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Certificate of Need Long-Term Care Capacity Rulemaking Advisory Committee (RAC)

September 15, 2026
9:00 am via Microsoft Teams

RAC MEMBER ATTENDEES

Andre Rapp	Regency Pacific Management
Danielle Meyer	Hospital Association of Oregon
Emily Sokolski	SEIU 503
Eugenia Liu	Oregon Health Care Association
Kristin Milligan	LeadingAge Oregon
Marcus Roshak	Sapphire Health Services
Peter Stoloff	Peter Stoloff, P.C., Attorney
Steve Fogg	Marquis Companies
Susan King (for Justin Hurley Braswell)	
Tasha Goettel	Avamere

OTHER INTERESTED PARTY ATTENDEES

Marissa Fritz	Hospital Association of Oregon

OHA and ODHS ATTENDEES

Andrea Ogston	DOJ
David Allm	ODHS-SOQ
Dana Selover	PHD-HCRQI
Matt Gilman	PHD-HCRQI
Mellony Bernal	PHD-HCRQI
Jeremiah Adams	ODHS-SOQ
Sadie Morrissey	PHD-HCRQI

WELCOME AND MEETING PROCEDURES

Mellony Bernal welcomed RAC members, reviewed the 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, matt.s.gilman@oha.oregon.gov or sadie.morrissey@oha.oregon.gov following the meeting. Any information received will be shared with RAC members and OHA staff.
- Microsoft Teams features such as 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 (HCRQI) 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. (http://healthoregon.org/hcrqirules)

INTRODUCTIONS

RAC members introduced themselves.

OVERVIEW, SCOPE AND TIMELINE

Mellony Bernal provided an overview of the rulemaking process explaining the steps involved, including when a RAC may or may not be convened, the rule 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.

The purpose of this rulemaking is to seek input and suggestions on proposed changes to OAR chapter 333, division 610. Changes are necessary to update relevant data, methods, and timeline for purposes of evaluating a Certificate of Need Application for long-term care facilities.

RAC members will be asked to provide input on the proposed changes to administrative rules, the fiscal and economic impact, and how the rule may affect racial equity in Oregon.

One additional meeting has been scheduled for September 24. Meeting dates may change based on how quickly the RAC is able to review the proposed rules.

The tentative time frames for the rulemaking process were shared:

Scope – Rule Text Filing Deadlines

October 16, 2026	Deadline to submit rule text and filing forms to PHD Rules Coordinator
October 28-30, 2026	• PHD Rules Coordinator to file notice of proposed rulemaking with Secretary of State • Notify interested parties about public hearing and how persons may provide oral testimony or submit written comments.
November 1, 2026	Notice appears in the Oregon Bulletin
November 16 (or later)*	Public hearing to be held to seek public comments
November 20 (or later)*	Public comment period will close
November 30 – December 11, 2026*	Program to review public comments, consider possible changes to rule and respond to public comments
December 16, 2026*	Final rule text showing changes and responses to public comment due to the PHD Rules Coordinator. PHD Rules Coordinator files permanent rules
December 22, 2026	Proposed effective date

- Date(s) will adjust based on when the public hearing is scheduled, receipt of Hearing's Officer report, and length of time needed to review public comment

ADMINISTRATIVE RULE REVIEW

Dana Selover opened discussion noting that the OHA has not reviewed a long-term care Certificate of Need (CN) application in at least eight years and given that the rules have not been modified since the early 1990's, the CN Program needs to update them and make necessary alignment with changes to terms within the industry. This allows the OHA to review an application with some integrity, relevance and effectiveness.

OAR 333-610-0000 – Minor changes were made to this rule that briefly summarizes the general purpose of the rules.

RAC members had no comments.

OAR 333-610-0010 – This rule identifies specific terms and definitions. D. Selover shared that rather than reviewing definitions in the beginning, she would suggest reviewing definitions as the terms are used while reviewing

other rule sets. Generally, definitions have been updated to align with current use of terms and definitions from other administrative rules or statutes (i.e. nursing facilities). It was further noted that terms not used in the rules do not need to be defined.

