authority to submit healthcare claims data files on an alternative schedule.

(2) Mandatory and voluntary reporters shall submit data files directly to the data vendor unless otherwise specified by the Authority.

(3) Mandatory and voluntary reporters shall transmit data files using one of the following approved processes:

- (a) Secure file transfer protocol (SFTP) including separate strong encryption of data files prior to SFTP transmission; or
- (b) Any process incorporating strong encryption that is approved in writing by both the Authority and the data vendor.

[ED. NOTE: Schedule A referenced is available from the agency]
 Stat. Auth.: ORS 442.466
 Stats. Implemented: ORS 442.464 & 442.466
 Hist.: OHP 1-2010, f. 2-26-10, cert. ef. 3-1-10; OHP 4-2012, f. 5-23-12, cert. ef. 6-1-12; OHP 1-2016, f. & cert. ef. 1-5-16; OHP 10-2016, f. 6-22-16, cert. ef. 1-1-17; OHP 13-2016, f. & cert. ef. 9-13-16

**409-025-0140
 Waivers and Exceptions**

(1) The Authority may grant a waiver, deadline extension, or exception to the reporting and validation requirements.

(2) Mandatory reporters shall notify the Authority of their inability to meet requirements.

(a) A mandatory reporter shall submit a Waiver or Exception of Reporting Requirements Form (APAC-1) to the Authority. Mandatory reporters may submit an APAC-1 form for the following reasons:

(A) To request an exception to the data file layout, format or threshold prior to data submission. The request shall be submitted 14 calendar days prior to the applicable reporting deadline;

(B) To request a deadline extension for any of the following scenarios: initial submission, data correction or validation. The request shall be submitted 14 calendar days prior to the applicable reporting deadline; or

(C) To request a waiver of all reporting or validation requirements. The request shall be submitted 60 calendar days prior to the applicable reporting deadline.

(b) Mandatory reporters seeking exception requests for data element formats or thresholds during the current data file submissions shall submit a request to the Authority's data vendor, using the data vendor's online interface. Requests must be made at time of quarterly submission.

(c) The Authority shall approve or deny the waiver or exception request and provide written notification to the requestor within 14 calendar days of receipt of the request.

(d) If the Authority denies the request, the requestor may appeal the denial by requesting a contested case hearing. The appeal must be filed within 30 business days of the denial. The appeal process is conducted pursuant to ORS Chapter 183 and the Attorney General's Uniform and Model rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700. The requestor shall have the burden to prove a compelling need for the waiver or exception.

(e) The waiver or exception shall expire at the end of the calendar year unless otherwise specified by the Authority.

[ED. NOTE: Forms referenced are available on the agency's website at <http://www.oregon.gov/oha/OHPR/RSCH/pages/apac.aspx>]

Stat. Auth.: ORS 442.466
 Stats. Implemented: ORS 442.464 & 442.466
 Hist.: OHP 1-2010, f. 2-26-10, cert. ef. 3-1-10; OHP 1-2016, f. & cert. ef. 1-5-16

**409-025-0150
 Compliance and Enforcement**

Penalties for failure to comply shall be enforced by the Authority.

(1) Unless approved by a waiver or exception, failure to comply with general reporting requirements shall include but is not limited to:

- (a) Failure to submit data files for a required line of business; and
- (b) Submitting health information for an excluded line of business.

(2) Unless approved by a waiver or exception, failure to comply with data file requirements shall include but is not limited to:

- (a) Submitting a data file in an unapproved layout;
- (b) Submitting a data element in an unapproved format;
- (c) Submitting a data element with unapproved coding;
- (d) Failure to submit a required data element; or
- (e) Failure to comply with validation and quality control efforts, including resubmitting or correcting data as requested by the Authority.

(3) Unless approved by a waiver or exception, failure to comply with data submission requirements shall include but is not limited to:

- (a) Failure to submit test files as specified by the data vendor;
- (b) Submitting data files later than five days after the submission due date as outlined in Schedule A;

(c) Rejection of a data file by the data vendor that is not resubmitted or corrected by the submitter within 14 calendar days from notification of error; or

(d) Transmitting data files using an unapproved process.

(4) The Authority shall provide mandatory reporters written notification of each failure to comply.

(5) The Authority may impose fines of up to \$500 per day for each failure to comply that is not resolved within 30 calendar days of written notification.

(6) If a mandatory reporter has made documented efforts to comply with these rules, the Authority may consider this a mitigating factor before imposing regulatory action against the mandatory reporter.

[ED. NOTE: Schedule A referenced is available from the agency.]
Stat. Auth.: ORS 442.466 & 442.993
Stats. Implemented: ORS 442.464, 442.466 & 442.993
Hist.: OHP 1-2010, f. 2-26-10, cert. ef. 3-1-10; OHP 1-2016, f. & cert. ef. 1-5-16; OHP 10-2016, f. 6-22-16, cert. ef. 1-1-17; OHP 13-2016, f. & cert. ef. 9-13-16

409-025-0160

Data Access and Release

(1) The Authority shall comply with all relevant state and federal data privacy, security, and antitrust regulations, including The Health Insurance Portability and Accountability Act (HIPAA), when sharing APAC data.

(2) The Authority may collect payment to recoup costs when APAC data requests are fulfilled.

(3) The Authority shall provide a public use data set, which shall include de-identified health information, in compliance with applicable Authority policies and state and federal rules, regulations, and statutes.

(a) The Authority shall maintain a list of data elements that may be included in APAC public use data sets. The public use data sets shall comply with applicable Authority policies and state and federal rules, regulations, and statutes.

(b) Requestors seeking access to an APAC public use data set shall complete a Pre-Application for APAC Data Files (APAC-2) and comply with the application procedures for public use data sets outlined on the APAC website.

(c) The Authority shall approve or deny the completed request and provide written notification to the requestor within 30 calendar days of receipt of the request.

(d) The Authority shall deny the completed request for reasons which include, but are not limited to:

(A) Requestor or any person who will have access to the data has previously violated a data use agreement with the Authority.

(B) The Authority finds that the specific details of the request do not sufficiently explain the proposed use.

(C) The Authority finds that the specific details of the request violate any state or federal rule, regulation, or statute.

(D) Full payment is not included with the application.

(e) If the Authority denies the Pre-Application for APAC Data Files (APAC-2):

(A) The Authority shall provide written notification stating the reason for the denial; and

(B) The requestor may appeal the denial by requesting a contested case hearing. The appeal must be filed within 30 business days of the denial. The appeal process is conducted pursuant to ORS chapter 183 and the Attorney General’s Uniform and Model Rules of Procedure, OAR 137-003-0501 to 137-003-0700. The requestor shall have the burden to prove that the Authority unreasonably denied the application.

(f) The public use data sets may not be used to identify any individual, including but not limited to patients, physicians, and other health care providers. The requestor may not use outside information to attempt to ascertain the identity of particular individuals who are the subject of public use data sets.

(4) The Authority shall provide limited data sets, in compliance with applicable Authority policies and state and federal rules, regulations, and statutes. Limited data sets may include protected health information from which certain direct identifiers have been removed.

(a) The Authority shall maintain a list of data elements that may be included in APAC limited data sets.

(b) APAC limited data sets may be disclosed for purposes allowed by state and federal regulations, including research, public health, and health care operations.

(c) Requestors seeking access to APAC limited data sets shall complete the Pre-Application for APAC Data Files (APAC-2). The Authority may require requestors to provide additional information by completing the Application for APAC Data Files (APAC-3). Requestors must comply with the application procedures for limited data sets outlined on the APAC website.

(5) The Authority shall create a process to request custom data sets.

(a) APAC custom data sets may be disclosed for purposes allowed by state and federal regulations, including research, public health, and health care operations.

(b) Requestors seeking access to APAC custom data sets shall complete the Pre-Application for APAC Data Files (APAC-2). The Authority may require requestors to provide additional information by completing the Application for APAC Data Files (APAC-3). Requestors must comply with the application procedures for custom data sets outlined on the APAC website.

(6) The Authority shall review for completeness all applications and provide requestors written notification of completeness within 30 calendar days of receipt of the request.

(a) If the Authority determines that the application is incomplete, the requestor shall have 30 calendar days from notification of incompleteness to complete the application. Incomplete applications that are not completed shall be discarded without further notification to the requestor.

(b) The Authority shall convene a Data Review Committee (DRC) to evaluate completed applications.

(A) The Authority may accept nominations for and make appointments to the DRC. The DRC shall include at least one mandatory reporter to serve in an advisory capacity.

(B) The DRC evaluation shall include, but is not limited to:

(i) Whether proposed purpose for accessing APAC data is allowable under Authority policies and state and federal rules, regulations, and statutes;

(ii) Whether IRB documentation is required and, if submitted, sufficient.

(iii) Whether the proposed privacy and security protections are sufficient.

(iv) Whether additional clarification is needed to complete the review.

(C) The Authority shall publish a DRC meeting schedule on its website and post applications scheduled to be reviewed, which detail the proposed use of the data and detail the data elements requested to be released, at least two weeks prior to the next DRC meeting. The Authority shall receive public comment on applications scheduled for review. The DRC will review and consider all public comments as part of the data request review process.

(D) The Authority shall schedule completed applications for review by the DRC on a first-come-first-served basis.

(E) The DRC shall recommend that The Authority approve or deny the application, or defer action pending clarification from the requestor.

(F) The Authority shall accept or reject the DRC’s recommendation and notify the requestor within ten business days of the review.

(G) The Authority shall deny a completed application for reasons which include, but are not limited to:

(i) Requestor or any person who will have access to the data has previously violated a data use agreement with the Authority.

(ii) Full payment is not included with the application.

(iii) The proposed privacy and security protections are not sufficient.

(iv) Information provided is not sufficient to approve the request.

(v) Proposed purpose for accessing APAC data is not allowable under authority policies or state or federal rules, regulations, or statutes.

(H) If the DRC requests clarification, the requestor shall have 30 calendar days to provide the requested information to the Authority. After 30 calendar days, applications with incomplete

requests for clarification shall be discarded without further notification to the requestor.

(I) Upon receipt of the requested clarification the Authority shall schedule re-evaluation with the DRC on a first-come-first-served basis.

(J) If the Authority denies the application:

(i) The Authority shall provide written notification stating the reason for the denial.

(ii) The requestor may appeal the denial by requesting a contested case hearing. The appeal must be filed within 30 business days of the denial. The appeal process is conducted pursuant to ORS Chapter 183 and the Attorney General’s Uniform and Model rules of Procedure, OAR 137-003-0501 to 137-003-0700. The requestor shall have the burden to prove that the Authority unreasonably denied the application.

[ED. NOTE: Forms and lists referenced are available on the agency’s website:

<http://www.oregon.gov/oha/OHPR/RSCH/pages/apac.aspx>

Stat. Auth.: ORS 442.466

Stats. Implemented: ORS 442.464 & 442.466

Hist.: OHP 1-2010, f. 2-26-10, cert. ef. 3-1-10; OHP 4-2012, f. 5-23-12, cert. ef.

6-1-12; OHP 2-2013, f. 1-24-13, cert. ef. 2-1-13; OHP 1-2016, f. & cert. ef. 1-5-

16; OHP 1-2016, f. & cert. ef. 1-5-16

409-025-0170

Public Disclosure

(1) The Authority and applicable contractors, shall perform data analyses and publish data and reports that serve the public’s interest. This may include, but is not limited to:

- (a) Comparing healthcare cost and quality;
(b) Assessing health care utilization;
(c) Assessing the capacity and distribution of healthcare resources;
(d) Assessing health care purchasing decisions;
(e) Assessing the effectiveness of public health programs; or
(f) Assessing disparities in health care delivery and outcomes.

(2) The Authority may convene advisory groups to advise the Authority on topics related to the All Payer All Claims Reporting Program. The advisory groups shall include, but not be limited to representatives from:

- (a) Mandatory reporters, including carriers, TPAs, PBMs, and CCOs; and;
(b) Other stakeholders and interested parties.

Stat. Auth.: ORS 442.466

Stats. Implemented: ORS 442.464 & 442.466

Hist.: OHP 1-2010, f. 2-26-10, cert. ef. 3-1-10; OHP 1-2016, f. & cert. ef. 1-5-16

DIVISION 26

OREGON HEALTHCARE WORKFORCE DATABASE

409-026-0100

Definitions

The following definitions apply to OAR 409-026-0100 to 409-026-0140:

- (1) “Authority” means the Oregon Health Authority.
(2) “Electronic media” means an electronic data storage medium.

(3) “Health care workforce information” means data collected using the license renewal process for selected Oregon health care professionals.

(4) “Health care workforce regulatory board” means the following:

- (a) Board of Licensed Dietitians;
(b) Board of Medical Imaging;
(c) Occupational Therapy Licensing Board;
(d) Oregon Board of Dentistry;
(e) Oregon Board of Examiners for Speech-Language Pathology and Audiology;
(f) Oregon Board of Licensed Professional Counselors and Therapists;
(g) Oregon Board of Naturopathic Medicine;
(h) Oregon Board of Optometry;
(i) Oregon Medical Board;
(j) Oregon State Board of Licensed Social Workers;
(k) Oregon State Board of Nursing;
(l) Physical Therapist Licensing Board;
(m) Respiratory Therapist and Polysomnographic Technologist Licensing Board;
(n) State Board of Chiropractic Examiners;
(o) State Board of Massage Therapists;
(p) State Board of Pharmacy; and
(q) State Board of Psychologist Examiners.

Stat. Auth.: ORS 676.410

Stats. Implemented: ORS 676.410

Hist.: OHP 4-2009, f. 12-23-09, cert. ef. 1-1-10; OHP 2-2016(Temp), f. & cert. ef. 2-8-16 thru 8-2-16; OHP 3-2016, f. & cert. ef. 3-25-16

409-026-0110

Data Elements

(1) Pursuant to ORS 676.410, a health care workforce regulatory board must collaborate with the Oregon Health Authority to collect health care workforce information. The information may include but is not limited to the following:

- (a) Gender;

- (b) Race;
- (c) Ethnicity
- (d) Languages spoken;
- (e) Year of birth;
- (f) Educational background;
- (g) Specialty training or certification;
- (h) Practice status and hours;
- (i) Practice type and setting;
- (j) Geographic location of practice; and
- (k) Future practice plans.

(2) The Authority may not include any health care workforce information relating to licensees' disciplinary actions or criminal background.

(3) The Authority shall collaborate with health care workforce regulatory boards to determine data elements and specifications and communicate the information to the health care workforce regulatory boards no later than six months prior to data collection.

(4) The Authority shall provide a data collection tool that health care workforce regulatory boards may use to collect required data elements.

(5) The healthcare workforce regulatory boards that utilize the Authority's data collection tool shall provide verification information to the Authority, which may include:

- (a) License number;
- (b) Name;
- (c) Birth year; and
- (d) Original license date.

Stat. Auth.: ORS 676.410

Stats. Implemented: ORS 676.410

Hist.: OHP 4-2009, f. 12-23-09, cert. ef. 1-1-10; OHP 2-2016(Temp), f. & cert. ef. 2-8-16 thru 8-2-16; OHP 3-2016, f. & cert. ef. 3-25-16

**409-026-0120
Reporting Schedule and Format**

(1) Health care licensing boards shall include data collection set forth OAR 409-026-0110 in the license renewal process, using the Authority's provided data collection tool or other tool agreed upon by the Authority.

(2) Collection of the health care workforce information required by this rule shall begin on the following dates:

(a) For health care professionals licensed by the Oregon State Board of Nursing; May 1, 2009;

(b) For health care professionals licensed by the Oregon Medical Board; October 1, 2009;

(c) For health care professionals licensed by the Oregon Occupational Therapy Licensing Board, the Oregon Board of Dentistry, the Oregon Physical Therapist Licensing Board, the State Board of Pharmacy, and the Board of Examiners of Licensed Dietitians; for license renewal periods on or after January 1, 2010.

(d) For health care professionals licensed by the Respiratory Therapist and Polysomnographic Technologist Licensing Board, and Oregon State Board of Social Workers; June 1, 2016.

(e) For chiropractic physicians licensed by the Oregon Board of Chiropractic Examiners; June 1, 2016. For chiropractic assistants licensed by the Oregon Board of Chiropractic Examiners; June 1, 2017.

(f) For health care professionals licensed by the Oregon Board of Massage Therapists, Oregon State Board of Licensed Professional Counselors and Therapists, and Oregon State Board of Psychologist Examiners; July 1, 2016.

(g) For the health care professionals licensed by the Oregon Board of Medical Imaging; September 1, 2016.

