Certificate of Need Rulemaking Advisory Committee
January 7, 2026
9 a.m. via Microsoft Teams

RAC MEMBER ATTENDEES	
Chris Bouneff	Oregon Chapter, National Alliance on Mental Illness
Danielle Meyer	Hospital Association of Oregon
Eugenia Liu	Oregon Health Care Association
Jody Corona	Health Facilities Planning and Development
John Bauer	Salem Health
Laura Johnson	SEIU Local 49
Maggie Hilty	Avamere
Melissa Eckstein	Legacy, Unity Center for Behavioral Health
Robin Henderson	Providence Health
OTHER INTERESTED PARTY ATTENDEES	
Gina Cole	Legacy Health
Jackie Fabrick	Providence Health
Marissa Fritz	
Ruth Miles	Salem Health
OHA and State Partners	
Andrea Ogston	Department of Justice
Matt Gilman	Public Health Division (PHD), Certificate of Need Program
Mellony Bernal	PHD, Health Care Regulation & Quality Improvement Section
Sadie Morrissey	PHD, Health Care Regulation & Quality Improvement Section
Sam Dickson	Behavioral Health Division, Licensing and Certification Unit
Steven Ranzoni	Health Policy and Analytics, Hospital Reporting Program

Welcome and Meeting Procedures

Mellony Bernal welcomed RAC members and introduced the meeting and went over meeting procedures and expectations.

- It was noted that the meeting is being recorded and all information shared is a matter of public record and may be disclosed.
- Per OHA policy, members of the public may observe only. Should public members have information they would like to share, they can send information by email to

mellony.c.bernal@oha.oregon.gov or to sadie.morrissey@oha.oregon.gov. Any information received will be shared with RAC members and OHA staff.
- Microsoft Teams features such as the Chat and Raise Hand features were reviewed and instructions on how to communicate during the RAC were shared.
- Information about the Health Care Regulation and Quality Improvement Section's rulemaking activity website was shared including where people can find information about new and amended rules, temporary rules, proposed rules, and other relevant information.

Roll call was taken and RAC members introduced themselves.

Overview

Mellony Bernal provided an overview of the rulemaking process, explaining the steps involved, including the drafting process, convening rulemaking advisory committees (RACs), submitting rules to the Secretary of State's Office, holding a public hearing, responding to public comment, and finalizing rules.

M. Bernal shared that the purpose of this RAC is to seek input and suggestions on the temporary rules for evaluating a Certificate of Need (CN) applications using relevant data, methods and timelines. RAC members were asked to provide input on the proposed revisions, the potential fiscal and economic impact; how the adoption of rules may affect racial equity in Oregon; and whether the rules may have an adverse impact on small businesses.

One additional meeting has been scheduled for January 14, 2026.

It was noted that all comments received from RAC members or members of the public will be shared with staff and all RAC members.

Proposed deadline dates were shared in order to have permanent rules in place by April 19, 2026.

OAR 333-590 – Demonstration of Need for Acute Inpatient Beds and Facilities
OAR 333-615 – Demonstration of Need for Psychiatric Hospitals

Matt Gilman opened discussion noting that the rules being amended are specific to the analysis for proposed psychiatric hospital Certificate of Need (CN) applications. In addition to updating the rules to require more relevant data analysis, the CN Program has worked to make the rules more concise, straightforward and easier to follow. It was noted that the title of the Division 615 ruleset was made more general by removing the reference to 'inpatient beds.'

- RAC member asked for clarification on whether the removal of the term 'inpatient beds' means that a hospital may expand existing psychiatric beds without obtaining a CN.
- RAC member expressed concern that the proposed rules do not appear to address the needs of Oregon hospitals and asked what's the state's overall strategic vision for a CN and what the rules are trying to accomplish.

- RAC member expressed confusion regarding why the title of the rule for OAR 333-590 includes reference to inpatient beds, yet in OAR 333-615 the reference to inpatient beds is removed.

333-590-0000 – General

Minor changes to section (1) were made to clarify terminology.

The proposed new language for section (2) is intended to clarify that OAR 333-590 rules do not apply to a CN application for a psychiatric hospital. A CN application for a psychiatric hospital will be subject to the methodology described under OAR 333-615 and OAR 333-580.