RAC members had no initial comments.

OAR 333-610-0020 – This rule outlines the principles OHA will use in evaluating a CN application and replaces outdated text that references data requirements from the 1980's and 90's. New principles and indicators have been added.

Section (1) – Indicators for evaluating need in a service area include whether patients can access appropriate long-term care in a timely manner, consideration of delays in hospital discharge due to lack of nursing facility beds, challenges related to long distance travel for care, shortages in specialized services, workforce limitations, and hospital readmission. RAC discussion:

- RAC member inquired about why the OHA removed the current ratio of 30 beds/1,000 persons age 65 and over and what is the basis for the new criteria. Matt Gilman and Andrea Ogston explained the rationale for moving away from rigid ratios, citing Oregon's unique approach to community-based care and the need for more flexible, evidence-based criteria. It was noted that specific ratios may lead to an inflexible review of a CN application and does not account for changes over time; furthermore, the ratio identified previously is no longer supported by the current literature. Additionally, Oregon has a unique approach to Home and Community-Based Services (HBCS), and the intent of the revised rules is to analyze need based on how nursing facilities are currently used in Oregon.
- RAC member asked how the OHA will distinguish between a shortage of licensed and physical bed capacity versus beds that exist but cannot be used due to workforce shortages. Workforce driven limits should not be misinterpreted as insufficient bed supply. It was also requested that there be clearer language making hospital readmissions [*readmission is defined as a patient discharge and readmission to the hospital within 30 days for the same or related diagnosis. Readmission does not include a readmission for an unrelated diagnosis, readmission occurring more than 30 days after the date of discharge, or readmission for episodic (a series) acute*

care hospitalizations to stabilize the medical condition such as, but not limited to: diabetes, asthma, or chronic obstructive pulmonary disease] only attributable to inadequate nursing facility access or availability, not general readmissions. Concerns were noted that confusion around the rule language could allow workforce challenges to be misinterpreted as bed shortages.

- M. Gilman noted the importance of distinguishing between "set-up" beds (*defined as a bed that is licensed by the Oregon Department of Human Services and is ready for immediate use*) and licensed beds that cannot operate due to staffing shortages. It was noted that this mirrors distinctions in other CN contexts such as acute care.
- A. Ogston noted that long-term patterns of operating below licensed capacity could indicate workforce-driven limitations that may be relevant in evaluating a CN application.
- M. Gilman and A. Ogston agreed to further consider changes to the definition of readmission and tying to insufficient skilled nursing beds.
- RAC member stated that Oregon has the lowest occupancy in nursing homes of any state in the country, and as such may not warrant amending the rules. RAC member emphasized the importance of focusing on macro-level supply and demand dynamics rather than micro-level issues which may cloud or cause decisions to be made on future supply growth that may be damaging. RAC member cautioned against including workforce constraints as a primary factor in CN decisions. It was suggested that the indicators in this section are all "micro" and move away from the primary objective of supply and demand. Additional RAC members expressed support with this sentiment, suggesting that adding supply does not address workforce shortages and may exacerbate them.
- RAC member via Chat noted that there are some facilities, their facility included, that operate below their licensed capacity due to current layout (private rooms and doubles vs triples) versus any staffing constraints.
- RAC member agreed with comment in the Chat and expressed concern that the current definition of "set-up bed" does not reflect how nursing facilities operate. Many facilities are licensed for three- or four-bed rooms but intentionally use fewer beds due to consumer preference for private or semi-private rooms. Providers may not activate all licensed beds even if they could, making "immediate use" a misleading standard. It was

further recommended that "Medicaid upper payment limit" be added to the rules. Because Medicaid cannot reimburse more than Medicare for the same services, exceeding this limit poses financial risk to the state. She suggested explicitly incorporating this factor when assessing overall system cost and need. A. Ogston asked for further clarification about why the Medicaid upper payment limit matters when evaluating need. RAC member explained that if the Medicaid reimbursement exceeds the federal upper payment limit, the federal government can take back funds. Because of this risk, adding more nursing facility beds could create financial problems for the state if it pushes Medicaid payments above the limit. It was suggested that OHA consult with Cindy Susee with ODHS.

