DATE: April 15, 2026

TO: Hearing Attendees and Commenters –
Oregon Administrative Rules chapter 333, divisions 590 and 615 – Demonstration of Need for Acute Inpatient Beds and Psychiatric Hospitals (Certificate of Need)

FROM: Brittany Hall, Hearing Officer and Administrative Rules Coordinator

cc: Dana Selover, Section Manager
Health Care Regulation and Quality Improvement

SUBJECT: Presiding Hearing Officer's Report on Rulemaking Hearing, Public Comment Period, and Agency Response to Written Comments

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Hearing Officer Report

Date of Hearing: March 18, 2026, via Microsoft Teams

Purpose of Hearing: The purpose of this hearing was to receive testimony regarding the Oregon Health Authority (OHA), Public Health Division, Certificate of Need (CN) Program's proposed permanent amendments to OAR 333-590-0000, and proposed permanent adoption, repeal and amendment of administrative rules in OAR chapter 333, division 615 relating to the analysis of information an applicant must provide to OHA to demonstrate the need for psychiatric inpatient beds.

These rules will make permanent a temporary rulemaking that will expire on April 19, 2026 (Temporary Administrative Order PH 20-2025) and are necessary to be able to continue to adequately evaluate a Certificate of Need application using relevant data, methods, and timelines.

Hearing Officer: Brittany Hall

Testimony Received: No individuals provided testimony at the hearing.

Other Comments: Four individuals or organizations submitted written comments during the rule advisory committee (RAC) process. Written comments received during the RAC process are attached to this report as **EXHIBIT 1.** Three individuals or organizations submitted written comments to OHA within the period allotted for public comment, which closed at 5:00 PM on March 23, 2026. Written comments received during the public comment period are attached to this report as **EXHIBIT 2.**

In written comments received during the rule advisory committee (RAC) process, OHA received a suggestion for replacement language in OAR 333-615-0030(2)(a) regarding the use of All Payer All Claims (APAC) data in the version of the proposed rule text reviewed by the RAC:

"(a) Determine current year and historical utilization by Health Service Area population of existing facilities. For this step, the applicant shall use timely and relevant data sources. Examples of acceptable data sources include but are not limited to: All Payer All Claims (APAC), Hospital Discharge Data (HDD), Centers for Medicare and Medicaid Services (CMS) data, provider data, or trade association data. For the current year, and each of the prior 10 years, the applicant shall explain factors which may have affected identified trends. Factors to be addressed include, but are not limited to, changes in: population, public health needs (including any public health emergency), hospital location, service mix, age mix, reimbursement mix, transportation patterns, locations of physicians, specialists, unmet need, and the intensity or types of services delivered;"

Agency response: In response to written feedback and discussions at the RAC, OAR 333-615-0030(1)(c) was amended to clarify that APAC data is optional rather than mandatory. The rule does not require access to specific proprietary datasets. No further modification is needed because the rule provides adequate flexibility and does not impose unavailable data requirements. Revised rule language was shared at the February 3, 2026, RAC meeting and was included in the notice of proposed rulemaking filed with the Secretary of State on February 26, 2026.

In written comments received during the RAC process, OHA received comments requesting clarification of the scope between OAR 333-590 and OAR 333-615, specifically, clarification on whether the rules are for "psychiatric hospitals" or "inpatient psychiatric beds", noting use of both terms in the proposed rule text reviewed by the RAC, and the recommendation to maintain consistency in the use of terms throughout the rules.

Agency response: In response to written feedback and discussions at the RAC, language was modified to clarify that a freestanding psychiatric hospital and psychiatric units that meet the criteria for a "new hospital as defined by ORS 442.015" will be subject to the methodology described in OAR chapter 333, divisions 615 and 580. The following rules were amended providing additional clarification - OAR 333-590-0000(2), OAR 333-615-0010, and OAR 333-615-0025. A majority of these changes were shared at the February 3, 2026, RAC meeting and additional clarifying language was included in the notice of proposed rulemaking filed with the Secretary of State on February 26, 2026.

In written comments received during the RAC process and during the public comment period, OHA received a recommendation to "remove the definition of 'Alternative Service Area' [from OAR 333-615-0010, Definitions, section (1)] and rely exclusively on Trauma Service Area or better define the parameters when this would be used (i.e. children, adolescents, geriatrics and other populations that have small numbers)." Written comments note that "in recent years, there has been a move to Trauma Service Areas as the coordinating geographic area for hospital level care."

Agency response: For clarification, the term used in OAR 333-615-0010 is "*Alternate* Health Service Area." At the January 7, 2026, RAC meeting OHA staff noted that the OHA is offering a deviation from the trauma system as an acknowledgement that there may be rare occasions when the Trauma Service Area does not adequately address the need for inpatient psychiatric hospitals. The currently adopted rules specify that OHA may allow an Alternate Health Service Area based on the evidence presented. This discretionary standard is intentional

and allows OHA to account for the diversity in psychiatric service delivery across regions. The OHA will maintain the rule as currently written.

Regarding OAR 333-615-0010(2), the definition of "Alternatives," written comments received during the RAC process related to proposed rule text reviewed by the RAC state that "the list of alternative levels of care do not have definitions or stated rationale for listing these alternatives. The listed alternatives are distinct levels of care and, while essential for a robust behavioral health system, they are not alternatives to inpatient level of care, except for (e) 'inpatient psychiatric unit or floor in a hospital,'" and "while the alternatives listed are all important parts of the behavioral health continuum, they are not interchangeable levels of care."

Subsequent comments regarding OAR 333-615-0010(2) received during the public comment period expressed appreciation for amendments to the definition that clarify "that these are not 'interchangeable with inpatient psychiatric hospitalization.'" Written comments received during the public comment period further recommend "defining the listed alternatives by referencing either statute or rule: residential treatment facility, residential treatment home, adult foster home, and residential substance use disorder facility."

Agency response: The OHA concurs with the suggestion that the "alternatives" listed under OAR 333-615-0010 further reference appropriate definitions. The rule will be amended as follows:

> (2) "Alternatives" means other settings within the behavioral health continuum that may reduce demand for inpatient psychiatric hospital beds by providing appropriate care at a lower level of intensity or cost. These settings are not clinically interchangeable with inpatient psychiatric hospitalization but must be considered in evaluating system capacity and flow. Alternatives include, but are not limited to:
> (a) Residential T~~t~~reatment F~~f~~acility (RTF) as defined under ORS 443.400;
> (b) Residential T~~t~~reatment H~~h~~ome (RTH) as defined under ORS 443.400;
> (c) Adult F~~f~~oster Hhome (AFH) as defined under ORS 443.705; and
> (d) Residential S~~s~~ubstance U~~u~~se D~~d~~isorder ~~facility~~ Treatment Program means a publicly or privately operated program as defined in ORS 430.010 that provides assessment, treatment, rehabilitation, and twenty-four hour

observation and monitoring for individuals with substance use dependence, consistent with Level 3 of The ASAM Criteria, Third Edition.

