



TEMPORARY ADMINISTRATIVE ORDER

INCLUDING STATEMENT OF NEED & JUSTIFICATION

PH 30-2026

CHAPTER 333

OREGON HEALTH AUTHORITY

PUBLIC HEALTH DIVISION

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FILING CAPTION: Temporary Rules for Demonstration of Need for Long-Term Care Services Retroactive to Adoption Date

EFFECTIVE DATE: 08/14/2026 THROUGH 12/21/2026

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NEED FOR THE RULE(S):

On June 25, 2026, the Oregon Health Authority (OHA) filed temporary amendments to OAR chapter 333, division 610 pertaining to demonstration of need for long-term care services (Temporary Administrative Order PH 27-2026). OHA needs to suspend the temporary rules to avoid legal uncertainty, prevent prejudice to applicants and interested parties, and restore the prior rules that existed prior to the temporary filings. Suspension is necessary because on July 22, 2026, OHA received the "Petition to Request Repeal of Temporary Rules Amending OAR Chapter 333, Division 610" by the Oregon Health Care Association. The petition to repeal the temporary rules is likely to succeed, and maintaining temporary rules that are likely to be held invalid will seriously prejudice interested parties and applicants because any application reviewed under the temporary rules may be improperly granted or denied certificates of need.

OHA will promptly engage in a permanent rulemaking process where the proposed new concepts and criteria to demonstrate need for long-term care services in the temporary rules can be discussed and developed with community partners. Retroactively suspending the temporary rules will allow for permanent rulemaking and avoid the serious prejudice associated with rules that OHA finds will likely be held invalid.

Retroactive suspension is required because certificate of need (CN) rules apply the rules in effect at the time a Letter of Intent is filed. Without retroactive suspension, applications or letters of intent submitted during the temporary rule period would be evaluated under rules that OHA finds are likely to be held invalid based on the petition for repeal received on July 22, 2026. Retroactive suspension ensures consistency, protects applicants, and prevents the prejudice identified by the petitioning parties.

JUSTIFICATION OF TEMPORARY FILING:

Statement of Findings of Serious Prejudice and Specific Reasons for Those Findings

The Oregon Health Authority (OHA) finds that failure to act promptly to suspend the temporary rules amending OAR chapter 333, division 610 will result in serious prejudice to the public interest and to the interests of the parties concerned, for the following specific reasons:

1. Applicants submitting Letters of Intent or applications during the period in which the temporary rules were in effect would be subjected to rules likely to be held invalid.

Under OAR 333 560 0030(2) the rules in effect at the time an applicant submits a Letter of Intent govern the evaluation of that application. Because the temporary rules introduced substantive methodological changes without partner input, some of whom have joined the petition for repeal, OHA finds that the rules are likely to be declared invalid.

Consequently, failure to promptly suspend those temporary rules would expose applicants to uncertainty and unenforceable decisions. This constitutes serious prejudice under ORS 183.355(5)(a).

2. Interested parties who petitioned for repeal would be seriously prejudiced if the temporary rules remain in place because applications submitted while the temporary rules were in effect would be evaluated under rules to which they have petitioned for repeal.

The Petition for Repeal identifies substantial concerns from long term care providers about the lack of notice, the absence of partner engagement, and significant methodological changes made without their opportunity to participate in rulemaking. Allowing the temporary rules to remain in effect would allow applications to be evaluated under the temporary rules without considering the concerns raised in the Petition for Repeal. OHA plans to promptly start permanent rulemaking to allow full partner participation.

Prompt, retroactive suspension is therefore needed to prevent serious prejudice to both applicants and affected long term care providers because it will prevent rules likely to be held invalid from applying.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

- ORS chapter 431: https://www.oregonlegislature.gov/bills_laws/ors/ors431.html
- ORS chapter 442: https://www.oregonlegislature.gov/bills_laws/ors/ors442.html
- ORS 183.355(5): https://www.oregonlegislature.gov/bills_laws/ors/ors183.html
- Petition to Request Repeal of Temporary Rules Amending OAR Chapter 333, Division 610, submitted July 22, 2026, by the Oregon Health Care Association. (Information on requesting a public record can be found at: <https://www.oregon.gov/oha/erd/pages/records.aspx>)

RULES:

333-610-0000, 333-610-0010, 333-610-0020, 333-610-0030, 333-610-0060, 333-610-0070, 333-610-0080, 333-610-0090, 333-610-0100, 333-610-0110

AMEND: 333-610-0000

SUSPEND: Temporary 333-610-0000 from PH 27-2026

RULE SUMMARY: Amend OAR 333-610-0000[T] – Identifies an operative date and deletes the text of the temporary rule and reinstates prior permanent rule as it existed immediately before the temporary rule. This rule specifies the criteria that an applicant must satisfy in the Certificate of Need (CN) application instructions in OAR chapter 333, division 580 and responses to those instructions must be based on the methodology identified in OAR chapter 333, division 610.

CHANGES TO RULE:

333-610-0000

General **II**

This rule has an operative date of June 24, 2026. **II**

(1) In order to demonstrate need for nursing home beds, an applicant must satisfy the criteria specified in the Certificate of Need Application Instructions (division 580). **II**

(2) Where appropriate, responses to these instructions shall be based on the methodology of this division (division 610).

