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2 Secretary of State

3 **OREGON HEALTH AUTHORITY, HEALTH POLICY AND ANALYTICS**

4 **DIVISION 25**

5 **ALL PAYER ALL CLAIMS DATA REPORTING PROGRAM**

6 **409-025-0100**

7 **Definitions**

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

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

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

14 ~~(3) "Annual supplemental provider level APM summary file" means a data set composed~~
15 ~~of total and primary care-related dollars disbursed, by payment arrangement and line of~~
16 ~~business.~~

17 ~~(43)~~ "APAC" means all payer all claims.

18 ~~(54)~~ "APM" means alternative payment methodology.

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

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

25 ~~(87)~~ "Authority" means the Oregon Health Authority.

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

28 ~~(409)~~ "Capitated services" means services rendered by a provider through a contract in
29 which payments are based upon a fixed dollar amount for each enrollee on a monthly
30 basis.

- 1 (~~4110~~) "Carrier" shall have the meaning given that term in ORS 743B.005.
- 2 (~~4211~~) "Certificate of authority" shall have the meaning given that term in ORS 731.072.
- 3 (~~4312~~) "Charges" means the actual dollar amount charged on the claim.
- 4 (~~4413~~) "Claim" means an encounter or request for payment under the terms of an
5 insurance policy, health benefits plan, Medicare, or Medicaid.
- 6 (~~4514~~) "Co-insurance" means the percentage an enrollee pays toward the cost of a
7 covered service.
- 8 (~~4615~~) "Coordinated Care Organization (CCO)" shall have the meaning given that term
9 in ORS 414.025.
- 10 (~~4716~~) "Co-payment" means the fixed dollar amount an enrollee pays to a health care
11 provider at the time a covered service is provided or the full cost of a service when that
12 is less than the fixed dollar amount.
- 13 (~~4817~~) "Data file" means electronic health information including medical claims files,
14 eligibility files, medical provider files, pharmacy claims files, dental claims files, control
15 totals files, subscriber-billed premiums files, APM-payment arrangement files and any
16 other related information specified in these rules.
- 17 (~~4918~~) "Data set" means a collection of individual data records, whether in electronic or
18 manual files.
- 19 (~~2019~~) "Data vendor" means the entity under contract with the Authority to administer in
20 whole or in part the all payer all claims database and related functions.
- 21 (~~2420~~) "DCBS" means the Oregon Department of Consumer and Business Services.
- 22 (~~2221~~) "Deductible" means the total dollar amount an enrollee pays toward the cost of
23 covered services over an established period of time before the carrier or third-party
24 administrator makes any payments under an insurance policy or health benefit plan.
- 25 (~~2322~~) "De-identified health information" means health information that does not identify
26 an individual and with respect to which there is no reasonable basis to believe that the
27 information can be used to identify an individual.
- 28 (23) "Dental claims file" means a data set composed of dental health care service level
29 remittance information for all adjudicated claims for each billed service including but not
30 limited to member demographics, provider information, charge and payment
31 information, and clinical diagnosis and procedure codes for an Oregon resident as
32 defined in ORS 803.355 or a non-Oregon resident who is a member of a PEGB or
33 OEGB group health insurance plan.

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(24) “Direct personal identifier” means information relating to an individual patient or enrollee 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.

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

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

(27) “DRC” means Data Review Committee.

(28) “Dual eligible special needs plan” means a special needs plan that enrolls beneficiaries entitled to both Medicare and Medicaid.