Written comments received during the public comment period regarding OAR 333-615-0010, definition of "subspecialty beds", support changes made to the definition within versions of the proposed rule text, but further recommend "adopting the Joint Commission [Hospital Based Inpatient Psychiatric Services] HBIPS definitions of children as 1-12 years old, and adolescents as 12-17 years old" or "delineating between child programs (age 5-11) and adolescent (12-17)." Suggested changes to the rule text were also provided as follows:
(6) "Subspeciality beds" means an inpatient setting designed specifically for:
~~(a) Individuals under the age of 18; or~~
(a) Individuals under the age of 12;
(b) Individuals between 12 and 17 years of age; or
(~~b~~c) Individuals 65 and older."

Agency response: In consultation with the OHA, Behavioral Health Division, the OHA does not support further delineating individuals under the age of 18. The currently adopted rule defines subspecialty beds in a manner that allows OHA to evaluate age specific inpatient needs consistent with other setting definitions. Further granularity is not required for the rule to function and is better addressed during application review. The OHA will maintain the rule as currently written.

Written comments received during the RAC process regarding OAR 333-615-0025, Criteria for Approval of a New Psychiatric Hospital, note that in the proposed rule text reviewed by the RAC section (2) "stipulates that the number of beds in a health service area will not exceed 36 beds per 100,000 individuals." Comments opine that this number comes from the Behavioral Health Residential Facility Study, but notes that "the study states they did not fully and comprehensively evaluate inpatient psychiatric needs in the state and that further analysis is needed." Written comments recommend that "the study should be used as contextual input rather than fixed thresholds," and that the bed-per-capita caps should be avoided until subspecialty-inclusive assessment is complete. Written comments also

request that the "rules specify which cohorts (child, adolescent, adult and geriatric) each ratio is to be used for."

Agency response: In response to written feedback and the RAC discussion held on January 7, 2026, the limitation on the number of beds in a psychiatric hospital Health Service Area was removed. Revised rule language was shared at the February 3, 2026, RAC meeting and was included in the notice of proposed rulemaking filed with the Secretary of State on February 26, 2026.

Written comments received during the RAC process and during the public comment period regarding OAR 333-615-0040, The Availability of Alternatives in the Health Service Area, note that section (1) "requires the applicant provide a complete list of all alternatives to inpatient treatment in the HSA, including an inventory of provider type, address, bed capacity, and utilization." Written comments recommend "the agency publish a standardized inventory template, including crisis services." Written comments received during the RAC process state support for "adding a requirement the applicant be required to consult with regional behavioral health planning bodies, including the local mental health authority, local Community Health Needs Assessment, local Community Health Improvement Plan and coordinated care organizations."

Agency response: OHA appreciates the comments and notes that applicants have the burden of responsibility to demonstrate their efforts to obtain information related to a list or inventory of providers, bed capacity, and utilization within the Health Service Area. Further, the rule defines what alternatives are and limits the information that an applicant is required to provide. The currently adopted rule requires applicants only to provide information reasonably available to them. The OHA will maintain the rule as currently written.

Also, regarding OAR 333-615-0040, The Availability of Alternatives in the Health Service Area, written comments received during the RAC process and during the public comment period note that section (2) "requires information that may not be available to the applicant or the public. For example, market rates or outcomes for other hospitals or providers. Other information, such as regulatory compliance, accreditation and certification is information readily available to agency staff, but

not the public." Written comments opine that "this information will not be readily available or accessible, and it is unclear how OHA will determine feasibility." Written comments request that "OHA clarify data responsibility and the validation process," and "clarify the factors that will be evaluated after reconsidering what information is available and appropriate." Written comments received during the public comment period also request that "additional definitions and sources for determining reasonable charges and market rates should be specified" and question "what source will be utilized for the market-rate data for similar services," opining that "if not publicly available, it should not be a requirement."

Agency response: OHA appreciates the comments. As with the previous comment, the rule requires that applicants provide data and information that is reasonably available to them. The OHA will maintain the rule as currently written.

Also, regarding OAR 333-615-0040(4), written comments received during the public comment period opine that in the rule "OHA is requesting a pro forma from any existing providers that could be impacted by a new market provider; and the pro forma should include impact on payer mix and staffing. The standard also refers to ability to maintain quality standards at reasonable cost." Written comments request that OHA provide "additional details on the data necessary to link finance to maintenance of quality and reasonable costs."

Agency response: OHA appreciates this comment and notes that payer mix, staffing, and quality standards are captured and addressed in other areas of the application**.** The OHA will maintain the rule as currently written.

Written comments received during the RAC process regarding OAR 333-615-0050, Quality, opines that section (3) of the proposed rule text reviewed by the RAC "allows a loophole for providers to not accept Medicaid and Medicare." Written comments recommend "that this language be strengthened to require any provider to accept patients regardless of payer," and that section (3) be "amended to clarify that the applicant be certified under [Medicaid or Medicare] programs to be considered for Certificate of Need approval."

Agency response: In response to written feedback and the RAC discussion held on January 7, 2026, the OHA revised language under section (3) to ensure that the proposed project will be certified under the Medicaid and Medicare program. Revised rule language was shared at the February 3, 2026, RAC meeting and was included in the notice of proposed rulemaking filed with the Secretary of State on February 26, 2026.

Also, regarding OAR 333-615-0050, Quality, written comments received during the RAC process note the emphasis on continuity of care in section (4) and opine that "this can be strengthened by requiring a transfer agreement with oversight from the agency." Recommended changes to OAR 333-615-0050(4) in the version of the proposed rule text reviewed by the RAC are as follows:

(4) The proposed project will promote continuity in the provision of health care, not result in an unwarranted fragmentation of services, and have an appropriate relationship to the Health Service Area's existing health care system, as demonstrated by a transfer agreement, which must include reason for transfer, medical records and a medication list along with a commitment to take the patient back as soon as they are medically cleared, that is monitored by the Agency on a biennial basis.

Subsequent written comments received during the public comment period note the addition of the transfer agreement in OAR 333-615-0030, Estimate of Need, but comments opine that "there is not a way to enforce or hold accountable and would recommend adding to OAR 333-615-0050:

(4) The proposed project will promote continuity in the provision of health care, not result in an unwarranted fragmentation of services, and have an appropriate relationship to the Health Service Area's existing health care system, as demonstrated by a transfer agreement that is monitored by the Agency on a biennial basis."