Statutory/Other Authority: ORS 431.120(~~6~~), 442.315

Statutes/Other Implemented: ORS 431.120(~~6~~), 442.315

AMEND: 333-610-0010

SUSPEND: Temporary 333-610-0010 from PH 27-2026

RULE SUMMARY: Amend OAR 333-610-0010[T] – Identifies an operative date and deletes the text of the temporary rule and reinstates prior permanent rule as it existed immediately before the temporary rule. This rule provides definitions for terms.

CHANGES TO RULE:

333-610-0010

Definitions ¶

This rule has an operative date of June 24, 2026. As used in this division: ¶

(1) "Alternative Services" means any long-term care services other than nursing homes. ¶

(2) "Adult Foster Care" means supervised living, like licensed residential care facility (home for the aged) but for five or fewer persons. ¶

(3) "Closed System Provider" means a facility or campus arrangement offering a continuing care contract for both unsupervised housing and licensed nursing facility care. ¶

(4) "Community Services/Nonresidential Services" means alternative services which do not involve 24-hour living outside of one's own home and may include in-home services or services provided outside of the home, such as meals, social activities, clinics, classes, organized day programs, etc. ¶

(5) "Continuing Care Contract" means a legally binding agreement between an individual and a closed system provider, which remains in effect for longer than two years, sometimes for the resident's lifetime. The contract states what shelter and services the home will provide to the resident over the time specified, and it states what obligations, including financial obligations, the resident will have to the home for the same time period. The contract will specify the nursing home services that the community will provide to residents, but will not be solely for the purpose of providing nursing home services. The primary purpose of the contract will be to provide a living situation to elderly persons who will usually be ambulatory and in good health upon entry into the community. Continuing care contracts are known by a variety of names, including life care contracts, entrance fee agreements, sustaining gift contracts, occupancy agreements, accommodation fee agreements, member trust fund contracts, founders' fees contracts, and community residence agreements. ¶

(6) "Home for the Aged/Rest Home." See licensed residential care facility. ¶

(7) "Home Nursing Care" or "Home Health Service" means nursing care provided in the home by a private duty nurse, visiting nurse, proprietary home care agency, or county home health agency. ¶

(8) "In-Home Services" means alternative services delivered to the home; may include telephone reassurance, home delivered meals, housekeeper, heavy chores, homemaker, personal care, home nursing care, special care or therapy. ¶

(9) "Institutional Care" means nursing home care. ¶

(10) "Intermediate Care Facility (ICF)" means a licensed long-term care facility (nursing home) providing care for persons with significant but stable health problems requiring availability of a registered nurse for one eight-hour shift daily, five days a week, together with additional light or heavy aide care. ICFs for the mentally retarded are not included in this definition. ¶

(11) "Licensed Residential Care Facility" (formerly called home for the aged). Under ORS 443.400(5), this type of substitute home/supervised living means "a facility that provides, for six or more physically handicapped or socially dependent individuals, residential care&". Under Seniors and People with Disabilities Division rules, residents may not require continuous nursing care but may require routine medication; special diets; assistance with activities of daily living; palliative skin care; simple dressings; maintenance of casts, braces, and prostheses. Periodic licensed nursing care (catheter irrigation, dressing change, or periodic injections) may be provided on contract just as in a person's own home. ¶

(12) "Long-Term Care Facility (LTCF)" refers to Oregon's current licensing category for all nursing home beds, as defined in Seniors and People with Disabilities Division licensure rules, whether freestanding or part of a hospital, and whether the patients are at skilled level of care or intermediate level. ¶

(13) "Long-Term Care Services/Continuum of Care" means the entire set of possible services for persons in need of long-term health and/or social services. ¶

(14) "Nursing Home" means long-term care facility, as defined in Seniors and People with Disabilities Division licensure rules, providing skilled and/or intermediate level nursing care. ¶

(15) "Personal Care" means physician prescribed, registered nurse supervised, services delivered by trained individuals, including: Basic personal hygiene; bowel and bladder care; assistance with self-administered

medications and oxygen; assistance with mobility, transfers and comfort; assistance with meal preparation and feeding; care of confused and/or mentally ill client; first aid and handling of emergencies; housekeeping necessary for health and safety; assistance to and from appointments; monitoring of client status.¶

(16) "Retirement Home" means a place where relatively independent older persons live together with little supervision with some common services such as housekeeping and some meals provided.¶

(17) "Satellite Apartment" means a periodically supervised living arrangement associated with a home for the aged, nursing home, or other 24-hour residential facility.¶

(18) "Semi-Independent Living" means cooperative small group living in freestanding housing, with limited supervision and assistance on the basis of daily or less frequent visits.¶

(19) "Skilled Nursing Facility (SNF)" means a licensed long-term care facility providing care for persons with severe and/or unstable health problems which cannot be managed at the intermediate care level, requiring the availability of a registered nurse 24 hours daily, seven days a week, but not requiring the levels of nursing, physician and specialized services available in a hospital.¶

(20) "Substitute Home/Supervised Living" means nonmedical alternative services involving 24-hour care and supervision. In Oregon, includes licensed residential care facility (home for the aged), adult foster care, satellite apartments, or semi-independent living.