- 1 (29) "Eligibility file" means a data set containing demographic information for each
2 individual enrollee eligible for medical benefits for one or more days of coverage at any
3 time during a calendar month for an Oregon resident as defined in ORS 803.355 or a
4 non-Oregon resident who is a member of a PEBB or OEGB group health insurance
5 plan.
- 6 (30) "Eligible employee" shall have the meaning given that term in ORS 743B.005.
- 7 (31) "Employee" shall have the meaning given that term in ORS 654.005.
- 8 (32) "Employer" shall have the meaning given that term in ORS 654.005.
- 9 (33) "Encrypted identifier" means a code or other means of identification to allow
10 individual patients or enrollees to be tracked across data sets without revealing their
11 identity.
- 12 (34) "Encryption" means a method by which the true value of data has been disguised
13 in order to prevent the identification of individual patients or enrollees and does not
14 provide the means for recovering the true value of the data.
- 15 (35) "Enrollee" means enrollee as defined in ORS 743B.005.
- 16 (36) "ERISA" means the Employee Retirement Income Security Act of 1974 (ERISA), 29
17 U.S.C. § 1001
- 18 (37) "Facility" means a health care facility as defined in ORS 442.015.
- 19 (38) "Genetic test" shall have the meaning given that term in ORS 192.531.
- 20 (39) "Group health insurance" shall have the meaning given that term in ORS 731.098.
- 21 (40) "Health benefit plan" shall have the meaning given that term in ORS 743B.005.
- 22 (41) "Health care" shall have the meaning given that term in ORS 192.556.
- 23 (42) "Health care operations" means certain administrative, financial, legal, and quality
24 improvement activities that are necessary to run programs including, but not limited to,
25 conducting quality assessment and improvement activities, population-based activities
26 relating to improving health or reducing health care costs, case management and care
27 coordination, evaluating practitioner, provider, or health plan performance, and
28 underwriting, enrollment, premium rating and other activities related to creation,
29 renewal, or replacement of a health insurance contract.
- 30 (43) "Health care provider" shall have the meaning given that term in ORS 192.556.
- 31 (44) "Health information" shall have the meaning given that term in ORS 192.556.

1 (45) "Health insurance exchange" shall have the meaning given that term in ORS
2 741.300.

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

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

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

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

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

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

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

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

26 (54) "LAN group" means the framework based on that used by the Health Care Payment
27 Learning and Action Network as payment arrangement categories.

28 (a) Category 1 is fee for service with no link to quality or value measures.

29 (b) Category 2 is fee for service with some link to quality or value and includes
30 foundational payments for infrastructure and operations, pay for reporting data,
31 and pay for performance.

32 (A) Category 2A(i) includes payments for recognition as a PCPCH, or per-
33 member per-month payment for members in a PCPCH.

1 (B) Category 2A(ii) includes payments for foundational payments for
2 infrastructure and operations that are not based on PCPCH tier level.

3 (B) Category 2A(iii) includes payments for foundational payments for
4 infrastructure and operations that are not based on PCPCH status.

5 (C) Category 2B includes bonus payments for reporting data on quality, or
6 penalties for not reporting data.

7 (D) Category 2C includes bonus payments for high performance on
8 clinical quality measures, or penalties for poor performance

9 (c) Category 3 is fee for service architecture with alternative payment
10 methodologies built on and includes shared savings and shared risk.

11 (A) Category 3A includes payments made under arrangements that are based
12 on cost (and occasionally utilization) performance, as long as quality targets are met.
13 Examples include: Bundled payment with upside risk only; episode-based payments for
14 procedure-based clinical episodes with shared savings only.

15 (B) Category 3B includes payments or penalties made under
16 arrangements that both reward and penalize cost (and occasionally utilization)
17 performance if quality targets are met.

18 (C) Category 3N is risk-based payments are not linked to quality
19 measures.

20 (d) Category 4 is population-based payments including condition-specific
21 population-based payments, comprehensive population-based payments and
22 integrated finance and delivery systems.

23 (A) Category 4A includes prospective, population-based payment for a
24 certain set of condition specific-services (e.g. oncology, mental health, diabetes)
25 or for care delivered by particular types of clinicians (e.g. primary care,
26 orthopedics).

27 (B) Category 4B includes prospective, population-based payments for all
28 (comprehensive) of an individual's health care needs.

29 (C) Category 4C includes payments for comprehensive care that integrate
30 the financing arm with a delivery organization.

31 (D) Category 4N is capitated payments not linked to quality.

32 (5455) "Large group" means health benefit plans for employers with more than 50
33 employees.

1 (5556) “Long-term care insurance” shall have the meaning given that term in ORS
2 743.652.

3 (5657) “Mandatory reporter” means any reporting entity defined as a mandatory reporter
4 in OAR 409-025-0110.

5 (5758) “Medicaid” means medical assistance provided under 42 U.S.C. section 1396a
6 (section 1902 of the Social Security Act) or Children’s Health Insurance Program (CHIP)
7 medical assistance provided under 42 U.S.C section 1397aa-mm (section 2103 of the
8 Social Security Act), as administered by the Division of Medical Assistance Programs.