- RAC member via Chat shared the following statements:
  - FYI - there are approximately 10,500 licensed nursing facility beds in Oregon. While I don't have current occupancy data industry as a whole, I estimate total occupancy at 7,000ish. That means there are 3,500 unoccupied licensed beds.
  - The reason nursing facility operators have downsized licensed beds to useable beds is that it is immensely competitive due to "lack" of demand overall (hence OR nursing occupancy being lowest in the country). Had there always been demand at Licensed Bed supply levels operators would not have reduced their useable bed count. If in fact macro level demand goes up, operators can "re setup" beds.
- RAC member via Chat concurred that there needs to be more of a nexus between readmission and number of beds. There are complicated reasons for patients to be readmitted to an acute care facility.

Sections (2) and (3) – Specifies that population forecasting must be evidence-based and must distinguish short and long-stay utilization. Forecasts must be based on expected hospital discharges, statewide clinical and demographic trends, HCBS use patterns, and projected growth of the 65+ population, while noting that age alone no longer predicts nursing facility use. RAC discussion:

- RAC member remarked that "hospital discharge volume" should be tied back to lack of skilled nursing facility beds since inability to discharge may occur in the hospital that is unrelated to need for a skilled nursing bed.

- RAC member via Chat stated, "the demand determination should be specific ONLY to SNF specific demand. Whether demand for CBC/ALF/etc. goes up or down over time, it shouldn't impact nursing facility demand/supply. Which is kind of what #5 is getting at even though it only hits increased CBC demand."
- RAC member asked whether CN applicants will be required to use certain datasets and should forecasting be tied back to the State Plan on Aging? M. Gilman responded that the rules do identify possible data sources that can be used and that OHA would want applicants to take the State Plan into consideration.

Sections (4) and (5) – Determinations of need must align with Oregon's law requiring that people receive support in the least restrictive setting. The increased use of HCBS does not automatically mean that fewer nursing facility beds are needed. RAC discussion:

- RAC member expressed that it is not clear what section (5) means and asked that it be re-written in plain language. A. Ogston shared that based on a report, nursing facility beds are mostly used for short, temporary stays, often by younger people. Older adults (65+) are increasingly getting support through home- and community-based services instead of going into nursing facilities. The intent is not to look at that trend by itself. The Oregon Department of Human Services (ODHS) is reporting a shortage of nursing facility beds for people who need post-acute care — those who are ready to leave the hospital but still need a lower level of medical support. So even though more older adults are using HCBS, the OHA still must make sure there are enough specialized nursing facility beds for people who need that step-down care.
- M. Gilman suggested changing the language as follows:
    - "(5) Increased utilization of Home and Community Based Services does not, by itself, demonstrate reduced need for nursing facility beds ~~if post-acute or specialized nursing facility capacity remains insufficient~~.
- RAC member expressed support for the suggested language change. And asked if the thought is that increased use of HCBS doesn't automatically mean there's less need for skilled nursing facility beds. It shouldn't be assumed that HCBS growth reduces demand for nursing facilities, and that future planning must consider both HCBS use and the ongoing need for skilled nursing beds.

- RAC member shared that the definitions for “intermediate care facility” and “institutional level of care” don’t align well and additional clarification is needed. The intermediate care definition describes people who don’t need hospital or skilled nursing care, but the institutional care definition describes people with significant impairments who typically do need specialized nursing facility services.
- RAC member via Chat stated, "the demand determination should be specific ONLY to SNF-specific demand. Whether demand for CBC/ALF/etc. goes up or down over time, it shouldn't impact nursing facility demand/supply, which is kind of what #5 is getting at even though it only hits increased CBC demand."