Statutory/Other Authority: ORS 431.120(4), 442.315

Statutes/Other Implemented: ORS 431.120(4), 442.315

AMEND: 333-610-0020

SUSPEND: Temporary 333-610-0020 from PH 27-2026

RULE SUMMARY: Amend OAR 333-610-0020[T] – Identifies an operative date and deletes the text of the temporary rule and reinstates prior permanent rule as it existed immediately before the temporary rule. This rule sets guidelines for evaluating applications for new nursing home beds in Oregon. It establishes target bed-to-population ratios for people age 65+, limits counties to no more than 40 beds per 1,000 older residents, sets timelines for reaching those limits, and requires high occupancy (95%, or sometimes 90%) before adding beds. Bed need must be based on projected elderly population, reviewed in the context of alternative care resources and statewide policies.

CHANGES TO RULE:

333-610-0020

Principles ¶

This rule has an operative date of June 24, 2026. The following principles will be applied in the review of applications for certificate of need for nursing home beds:¶

(1) Clinical and epidemiological research indicates that, on the average, 30 nursing home beds per 1,000 persons age 65 and over would be sufficient to meet the need for care for those functional deficits for which nursing home care is medically necessary and cost effective. This does not include utilization which is socially convenient rather than medically necessary. The experience of some states and some Oregon counties indicates that when sufficient alternatives are available, a ratio of less than 30 nursing home beds per 1,000 persons age 65 and over may be sufficient to meet the population's needs.¶

(2) Oregon data are consistent with section (1) of this rule. Because about ten percent of Oregon nursing home residents are not age 65 and over, and to allow for local variations, a goal of 40 beds (actually, a range of 35 to 45) (per 1,000 persons age 65 and older is hereby set, 33 percent greater than the research figure in section (1) of this rule. No county should exceed this bed ratio; although, as noted in section (1) of this rule, ratios well under 40 beds per 1,000 persons age 65 and over are often sufficient to meet community needs.¶

(3) By 1991, there shall be no more than 40 nursing home beds per 1,000 persons age 65 and over in any Oregon county:¶

(a) For counties which had 54 or fewer beds per 1,000 in 1980, the goal is to be reached by 1986;¶

(b) For counties which had more than 54 beds in 1980, or have population densities below the state median, up to five additional years are allowed (see Tables 1, 2, and 3), recognizing the greater amount of time required to organize the expansion of alternative care under such circumstances.¶

(4) An average county or service area minimum occupancy of 95 percent, before adding beds, is to be used except when plans of state agencies utilizing beds, anticipated population changes, plans of other service area providers, and considerations of maintaining access at reasonable cost indicate that 90 percent is appropriate.¶

(5) Proposed beds are evaluated in relation to the entire local long-term care system; to resources in the local service area and in the health service areas as a whole; to plans of state and local agencies; and to state policies expressed by the legislature. Additional beds will not be approved simply on the basis of "need" at a specific facility.¶

(6) Need should be projected on the basis of forecasted elderly population in three years. This time period will be extended for counties with population densities below the state median. It will be shortened when utilization of beds by state agencies has declined, and compensating utilization of alternative care has occurred and is projected to continue.¶

(7) For future years, population projections prepared and published by the Portland State University Center for Population Research and Census (CPRC) in Population Projections, Oregon and Its Counties: 1980 to 2000, June 1984, will be used unless the applicant can demonstrate invalidity. If existing projections are shown to be invalid, an alternative acceptable to both the Public Health Division and CPRC will be substituted.¶

(8) Separate capacity levels for ICF and SNF beds are not set because these bed categories are not separately licensed.¶

~~[ED. NOTE: Tables & Publications referenced are available from the agency.]~~

Statutory/Other Authority: ORS 431.120(6), 442.315

Statutes/Other Implemented: ORS 431.120(6), 442.315

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 333-610-0020.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
<https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=338835>

AMEND: 333-610-0030

SUSPEND: Temporary 333-610-0030 from PH 27-2026

RULE SUMMARY: Amend OAR 333-610-0030[T] – Identifies an operative date and deletes the text of the temporary rule and reinstates prior permanent rule as it existed immediately before the temporary rule. This rule outlines a method for determining the need for new nursing home beds. It defines how to set the service area, estimate elderly population, calculate historical and projected use rates, assess occupancy, determine future bed inventory, and evaluate whether additional beds are justified. It requires analysis of alternative care, future population trends, state agency plans, and consistency with state and local long term care goals before approving any new beds.

CHANGES TO RULE:

333-610-0030

Need ¶

This rule has an operative date of June 24, 2026. The following method is an extension of the general requirements for analysis of need set forth in OAR 333-580-0040(1):¶

(1) Determine service area:¶

(a) Except as provided in subsections (b) and (c) of this section, the geographical service area of the applicant will be considered to be the county in which the facility is located;¶

(b) Service areas in health service area III are defined as follows: Hood River, Sherman and Wasco Counties; Crook, Deschutes and Jefferson Counties; Gilliam, Morrow and Wheeler Counties; Union and Wallowa Counties; Baker County; Malheur County; Grant County; Harney County; Lake County; Umatilla County; and Klamath County;¶