9 (5859) “Medicaid fee-for-service” (Medicaid FFS) means that portion of Medicaid where
10 a health care provider is paid a fee for each covered health care service delivered to an
11 eligible Medicaid patient.

12 (5960) “Medical claims file” means a data set composed of health care service level
13 remittance information for all adjudicated claims for each billed service including but not
14 limited to member demographics, provider information, charge and payment
15 information, and clinical diagnosis and procedure codes for an Oregon resident as
16 defined in ORS 803.355 or a non-Oregon resident who is a member of a PEGB or
17 OEGB group health insurance plan.

18 ~~(60) “Medical provider file” means a data set containing information about health care~~
19 ~~providers providing health care services, equipment, or supplies to enrollees during the~~
20 ~~reporting period.~~

21 (6461) “Medicare” means coverage under Part A, Part B, Part C, or Part D of Title XVIII
22 of the Social Security Act, 42 U.S.C. 1395 et seq., as amended.

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

26 (62) “Membership Control and Totals File” means a data set containing summary
27 information on medical, pharmacy and dental claims, members, providers and
28 premiums used to validate the detailed files submitted.

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

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

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

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1 (665) "Patient" means any person in the data set who is the subject of the activities of
2 the claim performed by the health care provider.

3 ~~(66) "Paid amount" means the actual dollar amount paid for claims.~~ (67) "Patient-
4 Centered Primary Care Home" or "PCPCH" means a health care team or clinic as
5 defined in ORS 414.655 that has been recognized as meeting the relevant standards
6 pursuant to OAR 409-055-0040.

7 (68) "Payment Arrangement File" means a data set composed of total and primary care-
8 related dollars disbursed, by payment arrangement and line of business.

9 (6769) "PEBB" means the Oregon Public Employees' Benefit Board.

10 (6870) "Person" shall have the meaning given that term in ORS 731.116.

11 (6971) "Pharmacy benefit manager (PBM)" means a person or entity that performs
12 pharmacy benefit management, including a person or entity in a contractual or
13 employment relationship with a person or entity performing pharmacy benefit
14 management for a health benefits plan.

15 (7270) "Pharmacy claims file" means a data set containing service level remittance
16 information from all adjudicated claims including, but not limited to, enrollee
17 demographics, provider information, charge and payment information, and national drug
18 codes for an Oregon resident as defined in ORS 803.355 or a non-Oregon resident who
19 is a member of a PEBB or OEBB group health insurance plan.

20 (7473) "Policy" shall have the meaning given that term in ORS 731.122.

21 (7274) "Prepaid amount" means the fee for the service equivalent that would have been
22 paid for a specific service if the service had not been capitated.

23 (7375) "Premium" shall have the meaning given that term in ORS 743B.005.

24 (7476) "Principal investigator (PI)" means the person in charge of a research project that
25 makes use of limited data sets. The PI is the custodian of the data and shall comply with
26 all state and federal restrictions, limitations, and conditions of use associated with the
27 data release.

28 (7577) "Protected health information" shall have the meaning given that term in ORS
29 192.556.

30 (78) "Provider file" means a data set containing information about health care providers
31 providing health care services, equipment, or supplies to enrollees during the reporting
32 period.

- 1 (~~7679~~) “Public health authority” means the Public Health Division of the Authority or
2 local public health authority as defined in ORS 431A.005.
- 3 (~~7780~~) “Public health purposes” means the activities of a public health authority for the
4 purpose of preventing or controlling disease, injury, or disability including, but not limited
5 to, the reporting of disease, injury, vital events such as birth or death, and the conduct
6 of public health surveillance, investigations, and interventions.
- 7 (~~7881~~) “Registered entity” means any person required to register with DCBS under ORS
8 744.714.
- 9 (~~7982~~) “Reporting entity” means:
- 10 (a) An insurer as defined in ORS 731.106 or fraternal benefit society as defined
11 in ORS 748.106 required to have a certificate of authority to transact health
12 insurance business in Oregon.
- 13 (b) A health care service contractor as defined in ORS 750.005 that issues
14 medical insurance in Oregon.
- 15 (c) A third-party administrator required to obtain a license under ORS 744.702.
- 16 (d) A pharmacy benefit manager or fiscal intermediary, or other person that is by
17 statute, contract, or agreement legally responsible for payment of a claim for a
18 health care item or service.
- 19 (e) An insurer providing coverage funded under Part A, Part B, or Part D of Title
20 XVIII of the Social Security Act, subject to approval by the United States
21 Department of Health and Human Services.
- 22 (~~8083~~) “Research” means a systematic investigation, including research development,
23 testing and evaluation, designed to develop or contribute to generalized knowledge.
- 24 (~~8184~~) “Self-insured plan” means any plan, program, contract, or any other arrangement
25 under which one or more employers, unions, or other organizations provide health care
26 services or benefits to their employees or members in this state, either directly or
27 indirectly through a trust or third-party administrator.
- 28 (~~8285~~) “Small employer health insurance” means health benefit plans for employers
29 whose workforce consists of at least two but not more than 50 eligible employees.
- 30 (~~8386~~) “Special Needs Plan” means a Medicare health benefit plan created by the
31 Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law
32 108-173) and the federal regulations adopted to implement the Act~~Medicare~~
33 ~~Modernization Act~~ that is specifically designed to provide targeted care to individuals
34 with special needs.