333-615-0000 – General

This rule has been revised to focus on defining what is a "complete" application and removes historical references. A "complete" application is the point at which all information requested has been provided, a majority of OHA questions have been answered, and the application fee has been submitted.

In response to a question from a RAC member about clarifying the narrative process, M. Gilman noted that the narrative is an existing component of the CN application and is the applicant's opportunity to provide a general overview of their proposal, including what they're proposing to build and why. After the narrative, the remaining application consists of a detailed analysis of bed need, service area, and financial need. To be considered complete, the application must satisfy the criteria specified under OAR 333-580 and include the application fee. A reference to the fee table has been added to the rule for clarity.

333-615-0010 – Definitions

Definitions have been amended and include additional terms. Discussion:

- RAC member asked why the OHA is creating an "alternate health service area" and why OHA allowing for a deviation from the trauma system?" RAC member also asked that if citations for the definitions are available to provide. M. Gilman responded that the reason OHA is offering a deviation from the trauma system area is an acknowledgement that there may be other methodologies to demonstrate need outside the trauma system.
    - RAC member expressed concern about the vagueness of the term, and suggested adding protective language to clarify under what extraordinary circumstances deviations from the trauma system service area would be allowed.
    - RAC member concurred with comment above and suggested striking the concept emphasizing the importance of sticking to established parameters.
    - RAC member concurred with comments and noted that it's unclear what problem the “alternative” language is trying to be solve. Without a clear goal, the language should be stricken.
    - RAC member concurred with comments and shared that written comments were provided with the recommendation that the OHA propose a clearer, more objective rubric for granting an exception to using the Trauma Service Area or not allow the option of an alternative. (Written comments have been appended at end of minutes.)

    - RAC member highlighted the need to understand the impact on existing facilities wanting to expand psychiatric beds and how the rules align with the legislative priority of delivering care in the community to achieve maximum coordination of services.
    - RAC member, via Chat, noted that the PCG report on bed analysis is based on trauma region to it makes sense to stick to that versus create alternative services areas.

- The definition of "alternatives" was shared.
    - RAC member asked how inpatient psychiatric unit or floor is defined. M. Gilman responded that it means behavioral inpatient psychiatric units that currently exist within a hospital.
    - RAC expressed concern that the term should not include levels of placement that are not equivalent to inpatient beds, such as residential treatment facilities, as they serve different purposes. RAC member encouraged the committee to consider further as the rules are further reviewed.
    - RAC member concurred with comment above.
    - RAC member stated that a significant omission is the definition for psychiatric inpatient.
    - RAC member concurred with comments and stressed that alternative references are not equivalent to a psychiatric inpatient bed. It is not clear whether the rules are implying that if a region has sufficient alternatives (RTF, RTH, AFH, etc.) than additional inpatient psychiatric beds wouldn't be needed. Clearer definitions and decision-making criteria are needed to avoid inconsistent application across the state and potential inequities.
- Definition of "health service area for a psychiatric hospital" was discussed. M. Gilman shared that the purpose of pointing to trauma system service areas is they are an existing, well-established, structured geographic service area (GSA) with prescribed definitions.
    - Concern was expressed by RAC member that the proposed definition may imply that a psychiatric hospital is needed in every trauma system area, which appears to be differentiated from a psychiatric unit or floor within an existing hospital.
- Definition of "subspecialty beds" was discussed and RAC members expressed significant concerns regarding the age bands.
    - Pursuant to existing statute, the unit for adolescents extends up to a maximum age of 17. Persons ages 15 to 21, based on proposed definition, cannot be mixed.
    - Adolescents that turn 18 years of age must be transferred to an adult unit.
    - RAC members were asked to submit suggested changes to age bands. Via Chat, RAC member provided the following:
        - 11 and under;
        - 11-17;
        - 18-65;
        - 65+
    - RAC member remarked that the subspecialty beds based on age bands may be where an alternative service area would be applicable. The rules do not explain what an applicant proposing a subspecialty unit should do within a large hospital.

