Certificate of Need Rulemaking Advisory Committee
February 3, 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
John Bauer	Salem Health
Jody Corona	Health Facilities Planning and Development
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
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
Samuel Dickson	BHD, Licensing and Certification Unit
Steven Ranzoni	Health Policy and Analytics, Hospital Reporting Program

Welcome and Meeting Procedures

Mellony Bernal welcomed RAC members, reviewed the meeting agenda, 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 were reviewed, and instructions on how to communicate during the RAC were shared.

Proposed Changes to Rules in Follow-up to RAC Discussions

M. Gilman reviewed changes based on previous RAC discussions.

OAR 333-590-0000 – General

In response to questions proposed by RAC members in previous meetings, this rule was modified to clarify that the rules apply to new freestanding psychiatric hospitals and psychiatric units that would meet the criteria of "new hospital" which is defined under OAR 333-550-0010.

RAC member asked to ensure that it was clear which rules will apply to freestanding psychiatric hospitals or psychiatric units and under section (2) what the term "within" means as used in last sentence.

- Staff from the Department of Justice noted that the goal was to clarify that there are instances when changes made to an existing general acute care hospital will need a Certificate of Need based on the definition of "new hospital," which is a substantial increase in services or a substantial change in services provided.
- It was noted that for purposes of evaluating need for a new freestanding psychiatric hospital or psychiatric units that meet the definition of new hospital, the methodology applied will be OAR chapter 333, division 580 and division 615, NOT division 590.
- The term "within" is not meant to apply only to a unit that is existing in a specific structure, rather would apply to locations that are included as part of the hospital license. RAC member suggested adding the term "licensed" after the term 'within a.'
    - RAC member asked whether the change in service is measured by the change in psychiatric beds or the change in the hospital's total bed capacity? Staff responded that it would be measured by increase in total bed capacity. A substantial increase in services will be considered to include any increase in the total facility bed capacity or in the bed capacity of any hospital service of greater than ten beds or ten percent of the bed capacity of the facility or service.

OAR 333-615-0010 – Definitions

In response to previous RAC discussions, changes were made to the following definitions:

- Alternate Health Service Area – added more specificity; means an **approved** deviation from the Trauma System Area (TSA) as the Health Service Area **meeting exception criteria**.
    - RAC member inquired when is the approval sought – before application is submitted or during application review? Staff responded that it is part of the application as the justification for the alternative service area would need to be included.
- Alternatives – added more specificity describing that alternatives are non-hospital behavioral health settings that offer appropriate care at lower intensity or cost, helping reduce demand for inpatient psychiatric beds while remaining distinct and not clinically interchangeable with hospitalization.

- RAC member requested that appropriate definition citations be added to subsections (2)(a) through (d).

- Dual diagnosis – added per request from RAC.
  - RAC member suggested that language be added that would reference 'and any future definition changes' given reference to specific ICD-10 codes. It was noted that rules cannot reference a future change to codes or documents given previous court rulings as this creates a delegation of authority that is not allowed.
- Health Service Area (HSA) – Additional specificity was added referencing that in the case of new or substantial increase to psychiatric services, the HSA is the Trauma System Area in which the general acute care hospital is located.
  - RAC member suggested that additional changes be considered. As written, it basically states that the Health Service Area is the Trauma System Area, so why not just use Trauma System Area?
  - RAC member concurred and also asked whether the language was meant to tie back to when a CN is triggered? (Staff responded yes).
  - RAC member agreed with confusion and noted that TSAs were based on the Dartmouth Atlas many years ago which was inclusive of psychiatric services. It was also noted that by using the term TSA it may force the trauma systems to acknowledge mental health as being part of physical health.
  - Staff responded that the term "Health Service Area" is used throughout CN rules and as such, reference to TSA is being added only for purposes of psychiatric hospitals for this rulemaking. Future rulemaking will address alignment between these terms, as making the change at this time was considered too extensive. Staff encouraged RAC members to participate in any future rulemaking.
  - RAC member suggested that a cross-walk be created to identify where this term is used in other rules to better understand implications.
- Psychiatric admission and psychiatric discharge – added a definition for these terms based on the principal diagnosis code with ICD-10, Chapter F.
  - No comments from RAC members.
- Subspecialty beds – amended based on previous RAC discussions and limited to inpatient settings designed for individuals under the age of 18 and individuals over the age of 65.
  - No comments from RAC members.

