Welcome!

We will get started in a few minutes.
Please make sure you are muted.

Chat or email us if you have any technical issues:
Tiffany.Goetz2@OHA.Oregon.gov

Oregon Health Authority

2024 Hospital Community Benefit Summit

July 30, 2024

1 – 4 p.m.

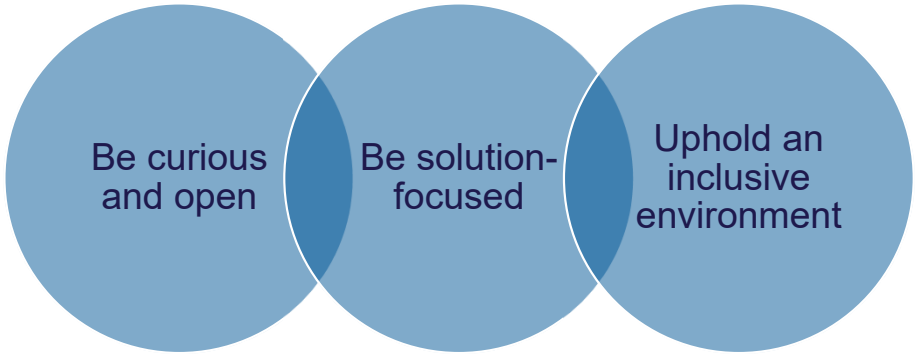
Steven Ranzoni, Hospital Policy Advisor

Sarah Grabe, Hospital Community Benefit Program Coordinator

Oregon Health Authority

Meeting functionality

- Zoom functions
- Please introduce yourself, your organization, and your pronouns before you speak
- We will take attendance from participant list, the meeting will be recorded
- Chat is monitored, questions will be addressed along the way



Public meeting

This is a **public meeting** that is being recorded

There will be time for public comment at the end. If you wish to make a public comment, please send a chat to Tiffany Goetz.

- OHA will not respond to public comments
- OHA will not correct misrepresentations or errors made in public comment
- Public comments are the views of the individual and not OHA
- Please limit comments to 2 minutes

Agenda

Time	Topic	Speaker
1 – 1:20 p.m.	Introduction	Sarah Grabe
1:20 – 1:35 p.m.	FY22 Spending Floor Data and Overall Spending Trends	Steven Ranzoni
1:35 – 1:45 p.m.	CBR-1 Reporting Tips	Steven Ranzoni
1:45 – 1:55 p.m.	FY22 Narrative Report	Sarah Grabe
1:55 – 2:05 p.m.	Break	
2:05 – 2:20 p.m.	HB 3320 Implementation	Sarah Grabe, Rachel Higgins
2:20 – 2:30 p.m.	Q&A, Public Comment	Steven Ranzoni, Sarah Grabe
2:30 p.m.	Adjourn	

Oregon Health Authority (OHA) staff introduction

Nikki Olson	Piper Block	Steven Ranzoni
• Interim Health Policy & Analytics Division Deputy Director	• Research & Data Unit Manager	• Hospital Reporting Program Manager/Policy Advisor

Sarah Grabe	Rachel Higgins	Tiffany Goetz
• Hospital Community Benefit Program Coordinator	• Community Benefit Research Analyst	• Hospital Reporting Program Analyst

Annual community benefit summit

Purpose of the meeting

- Stay up to date on Oregon's Community Benefit (CB) policies and procedures,
- Review the community benefit spending floor program,
- Discuss data and reports, new legislation, and
- Promote and incentivize social determinants of health (SDOH) investments to address community needs.

We want to move CB toward purposeful, planned programs that address health needs through SDOH.

CB spending is critical to achieving OHA's strategic goal

OHA's overarching strategic goal: to eliminate health disparities by 2030.

Oregon Administrative Rule (OAR) definition of CB: programs or activities that provide treatment or promote healing, address health disparities or address the SDOH in a response to identified community needs.

Community input led to OHA's overarching goal, just as community input must direct hospital CB spending.