It was suggested that for some of these, an applicant may want a larger service area than the GSA.
    - M. Gilman reviewed deleted text. Several RAC members commented on removal of 'dual diagnosis' and one RAC member asked, "What is a psychiatric hospital, and does it include a dual diagnosis?" RAC member further inquired whether the dual diagnosis is a subspecialty that should be kept as those services are in short supply and very difficult to find. The state should encourage these proposals and identify standards. Another RAC member supported retaining dual diagnosis and noted that a psychiatric inpatient hospital is fully able to manage the needs of an individual with a mental health and substance use disorder diagnosis. RAC member noted that more and more individuals have a dual diagnosis.
    - RAC member, via Chat, indicated it may be worth considering adding co-occurring with development disabilities as a subspecialty too. It is a need that is hard to meet today.

OAR 333-615-0020 - Principles

This rule is being repealed as it exists in statute and is therefore duplicative.

- RAC member expressed concern about removing reference to achieving reasonable access from a family and patient advocacy standpoint and the state should be striving to maintaining having services available where the person lives. It's a burden when someone has to travel, and the state is not set up for people to be able to easily get back to their community once completing treatment; families need to remain involved as much as possible and not everyone has access to internet.
- RAC member asked for clarification on a principle that appears to place inpatient psychiatric hospitals as the lowest priority and asked, 'compared to what?' Guidance is needed in the rules on how OHA will determine need, especially in situations where the methodology indicates additional inpatient beds are required, when there is capacity in the alternative levels. If there is capacity in alternative levels, where and how will that connect in a CN review?
- RAC member noted that any available psychiatric inpatient beds at any of the VA hospitals are not accessible by the general public.

333-615-0025 – Criteria for Approval for a New Psychiatric Hospital

This is a new rule that specifies that the OHA will grant a CN if it is determined that an applicant has shown, by preponderance of the evidence, that specified criteria have been met. This rule specifically proposes that the OHA will consider whether access to care is tailored to specific demographic needs, including access to public transportation, access for individuals with disabilities, availability of adequate staffing, and accessibility to other health care providers.
Discussion:

- RAC member reiterated the need to determine whether this rule is specific to a new hospital or will the rule also apply to existing hospitals that wish to expand psychiatric bed capacity on-site or in a separate unit off-site? M. Gilman indicated further follow-up will be needed given current requirements that expanding over 10% of bed capacity may be subject to CN.

- RAC member asked why the term "may" is used versus "shall" if criteria have been met? They also inquired about the use of very legal term, 'preponderous of evidence,' and suggested that it be written for easy reading. Consider 'reasonably demonstrates that…'
- For section (1), RAC member commented on the criterion, 'availability of staffing,' and raised concerns regarding how staffing shortages may affect the interpretation of availability of psychiatric capacity and how the OHA will analyze. It was noted that under a previous application, providers warned that new facilities could draw staff away and jeopardize the ability to operate. With the addition of new alternative health service areas, it is uncertain whether current capacity reflects true availability or simply an inability to fully staff existing units. It was suggested that the rules need a section where there's more direction about what the OHA will be looking at to make a determination about availability of staffing. M. Gilman responded that under previous applications OHA looked at existing relationships with local colleges, such as medical schools or nursing programs; demonstration that work has been done to establish connections so that staffing can be pulled in from schools or internships, rotations, etc.
- RAC member remarked that adequate staffing is nebulous, especially in terms of differing levels of care for children, adolescents, adults and geriatrics. Each have different staffing needs.
- RAC member remarked that both staffing and anticipated impact on current capacity that exists within a trauma region should be part of any analysis.
- RAC member acknowledged that the state has already made a lot of investments in the behavioral health workforce but is an area that should be emphasized as many new programs have been opened and closed because of staffing and safety concerns.
- RAC member commented that more consideration should be given to charity care and accepting Medicaid patients. M. Gilman responded it is elsewhere in the rules.
- RAC member asked where the 36 beds per 100,000 for number of beds needed came from under section (2). It was noted that the figure wasf in the PCG report, but the report also acknowledged that they were not experts. RAC member further stated that it will create a lot of anticipation of capacity that will suddenly overwhelm the system and may not be what Oregon needs based on how services are provided.
- 36 beds per 100,000 children or adolescents is not needed.
- Number seems high compared to national average.
- For the purposes of section (3) and attention to vulnerable populations, RAC member asked whether it was possible to call out the civil commitment population, since that is an overwhelming need that is landing in hospitals.
- In response to section (4), regarding an analysis of need, quality care, cost, and availability of alternative health services, RAC member suggested clarity is needed about how a proposed psychiatric hospital will show that it can coordinate step-down care, i.e. that the hospital should be able to show it knows where openings exist and how they can coordinate those transitions.
- RAC member noted that while many patients may be 'ready to place'. they are stuck in inpatient beds due to the lack of alternative health services, which creates a bottleneck that reduces acute care availability. Rules should account for this need analysis.