Section (6) - Rural areas or counties without nursing facilities may request a different service area. When reviewing these requests, the OHA will consider factors such as where hospitals send patients, how long it takes people to travel for care, what clinical services are available, and other statewide planning factors. RAC discussion:

- M. Gilman asked RAC members to consider whether other factors should be added and noted that while an applicant may propose an alternate service area, the OHA may not agree.
- RAC member via Chat stated, "conceptually it makes sense, would want to make sure that if the service area grows that the elements related to BOTH supply and demand are grown to the new service area determined. And not just the demand side of it."
- RAC member noted that when reviewing a proposed nursing facility in an expanded service area, the analysis should include not only the supply within the county but also facilities in nearby directions. People in the added area may already have easy access to nursing homes outside the applicant’s defined service area, so those options should be considered when evaluating actual demand.
- A. Ogston shared that when a county’s boundaries are expanded, the analysis must include everything that comes with that expansion: the population in the newly added area, the nursing facility beds located there, and how people move in and out of the area to get care. This means the need analysis must account for all the new factors. If the area is on a state line, the analysis must also consider cross-border patient movement — people coming in from the other state and people leaving to get care elsewhere.

Section (7) - All analyses must use the most reliable data available. This can include information like hospital discharge records, Medicaid claims, cost reports, Minimum Data Set data, nursing facility bed inventories, HCBS usage data, and population forecasts from approved sources such as Portland State University, or others. RAC discussion:

- M. Gilman asked RAC members to consider what other approved sources should be considered.
- RAC member asked where the set-up bed data is collected and how the data is tracked. Another RAC member asked for clarification from ODHS regarding how set-up beds are defined in the license application. Jeremiah Adams responded that data is collected when a nursing facility submits its application for licensure and includes total beds and set-up beds. Historical information was shared by David Allm and while the ODHS does not have a specific definition for set-up bed in rule, it is meant to capture if walking into a facility how many beds are set-up at that point in time; and for licensed capacity, beds that may not be immediately available but could be within a short period of time. It was further noted that ODHS will be looking at defining set-up beds in OAR chapter 411, division 085 licensing rules to align with CN rules.
- RAC member via Chat noted disagreement with use of "set-up beds" anywhere in the proposed rules.
- RAC member via Chat asked how often are "set-up bed" numbers reported by facilities and how do those reports account for the fluctuation that may occur.
- RAC member via Chat shared that "set-up beds" is only temporary and to keep in mind that operators can rearrange or change the bed setup in the future; and current operators may move their licenses to new locations and build a new facility. The occupancy rate should still be 95%.
- RAC member via Chat asked if OHA should be required to look at the reason licensed beds are not "set up;" example, renovation OR is this a long-term unavailability because a provider cannot staff or does not have true bed capacity. If long term, a time frame needs to be outlined.
- RAC member via Chat asked why the occupancy rate was stricken. M. Gilman responded that the language was stricken based on the age of the rules, but OHA is open to further discussions. RAC member agreed

there should be a minimum occupancy rate, though it may get complicated under a flexible definition of service area.

- RAC member via Chat indicated that there should be some minimum occupancy level in the "service area" that becomes a macro level control mechanism in managing new CN applications. The RAC member reiterated concerns that micro/less significant issues are going to override new supply decisions and not overall occupancy of a service area vs supply.
- RAC member reiterated that one of the main reasons for CN is to help maintain Medicaid cost efficiency, which needs to be considered when deciding whether more beds are needed. Instead of building a new facility, it was suggested to look at whether existing providers could bring their unused licensed beds back online, since using current facilities would likely be more cost-effective and avoid duplicative services. It was further suggested that existing providers have a first right of refusal.
- RAC member via Chat stated that any new application proposing a new facility will take two to three years from CN approval before becoming operational. A much quicker approach would be to have existing providers increase their useable beds.

OAR 333-610-0030 – The rule further outlines analysis of whether a community needs more nursing facility beds. It was noted that the goal of these changes is to simplify and modernize. The previous rule text may no longer be accurate in terms of travel patterns, population, access to health services, etc.

Section (1) - Explains how to define the nursing facility service area, which by default is the county where the facility is located, but OHA may consider referral patterns, geography, or access to determine whether a single county may reflect real use. Applicants may also propose an alternate service area if providing evidence that better matches actual utilization. RAC discussion:

- RAC member cautioned against assuming hospitals frequently have patients ready for nursing facility care that the nursing facility does not want to admit. There are very few instances where individuals need to be admitted that are not, and in the rare case it's usually due to a staffing

issue, or because the acuity of the patient does not warrant a skilled nursing facility. Concern was expressed that as the rules are currently written, a CN application could be approved based on the assumption that a new facility will solve those issues.