1 (~~8487~~) "Specific disease policy" means an insurance policy that provides benefits only
2 for a loss due to a covered disease.

3 (~~8588~~) "Strongly-encrypted" means an encryption method that uses a cryptographic key
4 with a large number of random keyboard characters.

5 (~~8689~~) "Subscriber" means the individual responsible for payment of premiums or
6 whose employment is the basis for eligibility for membership in a health benefit plan.

7 (90) "Subscriber-billed Premiums File" means the data set that includes premium
8 information at the subscriber level for medical, pharmacy and dental insurance.

9 (~~8791~~) "Summarized data" means data aggregated by one or more categories.
10 Summarized data created from protected health information may not contain direct or
11 indirect identifiers.

12 (~~8892~~) "Third-party administrator (TPA)" means any person who directly or indirectly
13 solicits or effects coverage of, underwrites, collects charges or premiums from, or
14 adjusts or settles claims on, residents of Oregon or residents of another state from
15 offices in Oregon, in connection with life insurance or health insurance coverage; or any
16 person or entity who must otherwise be licensed under ORS 744.702.

17 (~~8993~~) "Transact insurance" shall have the meaning given that term in ORS 731.146.

18 (~~9094~~) "Trust" means a fund established by two or more employers in the same or
19 related industry or by one or more labor unions or by one or more employers and one or
20 more labor unions or by an association.

21 (~~9195~~) "Vision policy" means a health benefits plan covering only vision health care.

22 (~~9296~~) "Voluntary reporter" means any registered or reporting entity, other than a
23 mandatory reporter, that voluntarily elects to comply with the reporting requirements in
24 OAR 409-025-0100 to 409-025-0170.

25 Stat. Auth.: ORS 442.466

26 Stats. Implemented: ORS 442.464 & 442.466

27 **409-025-0110**

28 **General Reporting Requirements**

29 (1) Determination of "mandatory reporter"

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

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

2 (B) The Authority shall calculate the mean total lives for each carrier and
3 licensed third-party administrator. Mean total lives shall be calculated by
4 using the total covered lives in all of the following lines of business for
5 each carrier and licensed third-party administrator:

6 (i) Large group;

7 (ii) Small group;

8 (iii) Individual market;

9 (iv) Medicare Advantage; and

10 (v) Self-insured.

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

13 (D) ~~(h)~~ Any carrier or licensed third-party administrator who has been
14 identified as a mandatory reporter and believes their entity has fewer than
15 5,000 mean total lives due to ERISA self-insured shall notify the Authority
16 by filing a request for waiver under OAR 409-025-0140.

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18 (b) All PBMs shall be mandatory reporters.

19 (c) All CCOs shall be mandatory reporters.

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

22 (e) All insurers providing coverage funded under ~~Part A, Part B or~~ Part D of ~~Title~~
23 ~~XVIII of the Social Security Act~~ Medicare, ~~subject to approval by the United States~~
24 ~~Department of Health and Human Services~~ shall be mandatory reporters.

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

27 (g) All insurers providing group health insurance plans to PEBB and OEGB
28 members shall be mandatory reporters.