Agency response: In response to questions about holding applicants accountable and enforcement, the OHA has the authority to place conditions on a Certificate of Need approval under OAR 333-570-0070. OHA will enforce requirements for a transfer agreement under OAR 333-575-0000.

Also, regarding OAR 333-615-0050(2) related to the supply of qualified personnel, OHA heard in written comments received during the public comment period a request for a modification to the rule to "clarify that this needs to be accomplished without adversely impacting current providers and the developing alternatives." Suggested rule change is as follows:

(2) A sufficient supply of qualified personnel, including clinical, administrative, operational, and technical staff, are available or can be timely recruited to ensure the hospital operates safely, efficiently, and in compliance with applicable standards, without negatively impacting existing hospitals and alternative providers.

Agency response: The OHA has considered the comment and finds that it is outside the scope of the Certificate of Need program. The OHA will maintain the rule as currently written.

Also, regarding OAR 333-615-0050(10) related to charity care, OHA heard in written comments received during the public comment period the request that "the standard be modified to add the word '***ongoing***' in front of compliance" [with federal and state law] and requested that OHA "specify how ongoing compliance will be measured" and make the results public.

Agency response: The OHA is amendable to adding the term "ongoing" as suggested. Ongoing compliance of facilities is conducted through OHA's, Health Facility Licensing and Certification program. OAR 333-615-0050 will be amended as follows:

> (10) The applicant will offer charity care, as defined in ORS 442.601(1), commensurate with other facilities with a comparable payor mix. Applicant must provide their policy for charity care and demonstrate ongoing compliance with federal and state law. The Oregon Health Authority (Authority) may consider the applicant's history of offering charity care in evaluating these criteria.

Written comments received during the RAC process regarding OAR 333-615-0035, Alternatives to Health Service Areas, opine that the proposed rule text reviewed by the RAC "lacks necessary specificity and grants too much discretion." Written comments recommend that "the agency propose a clearer, more objective rubric for granting an exception to using the Trauma Service Area or not allow the option of an alternative."

Agency response: The currently adopted rules already specify that OHA may allow an Alternate Health Service Area based on the evidence presented. This discretionary standard is intentional and allows OHA to account for the diversity in psychiatric service delivery across regions when the criteria are met. The OHA will maintain the rule as currently written.

Written comments received during the RAC process regarding OAR 333-615-0060, Cost, section (2) related to projects involving construction, recommend "adding that applicants must have pursued bids from at least three firms and require that applicants prove that they chose the least expensive, best quality construction partner."

Agency response: Procurement requirements fall outside the scope of the Certificate of Need program. The rule properly focuses on whether project costs are reasonable, which is the extent of OHA's statutory authority. Therefore, the OHA will maintain the rule as currently written.

Written comments received during the RAC process question why OAR 333-615-0070, Use of Other Sources for Evaluating Applications, is necessary. Comments opine that "if applications 'do not contain standards in sufficient detail to make the required determinations,' they should not be considered complete and should not be approved until they are."

Agency response: OAR 333-615-0070 does not alter application completeness standards. It applies only after an application is accepted as complete under OAR chapter 333, division 580. The rule already functions appropriately and does not

enable applicants to bypass completeness requirements. The OHA will maintain the rule as currently written.

In written comments received during the public comment period, OHA heard support for the addition of the definition of "Psychiatric Admission" in OAR 333-615-0010(5) (as noted was missing in the proposed rule text reviewed by the RAC in written comments received during the RAC process) as "an inpatient episode identified by a principal diagnosis code within ICD-10 Chapter F (Mental and Behavioral Disorders, F01-F99) or by a psychiatric DRG (Diagnosis Related Group) as defined under CMS DRG classifications (e.g., 885-887, 894-896, and any codes for psychoses, neuroses, and other mental health conditions)." Written comments opine that the Centers for Medicare and Medicaid Services (CMS) regularly modify codes and question "how will OHA ensure that definitions remain current?"

Agency response: As discussed at the February 3, 2026, RAC the OHA is unable to refer to 'future changes' to codes or documents in rule. The OHA will need to put systems in place to ensure that staff stay informed about changes to cited codes, consider whether changes are necessary to rule, and if so, convene a RAC for further review and updates to administrative rules.

Written comments received during the RAC process note that the principles that guide how OHA evaluates new psychiatric beds are being removed from Oregon Administrative Rule because they are in Oregon Revised Statutes. Written comments opine that "the principles of community-based care and new inpatient psychiatric hospitals being the lowest level priority for addressing any unmet need, are critical and should remain at the forefront in rule."

Agency response: The specific language on how the OHA will evaluate new psychiatric beds can be found in OAR 333-615-0030 and -0060, which both require consistency with ORS 442.310. The OHA will maintain the rule as currently written.

Written comments received during the RAC process requested to "understand how [inpatient psychiatric] beds located in acute care hospitals seeking to expand will

be treated (and which rules will apply)." Comments note that "CN review is required when a hospital proposes an increase deemed to be a substantial increase in services because the increase exceeds 10 beds or 10% of current bed capacity under OAR 333-550-0010(2)."

Agency response: The OHA provided information at the February 3, 2026 RAC meeting relating to when a change in beds is subject to a Certificate of Need. RAC meeting notes are available on the HCRQI Rulemaking Activity webpage, under Rulemaking Advisory Committees in Progress at: http://www.healthoregon.org/hcrqirules.

Written comments received during the RAC process state support for the rules in defining that alternatives to hospitalization should be considered. Comments reference OHA's commissioned report, *Oregon Health Authority Behavioral Health Residential+ Facility Study, June 2024 Final Report*, and note that the report identified eight options to a freestanding psychiatric hospital. Comments opine that "the rules should identify how these alternatives are to be considered," stating that "there is a need for clarity and specific guidance regarding how to quantify the supply of these alternatives." Comments request "explicit language regarding how existing or pending alternative beds are to be treated and 'subtracted' from gross bed need to determine adjusted inpatient psychiatric beds should be added." Comments further opine that "the rules should be sure to include consideration of emerging models, such as crisis stabilization, which may also reduce demand."

Agency response: The rules adequately address these concerns by requiring applicants to evaluate alternatives. The OHA will maintain the rules as currently written.

Written comments received during the RAC process request "more specificity in rule around the analysis to be used to determine that a new hospital, as it staffs up will not impact the availability of adequate staffing in the alternative settings."

