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SB 1575 Hospice Licensure Rulemaking Advisory Committee (RAC)

September 25, 2026

9:00 am via Microsoft Teams

RAC MEMBER ATTENDEES

Barb Hansen	Oregon Hospice and Palliative Care Association
Christiana Harrison	Legacy Hospice Services
Claire Cepuran	Compassion & Choices
Emily Cronan	Oregon Nurses Association
Iria Nishimura	Willamette Vital Health
Jeff Meyers, PA	Health Care Professional
Kristin Milligan	LeadingAge Oregon
Larry Lombard	Consumer/Consumer Advocate
Loril Eaton	SEIU

OTHER INTERESTED PARTY ATTENDEES

Megan Wai	Chief of Staff for Sen. Patterson
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OHA & ODHS ATTENDEES

Anna L Davis	PHD-HCRQI
Cady Handley	PHD-HCRQI
Dana Selover	PHD-HCRQI
David Allm	ODHS-SOQ
Jeremiah Adams	ODHS-SOQ
Jerry Walker	PHD-HCRQI
Liana Walta	PHD-HCRQI
Mellony Bernal	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 or to sadie.morrissey@oha.oregon.gov following the meeting. Any information received will be shared with RAC members and OHA staff.
- 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>)
- The timeline for submitting proposed rule language was highlighted. It was noted that per the Public Health Division's policy, the HCRQI program is unable to hold proposed permanent rulemaking hearings during legislative session. If the program is unable to post proposed rules in the Oregon Bulletin by December 1, then permanent rulemaking will have to be delayed until June or July 2027 and the current state moratorium on issuing new licenses would remain in place until after the permanent adoption of rules.

INTRODUCTIONS

In lieu of introductions, participants were asked to enter their first and last name into the Chat.

CONTINUED REVIEW OF HOSPICE RULES (Starting at 333-035-0157)

333-035-0157 - Fees

Anna Davis and Dana Selover summarized the proposed new initial, renewal, and late fees. Fees will be adopted in rule pursuant to SB 1575 versus in statute.

Expenses related to licensure must be covered by fees as no General Fund has been appropriated for this work. Fees cover the following:

- Developing and implementing the new licensing intake process and issuing licenses in a timely manner;
- Expanded oversight and compliance;
- Revising forms and materials.
- The addition of hospice programs to the on-line licensing system. This will allow the program to move away from paper and PDF forms and allow the OHA to collect data that can be shared with partners.
- Reviewing applications and new supporting documentation.

- Conducting criminal background checks and making fitness determinations.
- Education and training for new and existing licensees regarding new requirements.
- Survey and state complaint investigations.
- Department of Justice costs related to expanded license reviews.

A. Davis noted that an additional 1.0 FTE for a Compliance Specialist 2 is anticipated to be hired to help with reviewing requirement documentation. Currently, two client care surveyors conduct state and federal hospice survey work totaling 1.0 FTE, but only 0.5 FTE is assigned to state survey work.

RAC discussion:

- RAC member indicated that both the initial fee and Change of Ownership (CHOW) fee could be higher. Several RAC members expressed agreement in the Chat. It was further noted by this RAC member that they understand the need to cover costs which have gone up for everything including salary, travel, etc. Higher fees for initial licensure and a CHOW may be less objectionable and perhaps would buffer existing renewal license fees.
- RAC member via Chat indicated that given the increased expectations of, and limited, OHA staff, the rules should try and do the most for ensuring quality and preventing fraud in an efficient way.
- RAC member via Chat disagreed with higher fees and noted that rural areas are already struggling with higher prices. RAC member spoke of difficulties in rural Oregon and stated that more needs to be done to foster hospice care providers.
- RAC member via Chat noted that in drafting the bill, it was expected that fees would have to be raised to pay for additional staff needs.
- RAC member via Chat wondered if the lower daily census sliding scale could help account for rural communities who frequently need more help. This RAC member further asked about data on rural populations and hospice average census to identify those programs that may need more support versus those that are in a more urban area. A. Davis asked whether the RAC member was suggesting a bifurcated initial fee (urban versus rural). D. Selover noted that for purposes of initial licensure, there would be no average daily census yet and therefore would be reasonable to look at renewal sliding scale support. Current data availability is limited and unreliable including licensing information that is not stored in a usable database for analysis. It was noted that OHA can work with the Office of Rural Health for purposes of establishing reliable area classifications. The

goal is to create an equitable fee structure without imposing significant administrative burden on providers.