Opening remarks

Nikki Olson, Interim HPA Deputy Director

FY22 spending floor data and overall spending trends

Status of community benefit reporting as of July 2024

- FY 22 data is current, full data
- FY 23 final group data due end of August, dashboards refreshed in late October
- FY 24 – 25 spending floors are all assigned
- FY 26 – 27 spending floor cycle assignments will begin on Jan 1, 2025

FY 2022 first year spending floor data

- Of the 38 spending floors assigned to 58 hospitals or health systems, **35 out of 38 (92.1%) met or exceeded** their spending floor for FY 22.
- Community benefit spending increased significantly in FY22, mostly due to unreimbursed care.
- New spending floors are primarily based on previous years' spending. As a result, statewide FY 24 spending floors increased 16% from FY 23 spending floors.

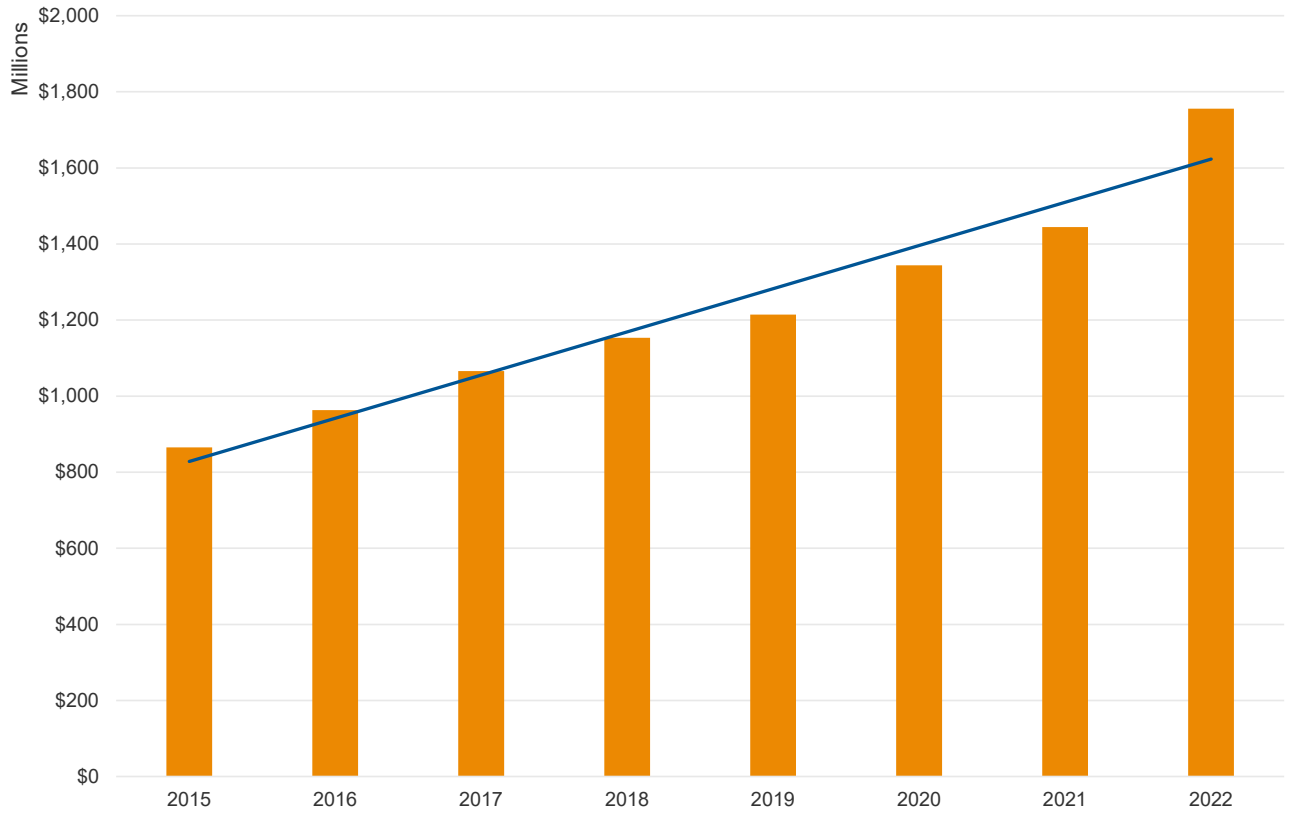
Fiscal Year	All Hospitals' Spending Floors Statewide	Total Community Benefit Spend Statewide
2020	NA	$1,743,577,906
2021	NA	$1,870,409,154
2022	$1,386,260,083	$2,195,458,810
2023	$1,433,782,658	October 2024
2024	$1,669,709,940	October 2025
2025	$1,756,718,037	October 2026