Agency response: OHA appreciates the comment. The rule already requires applicants to demonstrate a sufficient supply of personnel to operate safely and

effectively. This necessarily encompasses consideration of impacts on existing providers and alternative settings. No further specificity is needed, and the OHA will maintain the rule as currently written.

Written comments received during the RAC process stated that it was noted during the RAC discussion that "the sole existing freestanding psychiatric hospital in the State does not submit data to Apprise." Comments opine that this data needs to be available in order to quantify use rates, patient migration patterns, etc."

Agency response: The OHA agrees that properly reporting data is essential to a healthy and robust health care system. These requirements and their enforcement are outside of the Certificate of Need program.

Written comments received during the RAC process noted that there was discussion during the RAC about "how OHA intends to enforce any conditions placed on future applications post-operations." Comments request that this be outlined in rule.

Agency response: As stated previously conditions and their enforcement are both addressed in existing Certificate of Need rules.

In written comments received during the public comment period regarding OAR 333-615-0030, Estimate of Need, section (5) ...*The applicant shall document how the proposed capacity will serve Medicaid-eligible individuals, identify alternative funding strategies for non-covered stays, and explain the impact on projected utilization and financial feasibility on the applicant and alternatives*, OHA heard a request for the rules to "identify how conformance to the standard will be evaluated; especially for a new free-standing hospital of more than 16 beds. What is the source of the alternative funding? What percentage of days are non-covered? What percentage of TSA [Trauma Service Area] residents would not be eligible for care in the hospital and how will referrals be made for this cohort?"

Agency response: OHA appreciates the comment. The answers to these questions must be addressed in an application and will be different, depending on the applicant and the proposed location of a new facility. The OHA will maintain the rule as currently written.

Also, regarding OAR 333-615-0030(14)(a) *Applicants must document how the project will avoid adverse financial impact to existing psychiatric service providers and alternatives, particularly those serving high-acuity or underserved populations. The analysis shall address whether the proposed project will contribute to continuity or conversely, fragmentation of psychiatric care in the Health Service Area,* OHA heard in written comments received during the public comment period the recommendation that "the rules or interpretive guidelines require a comparison of payer mix of the applicant to existing providers serving residents of the TSA. It should also require explicit detail on how a provider would recruit a specialized behavioral health workforce without negatively impacting existing local behavioral health employers."

Agency response: OHA appreciates the comment and believes the currently proposed rule adequately addresses the concerns related to the analysis of negative financial impacts and the provision of a specialized staffing force.

EXHIBIT 1

From: Ranzoni Steven
To: GILMAN Matt S; Mellony Bernal
Subject: CN language for apac
Date: Friday, January 9, 2026 8:10:05 AM

Hi there,

I want to suggest the following as a replacement for 2(a) on page 9. The part about using APAC:

a. Determine current year and historical utilization by Health Service Area population of existing facilities. For this step, the applicant shall use timely and relevant data sources. Examples of acceptable data sources include but are not limited to: All Payer All Claims (APAC), Hospital Discharge Data (HDD), Centers for Medicare and Medicaid Services (CMS) data, provider data, or trade association data. For the current year, and each of the prior 10 years, the applicant shall explain factors which may have affected identified trends. Factors to be addressed include, but are not limited to, changes in: population, public health needs (including any public health emergency), hospital location, service mix, age mix, reimbursement mix, transportation patterns, locations of physicians, specialists, unmet need, and the intensity or types of services delivered;

Thanks,

Steven Ranzoni, MPH
Hospital Policy Advisor
OREGON HEALTH AUTHORITY
Health Policy and Analytics Division
Phone: (503) 480-9598
OHA Customer Service Survey (Health Policy and Analytics)

Providence

4400 NE Halsey Street
Portland, OR 97213
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January 8, 2026

Mellony Bernal
Oregon Health Authority
800 NE Oregon Street, Suite 465
Portland, OR, 97232

Re: Certificate of Need Program Rule Advisory Committee

Dear Ms. Bernal,

As the largest provider of behavioral health services in Oregon, Providence is committed to strengthening the state's behavioral health system so that patients receive safe, equitable, and timely care at the appropriate level of need. We appreciate the Oregon Health Authority's (OHA) decision to modernize certificate of need rules for inpatient psychiatric services, including the temporary amendments and adoptions in divisions 590 and 615 effective October 22, 2025 through April 19, 2026.

Our recommendations below are intended to (1) clarify the scope of the rules, (2) align methodologies with current data and system realities, (3) ensure patient safety and (4) strengthen continuity of care and equitable access, including for Medicaid, Medicare, and uninsured individuals.

Clarify the Scope Between OAR 333-590 and OAR 333-615 Division 590, Demonstration of Need for Acute Inpatient Beds and Facilities adds "evaluating need for a psychiatric hospital." Division 615 replaces "inpatient beds" with "hospital".

Recommendation: Clarify whether the rules are for "psychiatric hospitals" or inpatient beds" and maintain consistency throughout the rules.

333-615-0010 Definitions Section 1 defines "Alternative Health Service Area" as a "deviation from the Traum (sic) System Area as the Health Service Area". In recent years, there has been a move to Trauma Service Areas as the coordinating geographic area for hospital level care. During the Jan. 7, 2026 RAC, OHA explained that there may

be a need to demonstrate need outside of the alternative service area, however, it is not clear what circumstances would allow OHA to make this determination.

> **Recommendation:** Remove the definition of "Alternative Service Area" and rely exclusively on Trauma Service Area or better define the parameters when this would be used (i.e. children, adolescents, geriatrics and other populations that have small numbers).

Section 2 the list of alternative levels of care do not have definitions or stated rationale for listing these alternatives. The listed alternatives are distinct levels of care and, while essential for a robust behavioral health system, they are not alternatives to inpatient level of care, except for (e) "inpatient psychiatric unit or floor in a hospital".

> **Recommendation:** While we agree that state must build out all levels of care, we would like to better understand the OHA's intent. We request OHA clarify why the alternatives are listed and that OHA add concise definitions for each alternative. Rather than call them "alternatives" it would be more accurate to refer to them as "other levels of care essential for a complete behavioral health system".

Section 3 is limited to psychiatric hospitals. Our concern is that limiting to "psychiatric hospitals" will not fully capture the current capacity of inpatient psychiatric level of care in the Trauma Service Area.

> **Recommendation:** Broaden to include inpatient beds to ensure complete inclusion of the specific level of care for the Trauma Service Area.

Section 4 defines subspecialty beds as "an inpatient setting designed specifically for an (a) individual under the age of 15; (b) individual between the ages of 15 to 21; or (c) individual over the age of 65". As written, this would allow for an inpatient setting serving both adolescents age 15-17 and adults age 18-21 in the same unit, which isn't statutorily or clinically allowed.