- RAC member inquired about the removal of "health service area III" and whether the RAC should reconsider how to group areas based on population growth, hospitals, etc. If these health service area groupings appear in other CN rules, why are they being removed from long-term care rules? M. Gilman and A. Ogston provided some context noting that the health service areas as currently defined in CN rules are antiquated and no longer used by OHA. The trend is to consider trauma service areas (TSAs). For purposes of long-term care, the default service area is the county; however, for acute care, the service area is based on ZIP code and where hospitals anticipate a patient may come from which could be across county lines. It also aligns with providing services to patients within their own community.
- RAC member via Chat noted that if the supply availability in the possible 'increased service area' is included in overall supply vs demand calculation, the proposal seems reasonable.
- RAC member asked whether the OHA would apply consistent criteria when deciding whether to accept an alternate service area? The RAC member noted they are trying to understand if the intent is to keep flexibility or if the intent is that criteria must be met for a CN application to be accepted. M. Gilman responded that it's both to identify minimum criteria that the applicant and OHA must consider in analyzing whether an alternate service area is justified. It affords the applicant flexibility to propose an alternate service area based on, for example, location on the state border, travel patterns, etc.
- RAC member questioned rule content and noted what may be working now, may not work four years from now. D. Selover noted that a CN application must be completed using the most current data available for the specified criteria at the time application is made. A. Ogston suggested that the OHA consider whether more clarity about the time scale is needed for analyzing patterns.
- RAC member inquired via Chat, whether "rural health service availability" is envisioned to be individual providers including specialties, acute care,

home care as examples? M. Gilman and A. Ogston noted that the idea is to ensure that care is coordinated across all providers. M. Gilman responded that they would consider further.

- RAC member expressed concern that the concepts seem subjective with no objective data for purposes of health planning. Need seems to be based on fluctuating criteria, and the RAC should consider more data-driven criteria. RAC member responded via Chat that while they agree with comment on health planning, they are not sure if it should be tied to the State Plan on Aging or a community health needs assessment. It should not be case by case.
- RAC member via Chat stated, "this discussion brings light to the challenge of imbedding what I would call "subjective" characteristics, providing increased goalposts to approve or not approve, which leads to risk that the primary Macro level purpose of CN / controlling supply/demand becomes less significant, but comes with much larger possible ramifications..."

Section (2) clarifies what utilization data must be collected using the most recent five years of available data and includes hospital discharge data, short and long stay Minimum Data Set, annual nursing facility cost reports or other publicly available utilization reports, set-up bed inventory and HCBS utilization data. RAC discussion:

- For purposes of HCBS utilization data, A. Ogston noted that based on reports HCBS may be serving higher acuity persons and the goal is to better understand those utilization trends.
- RAC member noted that it's a combination of looking at HCBS data and trying to tie that with hospital discharge data. Does the patient need a skilled nursing facility or are they not going to a facility because there isn't one in the area?

Section (3) – Describes that the applicant must calculate service area capacity. RAC discussion:

- RAC member via Chat indicated this section may benefit from an analysis of licensed **and** set-up beds over the past five years.

Section (4) – Describes the historical utilization data that an applicant must determine. RAC discussion:

- RAC member via Chat shared that "it seems very reasonable to me that short stay and long-term livers should be separated since each have their own utilization/penetration rates."
- RAC member via Chat stated that is better to distinguish short stay/long stay by payor source and not 90 days less or more.
- For purposes of long stay utilization, RAC member inquired why a distinction is being made between 65 and older and 75 and older. A. Ogston noted that usage rate is significantly different based on age bands and considering trends in how nursing facilities are being used in the service area. RAC member noted that in their facility they are seeing a trend downwards in the number of younger people who are staying, thus age is no longer a determining factor for whether someone is going to become a long-term patient.

