Rules Advisory Committee Meeting
House Bill 2685
Meeting Minutes

Date: Wednesday, September 17, 2025
Time: 9:00 AM – 11:00 AM
Location: Virtual - Zoom OHA Public Health Division

Meeting Started: 9:04 AM

Meeting Recorded

Committee Members Present: Anna Agnew, Justine Clark, Annette Cole, Kate Dillon, Laura Erickson, Michael Gilbert, Sheevaun Khaki, Chad Ludwig, Emilia Allen Smith, David Stein, Louise Vaz, Shelley Weise, Mariah Wharton, Willa Woodard Ervin

Absent: Cynthia Luxford, Leonard Machado, Zilmullia Pittman

OHA Staff & **Consultants to OHA**: Catalina Aragon, Shelby Atwill, Mellony Bernal, Gianna Bortoli, Sarah Kowalski, Megan Sanders

Total Attendees: 20

Summary of Meeting

Agenda Item: Introductions & Housekeeping

Summary of Discussion: Meetings are recorded for note-taking purposes. Reviewed agenda. Welcome to the Rules Advisory Committee meeting for HB2685. This is our 1st meeting of the committee. Reviewed RAC meeting guidelines. Meeting was recorded.

Agenda Item: Review of the Rulemaking Process

Summary of Discussion: Reviewed materials packet document, Draft Rulemaking Process and Timeline. The Oregon Health Authority, Public Health Division has policies and procedures that guide the rulemaking process. Reviewed requirements in the timeline process in order to have the rules effective in January 2026. Reviewed the difference between ORS and OAR. The major goals of the meeting are to review the language in the statute that passed in the 2025 legislative session under House Bill 2685.

Agenda Item: Review of the Rulemaking Process

Summary of Discussion: Review Draft Amended Rules

RAC members provided feedback on the draft of the proposed rules Oregon Health Authority, Public Health Division - chapter 333, division 20, Early Hearing Detection and Intervention 333-020-0125 through 333-020-0165.

Reviewed definitions and proposed changes.

333-020-0125: Definitions

- Questions on the definitions of the Cytomegalovirus Screening Protocol will be in the administrative rule. A RAC member asked whether the congenital CMV screening protocol should be defined within the administrative rules, specifically whether the list of symptoms included in the expanded targeted protocol should be spelled out. They emphasized the need to ensure the rules clearly require an expanded targeted screening protocol rather than a hearing-only targeted protocol. In response, OHA staff noted that the protocol itself will be a separate referenced document within the rules and will be discussed, including clinical indications, at the second RAC meeting.
- A RAC member noted that while the rules require CMV testing within 14 days of birth and before discharge from a hospital or birthing center, there is an exception for Health Maintenance Organizations (HMOs). For HMOs, testing must still occur within 14 days of birth but not necessarily before discharge, since pediatricians are integrated within the same system and the risk of missed testing is lower. The member suggested this distinction should be referenced in the rules.
- A RAC member asked for clarification on whether the CMV testing requirements apply to home birth providers, noting that the rules reference birthing centers and facilities but not home births, where thousands of babies are delivered each year. OHA staff confirmed that the requirements apply only to licensed hospitals and free-standing birth centers as defined in statute, not to home births.
- A RAC member requested clarification on the term “mandated facility,” noting that some smaller hospitals, such as critical access hospitals, have fewer than 200 births per year. OHA staff explained that “mandated facility” refers specifically to newborn hearing screening requirements in statute, which apply only to facilities with more than 200 births annually. Smaller facilities may provide screenings voluntarily, which is encouraged, but they are not mandated.
- A RAC member clarified that the CMV screening bill amended existing law related to hearing screening, which is why the rules reference hearing screening language. The 200-live-birth threshold is longstanding law that applies only to hearing screening requirements. In contrast, the CMV screening protocol applies to all hospitals and birthing centers, regardless of the number of births.
- Participants clarified that the CMV screening bill amended existing hearing screening law, which is why the rules reference hearing screening language. The 200-live-birth

threshold applies only to hearing screening requirements and has been longstanding law intended to avoid burdening smaller or rural facilities. In contrast, the CMV screening protocol applies to all hospitals and birthing centers regardless of birth numbers. It was also noted that while smaller facilities with fewer than 200 births are not mandated to conduct hearing screenings, they may still choose to do so. A question was raised about how screenings would occur for home births or non-mandated facilities, with OHA staff confirming that the bill does not reference home births, though additional CMV information will be distributed to hospitals and birthing centers.

333-020-01xx: Determining Facility Requirements to Provide Hearing Screenings

- No feedback.

333-020-0130: Facility Requirements for Hearing Screening in Newborns

- Questions about parents who decline hearing screenings. OHA clarified there is language in rule for parents who choose to decline the hearing and CMV screenings.

333-010-01xx: Facility Requirements to Provide Congenital Cytomegalovirus Testing in Newborns:

- Discussion focused on clarifying the exception for Health Maintenance Organizations (HMOs). Members suggested specifying that all newborns must be tested within 14 days of birth, but for HMOs the test does not need to occur before discharge, consistent with statutory language. Additional feedback recommended that discharge communications include not only parents or guardians but also the outpatient primary care provider (PCP), to ensure appropriate follow-up. OHA staff agreed this could be incorporated into the protocol and confirmed the bill language already supports PCP notification. Members emphasized the importance of ensuring both families and PCPs receive clear information on follow-up diagnostic testing.