(c) An applicant may propose an alternative service area to that specified in subsection (a) or (b) of this section. Such alternative service area, if accepted by the division, will be applied only to the review of the applicant's proposal, and shall not affect the applicability of subsections (a) and (b) of this section to other applications. The appropriateness of such an alternative service area must be demonstrated by the applicant to the division's satisfaction. In demonstrating the appropriateness of the proposed alternative service area, the applicant shall discuss and provide data on the following:¶

(A) Patient origin and length of stay by zip code for admissions for the most recent completed fiscal or calendar year for all nursing homes in the proposed service area. The applicant should list zip code of origin and length of stay for each admission, but should not use any patient names. The proposed service area should account for at least 75 percent of all admissions to service area nursing homes. It is recognized that nursing homes other than the applicant may sometimes be unwilling to provide such data but at a minimum data must be provided for the applicant facility, and documentation must be submitted to show that other facilities were asked to provide data;¶

(B) Travel patterns and highways between the proposed service area and adjacent areas;¶

(C) Historical market patterns for health and other services; and¶

(D) Geographic or other considerations that might delineate the proposed areas as a distinct service area.¶

(2) Estimate population age 65 and over in service area:¶

(a) As a basis for estimating service population for particular past and future years, determine the population age 65 and over in the service areas as of 1970, 1980 through 1985, 1990 and 1995;¶

(b) For 1970 and 1980, use the U.S. census counts;¶

(c) For 1990 and 1995, use the projections provided in Population Projections, Oregon and Its Counties: 1980 to 2000, Center for Population Research and Census (CPRC), Portland State University, June 1984;¶

(d) For 1981 through 1986, use estimates of population age 65 and over developed by CPRC;¶

(e) Estimate the population age 65 and over for the tenth year prior to the application through 1979 using the following method:¶

(A) Determine the ratio of elderly to total population in both 1970 and 1980 by dividing the population over age 65 by the total population for each of these years;¶

(B) Estimate these ratios for the tenth year prior to the application through 1979 by applying linear interpolation to the 1970 and 1980 ratios from paragraph (A) of this subsection;¶

(C) Obtain estimates for total service area population in each year from the tenth year prior to the application through 1979 from CPRC's "Inter-Censal Estimates of Oregon, by County: 1970-1980," April 1982;¶

(D) To estimate the population age 65 and over for the tenth year prior to the application through 1979, multiply the ratio in paragraph (B) of this subsection by the total population from paragraph (C) of this subsection for each year.¶

(f) To estimate the population age 65 and over for the years 1987 through 1989, apply linear interpolation to the

1985 and 1990 figures for population age 65 and over;¶

(g) To estimate the population age 65 and over for any of the years 1991 through 1994 (if required by subsection (11)(a) of this rule), apply linear interpolation to the 1990 and 1995 projections of population age 65 and over.¶

(3) Obtain historical nursing home patient days: For each of the last 10 years, from the Annual Reports for nursing homes and hospital-based long-term care facilities, obtain the October 1 through September 30 yearly total patient days of nursing home care delivered in the service area.¶

(4) Determine historical use-rates:¶

(a) Based on section (2) of this rule, prepare a table, showing for each 10 years prior to the application to the fifth year following the year of submission of the application, the estimated age 65 and over population for the service area;¶

(b) Add to the table, a column, based on section (3) of this rule, showing annual historical patient days for each year from 10 years prior to the application to present;¶

(c) Determine use-rates (number of patient days per 1,000 persons age 65 and over in the service area) by dividing each figure entered under subsection (b) of this section, by the corresponding figure entered under subsection (a) of this section, divided by 1,000.¶

(5) Determine potential patient days: To the table prepared in section (4) of this rule, add columns as follows:¶

(a) For each year from 10 years prior to the application to present, the number of licensed nursing home beds (including hospital-based) in the service area. The two most recent years are available from the division. Historical data are available from the Seniors and People with Disabilities Division;¶

(b) For each bed number in subsection (a) of this section, multiply by 365 to obtain potential calendar year patient days available in the service area.¶

(6) Determine average occupancy: To the table prepared in sections (4) and (5) of this rule, add a column computed by dividing the historical patient days for each year, by the potential patient days, and converting to percent.¶

(7) Evaluate occupancy:¶

(a) If, in the most recent October 1 through September 30 year for which Annual Report data are available, average occupancy for the service area was 95 percent or more, more beds may be needed;¶

(b) If average occupancy for the service area was less than 95 percent, more beds may not be needed. Applicant must demonstrate, under these circumstances, that a combination of factors will assure 95 percent service area occupancy if the application is approved. Such factors may include the plans of state agencies utilizing nursing home beds; projected increases of user populations; plans of other nursing home providers in the service area;¶

(c) If 95 percent service area occupancy cannot be demonstrated, but 90 percent can be demonstrated, and applicant demonstrates that approval would result in maintaining access to nursing home care in the service area at reasonable cost, the beds may be needed.¶

(8) If, under section (7) of this rule, beds may be needed, proceed with the analysis.¶

(9) Determine future bed inventory: To the most recent available Seniors and People with Disabilities Division inventory of licensed nursing home beds (including hospital-based) in the service area, make the following adjustments:¶

(a) Add beds in the service area not yet licensed, for which there is an approved certificate of need in effect;¶

(b) Subtract beds in the service area for which there is a documented commitment to the division for delicensure within the next three years.¶