333-615-0030 – Estimate of Need

This rule is being amended to indicate that bed need will be evaluated using revised methodologies including: 1) estimated population for the Health Service Area for the prior 10 years in five-year increments, and five- and 10-year forecasts as a basis for estimating the population. Applicants must use Portland State University's Population Research Center Intercensal Estimate reports, when available. If the applicant uses an alternate data source, the applicant must provide justification for the alternate source. 2) Determine current year proposed Health Service Area and historical population-based discharge and patient day use rates including use of Medicare Cost Reports and All Payor All Claims (APAC) data; 3) Develop consistent and reasonable set of well-documented assumptions regarding appropriate use rates; 4) Analyze advantages and disadvantages of both new and replacement components of utilization; 5) Compute rand of possible future patient days in 5-year and 10-years based on proceeding steps; 6) Convert computed value of forecasted patient days based on proceeding steps to an average daily census; 7) Estimate statistically expected peak daily census; 8) Using 10-year projection from anticipated opening, identify supported mathematical estimates of utilization levels and patients days; 9) If analysis indicates that psychiatric inpatient beds are needed in proposed Health Service Area, the applicant for new facility shall weight it against availability of beds at other facilities with Health Service Area; 10) Applicants must document how the project will avoid adverse financial impact to existing psychiatric providers. Discussion:

- RAC member noted that the PSU data is at the county level only, and the trauma service areas are defined by zip code. As such, some trauma service areas are defined by ZIP code and may not include full counties.
- Steven Ranzoni with Health Policy and Analytics Division noted that they would be suggesting revisions to the language regarding the use of APAC data, suggesting that APAC data is an optional choice versus mandatory. Emphasis needs to be on use of timely and relevant data and provide potential uses. There are some access and equity problems with APAC data, including a severe time lag to obtain data. In response to a question from a RAC member, S. Ranzoni noted that the rule specifies that APAC data must be used as well as Medicare Cost Reports, and additional relevant sources may also be used.
- RAC member shared that Medicare Cost Reports will provide no data on children and adolescents. Another RAC member inquired what kind of data can be obtained from these reports. It was noted that these reports are financial reporting and were questionable as a requirement.
- RAC member asked if under subsection (2)(a), whether a requirement can be added to look at other existing programs in order to identify possible gaps. Applicants should be working with local county mental health authorities and the local trauma service area to consider existing need assessments.
- RAC member noted that sometimes the need is based on the entire state as opposed to one particular region.
- RAC member asked about where the calculation language came from and the difficulty in predicting needs in 5 or 10 years. M. Gilman responded that language is based on current rules, noting that the proposed rule is narrowing to five and 10 years.
- RAC member indicated that an analysis looking at population by coverage is also important in order to determine where there is aneed, and how can it be met financially.

- RAC member questioned the feasibility of calculating peak daily census and the availability of data to support such calculations. The average daily census shouldn't just include a historical review of patients that have access to psychiatric inpatient hospitalization. If including alternative health service areas, at what level should they be included? When looking at what the future need is, how do you determine what portion of that need should be met by inpatient hospitalization, dedicated psychiatric hospital, or other alternatives.
- RAC member, via Chat, stated that average daily census (ADC), length of stay (LOS), and days at "ready to place" would be helpful.
- RAC member stated that it's under section (8) where it would be helpful to include payor mix issues. Estimates can be made based on the assumption that there will be a commercial insurance population when the reality is that there is an overwhelming need for services to patients who are either Medicaid-eligible, civil commits, or both.
- RAC member noted for section (9); a gap is the lack of data about Cedar Hills Hospital that may be needed for an applicant's analysis. It was noted that some data may be available through APAC. Another RAC member commented that there should be minimum requirements, such as providing data that demonstrates that a freestanding psychiatric hospital has a relationship with an acute care hospital -there has to be some requirement from OHA to manage and follow-through on that requirement. Example provided of a freestanding psychiatric hospital, in partnership with an acute care hospital provider, not sending any patient records when transferring a patient. Everybody should play by the same rules, and action should be taken if they don't.
- For purposes of section (10), RAC member questioned whether consideration of workforce and other items that are not directly related to a financial analysis would be able to be pulled into this topic. Philosophically like the inclusion of this but question whether that would help complete the analysis of what the impacts on another provider's operations are. So, if they can't hire workforce, they may go out of business. Is that a financial impact under section (10)? Adverse financial impacts should be broad enough to cover things that someone may argue are is not financial, such as workforce.
- RAC member asked whether the term 'financial' can be removed and just say 'adverse impact to existing psychiatric service providers.' Another suggestion was to state 'adverse operational impact.'