- RAC member via Chat indicated that geographical consideration for purpose of identifying scope or size of program would not be a large lift.
- RAC member via Chat noted that perhaps an urban/rural mix and covering an "in need" county could help bring services to more rural areas if reduced fees would encourage providers to locate there.
- RAC member noted that most new hospice programs are going to urban areas, not rural. In the State of Washington, there is a Certificate of Need (CN) Program for hospice licensure, and an applicant would have to pay a \$35,000 CN fee. It was suggested that perhaps there could be a caveat for reduced license fees for going into a designated underserved area. A. Davis expressed concern based on applicants who have submitted moratorium exception requests where the geographic service area includes rural locations, but the office would be located in an urban area.
- RAC member suggested considering renewal fees for programs with an average daily census of 100 be higher to offset costs for smaller, rural programs.
- RAC member expressed concern about using rural or non-rural as the qualifier and noted more concerns about the renewal license fees versus initial licensure fee and CHOW fee.
- RAC member expressed frustration about limited hospice access in rural coastal areas and the growing involvement of private equity in hospice providers. There needs to be greater attention to Oregon's large rural regions and protecting locally driven care for Oregonians.
- RAC member shared via Chat a very common, questionable strategy to avoid completing the CAHPS survey is to keep the hospice patient census very low (less than 24). One of the goals of SB 1575 was to try and avoid future quality issues of hospice care.
- RAC member via Chat expressed appreciation for the comments and stated it's hard to know how to define what we need, but we do note there is a concern of making sure we can meet those areas that are "in need."
- D. Selover encouraged RAC members to send further ideas or criteria for development of a fee structure that is equitable and that may account for more than simple rural-urban distinctions. She further noted that since fees are being added to administrative rule, it would be easier to change in the future versus if the fee was in statute. A. Davis further noted that better data will be available in a year or two under the new licensing system that can be used in future fee discussions.
- RAC member suggested exploring a fee scale based on organizational revenue, noting that nonprofit financials are publicly available through

Form 990 and may provide a more accurate picture than census data, though applying this approach to for-profit agencies would be more complex.

- D. Selover responded that staff will consider further but noted concerns about verifiable information and whether a proposal would require financial expertise that the program does not have. RAC member via Chat stated that for-profits still must file taxes so perhaps there is consistent information on their tax filings that could be reviewed. Another RAC member asked via Chat, "By revenue, are we asking dollars taken in or profit margin?"

A. Davis shared information with the RAC related to the number of applicants who submitted their license renewal application late (submitted within 30 days of license expiration). These late applications cause a lot of additional work for staff. Out of 75 licensed programs:

- 2023 – 21 late applications
- 2024 – 34 late applications
- 2025 – 26 late applications
- 2026 (to date) – 6 late applications

Renewal applications will be much more complicated to review with the additional SB 1575 criteria and therefore a late fee has been added to rule.

- RAC member stated that a late fee is reasonable and questioned whether there is currently a late fee, which there is not. This RAC member further questioned whether a late fee could be on a sliding scale as well, or perhaps a specific percentage of renewal.
- RAC member stated via Chat that they are undecided on late fees, in general late fees seem appropriate, and a sliding scale would be good.
- RAC member inquired why such a large portion of renewal applications are late to help guide decisions. A. Davis responded that the OHA does not collect data on why an application is late; although, unlike other healthcare facilities licenses that all expire on December 31 of each year, hospice program licenses expire on a rolling basis. D. Selover noted that despite frequent postcards and other reminders, the OHA is always looking for ways to improve communication.

333-035-0160 – Geographical Service Area

A. Davis shared that the purpose of this rule is to allow a hospice program to request a waiver from rule to be able to expand its geographic service area beyond the 60 mile requirement, including but limited to if the patient hospice program proposes to provide services to an underserved area or underserved community. The existing definition of "underserved area or population" was

removed and replaced with the definitions used in SB 1575. A. Davis noted that the bill specifies the nine federally recognized Tribal Nations located in Oregon; however, it does not recognize the large number of Native Americans living in Oregon who belong to other Tribal Nations or are Alaska Natives. Oregon has a large, urban, Native American population that is not limited to the nine federally recognized Tribal Nations.