Hospital performance in FY 2022

- 35 of 38 assigned hospitals and health systems met their FY 2022 floor.
- Statewide **total spending was 154%** of the **statewide** assigned minimum **spending floor**.
- Statewide, hospitals **exceeded** the spending floor by **$749,516,322**.
- **Average** hospital **spent 171%** of their assigned floor.
- **Median** hospital **spent 149%** of their assigned floor.

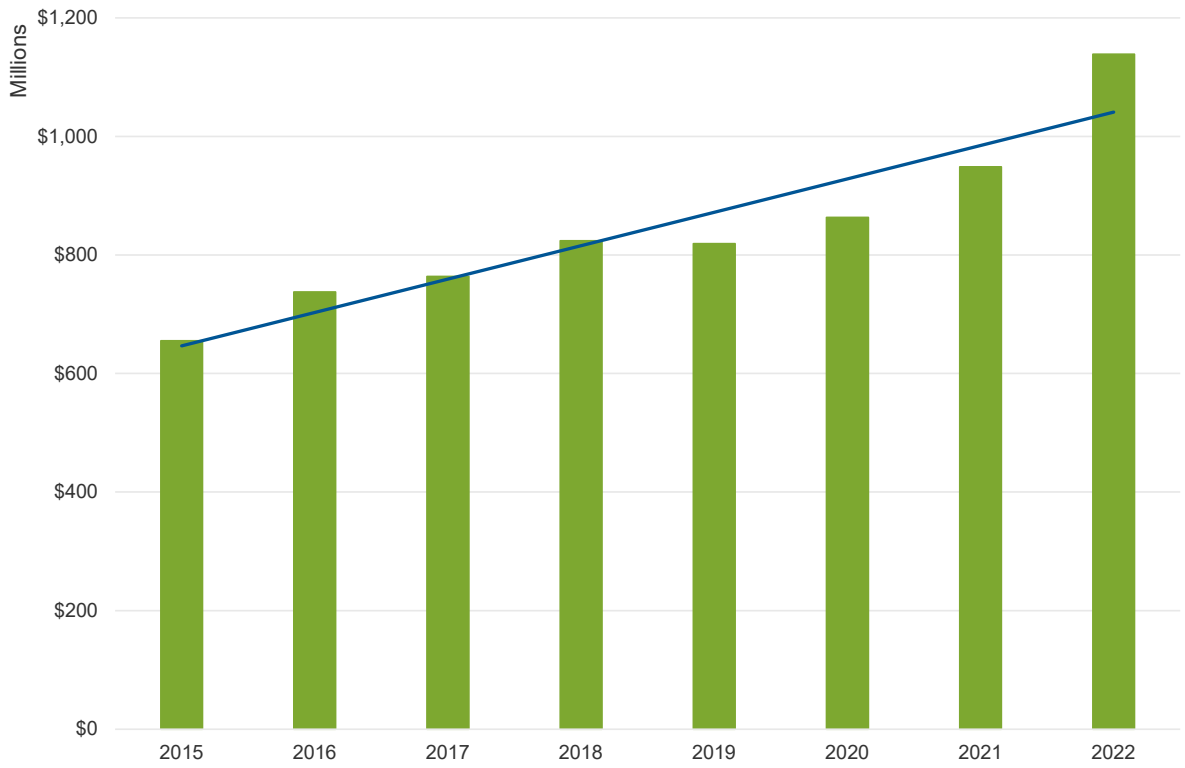
Unreimbursed care trends

- **Unreimbursed care grew 21.5%**, the highest year of growth in the history of OHA's data.
- This is an **outlier year** compared to the previous trend.
- This growth exceeds operating expense growth of 12%.
- Unreimbursed care and operating expenses historically trend closely and have identical long term annual growth rates (7.2%).
- FY22's 21.5% is nearly **triple the historic rate of growth.**