OAR 333-615-0025 – Criteria for Approval for a New Psychiatric Hospital (both freestanding and a substantial change or increase in an existing general acute hospital)

Staff noted that the title of this rule was modified for additional clarity.

- RAC member inquired about the intent of the additional language in the rule title being to clarify when a CN would be triggered. It was recommended that the OHA consider referencing a citation instead, such as defined under ORS. The statute would be more encompassing, whereas the rule title may be limiting.

Staff noted that the bed ratio was removed based on previous feedback from RAC members.

- RAC members thanked staff for this change.

RAC member asked the OHA to consider different language under the leading paragraph of this rule by eliminating "preponderance of the evidence" and use language that is easier to understand. RAC member asked staff to consider replacing language with, 'reasonably demonstrates.'

- Staff responded that language is based on the Administrative Procedures Act (APA) and using different language may create confusion suggesting a different standard must be met. Staff will consider further.

OAR 333-615-0030 – Estimate of Need

Staff summarized changes in section (1) reflecting that applicants **may** (versus shall) use specified applications for forecasting population and language was added clarifying that applicants must apportion estimates relating to zip codes that are included or excluded in a Trauma System Area and the apportionment method must include tabulations.

- RAC member asked staff to consider writing in plain language.

New language was added in subsection (1)(c) regarding calculating use-rates and projecting bed need, including inpatient episodes that meet the definition of psychiatric admission or discharge, and episode with dual diagnosis must be reported separately. Data sources must include All Payer All Claims (APAC), Medicare Cost Reports, and other relevant databases.

- RAC member asked where the data would come from. The only inpatient psychiatric hospital in the state does not report into the specified datasets so it would be hard to calculate use rates with missing data. RAC member further asked about access to APAC data. Additionally, it is uncertain what information can be obtained from the Medicare cost reports.
    - Staff from the Health Policy and Analytics (HPA) Division noted that outside entities can request APAC data, particularly for purposes of CN, but acknowledged it can be challenging with lengthy delays. It was further noted that accessing mental health coding as these are censored. Staff suggested that changes should be considered removing 'shall' so it's not a required source of data. Relevant data sources need to be used, but there options to access a variety of sources. Apprise would fall under "other trade association" data and hospitals should be actively working with the Hospital Association who provides OHA with hospital discharge data.
- RAC member asked about data relating to Cedar Hills Hospital.

- Staff from HPA indicated that claims from Cedar Hills will be in APAC by zip code for Medicare and commercial claims.

- RAC member inquired what 'other relevant data sets' may include?
  - Staff from PHD and HPA shared that other relevant data could including information from CMS for Medicare data, other claim warehouses, and discharge data from 'HCP.' It was acknowledged that there are not a lot of resources that wouldn't directly involve OHA; however, it's conceivable that if an applicant has relevant data, OHA would need to evaluate and determine whether it was appropriate, relevant and usable.
  - Staff indicated with these rules, the OHA is trying not to be overly prescriptive in the event that there are other relevant data sets.
  - RAC member suggested adding language that references data sets that are publicly available versus an applicant paying someone. Concern was noted from HPA staff regarding publicly available verbiage, stating that publicly available would infer no research question, no study protocol, etc.
  - RAC member stated concern about collecting the historical data on admissions, discharges, patient days, all by zip code, but also needing to understand occupancy.
  - RAC member concurred and indicated that the larger a corporation gets, the easier it is for them to produce their own data and producing a story based on data from similar sized states or other means that may not be relevant. RAC member expressed that everyone should be playing by the same set of rules.

Staff noted that language was updated under subsection (2)(a) to clarify examples of timely and relevant data sources to determine historical utilization.

- RAC member questioned where 'in and out migration' is addressed in the rules using a border with an adjacent Trauma System Area as an example. Discussion ensued regarding whether transportation patterns would address this or is there something more specific that needs to be considered.

Changes under subsection (2)(b) include new paragraph (D) regarding estimating future utilization rates specific to evaluating the age rage and payer implications tied to Medicaid eligibility. The paragraph further states that the applicant must identify how the proposed capacity will serve Medicaid members.