- RAC member asked that the OHA investigate expanding the definitions to address the foresaid oversight. Several RAC members via Chat supported adding more inclusive language. D. Selover and A. Davis discussed working with the Department of Justice to see if rules can be expanded to be more inclusive (e.g. including but limited to).
- RAC member asked via Chat whether the waiver application to serve an underserved population can require the submission of supporting data? A. Davis responded that OHA would welcome guidance on the data that should be submitted and how the data can be interpreted.
- RAC member asked A. Davis whether there are any insights learned from applicants seeking a waiver from the moratorium. A. Davis noted there has been more frustration than lessons learned given that applicants are repeating the definitions of underserved area and underserved population from the bill without any supporting data. Further, OHA lacks the knowledge whether any data submitted is valid.
- RAC member expressed concern that rules do not address language justice and eliminate groups of people that are interested in hospice care. This RAC member also expressed frustration that rules are not made available in other languages and the lack of representation on the RAC. D. Selover noted that the program continues to work diligently in seeking community representation on RACs in response to previous legislation (2021-HB 2993); noting that it is difficult to find persons interested in regulatory requirements.
- RAC member expressed thanks for the discussion and suggested that definitions could be improved and referenced definitions used for federally qualified health centers (FQHCs). It was noted that barriers to accessing hospice services are not limited to rural communities but can also occur in urban areas. Use of 'including but not limited to' may capture additional types of barriers to hospice access.
- RAC member noted that the largest growing populations and languages are Russian, Asian, and Spanish.
- RAC member asked that a "pediatric" category be added to underserved population since there are hospice programs that must travel beyond 60 miles to provide services to pediatric patients.

333-035-0161 – Medical Director and Administrator Criteria

This new rule is being proposed in response to SB 1575 which requires the OHA to establish in rule minimum training and qualification requirements for an individual to serve as a hospice administrator or an Oregon licensed physician to serve as a hospice medical director. The proposed criteria were identified using information from the American Academy of Hospice and Palliative Medicine and the [State of California's emergency rule](#). RAC members were specifically asked to consider whether the OHA should include a residency requirement for either the medical director or the administrator or to require residency within the 60-mile geographic service area. RAC discussion:

Medical Director qualifications

- RAC member acknowledged that the State of California requires the medical director to live within the same state. It was noted that CMS does not have any specific requirements in federal regulations. It was suggested that the administrator should be available at the location. Discussion ensued regarding whether a provider needs to live in Oregon if the licensed agency is in Idaho or Washington.
- RAC member expressed concern that a residency requirement may be overreaching considering many providers may prefer to live in Washington or Idaho but still able to provide services across the border. This RAC member further expressed concern regarding the certification requirement because CMS does not require. It was stated that there is shortage of certified physicians which would place a hardship on small or rural hospice programs. Staff noted that based on how the rule is written, a physician can serve as a medical director if they are certified **OR** have specific experience or work hours.
- RAC members via Chat noted the following:
 - Support for a residency requirement within the geographic service area;
 - "Same or adjacent state" would be reasonable; hospice practice varies by providers around the country;
 - Agreement that any geographic service requirement should be inclusive of providers who live close to the border in bordering states;
 - Support for 60-mile radius;
 - Acknowledgment that it should be okay for a provider to live in an adjacent state, but outside the 60 miles to give hospices back-up and flexibility;
 - Request to poll hospice providers to seek additional input. RAC member further expressed support for polling and expressed that the intent is to have good quality care and guarantee patient access.

- Medical directors may not be board certified in hospice and palliative medicine but may just have the Medical Director board exam. Consider legacy exception with the expectation that the physician works toward certification.
- Replace the "and" at the end of 333-035-0161(2)(c) with an "or" as it may be hard to find a hospice medical director who meets the specified criteria.
- Consider replacing the term "broad-hospice" under (2)(c) with the word "palliative" which would be more inclusive as many in primary care would meet that if they are doing palliative medicine within their practice.
- RAC member via Chat noted that especially for rural providers, Nurse Practitioners, in addition to a medical director, are used because of the difficulty finding providers.
- RAC member agreed with concerns about rural areas and suggested that OHA consider language used in the 'community palliative care bill.'
- RAC member shared information that an associate in California expressed that the California emergency rules may force some small hospice programs to close. This RAC member further noted that telehealth allows flexibility for hospices to utilize a medical director who does not live within a 60-mile radius.
- RAC member noted that the definition of "hospice-related activities" includes a reference to patient care. If a medical director is not in the area where they can see patients, it creates quality of patient care concerns. There is a difference between telehealth and in-person visits.
- RAC member expressed support for a 60-mile radius, including across the border, but expressed concern if a medical director, for example, lived in Southern California and was providing services to a program in Portland.
- RAC member expressed support for a legacy clause for existing medical directors and reiterated the need for alternate pathways given current data on the limited number of certified hospice medical directors in Oregon. It was noted that some hospice medical directors do not have two years of supervisory or managerial experience in a hospice or home health program due to a career change.
- RAC members shared that if not certified they should meet at least a minimum set of hours of education or be enrolled in a course.
- RAC member in response to question whether 400 hours should be reduced, shared that the 400 hours is less concerning than the two years of full-time supervisory or managerial experience.
- RAC members were encouraged to provide additional suggestions for criteria for minimum standards.