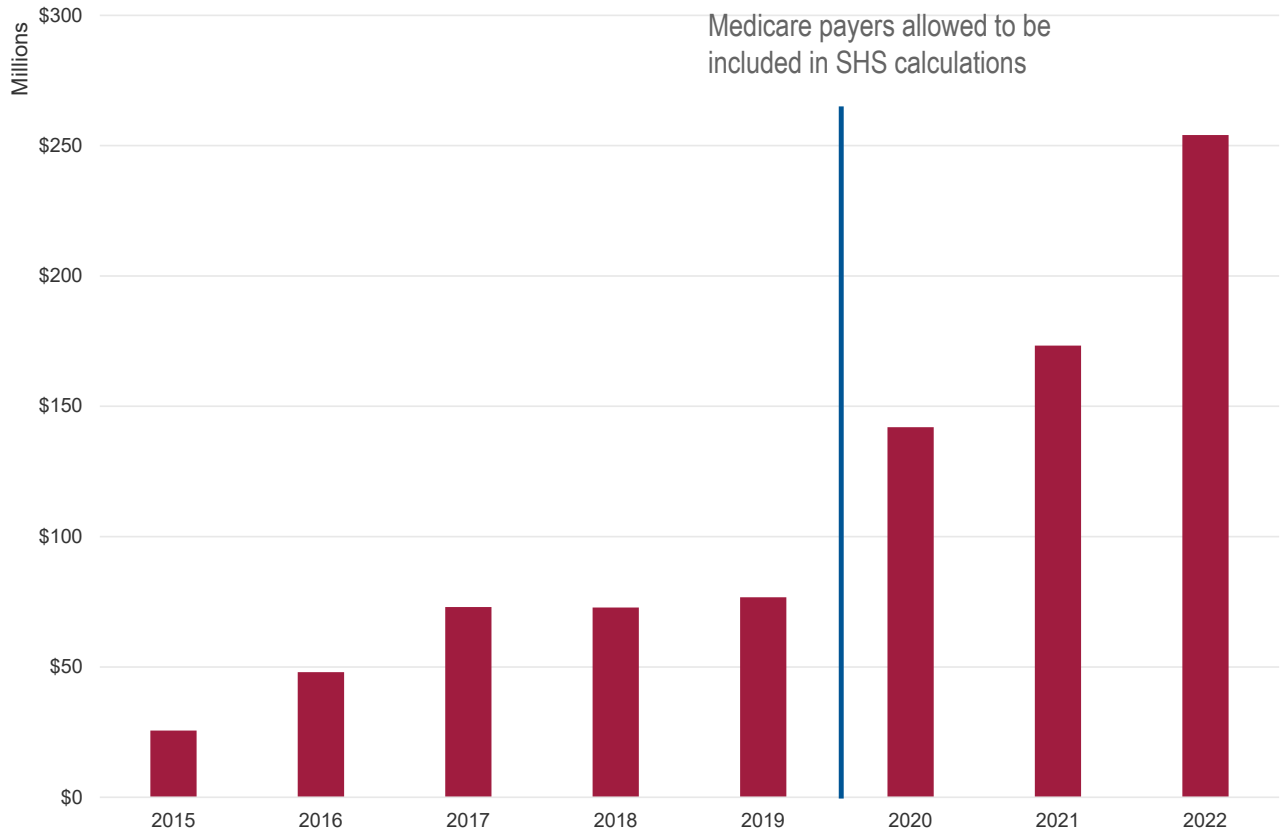


Unreimbursed Medicaid trends

- **Unreimbursed Medicaid grew 20%** in FY22, also representing an **outlier year**.
- Other years with high growth were 2012 and 2014-2015 which were all associated with significant changes or expansions of OHP.
- There was not a significant OHP expansion in FY 22. However, due to the redetermination pause, OHP enrollment did increase about 100,000 members.