(10) Determine the year by which to demonstrate need:¶

(a) Ordinarily, this will be three years after the calendar year of the letter of intent;¶

(b) If, according to Table 1, the estimated 1985 population density of the service area is in the lowest quartile of Oregon counties, this will be five years;¶

(c) If the population density is in the second quartile, this will be four years;¶

(d) If the data available from the central offices of the state agencies utilizing nursing home care in the service area meet the following criteria, then the indicated times in subsections (a), (b) and (c) of this section will be shortened by one year:¶

(A) Utilization of nursing home care in the service area by state agencies has decreased during the most recent 12 months;¶

(B) Utilization of alternative care in the service area by state agencies has increased, correspondingly, in the most recent 12 months;¶

(C) Projections and plans for utilization of nursing home care in the service area, and for alternative care, by state agencies, indicate stabilization or continuance of the trends in paragraphs (A) and (B) of this subsection, respectively.¶

(11) Construct table for analysis of need:¶

(a) Provide a column for each of the five years starting with the letter of intent year;¶

(b) Provide a row for the service area population age 65 and over for each year, estimated in section (2) of this rule;¶

- (c) Provide a row for each of the following possible use-rates:¶¶
 - (A) The 1980 service area bed supply per 1,000 persons age 65 and over, based on Table 2;¶¶
 - (B) The upper and lower bed supply objectives from Table 3 for the year identified in section (10) of this rule;¶¶
 - (C) The most recent use-rate identified in section (4) of this rule, divided by 365;¶¶
 - (D) The use-rate based on a projection of the use-rates for the last 10 years, divided by 365;¶¶
 - (E) If the series of use rates in section (4) of this rule shows a maximum or a minimum year prior to the most recent year, the use-rate based on a projection of the use-rates for the years starting with that maximum or minimum year, divided by 365;¶¶
 - (F) Standard bed supply figures of 30, 35, 40, and 45 nursing home beds per 1,000 persons age 65 and over.¶¶
- (d) Review prior years' bed supply as tabulated in section (5) of this rule in order to determine whether the rates projected in paragraphs (c)(D) and (E) of this section reflect changes in utilization with constant bed supply, or changes in utilization correlated with changes in bed supply. If the latter is the case, calculate alternative projections for paragraphs (c)(D) and (E) of this section;¶¶
- (e) Review performance and plans of state agencies utilizing nursing home and alternative care, as obtained for section (10) of this rule, in order to determine whether alternatives to the projections in paragraphs (c)(C), (D) and (E) of this section, adjusted numerically because of the performance and the plans, would lead to different projected rates and should also be tabulated.¶¶
- (12) Complete table for analysis of need: Fill in the table constructed in section (11) of this rule by multiplying the estimated service area population age 65 and over (second row), for each year, by the various flat, projected and adjusted use-rates indicated in subsections (11)(c), (d) and (e) of this rule. For each use-rate based projection (those based on the assumptions in paragraphs (11)(c)(C), (D) and (E) of this rule), divide the result of this multiplication by 0.95, in order to assume 95 percent occupancy.¶¶
- (13) Evaluate impact of application: Add the requested beds to the existing future inventory in section (9) of this rule. Compare the result to the column of the table completed in section (12) of this rule for the year selected in section (10) of this rule, and to the bed need indicated for that year in a county or service area plan, if available, that meets the criteria of section (14) of this rule.¶¶
- (14) Service area plans: For use in analysis by the division, a county or service area plan must meet the following criteria:¶¶
 - (a) Satisfy the service area definition in section (1) of this rule;¶¶
 - (b) Cover a time period, year-by-year, of at least five years, projecting:¶¶
 - (A) Nursing home caseloads; and¶¶
 - (B) Alternative care caseloads.¶¶
 - (c) Be within the yearly upper limits on service area bed supply established by application of section (10) and paragraph (11)(c)(B) of this rule, unless an analysis under subsection (16)(b) of this rule demonstrates that higher limits are justified;¶¶
 - (d) Be prepared by the local area agency on aging and/or the state Seniors and People with Disabilities Division, and approved by the Seniors and People with Disabilities Division.¶¶
- (15) Compare application to state goals:¶¶
 - (a) If a service area plan as defined in section (14) of this rule is available, the applicant is expected to demonstrate consistency with that plan and justify any inconsistencies;¶¶
 - (b) If there is no service area plan as defined in section (14) of this rule, then, depending on the relationship of the impact of the application on bed supply to the upper and lower bed supply objectives identified in paragraph (11)(c)(B), subsections (c), (d) or (e) of this section will apply;¶¶
 - (c) If approval of the application would result in:¶¶
 - (A) More beds than the 1980 ratio identified in Table 2, if that ratio is above the lower limit identified in paragraph (11)(c)(B) of this rule; or¶¶
 - (B) More beds than the upper limit identified in paragraph (11)(c)(B) of this rule; or¶¶
 - (C) Addition of beds in a service area which includes all or part of any county which is in the highest quartile of beds per 1,000 persons age 65 and over (see Table 2, or subsequent annual revisions as available), then the applicant is expected to demonstrate under subsection (16)(b) of this rule that, by the calendar year identified for paragraph (11)(c)(B) of this rule, there are no feasible long-term care alternatives to an increase in nursing home beds.¶¶
 - (d) If none of paragraphs (c)(A), (B) or (C) of this section are the case, and the approval of the application would result in:¶¶
 - (A) Maintaining the 1980 ratio identified in Table 2, if that ratio is above the lower limit identified in paragraph (11)(c)(B) of this rule but below the upper limit; or¶¶
 - (B) Falling below that ratio, but above the lower limit identified in paragraph (11)(c)(B) of this rule, then the applicant is expected to show that alternative care capacity in the locality has not been increasing; that nursing home utilization has not been decreasing; and there is no reasonable expectation that these utilization rates would change in those respective directions prior to the year determined in section (10) of this rule. Alternatively,

applicants whose projects fall into one of the categories of this subsection may demonstrate need under the criteria specified in subsection (16)(b) of this rule.¶