> **Recommendation**: ORS 309-032-0870 states that Regional Acute Care Units that provide hospital holds and can care for the civilly committed can only serve individuals 18 and older https://oregon.public.law/rules/oar_309-032-0870. Oregon statutes and rules do not specifically address child/adolescent psychiatric units, but the Joint Commission HBIPS defines children as 1-12 years old, and adolescents as 12-17 years old. Geriatric units are not specifically defined by statute, but there are requirements for medical care for individuals over 65 in psychiatric care. We recommend the rules align age categories with existing

statutes to clarify that subspecialty beds must be operated in separate, age-appropriate settings.

333-615-0025 Criteria for approval of a new psychiatric hospital Section 2 stipulates that the number of beds in a health service area will not exceed 36 beds per 100,000 individuals. We believe this number comes from the Behavioral Health Residential Facility Study. However, the study states they did not fully and comprehensively evaluate inpatient psychiatric needs in the state and that further analysis is needed. The study does not break out subspecialty populations either, so those under 19 and over 65 are counted as part of the adult population.

> **Recommendation:** The study should be used as contextual input rather than fixed thresholds. We recommend avoiding the bed-per-capita caps until subspecialty-inclusive assessment is complete.

333-615-0040 The Availability of Alternatives in the Health Service Area Section 1 requires the applicant provide a complete list of all alternatives to inpatient treatment in the HSA, including an inventory of provider type, address, bed capacity, and utilization.

> **Recommendation:** We recommend the agency publish a standardized inventory template, including crisis services. We support adding a requirement the applicant be required to consult with regional behavioral health planning bodies, including the local mental health authority, local Community Health Needs Assessment, local Community Health Improvement Plan and coordinated care organizations.

Section 2 requires information that may not be available to the applicant or the public. For example, market rates or outcomes for other hospitals or providers. Other information, such as regulatory compliance, accreditation and certification is information readily available to agency staff, but not the public. This information will not be readily available or accessible, and it is unclear how OHA will determine feasibility.

> **Recommendation:** We request OHA clarify data responsibility and the validation process.

333-615-0050 Quality Section 3 allows a loophole for providers to not accept Medicaid and Medicare. We highly recommend that this language be strengthened to require any provider to accept patients regardless of payer.

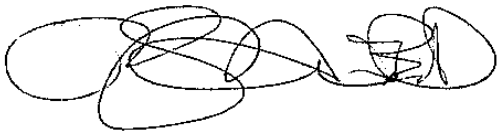
Recommendation: We recommend section three clarify that this is required to be considered for CON: *There is reasonable assurance that the project will be in conformance with applicable state licensing requirements and, ~~if~~ the applicant is ~~or plans to be~~ certified under the Medicaid or Medicare program, with the applicable conditions of participation related to those programs.*

Section 4 We appreciate the emphasis on continuity of care. We believe this can be strengthened by requiring a transfer agreement with oversight from the agency.

Recommendation: Add a requirement for a transfer agreement: *The proposed project will promote continuity in the provision of health care, not result in an unwarranted fragmentation of services, and have an appropriate relationship to the Health Service Area's existing health care system**, as demonstrated by a transfer agreement, which must include reason for transfer, medical records and a medication list along with a commitment to take the patient back as soon as they are medically cleared, that is monitored by the Agency on a biennial basis**.*

We appreciate the opportunity to provide comment on these rules.

Sincerely,



Robin Henderson, PsyD
Chief Executive, Behavioral Health
Providence Health and Services, Oregon

Public Comment on Rules for Demonstration of Need for Acute Inpatient Beds and Psychiatric Hospitals

SEIU Local 49 | January 6, 2026

SEIU Local 49 offers the following comments on the proposed permanent rules related to demonstrating need for inpatient psychiatric beds and psychiatric hospitals. We believe that Oregon's Certificate of Need program is a critical tool to ensure our state's healthcare resources are used as efficiently as possible, and we appreciate the important changes OHA has made to update references to outdated data sources and include additional criteria related to health equity and patient access. However, we do have some concerns and questions we look forward to discussing during the first RAC meeting on January 7. We have outlined our thoughts in greater detail below:

We appreciate the focus on health equity and patient access as an integral part of the proposed approval criteria. For example:

- OAR 333-615-0025 (1), which requires that access to care is "tailored to … specific demographical needs, including: (a) Access to public transportation; (b) Access for individuals with disabilities; (c) Availability of adequate staffing; and (d) Accessibility to other care providers."
- OAR 333-615-0025 (3), which requires that applicants to describe how the project would improve access to all individuals in the geographic areas, but "with particular attention to vulnerable populations, including those who are uninsured, underinsured, high-deductible plans, or enrolled in Medicaid."
- OAR 333-615-0040 (c), which gives OHA the ability to evaluate whether charges would be reasonable for patients.
- OAR 333-615-0050 (10), which requires applicants to offer charity care and allows OHA to consider the applicant's history of offering charity care.
- OAR 333-615-0050 (11), which ensures that applicants cannot have ever been convicted of any crimes related to the operations of healthcare facilities where they hold a direct or indirect ownership stake of five percent or more. Of particularly importance is (d), "Been decertified as a provider in the Medicare or Medicaid program due to non-compliance with federal participation conditions…."

However, there are three specific changes we think are needed:

- Our main priority is ensuring that any hospital operating in Oregon MUST accept all forms of insurance. We appreciate that in the Quality section (OAR 333-615-0050), the rules require that (6) "The applicant will accept and provide access to individuals enrolled in Medicaid, Medicare, or uninsured." However, we're concerned that (3) provides a potential loophole: "There is reasonable assurance that the project will be in conformance with applicable state licensing requirements and, if the applicant is or plans to be certified under the Medicaid or Medicare program, with the applicable conditions of participation related to those programs." We firmly believe section 3 should be amended to clarify that the applicant be certified under these programs to be considered for Certificate of Need approval.

- We are concerned that OAR section 333-615-0035 (Alternatives to Health Service Areas) lacks necessary specificity and grants the agency too much discretion. We recommend the agency propose a clearer, more objective rubric for granting an exception to using the Trauma Service Area, or not allow the option of an alternative.
- In the Cost section related to projects involving construction (OAR 333-615-0060 (2)), we recommend adding that applicants must have pursued bids from at least three firms and require that applicants prove that they chose the least expensive, best quality construction partner.