333-615-0035 – Alternatives to Health Service Areas

This rule indicates that if an application for a psychiatric hospital proposes a deviation from the Health Service Area based on the published Trauma Service Area, the applicant must provide justifications for changes. Discussion:

- RAC member reiterated concerns stated previously. It is unclear why an alternative is being offered.
- RAC member indicated that if the language is retained, additional language should be added to ensure that deviation from the trauma service area occurs only under extraordinary circumstances, and a very high threshold would have to be met.
- RAC member stated the need to understand what is happening with expansion of existing beds in community hospitals and new units in community hospitals. A community hospital in a region of a much larger trauma service area may not want to base their

analysis on the trauma service area; rather, they may want to base it on what they're experiencing in their community. If developing a psychiatric hospital with a subspecialty unit for adolescents, that subspeciality might be larger than the trauma service area.

- S. Ranzoni noted that the capacity to narrow within a region or adequately define a region should be kept in the criteria. Looking at a map, he can see how the trauma regions would be problematic to defending a facility. Example, does Hood River really need to include the population of Bend? There are some very large regions, especially in Eastern Oregon, and population centers are really far away from other areas. Confining the analysis to the utilization of the area trauma board perspective may lead to some problems and flexibility is needed for a hospital to say, this is my service area.
- RAC member stated that the converse is true as well – provider coming in to establish a hospital in a densely populated trauma service area can identify the need for a significant number of beds. They would need demonstrate why that entire team is a reasonable service area for them. Need to make sure that it's not just de facto.
- RAC member commented that one of the items under the principles section that got deleted had to do with geographic diversity and asked whether some generic language could be added to allow for a better analysis and give flexibility in terms of access to care. Geography and proximity are important.

OAR 333-615-0040 – Availability of Alternatives in the Health Service Area

The rule clarifies under section (1) that the applicant must provide a complete description of all alternatives to inpatient treatment at a psychiatric hospital available in the Health Service area including an inventory with provider name, type of mental health services provided, address, bed capacity, occupancy and utilization averages for each of the past 5-years.

- RAC member remarked that it depends on what the alternative is. Is the phrase 'alternative to inpatient treatment' equivalent to inpatient? What is the inventory of other services and how do they have access to step down levels of care?
- RAC member indicated its difficult to gather reliable data on alternative level of care, which is essential because alternatives don’t just replace hospitalization. They enable timely discharge that free up inpatient beds. It's not clear that this dynamic is addressed in the rules.

For section (2), rule text identifies methods of meeting acute inpatient psychiatric bed needed and that alternatives have been evaluated and found infeasible. Methods include conversion of existing licensed hospital space to purposes of psychiatric treatment; project results in smallest feasible net increase in acute licensed capacity with existing hospital; a separately licensed new psychiatric hospital, not part of a general hospital which will provide psychiatric inpatient care. Factors include market rates for similar services, patient outcomes and satisfaction, regulatory compliance, accreditation and qualification of staff.

- RAC member requested that the rules clarify the role or have language that it's not part of an acute medical surge hospital. Talking about freestanding psychiatric hospitals which are licensed differently than hospitals that include med surge and have units with a med surge facility. Billing and services provided vary depending on if the hospital is freestanding or licensed as a med surge unit.
- RAC member questioned what rule text was based on under subsection (2)(c) (require licensees to provide care at the most reasonable charges per day and per inpatient stay

event) and how will it be applied. S. Ranzoni remarked that there are some qualifying factors such as market rate for similar services and noted that the rule includes references to market rates for similar services, patient outcome and satisfaction, regulatory compliance, accreditation and staff qualification. RAC questioned whether hospitals have access to use of market rates. Another RAC member concurred.