(e) If neither subsection (c) nor (d) of this section is the case, then approval of the application would result in increasing the 1980 ratio identified in Table 2, up to or closer to the lower limit identified in paragraph (11)(c)(B) of this rule. In this case, the applicant is expected to inventory the alternative capacity and utilization in the locality and to indicate the criteria under which the nursing home will refer prospective patients to each alternative rather than admit them to the nursing home.¶

(16) Justification of bed capacity above state goals:¶

(a) If the criteria in subsection (15)(a), (d) or (e) of this rule apply and are satisfied, beds in the service area may be added or relocated provided all criteria specified in OAR 333-580-0040 through 333-580-0060 are met;¶

(b) If subsection (15)(c) of this rule applies, then the applicant must demonstrate that there are no feasible long-term care alternatives in the service area by the calendar year identified in paragraph (11)(c)(B) of this rule by demonstrating that at least one of the following conditions exist:¶

(A) Applicant must show that superior and accessible alternatives to the proposed added or relocated beds, in terms of appropriateness, efficiency, effectiveness or cost, have not been developed, and cannot be developed by this provider or another potential provider in time to meet needs, or would not be financially feasible; or have insufficient capacity, which could not be expanded in time to meet needs, or expansion is not financially feasible;¶

(B) Applicant may show that utilization of service area nursing home beds by persons under age 65 (mentally or emotionally disturbed, mentally retarded or developmentally disabled, alcohol or drug dependent, or physically handicapped) is occurring in numbers greater than 15 percent of the service area nursing home average daily census. This may justify adding or relocating beds under subsection (15)(c) of this rule to the extent that the placements are appropriate under the authorization criteria of the central offices of the state Department of Human Services;¶

(C) Applicant must show that the efficiency and appropriateness of utilization of existing nursing home beds and alternatives in the service area is as high as can be expected;¶

(D) Applicant must show that persons for whom nursing home care is necessary would experience serious problems in terms of availability, accessibility and cost in obtaining such care without the added or relocated beds;¶

(E) If proposal involves either permanent or "swing" utilization of hospital beds as long-term care beds, and subsection (15)(c) of this rule applies, applicant must present a justification consistent with paragraphs (A) to (D) of this subsection;¶

(F) If subsection (15)(c) of this rule applies, applicant may demonstrate need by showing that there is provider commitment to phase out (close, or convert to other uses) sufficient presently existing, specific beds so as to bring the local level of nursing home capacity back below the limit at which subsection (15)(c) of this rule would apply for future years, within 12 months after the projected opening of beds if the application is approved.¶

~~[ED. NOTE: Tables & Publications referenced are available from the agency.]~~

Statutory/Other Authority: ORS 431.120(6), 442.315

Statutes/Other Implemented: ORS 431.120(6), 442.315

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 333-610-0030.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:

<https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=338836>

AMEND: 333-610-0060

SUSPEND: Temporary 333-610-0060 from PH 27-2026

RULE SUMMARY: Amend OAR 333-610-0060[T] – Identifies an operative date and deletes the text of the temporary rule and reinstates prior permanent rule as it existed immediately before the temporary rule. This rule specifies that hospital-based long-term care facilities must be separately licensed, and creating such a facility is treated as establishing a new health care facility requiring certificate of need review. Any increase of more than 10 beds or more than 10 percent of existing long-term care bed capacity, or relocation of beds into a hospital-associated long-term care facility, also requires certificate of need review under the same standards applied to freestanding nursing homes.

CHANGES TO RULE:

333-610-0060

Hospital Long-Term Care Beds ¶

This rule has an operative date of June 24, 2026.¶

(1) Long-term care facility services and beds offered in or through a hospital must be separately licensed by the Seniors and People with Disabilities Division. Therefore, the creation of a long-term care facility by a hospital will be considered to constitute the establishment of a new health care facility, subject to review under OAR 333-550-0010(1). Additions to the bed capacity of such facilities will be subject to review if such additions are greater than 10 percent of the existing capacity of the long-term care facility, or greater than 10 beds, whichever is less, as provided in OAR 333-550-0010(3).¶

(2) When a hospital proposes to create a new long-term care facility which will either be associated with, or located in, the hospital; or increase the number of long-term care beds (as defined in OAR 333-610-0010(12)) in such a facility by more than 10 beds or 10 percent of the facility's bed capacity, whichever is less, or when a hospital proposes to relocate long-term care beds to such a facility, the project will be subject to certificate of need on the same basis as any freestanding nursing home project would be under OAR 333-610-0000 to 333-610-0030.