And finally, there are several things that we found unclear and would like additional clarity from the agency about the language's intent:

- There seems to be some inconsistency in the rules about their scope (some sections refer to "inpatient psychiatric beds" and others say "psychiatric hospitals" – e.g., OAR 333-590 vs. OAR 333-615).
- It would be helpful to hear more about the agency's intent in the Definitions section focused on "alternatives" (OAR 333-615-0010 (2)). It seems to us that the only true "alternative" to an inpatient psychiatric hospital bed listed in this section is "(e) Inpatient Psychiatric unit or floor in a hospital." While the alternatives listed are all important parts of the behavioral health continuum, they are not interchangeable levels of care.
- We are confused as to why section OAR 333-615-0070 (Use of Other Sources for Evaluating Applications) is necessary. If applications "do not contain standards in sufficient detail to make the required determinations," they should not be considered complete and should not be approved until they are.

In closing, we thank the agency again for its work to preserve the integrity of our state's Certificate of Need program and look forward to further discussion about the proposed rules in the coming weeks.

January 13, 2026

Mellony Bernal
Oregon Health Authority
Via email: *MELLONY.C.BERNAL@oha.oregon.gov*

Re: Certificate of Need Program Rule Advisory Committee

Dear Ms. Bernal,

Health Facilities Planning & Development (HFPD) appreciates the Oregon Health Authority's (OHA) effort and commitment to modernizing certificate of need rules for inpatient psychiatric services, including the temporary amendments and adoptions in Divisions 590 and 615 that became effective in late October.

Below are HFPD's comments after reviewing the draft rules and public input received to date, including the summary of the January 7, 2026, RAC meeting. HFPD's comments are offered in the spirit of ensuring that before any rules are made permanent, the current gaps and "disconnects" that are likely to have future, unintended impacts on patients, the community at large, the provider community and the CN Program's resources are identified, modified and mitigated. HFPD's comments are summarized below:

1. Retention of Principles: HFPD understands that the principles that guide how OHA evaluates new psychiatric beds are to be removed from the OAR because they remain in ORS. The principles of community-based care and new inpatient psychiatric hospitals being the lowest level priority for addressing any unmet need, are critical and should remain at the forefront in rule.

2. Treatment of Inpatient Psychiatric Beds Located in Acute Care Hospitals: As several RAC members noted during the meeting, it is necessary to understand how beds located in acute care hospitals seeking to expand will be treated (and which rules will apply). CN review is required when a hospital proposes an increase deemed to be a substantial increase in services because the increase exceeds 10 beds or 10% of current bed capacity under OAR 333-550-0010(2).

3. Definitions: There is no definition in the current rules directing how and which DRGs/ ICD10 codes, for purposes of projecting bed need, are considered to represent psychiatric admissions/discharges. This is foundational to calculating a use rate. There was discussion that at least some percentage of beds will be for dual diagnoses and so, the same level of definition should be included for substance use.

4. Bed to Population Ratio: The current rule indicates that the bed to population ratio in any Trauma Service Area cannot exceed 36 beds per 100,000 residents. HFPD respectfully requests the source of the ratio, and once final ratio(s) are set, we

respectfully request that the rules specify which cohorts (child, adolescent, adult and geriatric) each ratio is to be used for.

5. Consideration of Alternatives to Hospitalization: The rule nicely defines that alternatives to hospitalization should be considered. The rules should identify how these alternatives are to be considered. OHA's commissioned report, *Oregon Heath Authority Behavioral Health Residential+FacilityStudy, June 2024 Final Report,* identified eight options to a freestanding psychiatric hospital including State Hospitals, Inpatient Psych Facility -Unit in hospital, Residential Treatment Facility (RTF), Secure Residential Treatment Facility (SRTF), Residential Treatment Home (RTH), Adult Foster Home (AFH), Residential SUD Facility, Clinically Managed Withdrawal Management Facility

There is a need for clarity and specific guidance regarding how to quantify the supply of these alternatives. Explicit language regarding how existing or pending alternative beds are to be treated and "subtracted" from gross bed need to determine adjusted inpatient psychiatric beds should be added. During the January 7 RAC meeting, there was robust conversation regarding how existing inpatient providers may be able to reduce length of stay and timely discharge by having timely access to these alternatives when the patient is ready to be discharged. This, in turn, will increase bed availability and promote timely and more admissions. Further, the rules should be sure to include consideration of emerging models, such as crisis stabilization, which may also reduce demand. Quantifying the impact of these alternatives is critical.

6. Adequate Staffing: Per the RAC discussion, HFPD requests more specificity in rule around the analysis to be used to determine that a new hospital, as it staffs up will not impact the availability of adequate staffing in the alternative settings.

7. Data Availability: During the RAC meeting it was noted that the sole existing freestanding psychiatric hospital in the State does not submit data to Apprise. This data needs to be available in order to quantify use rates, patient migration patterns, etc.

8. Enforcement: There was discussion about how OHA intends to enforce any conditions placed on future applications post-operations. It should be outlined in rule.

HFPD very much appreciates the opportunity to provide this comment. We request that comments and changes provided by all parties being fully vetted before the rules are finalized.

Sincerely,

Jody Carona

EXHIBIT 2

Providence, Oregon
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Building 2, Suite 599
Portland, OR 97213
providence.org/oregon

March 18, 2026

Brittany Hall
Oregon Health Authority
800 NE Oregon Street, Suite 465
Portland, OR, 97232

Re: Certificate of Need Program Rule Advisory Committee

Dear Ms. Hall,

As Oregon's largest provider of behavioral health services, Providence remains deeply committed to supporting a comprehensive and sustainable behavioral health system in the state. We value the Oregon Health Authority's collaborative approach throughout the Certificate of Need Program Rule Advisory Council process and appreciate the revisions incorporated into the proposed rules. While many of our earlier concerns have been addressed, we respectfully offer the following comments for consideration.

333-615-0010 Definitions Section 1 defines "Alternative Health Service Area" as a "deviation from the Trauma System Area as the Health Service Area". In recent years, there has been a move to Trauma Service Areas as the coordinating geographic area for hospital level care.

> **Recommendation:** Remove the definition of alternative service area and require Trauma Service Area.

Section 2 lists "alternatives" lists different levels of care. We appreciate the addition to the definition, which clarifies that these are not "interchangeable with inpatient psychiatric hospitalization."

> **Recommendation:** We recommend defining the listed alternatives by referencing either statute or rule: residential treatment facility, residential treatment home, adult foster home, and residential substance use disorder facility.

Section 6 defines subspecialty beds as "an inpatient setting designed specifically for: (a) individuals under the age of 18; or (b) individuals 65 and older".

> **Recommendation**: We appreciate the changes OHA has made to this section. We would recommend adopting the Joint Commission HBIPS definitions of children as 1-12 years old, and adolescents as 12-17 years old.