(h) For health care professionals licensed by the Oregon Board of Naturopathic Medicine; November 1, 2016.

(i) For the health care professionals licensed by the Oregon Board of Optometry; June 1, 2017.

(j) For the health care professionals licensed by the Oregon Board of Examiners for Speech-language Pathology and Audiology; November 1, 2017.

(3) Health care workforce regulatory boards shall submit required information to the Authority according to the following schedule:

(a) For health care workforce regulatory boards with a fixed licensing period or periods, the information shall be submitted within 90 days of the close of each period;

(b) For health care workforce regulatory boards with rolling licensing periods, the information shall be submitted annually, no later than July 1 of each year, or a date agreed upon by the Authority.

(4) The health care workforce information shall be submitted in one file that includes unique records for each individual license renewed during the reporting period.

(5) The records must be assembled in the format proscribed by the Authority and must be submitted electronically or on electronic media.

Stat. Auth.: ORS 676.410

Stats. Implemented: ORS 676.410

Hist.: OHP 4-2009, f. 12-23-09, cert. ef. 1-1-10; OHP 2-2016(Temp), f. & cert. ef. 2-8-16 thru 8-2-16; OHP 3-2016, f. & cert. ef. 3-25-16

**409-026-0130
Fees**

(1) The Authority shall establish a per-license fee to cover the cost of collecting and reporting health care workforce information. The fee shall be calculated by adding the costs necessary to compile, maintain, and analyze the health care workforce information and dividing that cost by the approximate number of individuals licensed in Oregon.

(2) Each health care licensing board shall submit, in a format agreed to by the Authority and each Board, the total number of individuals renewed in accordance with the schedule set forth in OAR 409-026-0120 for use in determination of fee calculation for the previous license period.

(3) The fee may not exceed \$4.00 per individual licensed for two years and \$2.00 per individual licensed for one year for individuals renewing on or after January 1, 2016. If the per-license fee calculation results in a figure above \$4.00, the Authority shall review the process for calculating the fee with a stakeholder group with representation from each health care workforce regulatory board.

(4) The health care workforce information fees collected by health care workforce regulatory boards shall be paid to the Authority on a schedule agreed to by the Authority and each health care workforce regulatory board.

(5) Late payments are subject to recovery in accordance with the laws of the State of Oregon.

Stat. Auth.: ORS 676.410

Stats. Implemented: ORS 676.410

Hist.: OHP 4-2009, f. 12-23-09, cert. ef. 1-1-10; OHP 2-2016(Temp), f. & cert. ef. 2-8-16 thru 8-2-16; OHP 3-2016, f. & cert. ef. 3-25-16

**409-026-0140
Data Access**

(1) For purposes of planning or analysis, the Authority may share de-identified, individual-level health care workforce data with other state agencies, including but not limited to:

- (a) Agencies, offices, or contractors of the Authority.
- (b) The Oregon Employment Department.

(2) The Authority may not provide individual-level public data sets to a non-governmental agency without written consent from the relevant health care workforce regulatory board.

Stat. Auth.: ORS 676.410

Stats. Implemented: ORS 676.410

Hist.: OHP 4-2009, f. 12-23-09, cert. ef. 1-1-10; OHP 2-2016(Temp), f. & cert. ef. 2-8-16 thru 8-2-16; OHP 3-2016, f. & cert. ef. 3-25-16

DIVISION 27

PRIMARY CARE SERVICES REPORTING

**409-027-0005
Purpose and Scope**

These rules (OAR 409-027-0005 to 409-027-0025) define primary care services that must be reported by all Coordinated Care Organizations to the Oregon Health Authority no later than

October 1 of 2016–2018 for the prior calendar year’s data. The findings generated from these reports will be presented to the legislature no later than February 1 of 2017–2020.

Stat. Auth: 413.042; Sec. 1 to 4, Ch. 575, OL 2015; and Sec. 7, Ch. 26, OL 2016
Stats. Implemented: Sec. 1 to 4, Ch. 575, OL 2015; and Sec. 7, Ch. 26, OL 2016
Hist.: OHP 11-2016, f. & cert. ef. 7-8-16

409-027-0015

Definitions

The following definitions apply:

- (1) “Authority” means the Oregon Health Authority.
- (2) “Coordinated care organization (CCO)” has the meaning given that term in ORS 414.025.
- (3) “Non-claims based primary care expenditures” means resources given to a primary care provider or practice for the following services or arrangements:
 - (a) Capitation and salaried arrangements with primary care providers or practices not billed or captured through claims.
 - (b) Risk-based reconciliation for arrangements with primary care providers or practices not billed or captured through claims.
 - (c) Payments to Patient-Centered Primary Care Homes or Patient-Centered Medical Homes based upon that recognition or payments for participation in proprietary or other multi-payer medical home initiatives.
 - (d) Retrospective incentive payments to primary care providers or practices based on performance aimed at decreasing cost or improving value for a defined population of patients.
 - (e) Prospective incentive payments to primary care providers or practices aimed at developing capacity for improving care for a defined population of patients.
 - (f) Payments for Health Information Technology structural changes at a primary care practice such as electronic records and data reporting capacity from those records.
 - (g) Workforce expenses including payments or expenses for supplemental staff or supplemental activities integrated into the primary care practice such as practice coaches, patient educators, patient navigators, and nurse care managers.
- (4) “Non-claims based total health care expenditures” means resources given to a provider or practice for the following services or arrangements:
 - (a) Capitation or salaried arrangements with providers or practices not billed or captured through claims.
 - (b) Risk-based reconciliation for arrangements with providers or practices not billed or captured through claims.
 - (c) Payments to Patient-Centered Primary Care Homes, Patient-Centered Medical Homes, or Patient-Centered Specialty Practices based upon that recognition or payments for participation in proprietary or other multi-payer medical home or specialty care practice initiatives.
 - (d) Retrospective incentive payments to providers or practices based on performance aimed at decreasing cost or improving value for a defined population of patients.
 - (e) Prospective incentive payments to providers or practices aimed at developing capacity for improving care for a defined population of patients.
 - (f) Payments for Health Information Technology structural changes at a practice such as electronic records and data reporting capacity from those records.
 - (g) Workforce expenses including payments or expenses for supplemental staff or supplemental activities integrated into the practice such as practice coaches, patient educators, patient navigators, and nurse care managers.
- (5) “Patient-Centered Medical Home (PCMH)” means a practice or provider who has been recognized as such by the National Committee for Quality Assurance.
- (6) “Patient-Centered Primary Care Home (PCPCH)” means a health care team or clinic as defined in ORS 414.655, meets the standards pursuant to OAR 409-055-0040, and has been recognized through the process pursuant to OAR 409-055-0040.
- (7) “Patient Centered Specialty Practice (PCSP)” means a practice or provider who has been recognized as such by the National Committee for Quality Assurance.

(8) “Practice” means an individual, facility, institution, corporate entity, or other organization which provides direct health care services or items, also termed a performing provider, or bills, obligates and receives reimbursement on behalf of a performing provider of services, also termed a billing provider (BP). The term provider refers to both performing providers and BPs unless otherwise specified.

(9) “Primary care” means family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics or general psychiatry.

(10) “Primary care provider” means:

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

(b) A health care team or clinic certified by the Authority as a PCPCH.

Stat. Auth: 413.042; Sec. 1 to 4, Ch. 575, OL 2015; and Sec. 7, Ch. 26, OL 2016
Stats. Implemented: Sec. 1 to 4, Ch. 575, OL 2015; and Sec. 7, Ch. 26, OL 2016
Hist.: OHP 11-2016, f. & cert. ef. 7-8-16

409-027-0025

Coordinated Care Organization (CCO) Reporting Requirements

(1) No later than October 1 of each year from 2016 through 2018 each CCO shall submit all non-claims based primary care expenditures as defined in OAR 409-027-0020 for the prior calendar year’s data [Example: January 1, 2015 through December 31, 2015 data needs to be submitted by October 1, 2016] using the approved file layout and format available at: <http://www.oregon.gov/OHA/OHPR/pages/rulemaking/index.aspx>.

(2) No later than October 1 of each year from 2016 through 2018 each CCO shall submit all non-claims based total health care expenditures as defined in OAR 409-027-0020 for the prior calendar year’s data [Example: January 1, 2015 through December 31, 2015 data needs to be submitted by October 1, 2016] using the approved file layout and format available at: <http://www.oregon.gov/OHA/OHPR/pages/rulemaking/index.aspx>.

(3) Each category included in the approved file format is mutually exclusive; therefore, expenditures shall only be accounted for in one category.

(4) Claims-based primary care and total health care expenditures will be calculated for each CCO by the Authority using data from the Authority’s All-Payer All-Claims Database.

(5) Expenditures for services or activities outside the primary care setting, regardless of a primary care capacity building intent, are not considered primary care expenditures for purposes of this report.

NOTE: Other CCO rules can be found at OAR 410-141-3000 to 410-141-3485

Stat. Auth: 413.042; Sec. 1 to 4, Ch. 575, OL 2015; and Sec. 7, Ch. 26, OL 2016
Stats. Implemented: Sec. 1 to 4, Ch. 575, OL 2015; and Sec. 7, Ch. 26, OL 2016
Hist.: OHP 11-2016, f. & cert. ef. 7-8-16

DIVISION 30

ADMINISTRATIVE REQUIREMENTS FOR HEALTH PROFESSION STUDENT CLINICAL TRAINING

409-030-0100

Purpose

These rules (OAR 409-030-0100 to 409-030-0250) establish standards for administrative requirements for health professional student placements in clinical training settings within the state of Oregon. The purpose of these rules is to mitigate inconsistencies that currently exist across clinical placements; to promote efficient solutions to reduce costs for students, health profession programs and clinical placement sites; and to ensure patient, clinical staff and student safety. These rules pertain to credentials that students must obtain and requirements that clinical placement sites may set. These rules are effective July 1, 2014.

Stat. Auth.: ORS 413.435
Stats. Implemented: ORS 413.435
Hist.: OHP 8-2013, f. 9-30-13, cert. ef. 7-1-14

409-030-0110

Definitions

The following definitions apply to OAR 409-030-0100 to 409-030-0250:

(1) “Administrative requirements” means those requirements that must be documented and verified before health professions program students may begin clinical placements, and includes criminal background checks, drug testing for substance abuse, health screenings, immunizations, and basic training standards.

(2) “Advanced practice nurse” means nursing practice areas inclusive of nurse practitioners, nurse midwives, clinical nurse specialists, and nurse anesthetists.

(3) “Authority” means the Oregon Health Authority.

(4) “CDC” means the federal Centers for Disease Control and Prevention.

(5) “Clinical placement” means any clinical rotations, internships, and any other clinical training experience that a student undergoes as part of their health professions program.

(6) “Clinical setting” or “clinical site” means the clinical facility at which a student undergoes training during a clinical placement.

(7) “Direct contact with patients” means clinical or therapeutic interaction with a patient, in a one-on-one or group setting at the clinical placement setting or an associated location, including but not limited to meetings, examinations, or procedures.

(8) “Evidence of Immunization” means a statement signed and dated by a licensed practitioner who has within the scope of the practitioner’s license the authority to administer immunizations or a representative of the local health department certifying the immunizations the student has received.

(9) “For cause” means that the behavior of a student or instructor gives the health profession program or clinical site reason to believe that the individual is not complying with established standards set forth in these rules.

(10) “Health profession program” means a post-secondary course of study that concentrates on a health profession discipline as described in OAR 409-030-0130 and offers students instruction and training for becoming a health care professional.

(11) “Immunization” means receipt of any vaccine licensed by the United States Food and Drug Administration or the foreign equivalent for the prevention of a disease; proof of immunity to the disease via titer; or confirmed history of the disease.

(12) “Individually identifiable health information” has the meaning given that term in ORS 433.443.

(13) “Instructor” means a teacher, trainer, or advisor who is overseeing a student onsite during clinical training on behalf of the training program which the student attends. The degree of involvement of instructors in a student’s clinical training experience may vary between programs, and may include but is not limited to observation, demonstration of technique, modeling of behavior, and regular feedback.

(14) “Licensed independent practitioner” means an individual permitted by Oregon law to independently provide care and services, without direction or supervision, within the scope of the individual’s license.

(15) “Matriculated” means to be enrolled or registered for classes, as a student.

(16) “Patient” means an individual who is seeking care, guidance or treatment options at a clinical location.

(17) “School” or “educational institution” means the post-secondary college, university or other training program in which the student is matriculated for a health professions program.

(18) “Student” means an individual enrolled as a student or registered for a post-secondary school or training programs required minimum credit hours in an accredited health professions program of study.

(19) “Supervisor” means a staff member at a clinical facility who is delegated to provide supervision, to monitor student performance and to provide feedback to the student and the clinical educator and other educational training program faculty.

Stat. Auth.: ORS 413.435

Stats. Implemented: ORS 413.435

Hist.: OHP 8-2013, f. 9-30-13, cert. ef. 7-1-14; OHP 4-2015, f. & cert. ef. 7-1-15

409-030-0120

General applicability

(1) These rules apply to all students who:

(a) Plan to undergo clinical training at a setting listed in OAR 409-030-0140 within the state of Oregon; regardless of the location of the health profession program in which the student is matriculated;

(b) Concentrate on a health professional discipline listed in OAR 409-030-0130;

(c) Have direct contact with patients at any point during the clinical placement; and

(d) Are matriculated into and currently enrolled in a health professional training program as described in OAR 409-030-0130.

(2) Clinical sites may require instructors from the health profession program to satisfy the same requirements for immunizations, screenings, trainings, and other requirements set forth in these rules, if the instructor accompanies students onsite during clinical training and engages in direct contact with patients on behalf of or in support of the student.

(3) Except as provided in OAR 409-030-0150, covered clinical sites may not create additional or more stringent administrative requirements within the categories addressed by these rules for students and instructors covered by these rules.

Stat. Auth.: ORS 413.435

Stats. Implemented: ORS 413.435

Hist.: OHP 8-2013, f. 9-30-13, cert. ef. 7-1-14

409-030-0130

Health Professional Disciplines

(1) Except as provided in OAR 409-030-0150, these rules apply to students of the following health professions:

(a) Audiologists, as defined in ORS 681.205;

(b) Clinical laboratory science specialists, including medical technologists, clinical lab scientists, medical lab technologists, and clinical laboratory assistants, as defined in ORS 438.010;

(c) Dental hygienists, as defined in ORS 679.010;

(d) Dentists and dental assistants, as defined in ORS 679.010;

(e) Denturists, as defined in ORS 680.500;

(f) Dietitians, as defined in ORS 691.405;

(g) Emergency medical services providers, as defined in ORS 682.025;

(h) Hemodialysis technicians, as defined in ORS 688.635;

(i) Marriage and family therapists, as defined in ORS 675.705;

(j) Medical assistants (trained medical office and ancillary healthcare personnel who perform clinical tasks such as taking vital signs, preparing patients for examinations, or recording medical histories of patients, administrative duties, and other duties);

(k) Medical imaging practitioners and limited x-ray machine operators, as defined in ORS 688.405;

(l) Nurses, including registered nurses, practical nurses, advanced practice nurses, nurse practitioners, nursing assistants, medication aides and any other assistive nursing personnel licensed or certified under ORS 678.010 to 678.445;

(m) Occupational therapists and occupational therapy assistants, as defined in ORS 675.210;

(n) Optometrists, as described in ORS 683.010 to 683.310.

(o) Pharmacists and pharmacy technicians, as defined in ORS 689.005;

(p) Physical therapists, physical therapist aides, and physical therapist assistants, as defined in ORS 688.010;

(q) Physician assistants, as defined in ORS 677.495;

(r) Physicians (Medical/Osteopathic and Naturopathic), as defined in ORS 677.010 and 685.010;

(s) Podiatrists, as defined in ORS 677.805;

(t) Polysomnographic technologists, as defined in ORS 688.800;

(u) Professional counselors, as defined in ORS 675.705;

(v) Psychologists, as defined in ORS 675.010;

- (w) Regulated social workers, as defined in ORS 675.510;
- (x) Respiratory care practitioners, as defined in ORS 688.800;
- (y) Speech-language pathologists and speech-language pathologist assistants, as defined in ORS 681.205; and
- (z) Surgical technologists (allied health professionals under the supervision of a surgeon who are trained in advanced sterile techniques and theories and facilitate safety throughout the operative procedure);

(2) These rules do not apply to students engaged in a field of study that is not explicitly listed in section (1). Academic institutions and clinical placement settings should individually negotiate the terms of placement for students not covered by these rules. Clinical facilities may choose to require that such students follow the standards set forth in these rules but are not required to do so.