Statutory/Other Authority: ORS 431.120~~(6)~~, 442.315

Statutes/Other Implemented: ORS 431.120~~(6)~~, 442.315

AMEND: 333-610-0070

SUSPEND: Temporary 333-610-0070 from PH 27-2026

RULE SUMMARY: Amend OAR 333-610-0070[T] – Identifies an operative date and deletes the text of the temporary rule and reinstates prior permanent rule as it existed immediately before the temporary rule. This rule requires hospitals that plan to use acute care beds as skilled nursing “swing beds” to file a letter of intent and undergo review similar to that for new long term care facilities. Swing bed proposals are evaluated for policy alignment, alternative care impacts, quality, financial feasibility, and cost effectiveness, with emphasis on ensuring appropriate use of alternatives and avoiding increased Medicare costs.

CHANGES TO RULE:

333-610-0070

Swing Long-Term Care Beds in Hospitals ¶

This rule has an operative date of June 24, 2026. When a hospital proposes to utilize a given number of its licensed hospital acute beds intermittently as skilled nursing facility swing beds under applicable federal regulations, the hospital is expected to submit a letter of intent to the Public Health Division. The organized and regular provision of skilled nursing facility services within the licensed physical plant of the hospital may be subject to review as a new long-term care facility under OAR 333-550-0010(3)(a). In addition:¶

(1) The proposal will not be subject to county-specific nursing home bed need criteria under OAR 333-610-0000 to 333-610-0030 because it will not create permanent new nursing home beds. The division, in reviewing the proposal for need under OAR 333-580-0040 and for alternative uses of resources under OAR 333-580-0050, will take into consideration such factors as:¶

(a) Health policy of the state, as reflected in ORS 410.010, 410.020, 410.050 and 410.060; ORS Chapter 442 generally; and other applicable statutes;¶

(b) Interpretation of that policy, as reflected in the plans and administrative rules of the Health Division and the Senior and Disabled Services Division. In considering strategies for increasing the accessibility of nursing home beds, priority will be given to increasing the utilization of appropriate alternative care (thereby freeing up existing nursing home beds), rather than increasing the number of nursing home beds;¶

(c) Comparative experience with, and quality of, long-term care provided by staff in licensed acute care hospitals and in licensed long-term care facilities.¶

(2) The division, in reviewing the proposal for financial feasibility under OAR 333-580-0060, will take into consideration such factors as:¶

(a) A conservative projection of Medicare utilization according to the current stringent "skilled" level of care criteria of the fiscal intermediaries;¶

(b) Estimated potential for diversion of public and private funds now available for alternative care into facility-based long-term care when the patient needs involved could be met, at equal or lesser cost, through provision of alternative care;¶

(c) Balanced against section (3) of this rule, estimated potential for diversion of public and private funds now available for acute care into facility-based and alternative long-term care;¶

(d) Comparative costs of long-term care provided in licensed hospitals and in licensed long-term care facilities, and the feasibility of the hospitals contracting for skilled care in an existing long-term care facility at equal or lesser cost; and¶

(e) Potential that the proposal will or will not increase Medicare costs, per illness episode, beyond those allowed for under diagnosis-related groups reimbursement.

Statutory/Other Authority: ORS 431.120(~~6~~), 442.315

Statutes/Other Implemented: ORS 431.120(~~6~~), 442.315

AMEND: 333-610-0080

SUSPEND: Temporary 333-610-0080 from PH 27-2026

RULE SUMMARY: Amend OAR 333-610-0080[T] – Identifies an operative date and deletes the text of the temporary rule and reinstates prior permanent rule as it existed immediately before the temporary rule. This rule specifies that when a long-term care facility converts some or all of its beds to licensed residential care beds, it is not required to reduce its long-term care license unless federal rules require it. Residential care beds that are later converted back to nursing home beds may require certificate of need review. Such reconversion will be evaluated based on cost, comparative quality, and county specific bed need criteria.

CHANGES TO RULE:

333-610-0080

Residential Care Beds in Long-Term Care Facilities ~~¶~~

This rule has an operative date of June 24, 2026. When a long-term care facility chooses to obtain a Seniors and People with Disabilities Division license as a "licensed residential care facility" as described in OAR 333-610-0010(11) for all, or for a separate and distinct part of its currently licensed long-term care facility bed capacity, it is not required, under statute, to accept a correspondingly reduced Seniors and People with Disabilities Division "long-term care facility" license as described in OAR 333-610-0010(12). Federal regulations, however, may require this under some circumstances. The following certificate of need rules will apply at such time that appropriate, coordinated licensing rules are adopted by the Seniors and People with Disabilities Division:~~¶~~

(1) Future reconversion of such beds from residential care to long-term care (nursing home) beds will be considered an expansion of the then existing Seniors and People with Disabilities Division licensed long-term care facility service, and may be subject to the certificate of need law under applicable thresholds regarding expansions in long-term care bed capacity; and~~¶~~

(2) In evaluating a reconversion project, the division shall give strong consideration to the costs, compared to new construction, and to the comparative quality and cost of care currently provided at the facility; and~~¶~~

(3) Reconversion projects as described in this rule will be subject to county-specific bed need criteria under OAR 333-610-0020 to 333-610-0030.