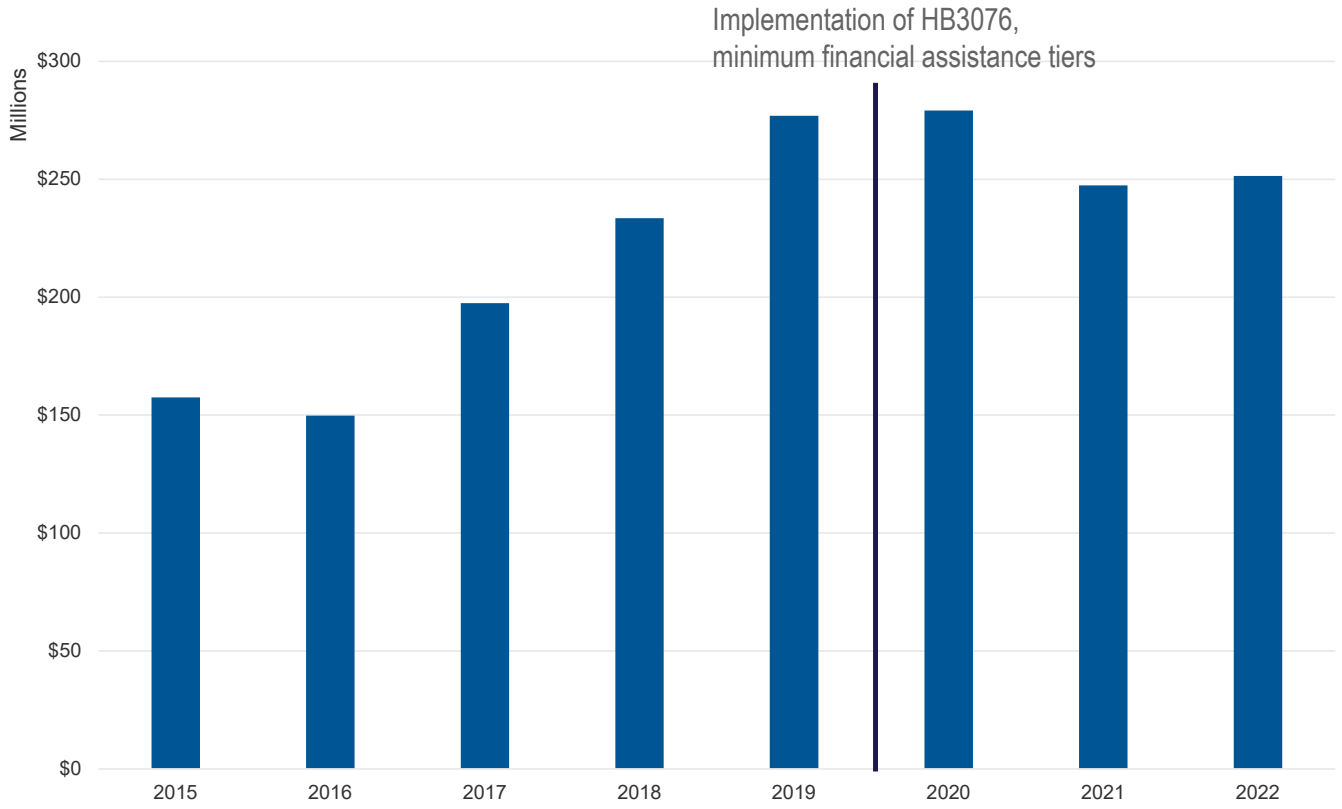


Subsidized health services (SHS) trends



- **Subsidized health services have grown by 85%, 22% and 47%** in FY 20, FY 21 and FY 22, respectively.
- Medicare payers being included in the calculation in 2020 is a major factor of this growth.
- Total spending in SHS ($254 million) now exceeds total spending in charity care ($251 million)
- DRG hospitals have the largest growth in percent and dollar amount of SHS spending: **269% and $177 million since 2019**.