Stat. Auth.: ORS 413.435
Stats. Implemented: ORS 413.435
Hist.: OHP 8-2013, f. 9-30-13, cert. ef. 7-1-14

**409-030-0140
Clinical Settings**

(1) Except as provided in OAR 409-030-0140 section (2) and 409-030-0150, these rules apply to the following clinical facilities hosting health professions students in the disciplines described in OAR 409-030-0130:

- (a) Ambulatory care settings, including but not limited to clinics, private practices, Federally Qualified Health Centers, and primary care homes;
- (b) Ambulatory surgical centers, as defined in ORS 442.015;
- (c) Hospice, as defined in ORS 443.860;
- (d) Hospitals and emergency departments, as defined in ORS 442.015;
- (e) Long term care facilities, as defined in ORS 442.015;
- (f) Residential care facilities, as defined in ORS 443.400; and
- (g) Skilled nursing facilities, as defined in ORS 442.015.

(2) In addition to the exceptions provided in OAR 409-030-0150, these rules do not apply to the following clinical facilities hosting health professions students in the disciplines described in OAR 409-030-0130 for a clinical placement:

- (a) Chiropractic, acupuncture, and massage therapy clinics that are independent and not associated with a clinical placement setting listed in OAR 409-030-0140(1).
- (b) Federal facilities, including Department of Veterans' Affairs facilities, Indian Health Service facilities, and federal prisons. Standards for clinical placement in federal facilities are set at the federal level.
- (c) Health management or administration departments.
- (d) Public elementary and secondary schools (grades K-12).
- (e) Radiosurgery clinical placements. The Nuclear Regulatory Commission sets requirements for students involved in radiosurgery.

- (f) State prisons and correctional facilities.
 - (g) Oregon State Hospital.
- (3) Completion of the administrative requirements in these rules only ensures administrative clearance for students. Clinical placement settings shall make all final clearance and placement decisions.
- Stat. Auth.: ORS 413.435
Stats. Implemented: ORS 413.435
Hist.: OHP 8-2013, f. 9-30-13, cert. ef. 7-1-14; OHP 4-2015, f. & cert. ef. 7-1-15

**409-030-0150
Exceptions**

(1) In addition to the exceptions listed in OAR 409-030-0130(2) and 409-030-0140(2), the standards in these rules do not apply to:

- (a) Students who will not have direct patient contact as part of their clinical placement.
- (b) Students who are undergoing training overseen by their employer, academic institution, or training program at facilities that are located on the premises of or operated solely by the employer, academic institution or training program, or are otherwise considered "in-house" clinics.

(2) Clinical placement sites that have fewer or less stringent administrative requirements for newly hired non-student employees may request exemption from specific provisions of OAR 409-030-0170 through 409-030-0240 for students performing clinical placements at that site. For example, a clinical placement site that does not require regular employees to take a drug screen prior to being hired may request exemption from the section of these rules that require students to take a drug screen prior to being placed at that clinical site. However:

- (a) All exemptions must be documented with the Authority prior to implementation of the exemption; and
- (b) Clinical placement sites may only request exemptions from the specific category or section of these rules in which their requirements for newly-hired non student employees are less (such as immunizations, screenings, trainings or other listed in Table 1). Clinical placement sites with an exemption to a specific category of the administrative requirements must still comply with all other sections of these rules.

(3) Exemption requests may be submitted by:

- (a) Clinical placement sites; or
- (b) Educational institutions, on behalf of and in consultation with the clinical placement sites with which they contract and place students for clinical training.

(4) A request for exemption must include:

- (a) The name and mailing address of the clinical placement setting.
- (b) The supervisor or manager of student clinical placements on site, and email address and a phone number.

(c) A request for exemption from a specific section of the rules, that includes a description of the clinical placement setting's requirements for newly hired non-student employees, and how they differ from the requirements set forth in these rules.

(5) Clinical placement settings may temporarily institute a site-specific variation or change to a requirement listed in OAR 409-030-0170 through 409-030-0240 in extenuating circumstances including but not limited to a public health emergency situation, such as an outbreak that requires new or different vaccination or a safety breach that requires immediate action, provided that the clinical placement setting clearly notifies all affected parties and the Authority in advance of the changes.

(6) Once instituted, a change or variation of these rule requirements may remain in place at the clinical training placement setting until the next annual review of the rules, at which point the Authority shall decide if:

(a) The change or variation is one mandated by a federal or state regulatory agency and will therefore be incorporated into these rules for all affected clinical placement settings and health profession students; or

(b) The change or variation would improve student and patient safety significantly and should be applied widely to clinical placement settings and health profession students in the state of Oregon, through an amendment to these rules; or

(c) The change or variation is not appropriate for widespread application to clinical placement settings and health professions students in the state of Oregon. In this case, the change or variation may not be re-instated by the clinical placement site after the annual review of the rules.

[ED. NOTE: Tables referenced can be obtained from the agency]

Stat. Auth.: ORS 413.435
Stats. Implemented: ORS 413.435
Hist.: OHP 8-2013, f. 9-30-13, cert. ef. 7-1-14; OHP 4-2015, f. & cert. ef. 7-1-15

**409-030-0160
Regular Review of Clinical Placement Standards**

(1) The Authority shall convene an advisory group that may include representatives of affected students, health profession programs, clinical settings, and healthcare boards that regulate health profession programs. The Authority and the advisory group shall review the standards set forth in sections OAR 409-030-0170 through 409-030-0240 of these rules annually. Affected parties may bring proposed changes to the annual review process.

(2) Standards for immunizations are based on the CDC Advisory Committee on Immunization Practices guidance and other state and federal regulatory bodies overseeing immunization and vaccinations. Rules shall be updated as needed to remain in compliance with suggested vaccination schedules and other recommendations from these regulatory bodies related to the applicable immunizations and screenings listed in Table 1.

(3) State and nationwide criminal background check standards are based on rules determined by authorized state and federal regulatory bodies, including but not limited to the Joint Commission.

[ED. NOTE: Tables referenced can be obtained from the agency]

Stat. Auth.: ORS 413.435

Stats. Implemented: ORS 413.435

Hist.: OHP 8-2013, f. 9-30-13, cert. ef. 7-1-14; OHP 4-2015, f. & cert. ef. 7-1-15

409-030-0170

Administrative Requirements for Clinical Placement

(1) To qualify for a clinical placement at a covered site within the state of Oregon, covered students must satisfy requirements for each of the following categories prior to the start of the intended placement period. See Table 1 for an expanded list relating to:

- (a) Immunizations;
- (b) Screenings;
- (c) Trainings; and
- (d) Evidence of coverage for professional liability and general liability.

(2) Health profession programs and clinical placement settings are not required to pay for or otherwise administer any screenings or tests listed in these rules.

(3) Health profession programs must verify and retain evidence demonstrating that a student has completed all requirements listed in these rules prior to starting a placement for the student at a clinical setting. The health profession program shall provide evidence of completed requirements to clinical sites, as requested.

[ED. NOTE: Tables referenced can be obtained from the agency]

Stat. Auth.: ORS 413.435

Stats. Implemented: ORS 413.435

Hist.: OHP 8-2013, f. 9-30-13, cert. ef. 7-1-14; OHP 4-2015, f. & cert. ef. 7-1-15

409-030-0180

Immunization Standards

(1) Table 1 lists the diseases and the corresponding required immunizations that students must have in order to receive a clinical placement or the immunizations that students are recommended to have but that are not required in order to receive a clinical placement.

(2) Evidence of immunization may be demonstrated through the following:

(a) A document appropriately signed or officially stamped and dated by a qualified medical professional or an authorized representative of the local health department, which must include the following:

(A) The month and year of each dose of each vaccine received; or

(B) Documentation of proof of immunity to the disease via titer; or

(C) Written documentation by a qualified medical professional indicating the month and year the diagnosis of the disease was confirmed.

(b) An official record from the Oregon ALERT Immunization Information System.

(3) Individual student medical exemptions from specific immunizations must be maintained by health profession programs as part of the overall record of the student. Documentation for exemption requires a written statement of exemption signed by a qualified medical professional. Non-medical exemptions from immunizations are not allowed.

[ED. NOTE: Tables referenced can be obtained from the agency]

Stat. Auth.: ORS 413.435

Stats. Implemented: ORS 413.435

Hist.: OHP 8-2013, f. 9-30-13, cert. ef. 7-1-14; OHP 4-2015, f. & cert. ef. 7-1-15

409-030-0190

Screening Standards

Table 1 provides detailed information related to required screenings for students' clinical placements. Required screenings consist of:

- (1) Tuberculosis (OAR 409-030-0200);
- (2) Substance abuse or misuse (OAR 409-030-0210); and
- (3) State and nationwide criminal background check (OAR 409-030-0220).

[ED. NOTE: Tables referenced can be obtained from the agency]

Stat. Auth.: ORS 413.435

Stats. Implemented: ORS 413.435

Hist.: OHP 8-2013, f. 9-30-13, cert. ef. 7-1-14; OHP 4-2015, f. & cert. ef. 7-1-15

409-030-0200

Tuberculosis Screening

(1) A student must obtain and provide documentation for TB screening consistent with the requirements for immunization in OAR 409-030-0180.

(2) TB screening must be conducted in a manner consistent with the CDC guidelines available at <http://www.cdc.gov/tb/topic/testing/> or other state or federal health authority guidelines prior to the start date of the initial clinical placement.

Stat. Auth.: ORS 413.435

Stats. Implemented: ORS 413.435

Hist.: OHP 8-2013, f. 9-30-13, cert. ef. 7-1-14

409-030-0210

Drug Testing for Substance Abuse and Misuse

(1) A student must undergo a drug test prior to the start date of initial placement at a covered clinical setting. Drug testing must take place prior to initial placement, but no more than three months before entry into the health profession training program requiring clinical training experience. A drug test is considered current while the student is enrolled and progressing in the health profession training program. Subsequent drug tests may not be required except for cause, or at re-entry into a program from which the student has taken leave or fallen out of progression. These rules do not aim to define an "acceptable" result to a drug screen. These rules ensure completion of the administrative requirements necessary for administrative clearance for students. Clinical placement settings shall make all final clearance and placement decisions.

(2) At a minimum, a covered student seeking a clinical placement at a covered clinical site must undergo a standard 10-panel drug test and must sign any necessary authorizations. Screens for the following eight substances must be included in the 10-panel drug screen:

- (a) Amphetamines (including methamphetamines);
- (b) Barbiturates;
- (c) Benzodiazepines;
- (d) Cocaine;
- (e) Marijuana;
- (f) Methadone;
- (g) Opiates; and
- (h) Phencyclidine.

(3) All drug testing must be conducted by a laboratory licensed and operated in accordance with ORS 438.010 and OAR 333-024-0305 through 333-024-0350. The health profession program must verify that screening is performed by a reputable vendor.

Stat. Auth.: ORS 413.435

Stats. Implemented: ORS 413.435

Hist.: OHP 8-2013, f. 9-30-13, cert. ef. 7-1-14; OHP 4-2015, f. & cert. ef. 7-1-15

409-030-0220

State and Nationwide Criminal Background Checks

(1) Students must undergo a state and nationwide criminal background check in advance of the start of their initial clinical placements, but no more than three months before entry into the health profession training program requiring clinical training experience. A criminal background check is considered current while

the student is enrolled and progressing in the health profession training program. Subsequent criminal background checks may not be required except for cause, or at re-entry into a program from which the student has taken leave or fallen out of progression.

(2) These rules do not aim to establish or define the composition of an “acceptable” result to a state and nationwide criminal background check. These rules ensure completion of the administrative requirements necessary for administrative clearance for students. Clinical placement settings shall make all final clearance and placement.

(3) State and nationwide criminal background checks must be:

(a) Performed by a vendor that is accredited by the National Association of Professional Background Screeners (NAPBS); or

(b) Performed by a vendor that meets the following criteria:

(A) Has been in the business of criminal background checks for at least two years;

(B) Has a current business license and private investigator license, if required in the company’s home state; and

(C) Maintains an errors and omissions insurance policy in an amount not less than \$1 million; or

(c) Conducted through an Oregon health professional licensing board, if required for students by such Board. (For example students of pharmacy are required by the Oregon Board of Pharmacy to obtain an intern license prior to engaging in clinical training and must undergo a national fingerprint-based background check.)

(4) A criminal records check must include the following:

(a) Name and address history trace;

(b) Verification that the students’ records have been correctly identified, using date of birth and a Social Security number trace;

(c) A local criminal records check, including city and county records for the student’s places of residence for the last seven years;

(d) A nationwide multijurisdictional criminal database search, including state and federal records;

(e) A nationwide sex offender registry search;

(f) A query with the Office of the Inspector General’s List of Excluded Individuals/Entities (LEIE);

(g) The name and contact information of the vendor who completed the records check;

(h) Arrest, warrant and conviction data, including but not limited to:

(A) Charges;

(B) Jurisdictions; and

(C) Date.

(i) Sources for data included in the report.

Stat. Auth.: ORS 413.435

Stats. Implemented: ORS 413.435

Hist.: OHP 8-2013, f. 9-30-13, cert. ef. 7-1-14; OHP 4-2015, f. & cert. ef. 7-1-15

**409-030-0230
Training Standards**

(1) Students must complete all listed trainings in advance of the start date of the students’ initial clinical placement. See Table 1 for additional descriptions and recommended training resources.

(2) Students must complete the following steps for trainings that require certification:

(a) Complete an in-person training program in cardiopulmonary resuscitation (CPR), also known as Basic Life Support (BLS), at the healthcare provider level. On-line training will not meet this requirement. Training programs for CPR/BLS must include the following components:

(A) 1-Rescuer CPR and AED for adult, child and infant;

(B) 2-Rescuer CPR and AED for adult, child and infant;

(C) Differences between adult, child and infant rescue techniques;

(D) Bag-mask techniques for adult, child and infant;

(E) Rescue breathing for adult, child and infant;

(F) Relief of choking for adult, child and infant;

(G) CPR with an advanced airway; and

(H) Skills testing.

(b) Provide verified documentation as to the successful completion of CPR/BLS training, and

(c) Maintain current certification for CPR/BLS during the clinical placement.

(3) Health profession programs must provide documentation or a signed statement that the student has received prior training, taken educational courses, or is otherwise familiar with the following:

(a) The Health Insurance Portability and Accountability Act (HIPAA)

(b) Bloodborne Pathogen training that is compliant with the federal Occupational Safety and Health Administration (OSHA) requirements.

(c) Federal OSHA recommended safety guidelines, including:

(A) Fire and electrical safety;

(B) Personal protective equipment;

(C) Hazard communications; and

(D) Infection prevention practices.

(4) Health profession programs shall provide documentation of completed trainings, as requested by clinical sites.

(5) Clinical sites may require students to complete additional site-specific trainings or on-boarding procedures, including:

(a) Site-specific privacy and confidentiality trainings.

(b) Site-specific orientation trainings and on-boarding procedures, such as facility-specific protocols for safety, security, documentation systems, and standards of behavior or signing a non-disclosure statement.

[ED. NOTE: Tables referenced can be obtained from the agency]

Stat. Auth.: ORS 413.435

Stats. Implemented: ORS 413.435

Hist.: OHP 8-2013, f. 9-30-13, cert. ef. 7-1-14; OHP 4-2015, f. & cert. ef. 7-1-15

**409-030-0240
Insurance and Liability Coverage**

(1) Prior to clinical training, students or health profession programs must demonstrate that students have one of the following types of coverage and that the coverage will remain in place for the entire duration of each placement:

(a) Professional liability insurance coverage, and

(b) General liability insurance coverage; or

(c) Coverage under a combined policy for professional and general liability insurance.

(2) A health profession program may offer coverage for students through a self-insurance program or the student may obtain coverage individually.

(3) Health profession programs shall maintain records related to insurance and provide them to clinical sites, as requested.

(4) Prior to clinical placement, it is recommended but not required that students obtain some form of health insurance coverage, such as personal major medical insurance or Workers’ Compensation insurance provided by the health profession program, and that the coverage remain in place for the entire duration of each placement.

Stat. Auth.: ORS 413.435

Stats. Implemented: ORS 413.435

Hist.: OHP 8-2013, f. 9-30-13, cert. ef. 7-1-14

**409-030-0250
Information Sharing or Use of Data**

(1) Only clinical sites that have a contractual agreement with a student’s training program may access the documentation and evidence related to completion of the administrative requirements.

(2) Students must provide written, signed permission that explicitly allows the sharing of required documents and necessary evidence with clinical sites, including but not limited to any release required under HIPAA or other applicable laws in order to disseminate the student’s personal health information under these rules.