Administrator qualifications

- RAC member via Chat supported a 60-mile residency for both administrator and medical director.
- RAC member expressed concerns regarding the baccalaureate degree requirement noting that several administrators have a business background. Typically, a hospice program will have an administrator with a business background and a registered nurse who is the director of clinical operations. A. Davis asked whether a person with a business background would need additional experience that is health-related? RAC responded that it may not be necessary if they have a clinical director and questioned whether the rule needs to address the clinical operations.
- RAC member suggested that the rule could reference "health care business" degree.
- RAC member expressed that while the preference is for an administrator to have a health care background, existing programs and their staff need to be considered, especially if at time of renewal they do not meet the minimum criteria. It was further suggested that an MBA is fine when there are additional team members with clinical background. It was suggested that rules could clarify there must be a director of patient care services who is a registered nurse.
- RAC member expressed concern for any regulation that requires a degree providing background on recently passed legislation ([2026-HB 4040, Section 2](#)) removing requirement that a long-term care administrator must have a degree. This requirement was very limiting and unintentionally excluded people who had a long work history in this sector.
- RAC member via Chat stated that the rules include a reference to nursing, which allows a nurse practitioner to be an administrator and they recommended including physician associate (PA), who can be a hospice attending per CMS guidelines, and thus should be able to be an administrator.
- RAC member via Chat suggested that waving managerial experience if there is also clinical experience in the program should be considered. This RAC member further clarification that the rules should be broad to consider rural areas and consider an individual who may have a combination of both managerial and clinical knowledge but the managerial experience may not be specifically in the stated care settings.
- RAC member suggested that it may make more sense to provide proof of hospice-specific regulatory training.
- RAC member indicated that several years ago about half of Oregon hospice programs had an administrator with a non-clinical background; and they had a nurse or physician as their director of patient care services.

Limitation on serving more than one hospice program

- RAC member suggested that additional clarification as to what exceeds the capacity of a medical director or administrator. Information was shared that there are hospice programs that have an administrator that serve more than one hospice program not in the same rural area (e.g. average daily census; rural area definition; etc.)

333-035-0210 – Criminal Background Check Requirements

Staff noted that this rule was initially written for requirements of a hospice program to conduct background checks on employees, contractors, volunteers, etc. and has been modified to incorporate language that the OHA will complete background checks on administrators, medical directors, and persons with 5% or more ownership interest. This rule already defines 'disqualifying condition' and 'fitness determination.' Hospice programs already must have policies and procedures in place for conducting a background check and making a fitness determination. Language has been added that clarifies the OHA shall make a fitness determination using criteria established under [ORS 181A.195](#) (10)(c) and (11)(a) which includes considering the following factors:

- Nature of the crime;
- Facts supporting the conviction or pending indictment or making a false statement;
- Relevancy of the crime or false statement to the position;
- Intervening circumstances relevant to responsibilities such as passage of time; age of the subject individual; likelihood of repeated offense; subsequent commission of other crimes; whether the conviction was set aside; recommendation of an employer.

Sub-section (11)(a) identifies factors that the OHA cannot take into consideration such as a conviction that is more than 10 years old unless it's a crime specified under ORS 443.004; charges or arrests for which there was no conviction (unless the care or arrest is specified under ORS 443.004); or a charge or arrest related to marijuana if the charge is no longer a criminal offense.

The rules have been amended to require that the hospice program report to the OHA with 10 days any criminal conviction, arrest, indictment or charge against an administrator, medical director, or person with 5% or more ownership interest so that the OHA may conduct another fitness determination.

RAC discussion:

- RAC member asked if the fee for the background check is included in the license fee. Staff reviewed the process of referring individuals to Fieldprint where the individual would be responsible for paying the fee of \$60.50 (\$48.00 for FBI print fee and Oregon State Police processing fee and \$12.50 for Fieldprint service fee.)

Next Steps

- RAC member thanked everyone for the thoughtful discussion and open dialogue.
- Staff thanked RAC members for their participation and asked that final suggested changes or additional comments be submitted to M. Bernal no later than Monday, September 28, by 5:00 P.M.
- Staff will review information shared in the RAC meetings and any follow-up comments received and will work on incorporating changes into a revised rule set that will be shared with RAC member prior to the October 5th meeting.
- M. Bernal will draft meeting notes and send out meeting reminder and comment deadline reminder.

The next meeting is scheduled for October 5, 2026, at 9:00 a.m.