Statutory/Other Authority: ORS 431.120~~(6)~~, 442.315

Statutes/Other Implemented: ORS 431.120~~(6)~~, 442.315

AMEND: 333-610-0090

SUSPEND: Temporary 333-610-0090 from PH 27-2026

RULE SUMMARY: Amend OAR 333-610-0090[T] – Identifies an operative date and restores the text of the prior permanent rule as it existed before the temporary suspension. This rule specifies that intermediate care beds for intellectually or developmentally disabled individuals must be licensed by the Oregon Department of Human Services (ODHS), Seniors and People with Disabilities Division if residents require nursing level care, and these beds are subject to certificate of need review. Need is assessed by considering state plans, bed ratios in other states, professional research, and statewide, regional, and local factors such as access, quality, and cost. Public and private beds are treated alike in determining overall need.

CHANGES TO RULE:

333-610-0090

Intermediate Care Facilities for the Mentally Retarded **II**

This rule has an operative date of June 24, 2026. Distinct part intermediate care beds for mentally retarded or developmentally disabled individuals, when the facility houses any individuals who require nursing care services of a level, frequency and duration equivalent to intermediate facility care nursing as defined by the Seniors and People with Disabilities Division, must be licensed by the Seniors and People with Disabilities Division, rather than by the Addictions and Mental Health Division, and are subject to certificate of need according to ORS Chapter 442. In determining need, the division shall take into account long-range plans of the Addictions and Mental Health Division; shall consider comparative bed ratios in other states; and shall search, review and analyze existing professional literature and reports. The division shall evaluate local, substate, regional and statewide need, considering access, quality and costs. Public and private facility beds shall be considered as equivalent for purposes of meeting the limited need for this category of care.

Statutory/Other Authority: ORS 431.120(6), 442.315

Statutes/Other Implemented: ORS 431.120(6), 442.315

AMEND: 333-610-0100

SUSPEND: Temporary 333-610-0100 from PH 27-2026

RULE SUMMARY: Amend OAR 333-610-0100[T] – Identifies an operative date and deletes the text of the temporary rule and reinstates prior permanent rule as it existed immediately before the temporary rule. This rule requires that intermediate care beds for persons with mental illness who need nursing level care be licensed by the Oregon Department of Human Services (ODHS), Seniors and People with Disabilities Division and be reviewed through the certificate of need process. Need evaluations must consider state mental health plans, bed ratios in other states, professional research, and statewide, regional, and local factors such as access, quality, and cost. Public and private beds count equally in assessing overall need.

CHANGES TO RULE:

333-610-0100

Intermediate Care Facilities for the Mentally or Emotionally Disturbed **II**

This rule has an operative date of June 24, 2026. Distinct part intermediate care beds for mentally or emotionally disturbed individuals, when the facility houses any such individuals who require nursing care services of a level, frequency and duration equivalent to intermediate care facility nursing as defined by the Seniors and People with Disabilities Division, must be licensed by the Seniors and People with Disabilities Division, rather than by the Addictions and Mental Health Division, and are subject to certificate of need according to ORS Chapter 442. In determining need, the division shall take into account long-range plans of the Addictions and Mental Health Division; shall consider comparative bed ratios in other states; and shall search, review and analyze existing professional literature and reports. The division shall evaluate local, substate, regional and statewide need, considering access, quality and costs. Public and private facility beds shall be considered as equivalent for purposes of meeting the limited need for this category of care.

Statutory/Other Authority: ORS 431.120~~(6)~~, 442.315

Statutes/Other Implemented: ORS 431.120~~(6)~~, 442.315

AMEND: 333-610-0110

SUSPEND: Temporary 333-610-0110 from PH 27-2026

RULE SUMMARY: Amend OAR 333-610-0110[T] – Identifies an operative date and deletes the text of the temporary rule and reinstates prior permanent rule as it existed immediately before the temporary rule. This rule requires that intermediate care beds for chemically dependent individuals who need nursing level care be licensed by the Oregon Department of Human Services (ODHS), Seniors and People with Disabilities Division and undergo certificate of need review. Need determinations must consider state mental health plans, bed ratios in other states, and professional research, along with statewide, regional, and local factors such as access, quality, and cost. Public and private beds are treated the same when assessing overall need.

CHANGES TO RULE:

333-610-0110

Intermediate Care Facilities for Chemically Dependent Persons, Including Alcoholics **II**

This rule has an operative date of June 24, 2026. Distinct part intermediate care beds for Chemically dependent persons, including alcoholics, when the facility houses any such individuals who require nursing care services of a level, frequency and duration equivalent to intermediate care facility nursing as defined by the Seniors and People with Disabilities Division, must be licensed by the Seniors and People with Disabilities Division, rather than by the Addictions and Mental Health Division, and are subject to certificate of need according to ORS Chapter 442. In determining need, the division shall take into account long-range plans of the Addictions and Mental Health Division; shall consider comparative bed ratios in other states; and shall search, review and analyze existing professional literature and reports. The division shall evaluate local, substate, regional and statewide need, considering access, quality and costs. Public and private facility beds shall be considered as equivalent for purposes of meeting the limited need for this category of care.

Statutory/Other Authority: ORS 431.120~~(6)~~, 442.315

Statutes/Other Implemented: ORS 431.120~~(6)~~, 442.315