(3) Dissemination of information received under these rules may only be made to individuals with a demonstrated and legitimate need to know the information.

Stat. Auth.: ORS 413.435

Stats. Implemented: ORS 413.435
Hist.: OHP 8-2013, f. 9-30-13, cert. ef. 7-1-14

DIVISION 35

PHYSICIAN VISA WAIVER PROGRAM

409-035-0000

Purpose of the Physician Visa Waiver Program

The purpose of the Physician Visa Waiver program is to make recommendations to the United States Department of State for waivers of the foreign country residency requirement on behalf of physicians holding visas who seek employment in federally designated areas having a shortage of physicians. These rules set forth the requirements for Oregon to make requests for waiver of the foreign country residency requirement as authorized under 8 U.S.C. secs. 1182(e) and 1184(l).

Stat. Auth.: ORS 413.248
Stats. Implemented: ORS 413.248
Hist.: PH 14-2003(Temp), f. 9-25-03 cert. ef. 10-1-03 thru 3-29-04; PH 11-2004, f. 3-25-04, cert. ef. 3-29-04; Renumbered from 333-005-0000 by OHP 7-2010, f. 12-29-10, cert. ef. 1-1-11

409-035-0010

Definitions

For the purposes of this Division, the following definitions apply:

- (1) "Application" means the Physician Visa Waiver Program application form and accompanying documentation.
- (2) "Authority" means the Oregon Health Authority.
- (3) "Department of State" means the federal agency that reviews J-1 applications.
- (4) "Flex Option" means the placement of a physician in an area that is not federally designated, who will serve patients living in designated shortage areas.
- (5) "Health Care Facility" means the clinic or hospital that employs the J-1 physician.
- (6) "Health Services and Resources Administration" (HRSA) means the branch of the Department of Health and Human Services that designates federal shortage areas.
- (7) "Health Care Shortage Area" means a geographic area or site approved by HRSA. Categories include Health Professional Shortage area (HPSA), Medically Underserved Area (MUA), and Medically Underserved Population (MUP).
- (8) "J-1 Application" refers to the application form and supporting material submitted jointly by the health care facility and the J-1 physician to the Authority.
- (9) "J-1 Physician" means allopathic or osteopathic physician who is requesting a waiver of the two-year foreign country residency requirement in order to practice in a facility that is either located in a federally designated shortage area or serves patients living in designated shortage areas.
- (10) "Low Income" means a patient whose income does not exceed 200% of the current Federal Poverty Guidelines (see: <http://aspe.hhs.gov/poverty>).
- (11) "Mental Health Facility" means an agency that provides mental health services in an outpatient, residential, or hospital setting.
- (12) "Primary Care Physician" means a physician licensed in Oregon to practice family medicine, general internal medicine, obstetrics and gynecology, pediatrics, or general psychiatry.
- (13) "United States Citizenship and Immigration Services" means the agency that replaced the Immigration and Naturalization Service, effective March 1, 2003.

Stat. Auth.: ORS 413.248
Stats. Implemented: ORS 413.248
Hist.: PH 14-2003(Temp), f. 9-25-03 cert. ef. 10-1-03 thru 3-29-04; PH 11-2004, f. 3-25-04, cert. ef. 3-29-04; Renumbered from 333-005-0010 by OHP 7-2010, f. 12-29-10, cert. ef. 1-1-11

409-035-0020

Health Care Facility Participation Requirements

- (1) Federally Qualified Health Centers with a:

(a) HPSA score at or above the requirements of 22 CFR 41.63 shall apply for a J-1 Waiver either through the Authority or through the United State Department of Health and Human Services (see: <http://www.globalhealth.gov/global-programs-and-initiatives/exchange-visitor-program>);

(b) HPSA score below the requirements of 22 CFR 41.63 shall apply for a J-1 Waiver through the Authority.

(2) If a health care facility is located in a Medically Underserved Area (MUA) or Medically Underserved Population (MUP) that is not a Health Professional Shortage Area (HPSA) or if the request is for a flex option, then the facility must obtain prior approval from the Authority and provide documentation substantiating the area's need for a physician.

(3) In order to qualify for the Oregon Physician Visa Waiver Program the health care facility must:

(a) Identify the nature of the business entity seeking to employ the physician, including but not limited to domestic or foreign professional corporation, domestic or foreign private corporation, LLC, or partnership, and provide a certificate of existence or proof of authorization to do business in Oregon;

(b) Have provided care for a minimum of six months in Oregon, or supply evidence of stability such as HRSA funding, prior to submitting an application;

(c) Currently serve Medicare, Medicaid, and low income uninsured patients that are members of the population of the local HRSA designation.

(A) At least 40 percent of patients must be Medicaid, Medicare or other low income patients.

(B) Medicaid patients must represent a share of the overall facility's patient population equal to or greater than the statewide percentage of the population eligible for Medicaid at the beginning of each program year as determined by the Authority. If the facility does not serve that percentage, it must provide a plan to achieve that level of service for review and approval by the Authority. Plans that do not outline a strategy to achieve the required level of service within the provider's first year will not typically be approved, but the Authority will consider additional information provided by the facility when making a final decision.

(d) Post a sliding fee schedule in the primary languages of the population being served;

(e) Document attempts to actively recruit an American doctor for at least six months prior to submission of the application;

(f) Execute an employment contract with the physician that includes the following provisions:

- (A) Duration of at least three years;
- (B) Wages and working conditions comparable to those for a graduate from an American medical school;
- (C) A signed U.S. Department of Labor Prevailing Wage Form (ETA-9035);
- (D) May not include a non-compete clause or restrictive covenant that prevents or discourages the physician from continuing to practice in any designated area after the term of the contract expires;

(E) Specifies the geographic shortage area within Oregon in which the physician will practice or, if requesting a flex option, the shortage area or areas where prospective patients live;

(F) The physician shall treat all patients regardless of their ability to pay; and

(G) The physician shall provide patient care on a full-time basis a minimum of 40 hours per week.

(4) The health care facility shall submit to the Authority a fee of \$2,000 and two original copies of the application packet for each waiver requested.

Stat. Auth.: ORS 413.248
Stats. Implemented: ORS 413.248
Hist.: PH 14-2003(Temp), f. 9-25-03 cert. ef. 10-1-03 thru 3-29-04; PH 11-2004, f. 3-25-04, cert. ef. 3-29-04; Renumbered from 333-005-0020 by OHP 7-2010, f. 12-29-10, cert. ef. 1-1-11; OHP 3-2013, f. 1-24-13, cert. ef. 2-1-13; OHP 1-2015, f. 1-15-15, cert. ef. 2-1-15; OHP 6-2015(Temp), f. & cert. ef. 2-22-15 thru 3-1-16; OHP 9-2015, f. & cert. ef. 11-24-15; OHP 6-2016, f. & cert. ef. 4-22-16

409-035-0030

Physician Participation Requirements

In order to qualify for consideration by this program the physician must:

- (1) Obtain a Department of State case number prior to submitting an application to the Authority;
- (2) Submit a completed application that:
 - (a) Documents having, or having applied for, an active Oregon medical license. If the residency or fellowship is not completed, the license application may be listed as “pending”;
 - (b) Documents board certification or, if the residency or fellowship is not yet completed, board eligibility upon completion of the program;
 - (c) Includes either a “No Objection” letter from the home country, or a statement that the physician is not contractually obligated to return to the home country.
 - (d) Includes a signed and dated statement certifying that the physician does not have any other pending J-1 waiver requests;
 - (e) Provides a letter of recommendation from the department head of the physician’s residency or fellowship program;
 - (f) Includes evidence of graduation or of the projected date of graduation from the residency or fellowship program.
 - (g) Documents an agreement to begin employment with the health care facility within 90 days from the date the waiver is granted;
 - (h) Includes a copy of the medical degree or diploma, translated into English;
 - (i) Includes legible copies of all DS 2019 Forms;
 - (j) Documents satisfactory completion of all examinations required by the United States Citizenship and Immigration Services;
 - (k) Includes a curriculum vita that documents the physician’s date of birth, city and country of birth.

Stat. Auth.: ORS 413.248

Stats. Implemented: ORS 413.248

Hist.: PH 14-2003(Temp), f. 9-25-03 cert. ef. 10-1-03 thru 3-29-04; PH 11-2004, f. 3-25-04, cert. ef. 3-29-04; Renumbered from 333-005-0030 by OHP 7-2010, f. 12-29-10, cert. ef. 1-1-11

409-035-0040

Application Review Process

- (1) The Authority shall review completed health care facility applications that meet all requirements of 409-035-0020. Potential physician participants must meet all requirements set forth in 409-035-0030.
- (2) The following factors shall be considered in determining whether to recommend a request for waiver of the foreign country residency requirement:
 - (a) The type of medicine to be practiced. Eighty percent of the slots allotted for each federal fiscal year are reserved for primary care physicians as defined in OAR 409-035-0010. Applications from community health centers with HPSA scores below 7 and from mental health facilities shall receive priority.
 - (b) Geographic distribution of physicians. To the extent possible, the Authority shall attempt equitable distribution of waiver requests for eligible areas of the state. The number of physicians already working under waivers or recommended for waivers in a particular geographic area shall be taken into consideration.
 - (c) Distribution of physicians among employers. The Authority may limit the number of slots to six per employer (as defined by EIN) in a program year.
 - (d) Facility patient profile. The health care facility’s percentage of patient visits which are covered by the state Medicaid program, Medicare, or are low income, uninsured.
- (3) The Authority shall return incomplete applications, including application fees. The Authority shall process completed resubmitted applications, including fees, as of the new date of receipt.
- (4) The Authority shall review each completed application and notify the applicant of the results within 15 business days.
- (5) The Authority shall forward the recommended waiver requests to the Department of State. The Department of State shall forward waiver requests recommended for approval to the United

States Citizenship and Immigration Services, which shall determine whether to issue or deny the waiver.

- (6) The Authority may re-allocate positions based on a review of current access needs in the state. The Authority may also recommend or decline to recommend a waiver request.

Stat. Auth.: ORS 413.248

Stats. Implemented: ORS 413.248

Hist.: PH 14-2003(Temp), f. 9-25-03 cert. ef. 10-1-03 thru 3-29-04; PH 11-2004, f. 3-25-04, cert. ef. 3-29-04; Renumbered from 333-005-0040 by OHP 7-2010, f. 12-29-10, cert. ef. 1-1-11; OHP 1-2015, f. 1-15-15, cert. ef. 2-1-15

409-035-0050

Monitoring and Follow-up Requirements

In order to maintain participation in the Physician Visa Waiver Program the health care facility must:

- (1) Notify the Authority in writing as soon as the physician starts work;
- (2) Promptly submit semi-annual reports signed by the physician and the Chief Executive Officer of the health care facility verifying the physician’s employment. The first report is due six months after employment begins, and every six months thereafter, until the term of the contract is complete. Failure to submit timely, accurate reports shall result in a report of non-compliance to the United States Citizenship and Immigration Services.
- (3) Notify the Authority immediately of any change or prospective change in the physician’s employment status.
- (4) Allow Authority auditors access to health care facility and physician records.

Stat. Auth.: ORS 413.248

Stats. Implemented: ORS 413.248

Hist.: PH 14-2003(Temp), f. 9-25-03 cert. ef. 10-1-03 thru 3-29-04; PH 11-2004, f. 3-25-04, cert. ef. 3-29-04; Renumbered from 333-005-0050 by OHP 7-2010, f. 12-29-10, cert. ef. 1-1-11

409-035-0060

Transfer of J-1 Waiver Physician Obligation

- (1) A physician who is granted a visa waiver and who encounters a practice failure due to extenuating circumstances may, with Authority approval, finish the three-year service obligation at another approved health care facility. A written transfer request must be submitted to the Authority documenting the need for the transfer.
 - (2) The request must include the reason for transfer, proposed new employer, the health care facility director’s name, practice name, address, telephone number, and proposed date of transfer.
 - (3) The original employer must provide a letter releasing the physician from the employment contract and providing an explanation for the termination. The Authority may waive this requirement if the original employer is in non-compliance with federal requirements, federal or state law, or with these rules.
 - (4) The new employer must:
 - (a) Provide a letter of intent to employ the physician;
 - (b) Provide a copy of the new employment contract;
 - (c) Meet health care facility participation requirements as set forth in these rules;
 - (d) Work with the physician to jointly submit semi-annual Verification of Employment forms as required by the Authority.

Stat. Auth.: ORS 413.248

Stats. Implemented: ORS 413.248

Hist.: PH 14-2003(Temp), f. 9-25-03 cert. ef. 10-1-03 thru 3-29-04; PH 11-2004, f. 3-25-04, cert. ef. 3-29-04; Renumbered from 333-005-0060 by OHP 7-2010, f. 12-29-10, cert. ef. 1-1-11

DIVISION 37

MEDICAID PRIMARY CARE LOAN REPAYMENT PROGRAM

409-037-0000

Purpose

The Medicaid Primary Care Loan Repayment Program (Program) is established in the Oregon Health Authority. The purpose of the Program is to provide loan repayment supports to primary care providers who commit to serving Medicaid patients in under-

served areas of the State. The Program supports the Affordable Care Act and Oregon’s health system transformation efforts to ensure an adequate supply of primary care providers.

Stat. Auth.: 2013 OL Ch. 177
 Stats. Implemented: 2013 OL Ch. 177
 Hist.: OHP 7-2013, f. & cert. ef. 9-4-13

409-037-0010

Definitions

The following definitions apply to OAR 409-037-0000 through 409-037-0080:

- (1) “Authority” means the Oregon Health Authority.
- (2) “Clinical Psychologist” means an individual licensed to practice psychology pursuant to ORS 675.010 to 675.090.
- (3) “Clinical Social Worker” means an individual licensed to practice clinical social work pursuant to ORS 675.510 to 675.600.
- (4) “Dentist” means any individual licensed to practice dentistry pursuant to ORS Chapter 679.
- (5) “Eligible provider” means a practitioner in Oregon delivering health care services to patients in Oregon, who meets the provider participation requirements of OAR 409-037-0030 and who is:
 - (a) A dentist in general or pediatric practice;
 - (b) An expanded practice dental hygienist;
 - (c) A physician who practices or intends to practice in the specialties of family medicine, general practice, general internal medicine, geriatrics, pediatrics, or obstetrics and gynecology;
 - (d) A nurse practitioner who practices or intends to practice in the specialties of adult health, women’s health care; geriatrics; pediatrics; psychiatric mental health; family practice, or nurse midwifery;
 - (e) A physician assistant who practices or intends to practice in the specialties of family medicine, general practice, general internal medicine, geriatrics, pediatrics or obstetrics and gynecology;
 - (f) A general, child and adolescent, or geriatric psychiatrist;
 - (g) A clinical psychologist;
 - (h) A clinical social worker; or
 - (i) A Marriage or Family Therapist.
- (6) “Expanded Practice Hygienist” means an individual licensed to practice dental hygiene with an expanded practice dental hygienist permit issued under ORS 680.200.
- (7) “Marriage and Family Therapist or Professional Counselor” has the meaning given that term in ORS 675.715 to 675.745.
- (8) “Nurse Practitioner” means any individual licensed pursuant to ORS 678.375.
- (9) “Physician” means any individual licensed pursuant to ORS 677.100 to 677.228.
- (10) “Physician Assistant” means any individual licensed pursuant to ORS 677.495 to 677.545.
- (11) “Practice full-time” means working at least 40 hours per week, with a minimum of 32 hours per week spent providing direct patient care, averaged over the month for a minimum of 45 weeks per service year. Patient charting is considered a component of offering direct patient care. Telemedicine may be considered direct patient care when both the originating site (location of the patient) and the distant site (the eligible site where the provider works) are located in Oregon.
- (12) “Practice part-time” means working at least 20 hours per week, with a minimum of 16 hours per week spent providing direct patient care, averaged over the month for a minimum of 45 weeks per service year. Patient charting is considered a component of offering direct patient care. Telemedicine may be considered direct patient care when both the originating site (location of the patient) and the distant site (the eligible site where the provider works) are located in Oregon.
- (13) “Qualifying Loan” means one or more government or commercial loans received solely to cover the cost of post-baccalaureate health professional training, or, in the case of an expanded practice dental hygienist, undergraduate educational training. This does not include credit card loans, lines of credit, and personal loans.