- RAC member asked if there will be some standard that is expected for patient outcomes and satisfaction under paragraph (2)(c)(B). This could be adding undue administrative burden to hospitals if the data isn't already collected in another form such as HBIPS. Another RAC member noted that just because a hospital participates in HBIPS doesn't mean they are incentivized to look great. Many facilities don't participate, and some providers use more flexible criteria. How will rules address this lack of standardization?

Section (3) notes that a proposed psychiatric hospital must be evaluated by comparison to alternatives with preference given to projects which include development of alternative care resources, projects for which formal arrangements are documented, and documentation of triage criteria and mechanisms consistent with level of care evaluation provided.

- RAC member remarked that transfer agreements are not noted in the rules and given language about triage requirements, requested that OHA consider a requirement that OHA monitor transfer agreements on a bi-annual basis.

Section (4) is existing text, updating terms, but also removes reference that impact on total community health costs, not merely charges per day or charges per stay would be considered.

OAR 333-615-0040 – Quality

Section (1) was revised and specifies that an application for a new psychiatric hospital must include evidence showing triage criteria and mechanisms including documentation that criteria and mechanisms are consistent with level of placement criteria developed by the Office of Health Policy and insurers.

- RAC member questioned how the state will ensure that facilities deliver the services that were identified in the CN application when they fail to follow through. For example, on conditions of approval,what oversight exists, who will verify compliance and what consequences apply when a facility stops offering the services that were stated in the CN application?
- RAC member noted that many levels of alternative care do not need 24/7 care because there are hospitals that already cover that. However, round-the-clock, walk-in triage is essential when evaluating new or expanded psychiatric hospitals. This is a critical community safety measure that should be consistent across all regions and align with EMTALA expectations. It was further noted that if hospitals are all reimbursed the same, but not required to meet same triage standards, the system becomes inequitable.

Section (2) specifies there must be a sufficient supply of qualified personnel.

- RAC member stated that this requirement is subjective and asked whether there could be objective standards.

Section (3) specifies there is reasonable assurance that the project will comply with state licensing requirements and federal Conditions of Participation if the applicant plans to be CMS

certified. M. Gilman further noted that any approved CN requires the proposed project or remodel to go through the Facility Planning and Safety Program to verify compliance with construction standards, as well as the final licensing survey to ensure state and federal standards are met.

- RAC member expressed concern that the language is ambiguous and suggested that additional language be added to ensure that rule language is connected to the process described.

Section (4) notes that the project will promote continuity of care and not result in fragmentation of services.

- RAC member suggested that rules make it clear to any freestanding psychiatric hospital what the expectations are in having a relationship with an acute care hospital, including specifying standards for a transfer agreement. Further, the RAC member stated that ultimately the state needs to enforce that requirement. It was noted that suggestions for requirements should come from the RAC members who are subject matter experts and RAC member suggested at a minimum, that medical records and medication lists be added as a requirement for patient transfer between facilities.
- RAC member inquired about what enforcement measures the state has for compliance with CN and conditions placed on a CN.
- RAC member commented that providers should report non-compliance to the state.
- RAC member expressed concern that certain freestanding psychiatric facilities believe EMTALA does not apply to them as they are not a covered entity based on percentage of walk-ins. This goes against the intention of the CN process.

Sections (5) through (7) state that the facility must show evidence of the ability to provide access to quality general and multispecialty medical care, that the applicant will accept and provide access to individuals enrolled in Medicaid, Medicare or uninsured, and that the applicant will facilitate coordination with alternative health services or other community resources.

- RAC member expressed concern with language around Medicaid and Medicare, suggesting that an applicant could take one Medicaid patient a year and potentially meet the intent of what is stated in the CN rules. Consider specifying a required percentage, based on the population of the health service area. Other RAC members concurred and expressed concern that financial-screening practices are inconsistent across providers and create inequities in how patients are admitted. There should be equitable expectations across all providers.
- RAC member reinforced previous comments that the OHA needs to be able to enforce the requirements and questioned what measures could be added to ensure this happens.
- RAC member noted that in the application, when the applicant is making projections and analysis of need, the applicant needs to provide details about the financial payor mix and economic feasibility as part of the larger narrative.