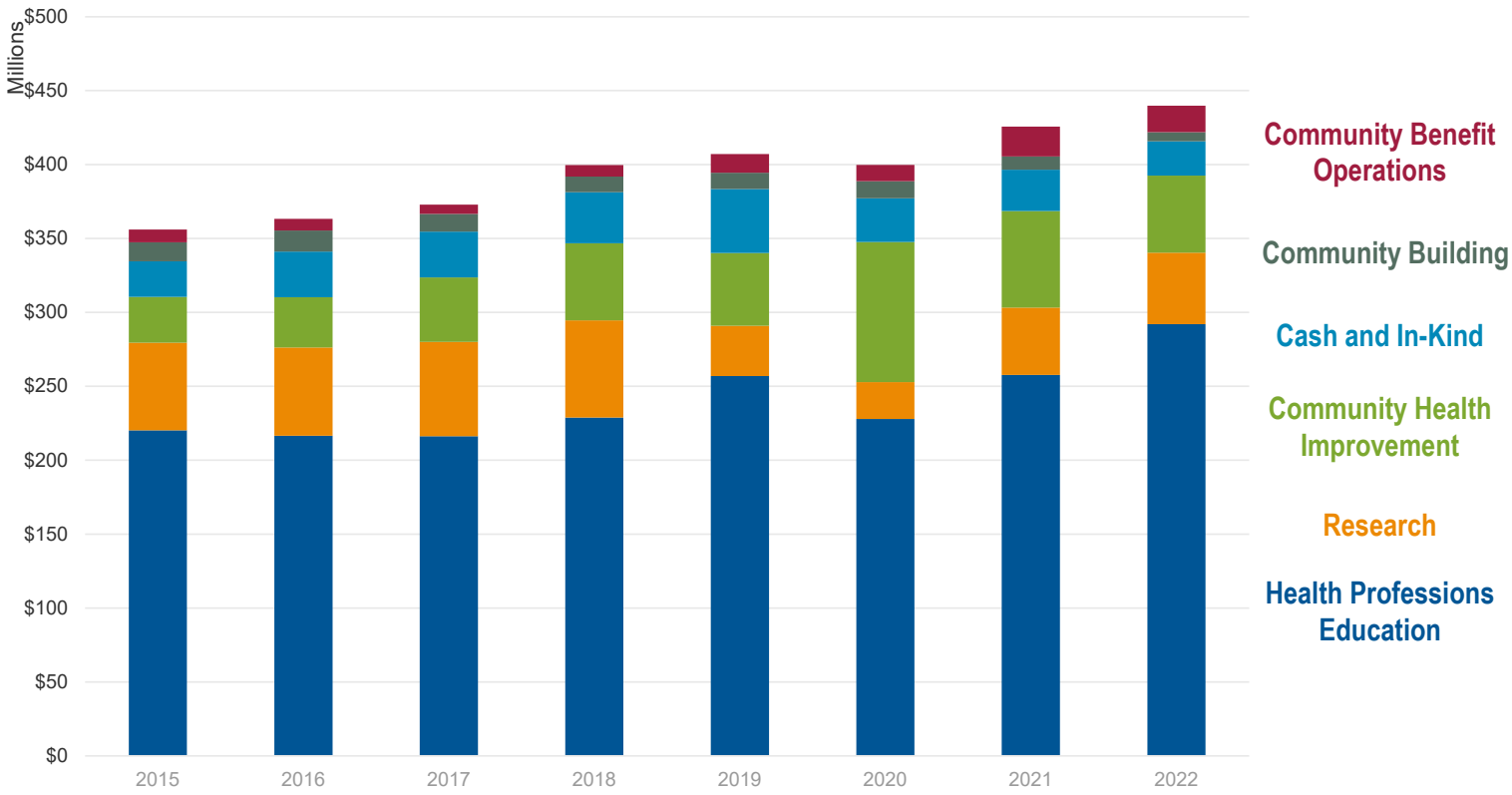
Charity care (financial assistance) trends



- Since implementation of minimum financial assistance tiers on Jan 1, 2020, **overall charity care spending has decreased**.
- Charity care increased 1.6% in FY 22, following an 11% decrease in FY 21.
- The public health emergency and redetermination pause has kept OHP enrollment high, reducing need for financial assistance.