(14) “Qualifying practice site” means:

- (a) A rural hospital as defined in ORS 442.470;
- (b) A federally certified Rural Health Clinic;
- (c) A Federally Qualified Community Health Center;
- (d) A site providing primary care services in an area approved as a medical, dental or mental Health Professional Shortage Area (HPSA) as defined by the federal Health Resources and Services Administration; or
- (e) Another site providing primary care services to an underserved population, as determined by the Authority.

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

Stat. Auth.: 2013 OL Ch. 177
 Stats. Implemented: 2013 OL Ch. 177
 Hist.: OHP 7-2013, f. & cert. ef. 9-4-13

409-037-0020

Participation and Application Requirements

- (1) Program participants must agree to serve Medicaid patients in the same approximate proportion of such patients in the county or other service area, up to a maximum requirement of 15 percent of patient mix.
- (2) Program participants must commit to practice either:
 - (a) Full-time in a qualifying practice site for at least three years. Full-time participants may request, and the Authority may extend the service period to a total of five years, depending on available funds; or
 - (b) Part-time in a qualifying practice site for at least five years. Part-time participants may request, and the Authority may extend the service period to a total of seven years, depending on the available funds.
- (3) To qualify for consideration in the Program, a primary care provider must submit an application that:
 - (a) Documents the individual having, or having applied for, an unrestricted license to practice in Oregon within their discipline;
 - (b) Includes a signed and dated statement certifying that the individual is not currently participating in the National Health Services Corps (NHSC), Nursing Corps, or State Loan Repayment Programs or the NHSC Scholarship Program; or
 - (c) Documents the individual having:
 - (A) An employment contract with a qualifying practice site that began within the previous 24 months or an agreement to begin practice with a qualifying practice site within 120 days from the date of the application, or
 - (B) A sole proprietorship, Limited Liability Corporation, Limited Liability Partnership, or Professional Corporation for the purpose of providing health care that meets the definition of a qualifying practice site and that was established within the previous 24 months or will be established with 120 days from the date of application.
 - (d) Attests that the individual is willing to make a service commitment of at least three years work in a qualifying practice site, during which time the individual agrees to serve Medicaid patients in the same approximate proportion of the patients in the county or other service area, up to a maximum of 15 percent of patient mix; and
 - (e) Provides all other information required by the Program.
- (4) To make a primary care provider’s application complete, the sole proprietor or the qualifying practice site at which the provider works or intends to work must submit a letter of support attesting that the site meets the definition set out in OAR 409-037-0010 (14) and providing other information as requested by the Authority.

Stat. Auth.: 2013 OL Ch. 177
 Stats. Implemented: 2013 OL Ch. 177
 Hist.: OHP 7-2013, f. & cert. ef. 9-4-13

409-037-0030

Application and Review Process

- (1) As of the effective date of the filing of this proposed rule, the Program is still developing application processes. When the Authority has finalized the process, the Authority shall provide

application format and submission requirements at the Program website.

(2) The Authority shall review completed applications that meet all requirements of OAR 409-037-0020.

(a) The Authority shall return incomplete applications. Completed resubmitted applications shall be processed as of the new date of receipt.

(b) The Authority shall notify applicants of the status of their completed applications within 60 days of application submission.

(3) The following factors may be considered in determining whether to accept an eligible provider for participation in the program, including but not limited to:

(a) Provider type. Providers who may be counted as primary care medical, dental, or mental health providers for federal HPSA designations may be given priority consideration for Program participation.

(b) Determined need of the area. The Authority may prioritize applications from providers who apply to practice at a qualifying practice site with a HPSA score of 10 or higher, or that serves an area or special population with a HPSA score of 10 or higher. The Authority may also prioritize provider applications based on the number of new Medicaid eligibles in the area served by the qualifying practice site as of January 1, 2014.

(c) PCPCH status. The Authority may award priority to eligible providers who will provide services in, or in affiliation with, a Patient Centered Primary Care Home (PCPCH) recognized by the State of Oregon.

(d) Duration of time in practice site, or in Oregon. Priority may be given to providers based on the duration of time they have spent at their practice site or in the state, with a priority for new providers. No more than 20 percent of all awards shall be made to providers already practicing at a qualified practice site.

Stat. Auth.: 2013 OL Ch. 177
Stats. Implemented: 2013 OL Ch. 177
Hist.: OHP 7-2013, f. & cert. ef. 9-4-13

409-037-0040

Maximum Award Amounts

Program participants are eligible for a maximum loan repayment award of:

(1) Twenty percent of the balance owed on qualifying loans upon program entry, up to an annual maximum amount of \$35,000 for each year of full-time service.

(2) Ten percent of the balance owed on qualifying loans upon program entry, up to an annual maximum amount of \$17,500 for each year of part-time service.

Stat. Auth.: 2013 OL Ch. 177
Stats. Implemented: 2013 OL Ch. 177
Hist.: OHP 7-2013, f. & cert. ef. 9-4-13

409-037-0050

Transfer of Medicaid Loan Repayment Provider Service Obligation

(1) In the event of a practice failure or other extenuating circumstance, a participating provider may, with Authority approval, transfer his or her service obligation to another qualifying practice site. A written transfer request must be submitted to the Authority documenting the:

- (a) Need or reason for the transfer;
- (b) Proposed new qualifying practice site; and
- (c) The name of the director at the proposed new practice site.

(2) Along with the written transfer request, the participating provider must submit:

(a) A letter from the original practice site releasing the eligible provider from any employment contract (if applicable) and providing an explanation for the termination of employment. The Authority may waive this requirement if the original practice site is in non-compliance with federal requirements, federal or state law, or these rules.

(b) An employment contract with the new qualifying practice site, a letter of intent from the new qualifying practice site to employ the provider, or documentation of the provider having established a sole proprietorship, Limited Liability Corporation,

Limited Liability Partnership, or Professional Corporation that meets the definition of a qualifying practice site.

(3) The new practice site, in collaboration with the provider, must:

(a) Submit a letter of support documenting the site meets the definition in OAR 409-037-0010 (14) and providing other information as requested by the Authority.

(b) Provide confirmation that the site will cooperate with the provider to comply with the monitoring and follow-up requirements set forth in these rules.

Stat. Auth.: 2013 OL Ch. 177
Stats. Implemented: 2013 OL Ch. 177
Hist.: OHP 7-2013, f. & cert. ef. 9-4-13

409-037-0060

Suspension or Waiver of Minimum Service Obligation

(1) The Authority may agree to suspend a participating provider's service obligation under circumstances it deems appropriate, including, but not limited to parental leave, medical leave, military service leave, or other factors beyond a provider's control. During the time of suspension, awards are also suspended.

(2) A participant requesting a suspension of minimum service obligation shall make a written request to the Authority, citing the reasons and providing documentation of the circumstances.

(3) The Authority may waive all or part of the minimum service obligation under the following circumstances:

(a) Upon receipt of written documentation acceptable to the Authority of the death of the participant;

(b) Upon receipt of written documentation acceptable to the Authority of the total and permanent disability of the participant; or

(c) Upon receipt of documentation of other significant changes in life circumstances that are out of the control of the participant and that the Authority determines warrant a waiver of service commitment.

(4) If all or part of the minimum service obligation is waived, the Authority may not impose any penalty for failure to meet the obligation.

Stat. Auth.: 2013 OL Ch. 177
Stats. Implemented: 2013 OL Ch. 177
Hist.: OHP 7-2013, f. & cert. ef. 9-4-13

409-037-0070

Failure to Comply; Penalties

(1) A participant who fails to complete the minimum service obligation in a qualifying practice site and does not receive a waiver shall be considered to have breached the terms of the loan repayment program. The Authority shall impose a penalty on any such provider in an amount up to the sum of:

(a) The total paid on behalf of the participant for loan repayments for any periods of obligated service not served;

(b) \$7,500 for each month of the minimum service period not completed according to the terms of the obligation; and

(c) Interest on the above amounts at the maximum prevailing rate, as determined by the Oregon Department of Revenue, calculated from the date of breach until full repayment has been made.

(2) Any amount determined to be due under this section shall be collected by the Collections Unit in the Oregon Department of Revenue under ORS 293.250.

(3) A participant may appeal decisions made by the Authority under the provisions of ORS Chapter 183.

Stat. Auth.: 2013 OL Ch. 177
Stats. Implemented: 2013 OL Ch. 177
Hist.: OHP 7-2013, f. & cert. ef. 9-4-13

409-037-0080

Monitoring and Follow-up Requirements

To maintain participation in the Program, an eligible provider must:

(1) Notify the Authority immediately upon beginning work at a qualifying practice site.

(2) Promptly submit semi-annual reports signed by the provider and the administrator of the qualifying practice site verifying the provider's employment, or licensed business, in the case

of a sole provider, and providing any additional information as requested by the Authority, including but not limited to:

- (a) Provider’s caseload (panel size or equivalent);
- (b) Provider’s Medicaid caseload;
- (c) Provider full time equivalent (FTE) status; and
- (d) Number and percentage of practice site’s patients who are Medicaid beneficiaries.

(3) The first report is due six months after employment begins, and every six months thereafter, until the term of the contract is complete.

(4) Notify the Authority immediately of any change in employment or practice status.

Stat. Auth.: 2013 OL Ch. 177
 Stats. Implemented: 2013 OL Ch. 177
 Hist.: OHP 7-2013, f. & cert. ef. 9-4-13

DIVISION 45

HEALTH CARE PRACTITIONER CREDENTIALING

409-045-0025

Definitions

The following definitions apply to OAR 409-045-0025 to 409-045-0135:

(1) “Accreditation” means a comprehensive evaluation process in which a health care organization’s systems, processes and performance are examined by an impartial external organization (accrediting entity) to ensure that it is conducting business in a manner that meets predetermined criteria and is consistent with national standards.

(2) “Advisory Group” means the Common Credentialing Advisory Group.

(3) “Authority” means the Oregon Health Authority.

(4) “Board” means a health care regulatory board or other agency that authorizes individuals to practice a profession in Oregon related to providing health care services for which the individual must be credentialed.

(5) “Credentialing” means a standardized process of inquiry undertaken to validate specific information that confirms a health care practitioner’s identity, background, education, competency and qualifications related to a specific set of established standards or criteria.

(6) “Credentialing information” means information necessary to credential or recredential a health care practitioner.

(7) “Credentialing organization” means a hospital or other health care facility, physician organization or other health care provider organization, coordinated care organization, business organization, insurer or other organization that credentials health care practitioners. This includes, but is not limited to the following:

- (a) Ambulatory Surgical Centers.
- (b) Coordinated Care Organizations.
- (c) Dental Plan Issuers.
- (d) Health Plan Issuers.
- (e) Hospitals and Health Systems.
- (f) Independent Physician Associations.

(8) “Delegated credentialing agreement” means a written agreement between credentialing organizations that delegates the responsibility to perform specific activities related to the credentialing and recredentialing of health care practitioners. For telemedicine credentialing, delegated credentialing agreement has the same meaning given that term in ORS 442.015.

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

(10) “Health care facility” has the same meaning given that term in ORS 442.015.

(11) “Health care practitioner” means an individual authorized to practice a profession related to the provision of health care services in Oregon for which the individual must be credentialed. This includes, but is not limited to the following:

- (a) Acupuncturists.
- (b) Audiologists.
- (c) Certified Registered Nurse Anesthetist.
- (d) Chiropractor.
- (e) Clinical Nurse Specialist.
- (f) Doctor of Dental Medicine.
- (g) Doctor of Dental Surgery.
- (h) Doctor of Medicine.
- (i) Doctor of Osteopathy.
- (j) Doctor of Podiatric Medicine.
- (k) Licensed Clinical Social Worker.
- (l) Licensed Dietitians.
- (m) Licensed Marriage and Family Therapists.
- (n) Licensed Massage Therapists.
- (o) Licensed Professional Counselor.
- (p) Naturopathic Physician.
- (q) Nurse Practitioner.
- (r) Occupational Therapists.
- (s) Optometrist.
- (t) Oral and Maxillofacial Surgeons.
- (u) Psychologists.
- (v) Physical Therapists.
- (w) Physician Assistants.
- (x) Psychologist Associate.
- (y) Registered Nurse First Assistant.
- (z) Speech Therapists.

(12) “Health services” has the same meaning given that term in ORS 442.015.

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

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

(15) “Primary source verification” means the verification of an individual practitioner’s reported qualifications by the original source.

(16) “Program” means the Oregon Common Credentialing Program.

(17) “Solution” means the Oregon Common Credentialing Program’s electronic system through which credentialing information may be submitted to an electronic database and accessed.

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

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603
 Stats. Implemented: ORS 441.056, 441.223, 442.015 & 2013 OL Ch. 603
 Hist.: OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0030

Oregon Common Credentialing Program

The Oregon Common Credentialing Program is established within the Authority for the purpose of providing a credentialing organization access to information necessary to credential or recredential a health care practitioner. The Program shall include, but is not limited to the following:

(1) An electronic solution through which health care practitioner credentialing information must be submitted.

(2) A process by which health care practitioners or designees may access the Solution to submit information necessary for credentialing.

(3) A process by which credentialing organizations may input, access, and retrieve health care practitioner credentialing information.

(4) A process by which Boards may input and access health care practitioner credentialing information.

(5) Coordination with Boards and the process of primary source verification of credentialing information.

Stat. Auth.: ORS 413.042 & 2013 OL Ch. 603
 Stats. Implemented: 2013 OL Ch. 603
 Hist.: OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0035

Oregon Practitioner Credentialing Application

(1) Credentialing organization shall use the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application, both approved by the Authority based on recommendations from the Advisory Committee on Physician Credentialing Information. The Authority approved applications are available at the on the Committee's website at <http://www.oregon.gov/OHA/OHPR/ACPCI/Pages/index.aspx>.

(2) Each credentialing organization shall use the application forms listed in section (1) of this rule for the purpose of credentialing and recredentialing health care practitioners.

(3) The Program shall use the application forms listed in section (1) of this rule as the template for health care practitioner credentialing information.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603
 Stats. Implemented: ORS 441.056, 441.221 - 441.223 & 2013 OL Ch. 603
 Hist.: OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0040

Credentialing Information Verifications

(1) The Program shall accept all Board verifications of credentialing information as provided in accordance with OAR 409-045-0055 and shall supplement those verifications, if necessary, to ensure compliance with national accrediting entity standards.

(2) Methods for conducting primary source verification of credentials include direct correspondence, documented telephone verification, secure electronic verification from the original qualification source or sources that meet accrediting entity requirements.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603
 Stats. Implemented: ORS 441.056, 441.221 - 441.223 & 2013 OL Ch. 603
 Hist.: OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0045

Health Care Regulatory Board Participation

(1) A Board that licenses health care practitioners shall provide practitioner information and documentation to the Solution in a format and frequency as agreed by the Board and the Authority beginning January 1, 2016. A Board may agree to provide practitioner information and documentation to the Solution prior to January 1, 2016.

(2) A Board that provides information to the Solution must also provide an annual attestation to the Authority that clearly identifies the Boards specific practices related to the process of primary source verification of health care practitioner information.

(3) Use of practitioner information provided by Boards shall be authorized through data use agreements that define the rights to use or disclose the practitioner information and any limitations to that use.

(4) A Board unable to provide information to the Solution by January 1, 2016, may submit a petition to the Authority director for consideration of a waiver from the requirements of section (1). The Authority shall review the waivers at least every two years for validity. The petition for a waiver must include:

- (a) The name of the Board;
- (b) The phone number and email address for the Board contact person;
- (c) A description of specific barrier to submitting information and documentation;
- (d) Efforts or ideas to address the barrier and the timeframe for doing so; and
- (e) The identification of support, including funding, needed to accomplish the efforts or ideas.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603
 Stats. Implemented: ORS 441.056, 441.221 - 441.223 & 2013 OL Ch. 603
 Hist.: OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0050

Credentialing Organization Participation

(1) Credentialing organizations shall obtain health care practitioner credentialing information from the Solution beginning January 1, 2016, if that information is kept and maintained by the Solution.

(2) Credentialing organizations may not request credentialing information from a health care practitioner if that information is available through the Solution. Credentialing organizations may request additional credentialing information from a health care practitioner for the purpose of completing credentialing procedures as required by the credentialing organization.