333-020-01xx Dissemination of Cytomegalovirus Information

- Discussion on CMV information dissemination focused on whether to specifically name certain provider types. Some members questioned if calling out OB/GYNs was necessary, while others stressed the importance of emphasizing prenatal health care providers overall, since prevention is most effective before or during pregnancy. Suggestions included explicitly listing OB/GYNs, midwives, and family medicine providers, and moving prenatal care references to the top of the list to highlight their role.

- Members also discussed the bill's language requiring materials to be provided within 48 hours after birth, noting that earlier drafts had emphasized providing information during pregnancy. Several recommended adding rule language to encourage prenatal providers to share CMV information as early as possible in pregnancy or even preconception, aligning with prevention goals and existing OHA communications. Overall, the group agreed on strengthening the focus on prenatal care providers in the rule language while staying consistent with statutory requirements.

333-020-0132: Requirements for Screening Facilities Shall

- No feedback.

333-020-0135: Facility Responsibility if Hearing Screening is Not Conducted Timely

- Discussion on facility responsibilities for newborn hearing screening centered on clarifying timing, medical exceptions, and accountability when infants are discharged before screening is completed.
- Medical Exceptions: Members raised whether, like hearing screening, CMV testing might also need a provision allowing delays when medically indicated (e.g., NICU infants who cannot produce urine or saliva immediately). It was suggested that input from neonatologists be included when developing protocols.
- Discharge & Responsibility: Concerns were raised about language placing responsibility on discharging facilities if families plan screening elsewhere (e.g., with midwives or outpatient providers). Some members felt responsibility should transfer to the receiving provider once care is transferred. Others noted that in practice, discharge usually involves confirming a follow-up plan to avoid gaps.
- Next Steps: OHA staff explained that protocol development with medical experts will address issues like medical complexity, timing exceptions, and transfer of responsibility. These points will be discussed further at the next RAC meeting.
- Overall, members emphasized clear rules and protocols to balance medical realities in NICU settings with practical responsibilities for screening follow-up after discharge.

333-020-0150: Collecting and Submitting Information Related to Hearing Screening

- No feedback

333-020-0151: **Collecting and Submitting Information Related to Diagnostic Testing for Hearing Loss in Children**

- No feedback

333-020-0155: Responsibility for Issuing Reports

- No feedback

333-020-0160: Appointment of an Advisory Committee

- No feedback

333-020-0165: Exemption from Screening

- Discussion clarified that exemptions apply separately to hearing screening and CMV screening, with current language drawn directly from statute. For hearing screening, exemptions are limited to religious tenets and practices, language established in earlier law and unchanged by HB 2685. For CMV screening, the bill does not specify such qualifications.

- Members raised questions about whether parents could decline for non-religious reasons, whether rules should address CMV screening when families decline hearing screening, and whether a single state form could cover opt-outs for both screenings. OHA staff confirmed these issues stem from statutory language and will be further addressed during protocol development, but agreed that a consolidated opt-out form could be beneficial.

Feedback for EHDI Draft rules:
A participant expressed appreciation for the thoughtful discussion and emphasized support for prioritizing prenatal providers in disseminating CMV information, suggesting they be listed first to highlight their importance. They also stressed the critical need for timely hearing and CMV screening to allow antiviral treatment to begin as early as possible. Drawing from personal experience, they noted that even with early CMV screening in a coordinated HMO setting, it was difficult to start treatment within the 30-day window, underscoring the urgency of rapid testing. They encouraged OHA to ensure that providers emphasize prompt screening in all educational materials given to families.

RAC members provided feedback on the draft of the proposed rules Oregon Health Authority, Public Health Division - Chapter 333, Division 505, Hospital Organization and Management, 333-505-0050 through 333-020-0165 and Chapter 333, Division 77, Birthing Centers.

333-505-0050: Medical Records

- The discussion clarified that a new requirement will be added to ensure medical records include documentation or a tag showing that both the newborn hearing screening and CMV testing were completed in accordance with the rules under review.

333-520-0060: Maternity Services

- The maternity services rule will be amended to require hospitals to ensure that, as part of their maternity services, both newborn hearing screening and CMV testing are conducted.

Division 77, BIRTHING CENTERS

333-077-0130: Medical Records

- Proposed changes include requiring medical records to document both newborn hearing screening and CMV testing. Additionally, a minor edit was made to separate metabolic screening from newborn hearing screening and CMV testing, placing them in distinct subsections for clarity.

333-077-0170: Newborn Care and Screening

- The newborn care and screening rule has been updated to include references to both newborn hearing screening and CMV testing, with a cross-reference to the Early Hearing Detection and Intervention (EHDI) rules.

Feedback: A participant raised concerns that CMV testing is new for hospital midwives and asked whether statewide training will be provided, as well as whether saliva or urine testing will be preferred under state regulations. OHA staff responded that these details will be addressed in the second RAC meeting when protocols are developed, and encouraged members to provide feedback on training needs and testing methods during that discussion.

Agenda Item: Public Comment

Summary of Discussion: There were no requests for public comments.

Agenda Item: Closing and Next Steps

Summary of Discussion: The closing recommendation emphasized the importance of setting a firm deadline for RAC feedback so comments do not continue up to the next session. Members should be asked to email their feedback to the RAC materials email, using reply-all so the full committee can see it. Any feedback received after the deadline will be queued for the next meeting. All communications will be documented and included in the official meeting minutes packet.

OHA explained there will be workgroup with medical professionals developing the protocol. Feedback recommended including a neonatologist.

Meeting Adjourned: 10:30 AM

Next Meeting: October 1, 2025, 9AM-11AM, Virtual via Zoom