29 ~~(h) Any carrier or licensed third-party administrator who has been identified as a~~
30 ~~mandatory reporter and believes their entity has fewer than 5,000 mean total~~

1 ~~lives due to ERISA self-insured shall notify the Authority by filing a request for~~
2 ~~waiver under OAR 409-025-0140.~~

3 (2) If an organization is notified of mandatory reporter status and believes the
4 determination to be in error, the organization must contact the Authority to contest the
5 determination as described in the notice no later than ninety days prior to the first
6 scheduled date of submission of production files.

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

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

11 (a) Required lines of business include:

12 (A) Medicare ~~(parts C and D)~~ Advantage (Part C) and Medicare Part D;

13 (B) Medicaid;

14 (C) Individual;

15 (D) Small employer health insurance;

16 (E) Large group;

17 (F) Associations and trusts;

18 (G) PEBB and OEGB group health insurance plans; ~~and~~

19 (H) Self-insured plans not subject to ERISA; and

20 (I) Dental insurance.

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

22 (c) Excluded lines of business include:

23 (A) Accident policy;

24 ~~(B) Dental insurance;~~

25 ~~(B) Disability policy;~~

26 ~~(D) Hospital indemnity policy;~~

- 1 (~~ED~~) Long-term care insurance;
- 2 (~~FE~~) Medicare supplemental insurance;
- 3 (~~GF~~) Specific disease policy;
- 4 (~~HG~~) Stop-loss plans;
- 5 (~~IH~~) Student health policy;
- 6 (~~JI~~) Supplemental insurance that pays deductibles, copays or coinsurance;
- 7 (~~KJ~~) Vision-only insurance; and
- 8 (~~LK~~) Workers compensation.

9 (d) A mandatory reporter that contracts with another entity remains responsible
10 for reporting all required lines of business. If the mandatory reporter elects to
11 have the data reported by a contracted entity, the mandatory reporter shall notify
12 the Authority and provide contact information for the contracted entity.

13 (~~45~~) Mandatory and voluntary reporters shall comply with data file layout, format, and
14 coding requirements in OAR 409-025-0120.

15 (~~65~~) Mandatory and voluntary reporters shall comply with data submission requirements
16 in OAR 409-025-0130.

17 (~~76~~) Unless otherwise required by state or federal rules, regulations or statutes,
18 mandatory and voluntary reporters may not submit claims subject to stricter disclosure
19 limits imposed by state or federal rules, regulations, or statutes.

20 (~~87~~) The Authority shall provide written notification by July 1 of each year to all
21 mandatory reporters subject to the reporting requirements of OAR 409-025-0100 to
22 409-025-~~0170-0150~~ for the following calendar year.

23 (~~98~~) New mandatory reporters submitting for the first time, or mandatory reporters that
24 did not submit data in the previous year, shall submit test files before production files
25 are due. The mandatory reporters shall submit test files no later than 60 days before the
26 mandatory reporter's first submission of production files.

27 Stat. Auth.: ORS 442.466
28 Stats. Implemented: ORS 442.464 & 442.466
29

30 **409-025-0120**

31 **Claims-based Data: File Layout, Format, and Coding Requirements**

1 (1) All mandatory reporters shall submit claims-based data for all claims where the
2 subscriber's residence is in Oregon or the subscriber is enrolled in a plan for which the
3 State of Oregon is the payer.

4 ~~(2) All data~~Claims-based data files shall include:

- 5 (a) ~~Eligibility~~ Medical claims;
- 6 (b) ~~Membership Total and Claims Controls~~; Eligibility;
- 7 (c) ~~Medical Subscriber billed premiums provider~~;
- 8 (d) ~~Pharmacy claims~~Provider;
- 9 (e) ~~Control totals~~Medical claims;
- 10 (f) ~~Subscriber billed premiums~~Pharmacy claims; and
- 11 (g) ~~Annual supplemental provider level APM summary~~; and Dental Claims.

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13 ~~(h) Control totals for annual supplemental provider level APM summary.~~

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

16 (3) The Eligibility file shall be submitted by all mandatory reporters except CCOs using
17 the approved layout, format, and coding described in Appendix BEligibility File Layout
18 version 2020.1.

19 (a) Mandatory reporters shall report race and ethnicity data as outlined in
20 Appendix Bthe Eligibility File Layout. This layout aligns with the Office of
21 Management and Budget's (OMB) Federal Register Notice of October 30, 1997
22 (62 FR 58782-58790).