(3) A prepaid group practice health plan that serves at least 200,000 members in Oregon and that has been issued a certificate of authority by the Department of Consumer and Business Services may petition the Authority director to be exempt from the requirements of this section. The director may award the petition if the director determines that subjecting the health plan to this section is not cost-effective. If the director grants an exemption, the exemption also applies to any health care facilities and health care provider groups associated with the health plan which refers to financial ownership and does not include services associations. Exemptions may be reviewed by the Authority every two-years for validity. The petition for exemption must include:

- (a) The name of the prepaid group practice health plan petitioning the Authority and the associated health care facilities and health care provider groups to be covered under the exemption;
- (b) The phone number and email address for the health plan contact person;
- (c) A description of the prepaid group practice health plan;
- (d) A brief description of the prepaid group practice health plan's current credentialing practices; and
- (e) A justification of why the Solution is not cost-effective.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603
 Stats. Implemented: ORS 441.056, 441.221 - 441.223 & 2013 OL Ch. 603
 Hist.: OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0055

Health Care Practitioner Participation

(1) Health care practitioners required to be credentialed by a credentialing organization shall submit information and documentation required pursuant to OAR 409-045-0040 to the Solution beginning on January 1, 2016 to the extent that information is not available to the Solution from the Boards. Health care practitioners or their designee may agree to provide information and documentation required pursuant to 409-045-0040 to the Solution prior to January 1, 2016.

(2) Health care practitioners must attest to all credentialing information in the Solution.

(3) Attestation of credentialing information must occur within 120 days once the complete initial credentialing application information is submitted. Re-attestation must occur within 120 days from the date of the initial attestation and every 120 days thereafter. If credentialing information is updated and attested to by a provider outside of this 120 day re-attestation cycle, the next required re-attestation shall be due 120 days from the most recent attestation.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603
 Stats. Implemented: ORS 441.056, 441.221 - 441.223 & 2013 OL Ch. 603
 Hist.: OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0060

Use of Health Care Practitioner Information

(1) A credentialing organization that, in good faith, uses credentialing information provided by the Solution for the purposes of credentialing health care practitioners is immune from civil liability that might otherwise be incurred or imposed with respect to the use of that credentialing information.

(2) Health care practitioner information obtained by Credentialing Organizations through the Solution may only be used for the intended purpose of credentialing.

(3) All health care practitioner information that is received, kept, and maintained in the Solution, except for general information used for directories, is exempt from public disclosure under ORS 192.410 to 192.505.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603
 Stats. Implemented: ORS 441.056, 441.221 - 441.223 & 2013 OL Ch. 603
 Hist.: OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0065

Common Credentialing Advisory Group

(1) The Authority establishes the Common Credentialing Advisory Group. Members of the Advisory Group shall be appointed by the director and shall include members who represent:

- (a) Credentialing organizations;
- (b) Health care regulatory boards;
- (c) Health care practitioners; and
- (d) The ACPCI.

(2) All members appointed shall be knowledgeable about national standards relating to health care practitioner credentialing.

(3) The term of appointment for each member is three years. If, during a member's term of appointment, the member no longer qualifies to serve, the member must resign. If there is a vacancy for any reason, the director shall appoint a new member which is effective immediately for the unexpired term.

(4) The Authority and the Advisory Group shall meet at least once per year.

(5) The Advisory Group shall advise the Authority on the credentialing process, including but not limited to the following:

- (a) Credentialing industry standards;
- (b) Common Credentialing Solution;
- (c) Recommended changes to the Oregon practitioner credentialing application pursuant to ORS 442.221 to 441.223; and
- (d) Other proposed changes or concerns brought forth by interested parties.

(6) Committee members may not receive compensation or reimbursement of expenses.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603
 Stats. Implemented: ORS 441.056, 441.221 - 441.223 & 2013 OL Ch. 603
 Hist.: OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0070

Imposition of Fees

Beginning January 1, 2016, the Authority shall impose fees on credentialing organizations that access the Solution and may impose fees on health care practitioners who submit credentialing information to the Solution. Fees may not exceed the cost of administering the Program.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603
 Stats. Implemented: ORS 441.056, 441.221 - 441.223 & 2013 OL Ch. 603
 Hist.: OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0075

Complaints

Complaints regarding the Program and the Program's activities shall be submitted to Authority for evaluation through the Program's website. The Authority shall provide a response to each complaint within two weeks of receiving the complaint.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603
 Stats. Implemented: ORS 441.056, 441.221 - 441.223 & 2013 OL Ch. 603
 Hist.: OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0115

General Applicability

(1) These rules apply to all:

(a) Telemedicine health care practitioners who provide telemedicine services from any distant-site hospital in Oregon to patients in originating-site hospitals in Oregon.

(b) Originating-site hospitals located in Oregon that credential telemedicine health care practitioners located at distant-site hospitals in Oregon.

(2) Completion of credentialing requirements does not require a governing body of a hospital to grant privileges to a telemedicine health care practitioner and does not affect the responsibilities of a governing body under ORS 441.055.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603
 Stats. Implemented: ORS 441.056, 441.223, 442.015 & 2013 OL Ch. 603
 Hist.: OHP 10-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0120

Standard List of Credentialing Documents

(1) To become credentialed by an originating-site hospital, a telemedicine healthcare practitioner or the distant-site hospital must provide the following information and documentation to the originating-site hospital:

(a) A completed current (within the past 6 months) Oregon Practitioner Credentialing Application (OPCA) and the following documents:

- (A) A copy of state medical license;
- (B) Drug Enforcement Agency certificate;
- (C) State approved foreign education equivalency certificate or report, if applicable; and
- (D) Certification of professional liability insurance.

(b) Attestation by medical staff at the distant-site hospital that they have conducted primary source verification of all materials of the OPCA except for:

- (A) Hospital affiliations other than to the distant-site hospital;
- (B) Work history beyond the previous five years.

(2) Originating-site hospitals may request documentation of all the verifications above from the distant-site hospital or the telemedicine health practitioner. Verifications that are not provided may be obtained separately by the originating-site hospital.

(3) Originating-site hospitals may not require either the telemedicine healthcare practitioner or the distant-site hospital to provide the following documentation for the purposes of credentialing or privileging a telemedicine provider:

- (a) Proof of Tuberculosis Screening;
- (b) Proof of vaccination or immunity to communicable diseases;
- (c) HIPAA training verification;

(4) Originating-site hospitals may not require a telemedicine provider to attend physician and staff meetings at the originating-site hospital.

(5) Originating-site hospitals may not request credentialing information if the credentialing information was made available under OAR 409-045-0120(1) and is not subject to change.

(6) To become recredentialed by an originating-site hospital, every two years a telemedicine healthcare practitioner or the distant-site hospital must provide a completed current Oregon Practitioner Recredentialing Application and all other information required in OAR 409-045-0120(1).

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603
 Stats. Implemented: ORS 441.056, 441.223, 442.015 & 2013 OL Ch. 603
 Hist.: OHP 10-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0125

Distant-Site Hospital Agreements

Hospitals may use delegated credentialing agreements instead of the requirements in OAR-409-045-0120 to stipulate that the medical staff of the originating-site hospital shall rely upon the credentialing and privileging decisions of the distant-site hospital in making recommendations to the governing body of the originating-site hospital as to whether to credential a telemedicine provider, practicing at the distant-site hospital either as an employee or under contract, to provide telemedicine services to patients in the originating-site hospital. If a delegated credentialing agreement is in place the originating-site hospital is not limited to the information and documents prescribed by the Authority in OAR 409-045-0120.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603
 Stats. Implemented: ORS 441.056, 441.223, 442.015 & 2013 OL Ch. 603
 Hist.: OHP 10-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0130

Hold Harmless Clause

Originating-site hospitals that use credentialing information provided by distant-site hospitals are immune from civil liability that might otherwise be incurred or imposed with respect to the use of that credentialing information.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603
Stats. Implemented: ORS 441.056, 441.223, 442.015 & 2013 OL Ch. 603
Hist.: OHP 10-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0135

Information Sharing or Use of Data

(1) Telemedicine healthcare practitioners must provide written, signed permission that explicitly allows the sharing of required documents and necessary evidence by a distant-site hospital with originating-site hospitals, including but not limited to any release required under HIPAA or other applicable laws.

(2) Dissemination of information received under these rules shall only be made to individuals with a demonstrated and legitimate need to know the information.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603
Stats. Implemented: ORS 441.056, 441.223, 442.015 & 2013 OL Ch. 603
Hist.: OHP 10-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

DIVISION 50

PAIN MANAGEMENT

409-050-0100

Purpose

The Pain Management Commission is established within the Oregon Health Authority for the purpose of developing pain management educational programs, recommendations and curriculum; representing patient concerns to the Governor and Legislative Assembly; and creating ways to improve pain management in Oregon through research, policy analysis, and model projects. In addition, the Pain Management Commission is charged with developing a specific pain management educational program for required completion by health care professionals under specified Licensing Boards.

Stat. Authority: ORS 413.570
Stats. Implemented: ORS 413.570 - 413.599
Hist.: DHSD 1-2007, f. & cert. ef. 2-1-07; Renumbered from 407-020-0000, OHP 1-2011, f. 1-26-11, cert. ef. 2-1-11

409-050-0110

Definitions

For the purposes of this Division 409-050, the following definitions apply:

(1) "Commission" means the Oregon Pain Management Commission.

(2) "Licensed health care professionals" means those specifically identified licensees that report to the following Licensing Boards:

(a) Oregon Board of Medical Examiners, which includes: physicians, physician assistants and acupuncturists (with the exception of those listed under OAR chapter 847.677, identified as waived);

(b) Oregon State Board of Nursing, which includes: all registered nurses, licensed practical nurses and nurse practitioners;

(c) Oregon Board of Psychologist Examiners, which includes: all licensed psychologists;

(d) Oregon Board of Chiropractic Examiners, which includes: all licensed chiropractors;

(e) Oregon Board of Naturopathic Examiners, which includes: all licensed naturopathic physicians; and

(f) Oregon Board of Pharmacy, which includes: all licensed pharmacists.

(g) Oregon Board of Dentistry, which includes all licensed dentists.

(h) Oregon Board of Occupational Therapy, which includes all licensed occupational therapists.

(i) Oregon Board of Physical Therapy, which includes all licensed physical therapists.

(3) "Curriculum" means a recommended list of educational topics, compiled by the Commission, for medical professionals treating pain.

(4) "Pain management education program" means a specific one-hour web-based program developed by the Commission, in addition to six accredited hours of continuing education in pain management, end of life care or a combination of both.

Stat. Authority: ORS 413.570
Stats. Implemented: ORS 413.570 - 413.599
Hist.: DHSD 1-2007, f. & cert. ef. 2-1-07; Renumbered from 407-020-0005, OHP 1-2011, f. 1-26-11, cert. ef. 2-1-11; OHP 5-2011(Temp), f. 8-30-11, cert. ef. 9-1-11 thru 2-27-12; OHP 9-2011, f. 11-28-11, cert. ef. 12-1-11

409-050-0120

Commission Positions

(1) The Commission consists of:

(a) Nineteen members – seventeen voting members and two non-voting ex-officio members from the Oregon legislature; and

(b) Members that have experience or a demonstrated interest in pain management issues.

(2) In order to apply for a position on the Commission, an individual must:

(a) Complete a Commission interest form; and

(b) Submit the interest form to the Pain Management Program.

(3) Voting member appointments to the Commission are:

(a) Made by the Director of the Oregon Health Authority; and

(b) Must comply with the approved Commission bylaws.

(4) Prior to making appointments, the Director of the Oregon Health Authority shall request and consider recommendations from individuals, public and private agencies and organizations, but not limited to individuals with a healthcare background or individuals representing the healthcare industry or members of the public.

(5) Oregon Health Authority staff shall include a Pain Management Coordinator, who shall staff and facilitate Commission meetings, provide daily organization of Commission business and perform other duties as directed by the Commission.

Stat. Authority: ORS 413.570
Stats. Implemented: ORS 413.570 - 413.599
Hist.: DHSD 1-2007, f. & cert. ef. 2-1-07; Renumbered from 407-020-0010, OHP 1-2011, f. 1-26-11, cert. ef. 2-1-11; OHP 5-2011(Temp), f. 8-30-11, cert. ef. 9-1-11 thru 2-27-12; OHP 9-2011, f. 11-28-11, cert. ef. 12-1-11

409-050-0130

Pain Management Education Program Requirements

(1) Licensed health care professionals must complete a pain management education program in order to improve the care and treatment of individuals with painful conditions. The program includes:

(a) Six accredited hours of continuing education in pain management, end of life care or a combination of both; and

(b) The web-based training offered by the Commission.

(c) Dentists licensed under Oregon Board of Dentistry are only required to complete the web-based training offered by the Commission.

(2) For out of state health care professionals obtaining Oregon licensure or newly licensed health care professionals within Oregon, the pain management education program must be completed within 24 months of their first license renewal.

Example: If an individual becomes newly licensed in Oregon on June 15, 2009, their first renewal will be June 15, 2011. The individual may obtain their training from June 15, 2009 through June 15, 2013 under section (2) to comply with this requirement.

(3) If the licensing board for a licensed health care professional adopts, by rule, a pain management education program with topics substantially similar to the topics in the Commission's curriculum, that program satisfies this rule for the continuing education portion of the requirement, as long as the total number of hours is the same.

(4) The Commission shall review its curriculum every two years and update as needed.

Stat. Authority: ORS 413.570
Stats. Implemented: ORS 413.570 - 413.599
Hist.: DHSD 1-2007, f. & cert. ef. 2-1-07; Renumbered from 407-020-0015, OHP 1-2011, f. 1-26-11, cert. ef. 2-1-11; OHP 8-2011(Temp), f. & cert. ef. 10-19-11 thru 2-27-12; OHP 10-2011, f. & cert. ef. 12-22-11

DIVISION 55

PATIENT-CENTERED PRIMARY CARE HOME PROGRAM

409-055-0000

Purpose and Scope

These rules(OAR 409-055-0000 to 409-055-0090) establish the Patient-Centered Primary Care Home(PCPCH) Program and define criteria and process that the Authority shall use to recognize and verify status as PCPCHs. The PCPCH is a model of primary care that has received attention in Oregon and across the country for its potential to advance the “triple aim” goals of health reform: a healthy population, extraordinary patient care for everyone, and reasonable costs, shared by all. PCPCHs achieve these goals through a focus on wellness and prevention, coordination of care, active management and support of individuals with special health care needs, and a patient and family-centered approach to all aspects of care. PCPCHs emphasize whole-person care in order to address a patient and family’s physical and behavioral health care needs.

Stat. Auth: ORS 413.042, 413.259 & 414.655
 Stats. Implemented: ORS 413.259, 413.260 & 414.655
 Hist.: OHP 6-2011(Temp), f. 9-29-11, cert. ef. 10-1-11 thru 3-15-12; OHP 2-2012, f. 2-29-12, cert. ef. 3-1-12; OHP 9-2016, f. & cert. ef. 5-13-16

409-055-0010

Definitions

The following definitions apply to OAR 409-055-0000 to 409-055-0090:

- (1) “Authority” means the Oregon Health Authority.
- (2) “CHIPRA Core Measure Set” means the initial core set of children’s health care quality measures released by the Centers for Medicare and Medicaid Services in 2009 for voluntary use by Medicaid and CHIP programs.
- (3) “NCQA” means National Committee for Quality Assurance.
- (4) “Patient Centered Medical Home(PCMH)” means a practice or provider who has been recognized as such by the National Committee for Quality Assurance.
- (5) “Patient-Centered Primary Care Home(PCPCH)” means a health care team or clinic as defined in ORS 414.655, meets the standards pursuant to OAR 409-055-0040, and has been recognized through the process pursuant to OAR 409-055-0040.
- (6) “Personal Health Information” means demographic information, medical history, test and laboratory results, insurance information and other data that is collected by a health care professional to identify an individual and determine appropriate care.
- (7) “Practice” means an individual, facility, institution, corporate entity, or other organization which provides direct health care services or items, also termed a performing provider, or bills, obligates and receives reimbursement on behalf of a performing provider of services, also termed a billing provider(BP). The term provider refers to both performing providers and BP(s) unless otherwise specified.
- (8) “Program” means Patient-Centered Primary Care Home Program.
- (9) “Program website” means www.primarycarehome.oregon.gov.
- (10) “Provider” means an individual, facility, institution, corporate entity, or other organization which provides direct health care services or items, also termed a performing provider, or bills, obligates and receives reimbursement on behalf of a performing provider of services, also termed a billing provider(BP). The term provider refers to both performing providers and BP(s) unless otherwise specified.
- (11) “Recognition” means the process through which the Authority determines if a practice has met the Oregon Patient-Centered Primary Care Home Standards.
- (12) “Recognized” means that the Authority has affirmed that a practice meets the Oregon Patient-Centered Primary Care Home Standards.

(13) “Tier” means the level of Patient-Centered Primary Care Home at which the Authority has scored a practice.

(14) “Verification” means the process that the Authority shall conduct to ensure that a practice has submitted accurate information to the Authority for purposes of Patient-Centered Primary Care Home recognition.