Section (5) - identifies that the OHA will use smoothing or statistical adjustments to address unusual spikes or drops caused by factors such as COVID-19, temporary closures, or other events. RAC discussion:

- RAC member inquired about this analysis and what tools, algorithms, etc. may be used. M. Gilman noted that the OHA has a statistical analysis team that he will check with to determine what tools they are using to conduct the adjustment. RAC member further noted that there is still some residual recovery due to the pandemic.

Section (6) - Explains how to evaluate occupancy and utilization patterns using a specified formula and requires calculating occupancy, looking at five-year trends, and comparing short-stay versus long-stay use. Factors such as age of residents, geographic differences, and variations between facilities must also be considered. RAC discussion:

- RAC member commented that overall occupancy should be the main factor in deciding whether more nursing facility beds are needed. They noted that many other metrics exist, but the key question is whether facilities in the area are operating near full capacity. If occupancy isn’t close to 100%, it suggests there isn’t a real supply and demand problem, regardless of other demographic or utilization factors.

Section (7) – explains how to identify local access problems that shows a community may need more nursing facility beds including considering delayed hospital discharges, long travel times, lack of specialized care,

staffing shortages, too few facilities or hospital readmissions. RAC discussion:

- RAC member shared that hospital discharge delays aren't always caused by a lack of nursing facility beds. Sometimes patients haven't met the required three-day hospital stay, and other times they can't be placed because they don't have an established payer. Nursing facilities won't admit someone without a clear funding source. He noted that these issues should be reflected in the data because they add nuance to understanding discharge delays
- RAC member via Chat reiterated concerns and expressed caution of specialty service demand and discharge delays, both in terms of what the magnitude of that reality is and what that demand justifies in supply need vs available supply. Additionally, it was stated that staffing shortage/challenge has no place in these rules. Adding supply in no way improves the market workforce supply availability.
- RAC member via Chat asked how specialty services would apply? Would this be focused on an application for a more specialized post-acute care need? RAC member commented in response and emphasized focusing on whether a county lacks skilled nursing facility beds, not just specialty units or special-case resident needs. Specialized care types do not clarify whether there is a true shortage of general skilled nursing facility beds. A clearer explanation of what the rule intends to capture was requested.
- RAC member expressed confusion about subsection (7)(d), questioning whether chronic understaffing might indicate a local workforce shortage that a new facility could fix. A. Ogston noted that chronic understaffing could signal a staffing problem – not a need for more beds – and therefore may not support approval of a new facility. It was recommended that the criteria be re-written, for example, documenting that there's sufficient staff.
- RAC member via Chat stated that chronic understaffing preventing conversion of licensed beds to set-up beds should not be a demonstration of need.
- RAC member reiterated concerns about hospital readmissions as discussed previously. This was supported by another RAC member and further consider specific thresholds relating to readmissions.

- A. Ogston noted that the reason why OHA evaluates workforce availability or shortages is to assess if that is why a bed is not being staffed. Adding more beds when there is an issue with staffing is not going to fix the problem. It was noted that additional clarification may be needed to clarify that when we say a factor is being considered, it is being considered holistically.
- RAC member asked for further clarification about staffing shortages as they can be interpreted in different ways. It was noted that workforce challenges can stem from local conditions, such as an undesirable place to work. Another RAC member responded that a new facility does not solve workforce shortages; if a market has limited staff, creating more beds does not increase the number of available workers. Workforce issues should not be used to justify adding new facilities.
- RAC member shared that the rule language should be clarified further about how staffing factors should be interpreted.

Next steps –

- Meeting notes will be drafted and will be emailed to RAC members and posted on the HCRQI Rulemaking Activity webpage. Meeting notes will summarize the discussion as well as identify information provided in the Chat.
- RAC members were encouraged to submit any follow-up comments or proposed language changes by email to mellony.c.bernal@oha.oregon.gov, matt.s.gilman@oha.oregon.gov, or sadie.morrissey@oha.oregon.gov.

  Next meeting is scheduled for September 24, 2026, at 9:00 a.m.