Providence

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333-615-0030 Estimates of Need We appreciate the addition of the transfer agreement requirement; however, we are concerned that there is not a way to enforce or hold accountable and would recommend adding to OAR 333-0615-0050:

> *The proposed project will promote continuity in the provision of health care, not result in an unwarranted fragmentation of services, and have an appropriate relationship to the Health Service Area's existing health care system**, as demonstrated by a transfer agreement that is monitored by the Agency on a biennial basis***.

333-615-0040 The Availability of Alternatives in the Health Service Area Section 1 requires the applicant provide a complete list of all alternatives to inpatient treatment in the HSA, including an inventory of provider type, address, bed capacity, and utilization.

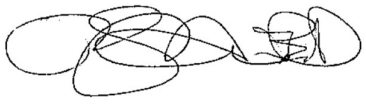
> **Recommendation:** We recommend the agency publish a standardized inventory template, including crisis services.

Section 2 requires information that may not be available to the applicant or the public. For example, market rates or outcomes for other hospitals or providers. Other information, such as regulatory compliance, accreditation and certification is information readily available to agency staff, but not the public. This information will not be available or accessible to applicants, and it is unclear how OHA will determine feasibility.

> **Recommendation:** We request OHA clarify data responsibility and the validation process.

We appreciate the opportunity to provide comment on these rules.

Sincerely,



Robin Henderson, PsyD
Chief Executive, Behavioral Health
Providence Health and Services, Oregon

Legacy Health

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March 19, 2026

Brittany Hall, Administrative Rules Coordinator
Oregon Health Authority
via email: publichealth.rules@odhsoha.oregon.gov

RE: Response to February 27, 2026, Notice of Proposed Permanent Rulemaking: OAR chapter 333, divisions 590 and 615 – Demonstration of Need for Acute Inpatient Beds and Psychiatric Hospitals (Certificate of Need)

Dear Ms. Hall,

Legacy Health (Legacy) provides comprehensive behavioral health services. Most relevant to the current rulemaking is the Unity Center for Behavioral Health (Unity) that has the only dedicated emergency department in Oregon explicitly designed to deliver immediate psychiatric care and a path to recovery for people experiencing a mental health crisis. Unity also operates 85 adult and 22 adolescent, inpatient beds and 50 emergency beds. More than 85% of Unity patients have a government payer or require uncompensated care.

Legacy finds the proposed permanent rules to be generally clear and reflective of many of the comments or suggested changes raised during the RAC process. We do request that OHA add additional definitions to select rules, or conversely, timely adopt interpretive guidelines, to provide explicit direction regarding the types of data expected in an application or during public comment related to how the impact on existing providers will be determined.

Legacy's comments regarding the *Notice of Proposed Permanent Rulemaking* are below. We have outlined the sections where we would request additional guidance/direction.

333-613-0010 (Definitions)

(1) Psychiatric Admission:

We were pleased to see a definition added for psychiatric admission or discharge. Per the OAR, it is an inpatient episode identified by a principal diagnosis code within ICD-10 Chapter F (Mental and Behavioral Disorders, F01-F99) or by a psychiatric DRG (885-887, 894-896, and any codes for psychoses, neuroses, and other mental health conditions).

Comment: CMS regularly modifies codes. How will OHA ensure that definitions remain current?

(6) Subspecialty Beds:

Thank you for modifying the age limits to (a) individuals under the age of 18 and (b) individuals 65 and older.

Comment: We do request that the Program add another modification, which is delineating between child programs (age 5-11) and adolescent (12-17).

333-615-0030 (Estimate of Need)

The rule indicates that bed need shall be evaluated consistent with select standards, methodology, and principles. We offer comments on the following:

(5) Evaluate the age range and payer implications tied to Medicaid eligibility, including analysis of the federal Institution for Mental Diseases (IMD) exclusion for individuals ages 21 through 64 as applicable. **The applicant shall document how the proposed capacity will serve Medicaid-eligible individuals, identify alternative funding strategies for non-covered stays, and explain the impact on projected utilization and financial feasibility on the applicant and alternatives**.

Comment: We request that the rules identify how conformance to the standard will be evaluated; especially for a new free-standing hospital of more than 16 beds. What is the source of the alternative funding? What percentage of days are non-covered? What percentage of TSA residents would not be eligible for care in the hospital and how will referrals be made for this cohort?

(14)(a) Applicants must document how the project will avoid adverse financial impact to existing psychiatric service providers and alternatives, particularly those serving high-acuity or underserved populations. The analysis shall address whether the proposed project will contribute to continuity or conversely, fragmentation of psychiatric care in the Health Service Area.

Comment: Legacy recommends the rules or interpretive guidelines require a comparison of payer mix of the applicant to existing providers serving residents of the TSA. It should also require explicit detail on how a provider would recruit a specialized behavioral health workforce without negatively impacting existing local behavioral health employers.

333-615-0040 (Availability of Alternatives in the Service Area)

(2) The methods of meeting acute inpatient psychiatric bed need, in order of preference, shall be (preceded by a demonstration that alternatives have been evaluated and found infeasible based on cost, capacity, or access barriers):

(a) Conversion of existing licensed hospital space to purposes of psychiatric treatment where such conversion is feasible to provide an adequate inpatient program at less cost than building new licensed space.
(b) A project resulting in the smallest feasible net increase in acute licensed capacity within an existing hospital or special inpatient care facility.

(c) A separately licensed new psychiatric hospital, not part of a hospital, which will provide psychiatric inpatient care at the most reasonable charges per day and per inpatient stay event, for care that must be rendered on an inpatient basis. Evaluation of reasonableness of charges are qualities that tend to show charges are fair, competitive, and consistent with quality care. These factors include, but are not limited to, consideration of:

- Market rates for similar services by similarly situated entities.
- Patient outcomes and satisfaction.
- Regulatory compliance.
- Accreditation and certification; and
- Qualification of staff.

Comment: Legacy appreciates the explicit rule language confirming that inpatient beds at a new hospital are the lowest priority for addressing any identified need. We also appreciate the inclusion of the language in 333-615-0025 which clarifies that an applicant ***may*** (not shall) be granted a CN. Additional definitions and sources for determining reasonable charges and market rates should be specified. We also question what source will be utilized for the market-rate data for similar services. If not publicly available, it should not be a requirement.

(4) In evaluating the relationship of the proposed project to the existing health care system of the Health Service Area, the applicant shall address possible compromising of quality of care. The Oregon Health Authority shall consider the conformity to state safety and program standards of both the proposed project and existing providers; related health services now provided to the population of the Health Service Area; the impact of the project, once completed and operational, upon the financial ability of providers of related services to maintain present quality; and the feasibility that the proposed project will be sufficiently efficient to maintain quality standards at reasonable cost.