Section (8) specifies the applicant must have treatment goal-setting protocols that focus on achieving sustained improvements.

- RAC member requested that a reference to current Oregon laws around discharge planning and policies be referenced, and the applicant needs to demonstrate how they will comply with the law, including engaging with lay caregivers, families, etc.

Section (9) specifies that the applicant will maintain a readmission rate lower than or comparable to available benchmarks.

- RAC member suggested that CMS may have abandoned this benchmark and noted that current facilities may not be meeting the national benchmark for readmission. It was suggested that holding providers to these benchmarks may be unrealistic given system wide barriers, such as limited step-down and placement options. It was recommended to either remove the benchmark requirement entirely or allow monitoring readmission rates without expecting providers to stay below regional or national standards.

Section (10) requires the applicant to offer charity care pursuant to ORS 443.601, commensurate with other facilities with comparable payor mix and demonstrate compliance.

- RAC member reiterated previous concerns about who will monitor and ensure compliance.
- S. Ranzoni noted that the correct statutory reference is ORS 442 (not ORS 443) and noted that there is a starkly different expectation between nonprofit hospitals and for-profit in terms of charity care that may need to be further considered.
- RAC member inquired whether the OHA would seek information for organizations will larger nationwide footprints, about patterns of offering charity care. M. Gilman responded that has been done in the past.
- RAC member remarked that when it comes to taking care of Oregonians, it should not matter if the facility is profit or non-profit. The state should weigh its review and approval based on how an applicant responds to charity care. The state's legal authority to impose such requirements on for-profit hospitals was noted and RAC member raised the possibility of advocating for statutory changes.
- RAC member suggested considering that because of Oregon's health equity goals and that it is expected, as part of the CN process, that a proposed facility will comply with charity care requirements.

Section (11) specifies that a project's proposed services will be delivered safety and adequately in compliance with all state and federal laws and regulations. The rule further specifies that the evaluation will consider whether applicants have criminal convictions, a history of denial or revocation of a license, revocation of health professional license, CMS decertification.

- RAC member agreed with the intent of the rule text but noted that there may be patterns of behavior that do not necessarily lead to revocation or decertification, but numerous investigations that must also be considered. For example, recent congressional inquiries of private equity.
- RAC member agreed.

333-615-0060 – Cost

This rule identifies criteria that the OHA will consider to determine whether a proposed project will foster cost-efficient services without compromising quality.

- RAC member asked for additional information regarding subsection (2)(b) relating to impact on social and financial costs being consistent with ORS 442.310, specifically what would the program be looking for?

- RAC member expressed concern about construction partners and expressed the need for bids. In written comments shared, it was recommended to add that applicants must have pursued three separate bids to prove that the least expense, best quality construction partner was selected.

333-615-0070 – Use of Other Sources for Evaluating Applications

This rule specifies that in the event that CN rules do not contain standards in sufficient detail to make required determinations, the OHA may consider nationally recognized standards, Oregon professional organization standards, CMS certification requirements and applicable standards developed by other individuals, groups, or organizations. Any external standards or guidelines may not conflict with Health Service Areas or methodology described in OAR 333-615.

- RAC member commented that with regard to external standards, it doesn't seem transparent who that would be or how it would be determined that they're qualified to comment.

NEXT STEPS

RAC discussed whether future communications could occur through email or whether the RAC should continue to meet on January 14 at 9:00 a.m.

- RAC member expressed appreciation for this meeting and asked that the second meeting occur.
- RAC member expressed appreciation for the openness of the discussion.
- It was noted that the Statement of Need, Fiscal and Equity Impact will still need to be considered.
- RAC member indicated that the three fundamental questions they continue to have are:
    - What happens to acute care hospital unit beds – Are they in or out? Do they need Certificate of Need?
    - The alternatives – how and when are they going to get counted, which ones get counted and where to obtain information?
    - Methodology inputs.
- Staff encouraged RAC members to submit recommended language for the rules.

Meeting adjourned at 12:05 p.m.