(15) “5 STAR” means a designation assigned to Patient-Centered Primary Care Homes meeting advanced PCPCH criteria.

Stat. Auth: ORS 413.042, 413.259 & 414.655
 Stats. Implemented: ORS 413.259, 413.260 & 414.655
 Hist.: OHP 6-2011(Temp), f. 9-29-11, cert. ef. 10-1-11 thru 3-15-12; OHP 2-2012, f. 2-29-12, cert. ef. 3-1-12; OHP 2-2015, f. 1-16-15, cert. ef. 2-1-15; OHP 10-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-24-16; OHP 9-2016, f. & cert. ef. 5-13-16

409-055-0020

Program Administration

(1) The Program is intended to ensure that there is a uniform process for recognizing PCPCHs throughout the State of Oregon in order to support primary care transformation.

(2) The Authority shall recognize practices as PCPCHs upon meeting defined criteria through the Program.

(3) The Authority shall administer the Program, including data collection and analysis, recognition, and verification that a practice meets the defined PCPCH criteria. The Authority may also provide technical assistance as is feasible.

(4) The Authority may contract for any of the work it deems necessary for efficient and effective administration of the Program.

Stat. Auth: ORS 413.042, 413.259 & 414.655
 Stats. Implemented: ORS 413.259, 413.260 & 414.655
 Hist.: OHP 6-2011(Temp), f. 9-29-11, cert. ef. 10-1-11 thru 3-15-12; OHP 2-2012, f. 2-29-12, cert. ef. 3-1-12; OHP 9-2016, f. & cert. ef. 5-13-16

409-055-0030

Practice Application and Recognition Process

(1) Practices, or other entities on behalf of the practice, that wish to be recognized as a PCPCH shall submit a PCPCH Recognition Application electronically to the Authority via the Program’s online application system found on the Program website or by mail to the address posted on the Program website. The application shall include the quantitative data described in OAR 409-055-0040.

(2) The Authority shall review the application within 60 days of its submission to determine whether it is accurate, complete, and meets the recognition requirements. If the application is incomplete the the Authority shall notify the applicant in writing of the information that is missing and when it must be submitted.

(3) The Authority shall review a complete application within 60 days of submission. If the Authority determines that the applicant has met the requirements of these rules the Authority shall:

- (a) Inform the applicant in writing that the application has been approved as a recognized PCPCH,
- (b) Assign a Tier level, and
- (c) Include the effective recognition date.

(4) The Authority shall maintain instructions and criteria for submitting a PCPCH Recognition Application posted on the Program website.

(5) The Authority may deny PCPCH recognition if an applicant does not meet the requirements of these rules.

(6) A practice may request that the Authority reconsider the denial of PCPCH recognition or reconsider the assigned tier level. A request for reconsideration must be submitted in writing to the Authority within 90 days of the date of the denial or approval letter and must include a detailed explanation of why the practice believes the Authority’s decision is in error along with any supporting documentation. The Authority shall inform the practice in writing whether it has reconsidered its decision.

(7) Practices submitting applications on or after September 3, 2013 must apply to renew their recognition once every two years. Recognition shall expire two years from the recognition effective date issued by the Authority.

(a) At the Authority’s discretion a 30-day grace period may be allowed for PCPCHs to submit a renewal application without having a lapse in recognition status.

(b) If a PCPCH believes that it meets the criteria to be recognized at a higher tier or increase its point threshold by at least 15 points, it may request to have its tier status reassessed by re-submitting an application not more than once every six months. The Authority may grant exceptions to the six month time period for good cause shown.

(c) Currently recognized PCPCHs that are due to reapply between January 1, 2016 and December 31, 2016 shall be granted an extension of their PCPCH recognition until January 1, 2017.

(d) Currently recognized PCPCHs that choose to reapply for recognition between January 1, 2016 and December 31, 2016 shall be recognized until January 1, 2017.

(e) Practices applying for PCPCH recognition for the first time between January 1, 2016 and December 31, 2016 shall be recognized until January 1, 2017.

(f) At the Authority’s discretion a 90-day grace period may be allowed for PCPCHs due to reapply on January 1, 2017 to submit a renewal application without having a lapse in recognition status.

Stat. Auth: ORS 413.042, 413.259 & 414.655
Stats. Implemented: ORS 413.259, 413.260 & 414.655
Hist.: OHP 6-2011(Temp), f. 9-29-11, cert. ef. 10-1-11 thru 3-15-12; OHP 2-2012, f. 2-29-12, cert. ef. 3-1-12; OHP 7-2012(Temp), f. & cert. ef. 10-4-12 thru 4-1-13; OHP 5-2013, f. 3-22-13, cert. ef. 4-1-13; OHP 6-2013, f. 8-23-13, cert. ef. 9-3-13; OHP 9-2013, f. 10-1-13, cert. ef. 1-1-14; OHP 2-2015, f. 1-16-15, cert. ef. 2-1-15; OHP 10-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-24-16; OHP 9-2016, f. & cert. ef. 5-13-16; OHP 12-2016(Temp), f. & cert. ef. 8-29-16 thru 2-21-17

**409-055-0040
Recognition Criteria**

(1) The PCPCH recognition criteria are divided into “Must-Pass” measures and other measures that place the practice on a scale of maturity or ‘tier’ that reflect basic to more advanced PCPCH functions.

(2) Must-Pass and 5 point measures focus on foundational PCPCH elements that should be achievable by most practices in Oregon with significant effort, but without significant financial outlay.

(3) 10 and 15 point measures reflect intermediate and advanced functions.

(4) Except for the 11 Must-Pass measures, each measure is assigned a point value. A practice must meet the following point allocation criteria to be recognized as a PCPCH:

- (a) Tier 1: 30–60 points and all 11 Must-Pass Measures
- (b) Tier 2: 65–125 points and all 11 Must-Pass Measures
- (c) Tier 3: 130 points–250 points and all 11 Must-Pass Measures

(d) Tier 4: 255–390 points and all 11 Must-Pass Measures

(5) The Authority may designate a practice as a Tier 5 STAR Patient-Centered Primary Care Home for implementing multiple advanced PCPCH criteria as described in OAR 409-055-0045.

(6) The Authority shall calculate a practice’s point score through the recognition process described in OAR 409-055-0030.

(7) Table 1, incorporated by reference, contains the detailed list of Measures and corresponding point assignments.

(8) Table 2, incorporated by reference, contains a detailed list of the PCPCH Quality Measures.

(9) Measure specifications, thresholds for demonstrating improvement, and benchmarks for quantitative data elements are available on the Program website.

(10) National Committee for Quality Assurance (NCQA) recognition shall be acknowledged in the Authority’s PCPCH recognition process; however, a practice is not required to use its NCQA recognition to meet the Oregon PCPCH standards. A practice that does not wish to use its NCQA recognition to meet the Oregon PCPCH standards must indicate so during the PCPCH application process and submit a complete PCPCH application.

(11) A practice seeking Oregon PCPCH Tier 1, 2 or 3 recognition based on its NCQA recognition must:

(a) Submit a PCPCH application and evidence of its NCQA recognition along with its application;

(b) Comply with Table 3, incorporated by reference, for NCQA PCMH practices using 2011 and 2014 NCQA criteria.

(12) A practice seeking Oregon PCPCH Tier 4 or 5 STAR recognition based on its NCQA recognition must submit a complete PCPCH application.

[ED. NOTE: Tables reference are available from the agency.]
Stat. Auth: ORS 413.042, 413.259 & 414.655
Stats. Implemented: ORS 413.259, 413.260 & 414.655
Hist.: OHP 6-2011(Temp), f. 9-29-11, cert. ef. 10-1-11 thru 3-15-12; OHP 2-2012, f. 2-29-12, cert. ef. 3-1-12; OHP 9-2013, f. 10-1-13, cert. ef. 1-1-14; OHP 2-2015, f. 1-16-15, cert. ef. 2-1-15; OHP 10-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-24-16; OHP 9-2016, f. & cert. ef. 5-13-16

**409-055-0045
3 STAR Designation**

(1) The Authority shall award 5 STAR designations to practices implementing multiple advanced PCPCH measures.

(2) A practice seeking 5 STAR designation, must meet the following criteria:

(a) Be recognized as a Tier 4 PCPCH under the Measures in Table 1, adopted and incorporated by reference;

(b) Attest to 255 points or more on the PCPCH application; and

(c) Attest to 11 or more of the 13 PCPCH Measures in Table 4, adopted and incorporated by reference.

(3) The Authority shall review PCPCH applications of practices attesting to the Measures in Table 1, to determine which practices meet the criteria in section (2) of this rule

(4) The Authority shall notify a practice meeting 5 STAR designation criteria in writing of their eligibility.

(5) The Authority shall contact the eligible practice to schedule an on-site verification visit as described in OAR 409-055-0060.

(6) A practice seeking 5 STAR designation must comply with an on-site verification site visit.

(7) The Authority shall award 5 STAR designation to a practice after verifying the practice meets all 5 STAR designation criteria.

(8) 5 STAR designation is valid for the duration of the practice’s current PCPCH recognition as described in OAR 409-055-0030(7).

[ED. NOTE: Tables reference are available from the agency.]
Stat. Auth: ORS 413.042, 413.259 & 414.655
Stats. Implemented: ORS 413.259, 413.260 & 414.655
Hist.: OHP 2-2015, f. 1-16-15, cert. ef. 2-1-15; OHP 9-2016, f. & cert. ef. 5-13-16

**409-055-0050
Data Reporting Requirements for Recognized PCPCHs**

(1) To be recognized as a PCPCH, a practice must attest to meeting the criteria and submit quantitative data elements to support its attestation in accordance with Tables 1 & 2, incorporated by reference.

(2) Quantitative data shall be aggregated at the practice level, not the individual patient level, and a practice may not transfer any personal health information to the Authority during the PCPCH application process.

(3) PCPCHs must submit new quantitative and attestation data as a part of the recognition renewal process and must use the specifications found on the Program website for calculating application data.

(4) If approved by the practice, other entities may submit information on behalf of a practice, as long as appropriate practice staff has reviewed all application information and data prior to submission.

(5) A practice may request an exception to any of the quantitative data reporting requirements in Table 2 or the Must-Pass criteria by submitting a form prescribed by the program. The Authority may grant exceptions for good cause shown.

(6) Practices are required to submit 12 months of quantitative data in order to meet standards 2.A., 4.A., and 4.B. A practice may

request an exception to the 12 month data reporting period by submitting a form prescribed by the program. The Authority may grant exceptions for good cause shown.

(7) The Authority shall notify the practice within 60 days of complete application and exception submission whether or not the requested exception has been granted.

[ED. NOTE: Tables reference are available from the agency.]
Stat. Auth: ORS 413.042, 413.259 & 414.655
Stats. Implemented: ORS 413.259, 413.260 & 414.655
Hist.: OHP 6-2011(Temp), f. 9-29-11, cert. ef. 10-1-11 thru 3-15-12; OHP 2-2012, f. 2-29-12, cert. ef. 3-1-12; OHP 9-2013, f. 10-1-13, cert. ef. 1-1-14; OHP 9-2016, f. & cert. ef. 5-13-16

409-055-0060

Verification

(1) The Authority shall conduct at least one on-site verification review of each recognized PCPCH to determine compliance with PCPCH criteria every five years and at such other times as the Authority deems necessary or at the request of the Health Systems Division (Division), or any other applicable program within the Authority. The purpose of the review is to verify reported attestation and quantitative data elements for the purposes of confirming recognition and Tier level.

(2) PCPCHs selected for verification shall be notified no less than 30 days prior to the scheduled review.

(3) PCPCHs shall permit Authority staff access to the practice’s place of business during the review.

(4) A verification review may include but is not limited to:

- (a) Review of documents and records.
- (b) Review of patient medical records.
- (c) Review of electronic medical record systems, electronic health record systems, and practice management systems.

(d) Review of data reports from electronic systems or other patient registry and tracking systems.

(e) Interviews with practice management, clinical and administrative staff.

- (f) On-site observation of practice staff.
- (g) On-site observation of patient environment and physical environment.

(5) Following a review, Authority staff may conduct an exit conference with the PCPCH representatives. During the exit conference Authority staff shall:

- (a) Inform the PCPCH representative of the preliminary findings of the review; and
- (b) Give the PCPCH a reasonable opportunity to submit additional facts or other information to the Authority staff in response to those findings.

(6) Following the review, Authority staff shall prepare and provide the PCPCH specific and timely written notice of the findings.

(7) If the findings result in a referral to the Division pursuant to OAR 409-055-0070, Authority staff shall submit the applicable information to the Division for its review and determination of appropriate action.

(8) If no deficiencies are found during a review, the Authority shall issue written findings to the PCPCH indicating that fact.

(9) If deficiencies are found, the Authority shall take informal or formal enforcement action pursuant to OAR 409-055-0070.

(10) The Authority may share application information and content submitted by practices and verification findings with managed or coordinated care plans, and insurance carriers.

Stat. Auth: ORS 413.042, 413.259 & 414.655
Stats. Implemented: ORS 413.259, 413.260 & 414.655
Hist.: OHP 6-2011(Temp), f. 9-29-11, cert. ef. 10-1-11 thru 3-15-12; OHP 2-2012, f. 2-29-12, cert. ef. 3-1-12; OHP 9-2013, f. 10-1-13, cert. ef. 1-1-14; OHP 10-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-24-16; OHP 9-2016, f. & cert. ef. 5-13-16

409-055-0070

Compliance

(1) If the Authority finds that the practice is not in compliance with processes as attested to, the Authority shall issue a written warning requiring the practice to submit an improvement plan within 90 days of the date of the written warning. The improvement

plan must include a description of the practice’s plan and timeline to correct the deficiency and proposed documentation or other demonstration that would verify the practice is in compliance.

(2) The Authority shall review the improvement plan and any documentation the practice submits in accordance with the deficiency, and if remedied, no further action shall be taken.

(3) If a practice fails to submit the improvement plan or move into compliance within 90 days of the date of the written warning, the Authority may issue a letter of non-compliance and amend the practice’s PCPCH recognition to reflect the appropriate Tier level or revoke its PCPCH status.

(4) If the Authority amends a practice’s tier level or revokes PCPCH status this information shall be made available to the Health Systems Division(Division), the coordinated care or managed care plans, and insurance carriers.

(5) A practice that has had its PCPCH status revoked may have it reissued after reapplying for recognition and when the Authority determines that compliance with PCPCH sStandards has been achieved satisfactorily.

(6) In order for the Authority to receive federal funding for Medicaid clients receiving services through a PCPCH, documentation of certain processes are required by the Centers for Medicare and Medicaid Services. Documentation requirements can be found in OAR 410-141-0860. If non-compliance is due to lack of service documentation required pursuant to OAR 410-141-0860, a referral may be made to the Division.

(7) If the Authority finds a lack of documentation pursuant to OAR 410-141-0860 to support the authorized tier level, the Authority may make a referral to the Division and may conduct an audit pursuant to OAR 943-120-1505.

Stat. Auth: ORS 413.042, 413.259 & 414.655
Stats. Implemented: ORS 413.259, 413.260 & 414.655
Hist.: OHP 6-2011(Temp), f. 9-29-11, cert. ef. 10-1-11 thru 3-15-12; OHP 2-2012, f. 2-29-12, cert. ef. 3-1-12; OHP 9-2013, f. 10-1-13, cert. ef. 1-1-14; OHP 10-2015(Temp), f. 12-29-15, cert. ef. 1-1-16 thru 6-24-16; OHP 9-2016, f. & cert. ef. 5-13-16

409-055-0080

Insurance Carrier, Managed Care Plan, and Public Stakeholder Communication

(1) The Authority shall develop a system for making recognized PCPCH Tier status recognition information available to insurance carriers and managed care organizations.

(2) The Authority shall maintain and update monthly the recognized PCPCH Tier status lists.

(3) The Authority shall develop a system for making recognized PCPCH practice names available to the general public through the Program website.

(4) Practices that do not wish to have their name listed on the publicly available list must send an e-mail to PCPCH@state.or.us with the title “opt-out” in the subject line within 10 business days of receiving confirmation of Tier status pursuant to OAR 409-055-0040.