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

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

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

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

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

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

3 ~~(4) The Membership Total and Claims Control file shall be submitted by all mandatory~~
4 ~~reporters except CCOs using the approved layout, format, and coding described in~~
5 ~~Claims Control File Layout version 2020.1.~~

6 ~~(5) The Subscriber billed premium file shall be submitted by all mandatory reporters~~
7 ~~except CCOs using the approved layout, format, and coding described in Subscriber~~
8 ~~billed Premium File Layout version 2020.1~~

9 ~~(45) The medical-Provider file shall be submitted by all mandatory reporters other than~~
10 ~~PBMs and CCOs using the approved layout, format, and coding described in Appendix~~
11 ~~C-Provider File Layout version 2020.1.~~

12 ~~(6) The Medical Claims file shall be submitted by all mandatory reporters other than~~
13 ~~PBMs, CCOs and dental carriers using the approved layout, format, and coding~~
14 ~~described in the Medical Claims File Layout version 2020.1.~~

15 ~~(57) The Pharmacy eClaims file shall be submitted by PBMs and carriers using the~~
16 ~~approved layout, format, and coding described in the Appendix D Pharmacy File Layout~~
17 ~~version 2020.1.~~

18 ~~(8) The Dental Claims file shall be submitted by all mandatory reporters other than~~
19 ~~PBMs and CCOs who provide dental coverage using the approved layout, format, and~~
20 ~~coding described in the Dental Claims File Layout version 2020.1.~~

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

23 ~~(7) The subscriber billed premium file shall be submitted using the approved layout,~~
24 ~~format, and coding described in Appendix F. (8) The annual supplemental provider level~~
25 ~~APM summary file shall be submitted using the approved layout, format, and coding~~
26 ~~described in Appendix G.~~

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

29 ~~(409)~~ All data elements are required unless specified as optional or situational.

30 ~~(410)~~ All required data files shall be submitted as delimited ASCII files.

31 ~~(4211)~~ Numeric data are positive integers unless otherwise specified.

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

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

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

1 ~~(a) Mandatory reporters;~~

2 ~~(b) Providers;~~

3 ~~(c) Researchers, and;~~

4 ~~(d) Other stakeholders and interested parties.~~

5 ~~(4412)~~ All data files shall pass edit checks and validations implemented by the Authority
6 or the data vendor.

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

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

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

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

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

29 [ED. NOTE: ~~Appendices Data file layouts~~ referenced and ~~Schedule A Data Submission~~
30 ~~Schedule~~ are not included in rule text. Click here for PDF copy of ~~Appendices and~~
31 ~~Schedule A documents~~.

32 [Under a contractual arrangement effective in 2020, OHA reports on eligibility, medical](#)
33 [claims, pharmacy claims, dental claims, premiums and membership control totals on](#)
34 [behalf of CCOs.](#)

35 Stat. Auth.: ORS 442.466

36 Stats. Implemented: ORS 442.464 & 442.466

37 [409-025-0125 new rule number](#)

38 [Payment Arrangement Reporting: File Layout, Format, and Coding Requirements](#)

1 (1) All mandatory reporters other than PBMs shall report payment arrangements for all
2 contracts situated in Oregon. For contracts issued at the group level, the contract is
3 considered situated where the contract is sold. For contracts that are issued at the
4 individual level, the contract is considered situated where the individual resides.

5 (2) All data files shall include:

6 (a) Payment arrangement file formerly designated Appendix G; and

7 (b) Payment arrangement control totals formerly designated Appendix H.

8 (3) The payment arrangement file shall be submitted using the approved layout, format,
9 and coding described in the Payment Arrangement File Layout version 2020.1.

10 (4) The Payment arrangement control file shall be submitted using the approved layout,
11 format, and coding described in Payment arrangement control totals file layout version
12 2020.1.

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

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

15 (7) Numeric data are positive integers unless otherwise specified.

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

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

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

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

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

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

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

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

5
6
7 **409-025-0127 new rule number**

8 **Technical Advisory Group**

9 (1) The Authority shall convene a technical advisory group to advise the Authority. The
10 advisory group shall include, but is not limited to representatives from:

11 (a) Mandatory reporters;

12 (b) Providers;

13 (c) Researchers, and;

14 (d) Other stakeholders and interested parties.