- RAC member asked for clarification on use of term "within these constraints." It was noted that the purpose was to acknowledge that there are exceptions, i.e. Medicaid will frequently not cover stays for that population.
- RAC member suggested that reference to "within these constraints" is not needed and suggested that it just state that the applicant must demonstrate how they will serve Medicaid members.

RAC member asked under section (7), relating to peak daily census, and where data would come from. In order to run a peak daily census analysis, census by day by unit is needed. This appears to be a holdover from previous methodology.

- Staff noted that this is language that was pulled from OAR chapter 333, division 590 and asked isn't this information that is needed to evaluate need how many beds? RAC member responded that perhaps the data existed when rules were initially adopted but there is no place to get census by day. Discussion ensured regarding data resources such Medicare reports and Poisson distribution. Staff asked for additional suggestions in lieu of this.

RAC member asked for clarification on the following language under section (9), "Applicants shall use inpatient psychiatric bed capacity for all facilities in the Health Service Area provided by the OHA." The rules do a nice job of identifying alternatives, but where do rules consider how the availability of alternates will improve due to faster discharge, or avoiding admissions? There should be an opportunity to subtract a percentage for these alternate beds.

- RAC member concurred. The goal is not to institutionalize people rather get them back into the community as soon as possible. The best bed may not be a psychiatric bed. It's appropriate to address utilization across the continuum.
- Additional discussion ensued regarding the possibility of having the applicant weigh against the availability of beds at other facilities and alternatives. RAC members agreed with concept.

Under section (10), a new subsection (b) has been added indicating that for a proposed freestanding psychiatric hospital, applicants must identify transfer agreements that must including reason for transfer, medical records, and a medication list and a commitment to take the patient back as soon as medically cleared.

- RAC member asked how OHA intends to enforce this provision. Staff responded that applications in the past have been approved with conditions and possible civil monetary penalties.
- RAC member asked what other criterion besides transfer agreement will be considered for avoiding adverse financial impact, e.g. 24/7 access to care, staffing, etc. Staff will consider further.

OAR 333-615-0035 – Alternatives to Health Service Areas

Minor changes were made to language including removing reference to "full" discretion and clarifying that the OHA must describe how it evaluated and weighed relevant factors for approving a deviation from a Trauma System Area.

- No comments from RAC members.

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

Staff shared new section (5), stating that an applicant shall address whether the insufficient availability of lower level of care options in the Health Service Area result in over utilization of

inpatient psychiatric services. After further review, staff suggested that perhaps "lower level of care" be updated to "alternatives."

- No comments from RAC members.

OAR 333-615-0050 – Quality

Under section (3) staff identified that reference to the applicant **plans to be** certified by CMS was removed.

- No comments from RAC members.

RAC member asked under section (11), to add a subsection that the applicant must identify any adverse actions that have been taken against them from regulatory bodies or other organizations. If an applicant has a history of adverse actions, it should be considered for possible condition of approval.

- RAC member concurred.

NEXT STEPS

RAC members were asked if they have any suggested changes to the Statement of Need and Fiscal Impact and Equity Impact to share or that they may submit additional comments by email.

The goal is to have permanent rules in place before the temporary rules expires on April 19th. In order to meet that deadline, the following timeline was shared:

- February 18 – Submit final proposed rule language to PHD Rules Coordinator.
- March 1 – Post proposed permanent rules in Oregon Bulletin
- On or after March 16 – Public hearing
- On or after March 23 – Written public comment deadline
- March 23-April 3 - Review oral testimony and written public comments
- April 6 – 17 – Develop response to Hearing's Officer report and consider additional changes needed to rules
- File permanent rules on or before April 19th.

Interested parties will be notified through the GovDelivery Hospital Listserv. There are approximately 5,600 subscribers to that listserv. RAC members will also be notified as well as a list of behavioral health organizations.

If RAC members have additional persons they would like us to reach out to, please notify Mellony Bernal by email.

RAC member asked if there will be another draft version shared with RAC members prior to filing for the public hearing. Staff responded that it likely would not be feasible.

Staff thanked RAC members for their participation in the rulemaking process and RAC members thanked staff for being receptive to listening and working through this together.

Meeting adjourned at 10:33 a.m.