Stat. Auth: ORS 413.042, 413.259 & 414.655
Stats. Implemented: ORS 413.259, 413.260 & 414.655
Hist.: OHP 6-2011(Temp), f. 9-29-11, cert. ef. 10-1-11 thru 3-15-12; OHP 2-2012, f. 2-29-12, cert. ef. 3-1-12; OHP 9-2016, f. & cert. ef. 5-13-16

409-055-0090

Reimbursement Objectives

(1) One objective of these standards is to facilitate appropriate reimbursement for PCPCHs consistent with their recognized Tier levels. The standards and Tier recognition process established in this rule are consistent with statutory objectives to align financial incentives to support utilization of PCPCHs, in recognition of the standards that are required to be met at different Tiers.

(2) Managed care plans and insurance carriers may obtain from the Authority the Tier level recognition of any practice.

(3) Within applicable programs, the Authority shall develop and implement reimbursement methodologies that reimburse practices based on recognition of Tier level, taking into consideration incurred practice costs for meeting the Tier criteria.

Stat. Auth: ORS 413.042, 413.259 & 414.655
Stats. Implemented: ORS 413.259, 413.260 & 414.655

DIVISION 60

HEALTH EVIDENCE REVIEW COMMISSION

409-060-0100

Scope

(1) These rules (OAR 409-060-0100 to 409-060-0150) define criteria and processes that the Health Evidence Review Commission shall use to develop evidence-based reports, including medical technology assessments, evidence-based guidelines and coverage guidances. These rules apply to evidence-based reports and revisions to approved evidence-based reports whose development commences on or after February 1, 2013.

(2) The Commission may consider evidence relating to prescription drugs that is relevant to an evidence-based report but may not conduct a drug class evidence review or evidence-based report solely of a prescription drug.

Stat. Auth.: ORS 414.695 & 413.042
Stats. Implemented: 414.695 & 414.698
Hist.: OHP 4-2013, f. & cert. ef. 2-1-13

409-060-0110

Definitions

The following definitions apply to OAR 409-060-0100 to 409-060-0150:

(1) "Ad hoc expert" means an individual identified by the Commission as having particular expertise in a technology or its application.

(2) "Authority" means the Oregon Health Authority.

(3) "Commission" means the Health Evidence Review Commission.

(4) "Coverage guidance" means a report approved by the Commission on a health service or technology which makes coverage recommendations for insurers and health care purchasers in furthering the use of evidence-based healthcare.

(5) "Evidence-based guideline" means an evidence-based report on a health service or technology, for use by health care providers in encouraging the use of the safest and most effective care possible.

(6) "Evidence-based report" means a medical technology assessment, evidence-based guideline or coverage guidance which includes conclusions and recommendations based on the information in the source documents, and which incorporates the clinical context necessary for the information to be properly interpreted by policymakers.

(7) "EbGS" means the Evidence-based Guidelines Subcommittee.

(8) "HTAS" means the Health Technology Assessment Subcommittee

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

(10) "Medical technology assessment" means an evidence-based report on the use, clinical effectiveness and risks, and cost of a technology in comparison with its alternatives.

(11) "Subcommittee" means a subcommittee established by the Commission.

(12) "Trusted source" means a source designated by the Commission for use in developing an evidence-based report.

Stat. Auth.: ORS 414.695 & 413.042
Stats. Implemented: 414.695 & 414.698
Hist.: OHP 4-2013, f. & cert. ef. 2-1-13; OHP 5-2016, f. & cert. ef. 4-19-16

409-060-0120

Health Evidence Review Commission Process for Evidence-based Reports

(1) The Commission shall develop evidence-based reports or may direct a Subcommittee to prepare these reports. The Commis-

sion shall identify reports from trusted sources to serve as the basis for these reports. Meetings shall be public and conducted in a manner consistent with the Commission's policies and procedures.

(2) Topics for review shall be publicly identified at least 30 days prior to the initial Subcommittee meeting at which a draft evidence-based report is reviewed. In this notice, the Subcommittee shall make publicly available the primary evidence source documents to be used in creating the initial draft report, except when source documents are proprietary. If additional sources are added to the initial draft report after this notice, the Subcommittee shall publicly identify them no later than 14 days prior to the Subcommittee meeting where they will be discussed. In lieu of proprietary source documents, the Subcommittee shall make publicly available a citation of the evidence source. In the case of a proprietary evidence source, a full listing of citations from the proprietary source shall be made available when allowed by the source. If providing the citations is not allowed or not otherwise feasible, a summary of the evidence findings will be provided at least 14 days in advance of the meeting at which the initial draft report will be discussed.

(3) When developing an evidence-based report, the Commission or its designated Subcommittee shall consult with two or more ad hoc experts on the subject matter of the evidence-based report. Subcommittee shall publicly solicit ad hoc experts at least 30 days prior to the meeting at which it reviews the initial draft evidence-based report. One of the ad hoc experts must be a provider who manages patients who would potentially receive the treatment, service or device in question. Candidates wishing to serve as ad hoc experts shall disclose conflicts of interest according to HERC bylaws. The Authority shall appoint ad hoc experts that best meet the needs of the state, considering any conflicts of interest, and shall not be limited to those who have volunteered to serve.

(4) After the Subcommittee reviews the initial draft report, the subcommittee may revise the initial draft report. The Subcommittee shall then solicit public comment on this version of the draft report over a 30-day period. Draft reports posted for comment shall include citations for all sources used in developing the report and a summary of evidence findings. The Subcommittee shall publicly disclose written comments received during the 30-day period, draft responses and additional revisions (if any) to the draft report at least seven days before the Subcommittee meeting at which the Subcommittee reviews public comments. After discussing the available evidence and considering public comment, including additional verbal testimony, the Subcommittee shall make conclusions as to the overall importance of beneficial effects versus potential harms and approve its final draft evidence-based report reflecting these conclusions.

(5) Before an evidence-based report is reviewed at a Commission meeting, a final draft report approved by the Subcommittee, along with all written public comments received during the public comment period and the Subcommittee's responses to these public comments shall be made publicly available for a period of at least 14 days. At the meeting, the Commission shall consider the Subcommittee's approved draft report and accept further public comment.

(6) After evaluating the report and public comments the Commission may take one of three actions:

- (a) Accept the report as written.
(b) Make edits to the report and accept as modified.
(c) Return the report to the Subcommittee with recommendations for further work.

(7) The Commission or its Subcommittees may revise evidence-based reports when additional information relevant to the report becomes available or if the findings of one or more of the source reports change. The Commission or its Subcommittees may initiate a review at the request of interested parties who provide information or interpretations not considered in developing an existing evidence-based report. At a minimum, the HERC or one of its Subcommittees shall review the need to update each report within two years after its adoption or most recent revision.

Stat. Auth.: ORS 414.695 & 413.042
Stats. Implemented: 414.695 & 414.698
Hist.: OHP 4-2013, f. & cert. ef. 2-1-13; OHP 5-2016, f. & cert. ef. 4-19-16

409-060-0130

Medical Technology Assessments

Medical technology assessments undertaken by the Commission shall be developed by HTAS and may include any technologies listed in the definition in ORS 414.695 and 414.698(1). Medical technology assessments shall be performed in cases where technology assessments from trusted sources do not exist or require the consideration of additional evidence. Medical Technology Assessments shall include a new search of the current peer-reviewed research on the topic. Assessments shall be developed according to the process described in OAR 409-060-0120 except as described in this section.

Stat. Auth.: ORS 414.695 & 413.042
 Stats. Implemented: 414.695 & 414.698
 Hist.: OHP 4-2013, f. & cert. ef. 2-1-13

409-060-0140

Evidence-based Guidelines

The EbGS shall develop evidence based guidelines based on one or more existing guideline from trusted sources, which may involve the consideration of additional research. Evidence-based guidelines shall be developed according to the process described in OAR 409-060-0120 except as described in this section.

Stat. Auth.: ORS 414.695 & 413.042
 Stats. Implemented: 414.695 & 414.698
 Hist.: OHP 4-2013, f. & cert. ef. 2-1-13

409-060-0150

Coverage Guidances

(1) A Subcommittee shall develop coverage guidances which shall be based on reports developed by trusted sources, and may cite supplemental evidence which is more recent or beyond the scope of the report. Coverage guidances shall be developed according to the process described in OAR 409-060-0120 except as described in this section.

(2) OAR 409-060-0120(3) does not apply to this section. Instead, if the Subcommittee responsible for development of the report determines that it lacks sufficient expertise in the relevant field, or a request is received from an interested outside party, the Subcommittee shall solicit an ad hoc expert to provide additional information. Requests from interested parties to appoint ad hoc experts must be submitted within fourteen days after the public notice announcing the subcommittee’s first review of the initial draft coverage guidance. The subcommittee may solicit ad hoc experts at any time thereafter if the committee determines such expertise is necessary. Candidates wishing to serve as ad hoc experts shall disclose conflicts of interest according to HERC bylaws. Ad hoc experts, if needed, shall be appointed by the Authority. The Authority shall select experts that best meet the needs of the state, considering any conflicts of interest, and shall not be limited to those who have volunteered to serve. Ad hoc experts shall answer technical questions and provide clinical context during the review of the evidence.

Stat. Auth.: ORS 414.695 & 413.042
 Stats. Implemented: 414.695 & 414.698
 Hist.: OHP 4-2013, f. & cert. ef. 2-1-13; OHP 5-2016, f. & cert. ef. 4-19-16

DIVISION 62

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC PROGRAM

409-062-0000

Purpose and Scope

These rules establish the Certified Community Behavioral Health Clinic (CCBHC) program and define the criteria and process that the Authority shall use to recognize and verify status as CCBHCs. These rules specify the standards for the CCBHC application and certification process. In addition to meeting all state and federal criteria, only organizations certified under OAR 309-019-0100 to 309-019-0220 (Outpatient Addictions and Mental Health Services) and OAR 309-008-0100 to 309-008-1600 (Standards for Certification of Behavioral Health Treatment Services)

may become certified.

Stat. Auth: ORS 413.042
 Stats. Implemented: ORS 413.042
 Hist.: OHP 7-2016(Temp), f. & cert. ef. 4-22-16 thru 10-18-16; OHP 14-2016, f. & cert. ef. 9-26-16

409-062-0010

Definitions

The following definitions apply to OAR 409-062-0000 to 409-062-0060:

- (1) “Authority” means the Oregon Health Authority.
- (2) “CCBHC” means the Certified Community Behavioral Health Clinic.
- (3) “CCBHC application” means the survey link that is posted on the CCBHC program website.
- (4) “Certification” means the process which the Authority uses to determine if a practice has met the criteria in the document titled “Criteria for the Demonstration Program to Improve Community mental Health Centers and to Established Certified Community Behavioral Health Clinics” as well as the Oregon state CCBHC standards.
- (5) “Certified” means that the Authority has affirmed that a practice substantially meets the federal and Oregon CCBHC standards

(6) “Practice” means an individual, facility, institution, corporate entity, or other organization which provides direct health care services or bills, obligates and receives reimbursement on behalf of a performing provider of services, also termed a billing provider (BP). The term provider refers to both performing providers and BPs unless otherwise specified.

(7) “Program” means activities associated with the CCBHC planning grant.

(8) “Program website” means <http://www.oregon.gov/oha/bhp/Pages/Community-BH-Clinics.aspx>.

(9) “Verification” means the process that the Authority shall conduct to ensure that a practice has submitted accurate information to the Authority for purposes of CCBHC certification.

Stat. Auth: ORS 413.042
 Stats. Implemented: ORS 413.042
 Hist.: OHP 7-2016(Temp), f. & cert. ef. 4-22-16 thru 10-18-16; OHP 14-2016, f. & cert. ef. 9-26-16

409-062-0020

Program Administration

(1) The Program shall develop and implement a uniform application and process for certifying CCBHCs throughout the state of Oregon.

(2) The Authority shall recognize practices as certified CCBHCs upon meeting criteria set forth in OAR 409-062-0040.

(3) The Authority shall administer the Program, including data collection and analysis, recognition, and verification that a practice meets the defined CCBHC criteria.

(4) The Authority may also provide technical assistance.

Stat. Auth: ORS 413.042
 Stats. Implemented: ORS 413.042
 Hist.: OHP 7-2016(Temp), f. & cert. ef. 4-22-16 thru 10-18-16; OHP 14-2016, f. & cert. ef. 9-26-16

409-062-0030

Application and Certification Process

(1) To be certified as a CCBHC, practices or their designee shall submit a CCBHC application electronically to the Authority using the Program’s online application system found on the program website or by mail to the address posted on the program website which shall be open for 30 days. The Authority may choose to extend the application period beyond 30 days.

(2) The Authority shall review the application within 30 days of its submission to determine whether it is accurate, complete, and meets the certified requirements. If the application is incomplete the Authority shall notify the applicant in writing of the information that is missing and when it must be submitted.

(3) The Authority shall review a complete application within 45 days of submission. If the Authority determines that the

applicant has met the requirements of these rules the Authority shall:

- (a) Inform the applicant in writing that the application has been approved as a potential CCBHC;
 - (b) Assign a preliminary level of readiness for certification; and
 - (c) Include information regarding site visit planning, including, but not limited to, needs assessment requests, an anticipated agenda, schedule, and materials required for site visit.
- (4) The Program shall post instructions and criteria for submitting a CCBHC application on the Program website.
- (5) The Authority may deny CCBHC certification if an applicant does not meet the requirements of these rules.

(6) A practice may request that the Authority reconsider the denial of CCBHC recognition or reconsider the assigned level of readiness.

(a) A request for reconsideration must be submitted in writing to the Authority within 30 days of the date of the denial or approval letter and must include a detailed explanation of why the practice believes the Authority’s decision is in error along with any supporting documentation.

(b) The Authority shall inform the practice in writing whether it has reconsidered its decision.

Stat. Auth: ORS 413.042
Stats. Implemented: ORS 413.042
Hist.: OHP 7-2016(Temp), f. & cert. ef. 4-22-16 thru 10-18-16; OHP 14-2016, f. & cert. ef. 9-26-16

**409-062-0040
Certification Criteria**

A practice seeking CCBHC certification must meet the following criteria:

- (1) Complete CCBHC application process, meeting the “ready to certify” or “mostly ready to certify” designation;
- (2) Meet all federal criteria stated in the document titled “Criteria for the Demonstration program to Improve Community mental health Centers and to Establish Certified Community Behavioral Health Clinics”;
- (3) Meet all Oregon criteria stated in the Oregon CCBHC standards;
- (4) Agree to a verification site visit and follow up activities with the CCBHC site review team; and
- (5) Agree to contributing to and participating in the statewide needs assessment process.

Stat. Auth: ORS 413.042
Stats. Implemented: ORS 413.042
Hist.: OHP 7-2016(Temp), f. & cert. ef. 4-22-16 thru 10-18-16; OHP 14-2016, f. & cert. ef. 9-26-16

**409-062-0050
Level of Readiness Designation**

(1) The Authority shall award three levels of readiness designations to practices implementing multiple advanced CCBHC measures, including:

- (a) Ready to certify: Currently meets the required criteria.

(b) Mostly ready to certify: Currently meets the majority of required criteria and has plans and a timeline in place to meet remaining required criteria.

(c) Mostly ready to certify with assistance: Currently meets the majority of required criteria with needs for significant technical assistance to meet required criteria and develop a plan and timeline to meet remaining required criteria.

(2) Not ready to certify: Does not meet all certification criteria.

Stat. Auth: ORS 413.042
Stats. Implemented: ORS 413.042
Hist.: OHP 7-2016(Temp), f. & cert. ef. 4-22-16 thru 10-18-16; OHP 14-2016, f. & cert. ef. 9-26-16

**409-062-0060
Variances**

(1) The Authority may grant a variance to a CCBHC applicant or provider if:

(a) There is a lack of resources to meet the criteria required in these rules; or

(b) Implementation of the proposed alternative services, methods, concepts or procedures would result of improved outcomes for the individual.

(2) CCBHC applicants must submit the variance request directly to the CCBHC project team.

(3) The request must be in writing and must contain the following:

- (a) Criteria from which the variance is sought;
- (a) The reason for the proposed variance;
- (c) The alternative practice, service, method, concept, or procedure proposed, and;
- (d) A plan and timetable for compliance with the section of criteria for which the variance applies.

(4) The CCBHC principal investigator must approve or deny the request for a variance and must notify the provider in writing of the decision to approve or deny the requested variance, within 30 days of receipt of the variance. The written notification must include the specific alternative practice, service, method, concept, or procedure that is approved and the duration of the approval.

(5) Granting a variance for one request does not set a precedent that must be followed by the Authority when evaluating subsequent requests for variance.

Stat. Auth: ORS 413.042
Stats. Implemented: ORS 413.042
Hist.: OHP 7-2016(Temp), f. & cert. ef. 4-22-16 thru 10-18-16; OHP 14-2016, f. & cert. ef. 9-26-16