15 (2) The technical advisory group will advise the Authority on submission specifications
16 including but not limited to file layouts, the Data Submission Schedule and any
17 additional data submission requirements.

18 **409-025-0130**

19 **Data Submission Requirements**

20 (1) Mandatory reporters shall submit data files as specified in [Schedule A Data](#)
21 [Submission Schedule](#). Voluntary reporters may consult with the Authority to submit
22 healthcare claims data files on an alternative schedule.

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

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

27 (a) Secure file transfer protocol (SFTP) including separate strong encryption of
28 data files prior to SFTP transmission; or

29 (b) Any process incorporating strong encryption that is approved in writing by
30 both the Authority and the data vendor.

31 [ED. NOTE: [Schedule A Data Submission Schedule](#) referenced is not included in rule
32 text. [Click here for PDF copy of Schedule A the Data Submission Schedule.](#)]

33 Stat. Auth.: ORS 442.466

34 Stats. Implemented: ORS 442.464 & 442.466

35

1 **409-025-0140**
2 **Waivers and Exceptions – no changes proposed**

3 **409-025-0150**
4 **Compliance and Enforcement**

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

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

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

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

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

- 19 (a) Failure to submit test files as specified by the data vendor;
- 20 (b) Submitting data files later than five days after the submission due date as
21 ~~outlined in Schedule A~~ detailed in the Data Submission Schedule;
- 22 (c) Rejection of a data file by the data vendor that is not resubmitted or corrected
23 by the submitter within 14 calendar days from notification of error; or
- 24 (d) Transmitting data files using an unapproved process.

25 (4) The Authority shall provide mandatory reporters written notification of each failure to
26 comply prior to imposing a civil penalty under this rule. Mandatory reporters will have 30
27 calendar days to come into compliance.

28 (5) The Authority may impose civil penalties against mandatory reporters for each
29 failure to comply that is not resolved within 30 calendar days of written notification. If a
30 mandatory reporter does not come into compliance within 30 days of written notification,
31 penalties will be assessed starting from the date the mandatory reporter was notified of
32 non-compliance. Pursuant to ORS 442.993, the Authority adopts the following schedule
33 of civil penalties:

- 34 (a) Up to \$400.00 per day for violations of OAR 409-025-0150(1);

1 (b) Up to \$300.00 per day for violations of OAR 409-025-0150(2) or OAR 409-
2 025-0140(2)(a); and

3 (c) Up to \$200.00 per day for violations of OAR 409-025-0150(3);

4 (6) If a mandatory reporter was issued a final order imposing civil penalties within 24
5 months from the date the Authority issues a notice of intent to impose a civil penalty, the
6 Authority may impose an additional \$100.00 per day for each of the category of
7 violations listed in section (5) of this rule.

8 (7) If a mandatory reporter has made documented efforts to comply with these rules, the
9 Authority may consider this a mitigating factor before imposing civil penalties against the
10 mandatory reporter.

11 [ED. NOTE: ~~Schedule A~~ Data Submission Schedule referenced is not included in rule
12 text. Click here for PDF copy of the Data Submission Schedule A.]

13 Stat. Auth.: ORS 442.466 & 442.993

14 Stats. Implemented: ORS 442.464, 442.466 & 442.993

15
16 **409-025-0160**

17 **Data Access and Release**

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

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

23 (3) The Authority shall establish procedures to request a public use data set file or a
24 limited data set file. The procedure shall collect sufficient information to evaluate any
25 request for APAC data. Requestors must comply with the application procedures for
26 data sets as communicated on the APAC website.

27 ~~(34)~~ (34) The Authority shall provide a public use data set, which shall include de-identified
28 health information, in compliance with applicable Authority policies and state and federal
29 rules, regulations, and statutes.

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

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

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

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

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

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

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

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

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

14 (A) The Authority shall provide written notification stating the reason for
15 the denial and process return of payment; and

16 (B) The requestor may appeal the denial by requesting a contested case
17 hearing. The appeal must be filed within 30 business days of the denial.
18 The appeal process is conducted pursuant to ORS chapter 183 and the
19 Attorney General's Uniform and Model Rules of Procedure, OAR 137-003-
20 0501 to 137-003-0700. The requestor shall have the burden to prove that
21 the Authority unreasonably denied the application.