Comment: Here, Legacy assumes the OHA is requesting a pro forma from any existing providers that could be impacted by a new market provider; and the pro forma should include impact on payer mix and staffing. The standard also refers to ability to maintain quality standards at reasonable cost. Additional details on the data necessary to link finance to maintenance of quality and reasonable costs should be provided by OHA.

333-615-0050 (Quality)

(2) A sufficient supply of qualified personnel, including clinical, administrative, operational, and technical staff, are available or can be recruited timely to ensure the hospital operates safely, efficiently, and in compliance with applicable standards.

> ***Comment***: A slight modification to the rule would clarify that this needs to be accomplished without adversely impacting current providers and the developing alternatives. We recommend the following modification:
>
> *A sufficient supply of qualified personnel, including clinical, administrative, operational, and technical staff, are available or can be timely recruited to ensure the hospital operates safely, efficiently, and in compliance with applicable standards,* ***without negatively impacting existing hospitals and alternative providers.***

(10) The applicant will offer charity care, as defined in ORS 442.601(1), commensurate with other facilities with a comparable payor mix. Applicant must provide their policy for charity care and demonstrate compliance with federal and state law. The Oregon Health Authority (Authority) may consider the applicant's history of offering charity care in evaluating these criteria.

> ***Comment***: Legacy requests that the standard be modified to add the word ***ongoing*** in front of compliance**.** OHA should also specify how ongoing compliance will be measured. The results should be public.

Again, we appreciated the opportunity to participate in the process and acknowledge the work of the OHA team that drafted the rules and organized and staffed the RAC.

Sincerely,

Melissa L. Eckstein, LCSW-S

Melissa L. Eckstein, MSSW, MBA, LCSW-S
President
Unity Center and Legacy Behavioral Health Services

March 23, 2026

Oregon Health Authority
Public Health Division
800 NE Oregon St. Suite 930
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Submitted electronically to: publichealth.rules@odhsoha.oregon.gov

RE: Notice of Proposed Rulemaking – OAR chapter 333, divisions 590 and 615 – Demonstration of Need for Acute Inpatient Beds and Psychiatric Hospitals (Certificate of Need)

Matt Gilman:

On behalf of the Hospital Association of Oregon, we write to express appreciation for the Oregon Health Authority's rulemaking process on these Certificate of Need rules and to provide feedback on some of the rules. This has been a collaborative rulemaking, and many of the suggestions from the rulemaking advisory committee have already been incorporated into these rules. We appreciated the opportunity to engage with other RAC members and OHA throughout this process.

OAR 333-615-0010
Definitions for Psychiatric Hospitals' Demonstration of Need
(2) "Alternatives" means other settings within the behavioral health continuum that may reduce demand for inpatient psychiatric hospital beds by providing appropriate care at a lower level of intensity or cost. These settings are not clinically interchangeable with inpatient psychiatric hospitalization but must be considered in evaluating system capacity and flow. Alternatives include, but are not limited to:
(a) Residential treatment facility (RTF);
(b) Residential treatment home (RTH);
(c) Adult foster home (AFH); and
(d) Residential substance use disorder facility.

- **HAO Comment:** We appreciate OHA's modifications to the definition of "Alternatives." We request that OHA include references to the statutory definitions for the alternatives listed in subsections (a) through (d).

(6) "Subspeciality beds" means an inpatient setting designed specifically for:
(a) Individuals under the age of 18; or
(b) Individuals 65 and older.

We appreciate the revisions that OHA has already made to this definition. We request an additional revision, below.

- **HAO Comment:** We request that OHA delineate the age ranges for children and adolescents by further revising the definition as follows:

"(6) 'Subspeciality beds' means an inpatient setting designed specifically for:
~~(a) Individuals under the age of 18; or~~
(a) individuals under the age of 12;
(b) individuals between 12 and 17 years of age; or
(c~~b~~) Individuals 65 and older."

OAR 333-615-0030
Estimate of Need
Bed need shall be evaluated consistent with the below standards, methodology, and principles:
...
(14) (a) Applicants must document how the project will avoid adverse financial impact to existing psychiatric service providers and alternatives, particularly those serving high-acuity or underserved populations. The analysis shall address whether the proposed project will contribute to continuity or conversely, fragmentation of psychiatric care in the Health Service Area.

(b) For a proposed freestanding psychiatric hospital this shall include a transfer agreement, which must include reason for transfer, medical records and a medication list along with a commitment to take the patient back as soon as they are medically cleared.

We appreciate that OHA is evaluating how new projects will affect existing psychiatric service providers and alternatives. We request that OHA add a revision consistent with the comment below.

- **HAO Comment:** We request that OHA oversee any new freestanding psychiatric hospital's compliance with the transfer agreement.

OAR 333-615-0040

The Availability of Alternatives in the Health Service Area

...(2) The methods of meeting acute inpatient psychiatric bed need, in order of preference, shall be preceded by a demonstration that alternatives have been evaluated and found infeasible based on cost, capacity, or access barriers:

...

(c) A separately licensed new psychiatric hospital, not part of an existing licensed hospital, which will provide psychiatric inpatient care at the most reasonable charges per day and per inpatient stay event, for care that must be rendered on an inpatient basis. Evaluation of reasonableness of charges are qualities that tend to show charges are fair, competitive, and consistent with quality care. These factors include, but are not limited to, consideration of:

(A) Market rates for similar services by similarly situated entities;

(B) Patient outcomes and satisfaction;

(C) Regulatory compliance;

(D) Accreditation and certification; and

(E) Qualification of staff.

Some of this information may not be appropriate or available.

- **HAO Comment:** We request that OHA clarify the factors that will be evaluated after reconsidering what information is available and appropriate.

The hospital association is committed to continuing to collaborate with OHA to help Oregon's hospitals support their communities.

Sincerely,

Danielle Meyer
Senior Public Policy Advisor
Hospital Association of Oregon

About the Hospital Association of Oregon

Founded in 1934, the Hospital Association of Oregon (HAO) is a mission-driven, nonprofit trade association representing Oregon's 60 hospitals. Together, hospitals are the sixth largest private employer statewide, employing more than 70,000 employees. Committed to fostering a stronger, safer, more equitable Oregon where all people have access to the high-quality care they need, the hospital association supports Oregon's hospitals so they can support their communities; educates government officials and the public on the state's health landscape, and works collaboratively with policymakers, community based organizations and the health care community to build consensus on and advance health care policy benefiting the state's four million residents.