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

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

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

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

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

1 (d) Requestors must identify each data element requested and explain the use of
2 the data element within the description of activity in the application. The Authority
3 will determine which data elements will be released after review under HIPAA
4 and other applicable laws, regulations and rules.

5 (e) The Authority shall determine the hours required to complete the data request
6 and inform the requestor of the cost of the resulting data set.

7 (6) Requestors who receive a limited data set must maintain IRB approval, if required
8 for the data use agreement, throughout the span of authorized use of the data and until
9 the data is destroyed. Requestors must submit updated documentation authorizing
10 continued activity prior to the expiration of the previous authorization.

11 (7) Requestors who receive a limited data set must submit an amendment to the
12 Authority anytime there is a change in proposed use of the data within the scope of the
13 original data request.

14 (a) Requestors shall file such an amendment when any of the following is
15 anticipated:

16 _____ (A) change in persons accessing data

17 _____ (B) additional data elements are requested

18 _____ (C) additional years of data are requested

19 _____ (D) any change in use of data including linking or addition of research
20 questions

21 _____ (E) any change in research protocol, regardless of approval by Institutional
22 Review Board.

23 (b) Requestors may not implement any change prior to receiving approval from
24 the Authority.

25 (c) All changes in data elements, data use or research protocol must be reviewed
26 by the Data Review Committee. In addition, a recommendation by the Data
27 Review Committee may be sought for additional years of data or new project
28 staff for limited data sets the Authority determines to include vulnerable
29 populations.

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

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

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

8 ~~(6)~~ (d) The Authority shall review for completeness all applications and provide
9 requestors written notification of completeness within 30 calendar days of receipt
10 of the request. If the Authority determines that the application is incomplete, the
11 requestor shall have 30 calendar days from notification of incompleteness to
12 complete the application. Incomplete applications that are not completed shall be
13 discarded without further notification to the requestor.

14
15 ~~(a) If the Authority determines that the application is incomplete, the requestor~~
16 ~~shall have 30 calendar days from notification of incompleteness to complete the~~
17 ~~application. Incomplete applications that are not completed shall be discarded~~
18 ~~without further notification to the requestor.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 ~~(H) If the DRC requests clarification, the requestor shall have 30 calendar~~
18 ~~days to provide the requested information to the Authority. After 30~~
19 ~~calendar days, applications with incomplete requests for clarification shall~~
20 ~~be discarded without further notification to the requestor.~~

21 ~~(I) Upon receipt of the requested clarification the Authority shall schedule~~
22 ~~reevaluation with the DRC on a first-come-first-served basis.~~

23 ~~(J) If the Authority denies the application:~~

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

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

33 [ED. NOTE: Forms and lists referenced are available on the agency's website:
34 <http://www.oregon.gov/oha/hpa/analytics/Pages/All-Payer-All-Claims.aspx>]

35 Stat. Auth.: ORS 442.466 Stats. Implemented: ORS 442.464 & 442.466

36 **409-025-0165 – new rule number**

1 **Data Review Committee**

2 (1) The Authority shall convene a Data Review Committee (DRC) to evaluate completed
3 applications for limited data sets.

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

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

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

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

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

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

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

18 (5) Consideration of applications for limited data sets:

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

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

23 (c) The Authority shall accept or reject the DRC's recommendation and notify the
24 requestor within ten business days of the review.

25 (d) The Authority may deny a completed application for reasons which include,
26 but are not limited to:

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

29 (B) Full payment is not received for the application.

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

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

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

5 (e) If the DRC requests clarification, the requestor shall have 30 calendar days to
6 provide the requested information to the Authority. After 30 calendar days,
7 applications with incomplete requests for clarification shall be discarded without
8 further notification to the requestor.

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

11 (g) If the Authority denies the application:

12 (A) The Authority shall provide written notification stating the reason for
13 the denial.

14 (B) The requestor may appeal the denial by requesting a contested case
15 hearing. The appeal must be filed within 30 business days of the denial.
16 The appeal process is conducted pursuant to ORS Chapter 183 and the
17 Attorney General's Uniform and Model rules of Procedure, OAR 137-003-
18 0501 to 137-003-0700. The requestor shall have the burden to prove that
19 the Authority unreasonably denied the application.

20 Statutory/Other Authority: ORS 442.466

21
22 **409-025-0170**

23 **Public Disclosure – no changes proposed**

24