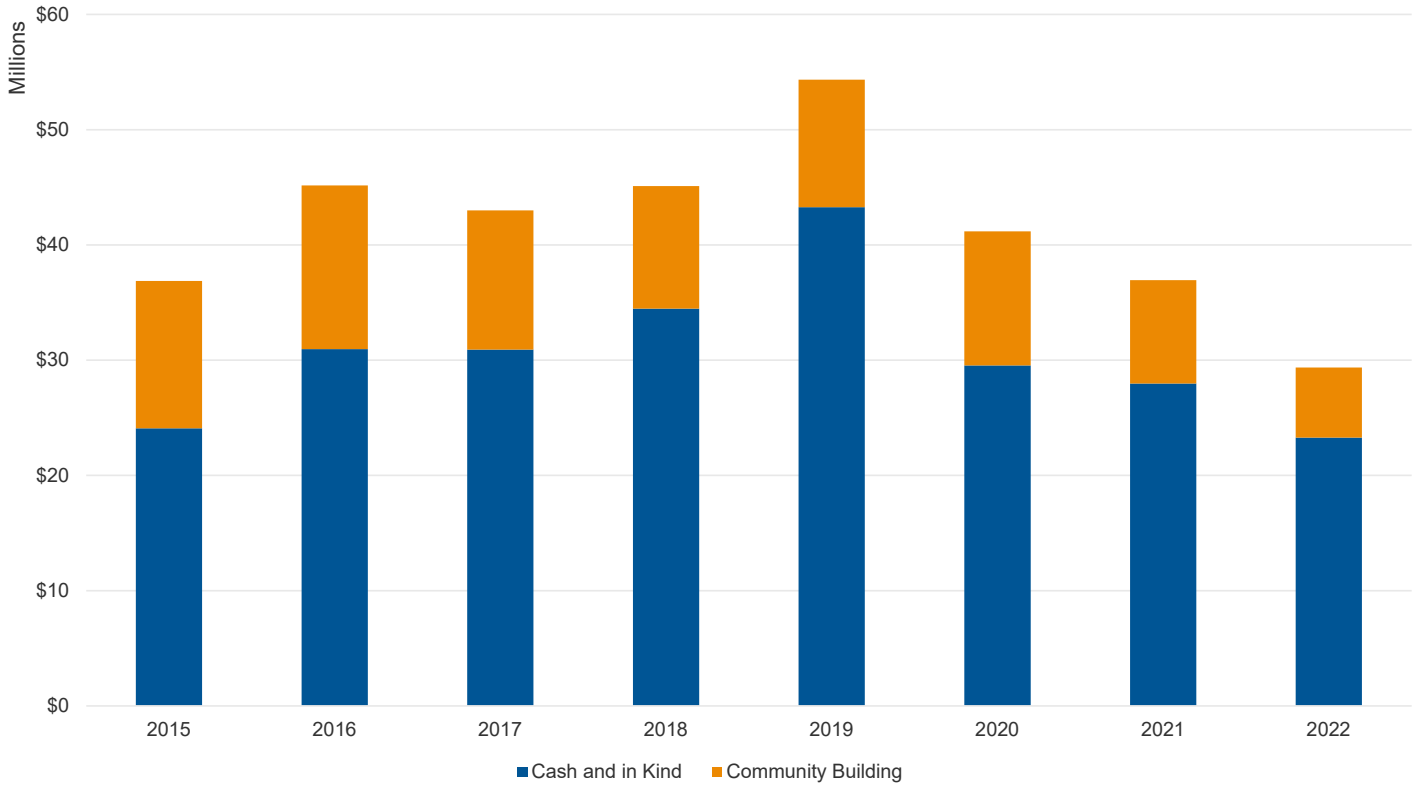
Direct spending trends

- **Health professions education** accounts for 67% of all direct spending categories.
- Direct spending grew $14 million in FY22. **Health professions education grew by $34** million while **all other direct spending decreased by $20 million**.



Social Determinants of Health trends

- **Cash and In-Kind Contributions** and **Community Building** are the categories that most closely align to SDOH-type activities.
- These combined categories fell 20.5% in FY 22, **a decrease of $7.6 million**
- Combined SDOH-type spending has steadily decreased since 2019.



Spending floor recommendation

OHA recommends retaining the current spending floor methodology for FY 2026 - 2027.

While total community benefit spending increased significantly and hospitals greatly surpassed the floor amount in actual spending, this was primarily due to unusually large increases in unreimbursed care that OHA does not anticipate will continue.

Preliminary FY 23 data indicates a 7% decrease in unreimbursed care from the hospitals that have reported so far.

OHA is concerned about the trends in SDOH-type spending but recognizes that the difficult financial situation hospitals have faced is impacting this trend.

Spending floor calculation reminder

The spending floor is based on individual hospital or health system past spending trends.

- Past and present unreimbursed care spending is the greatest spending floor driver for future years.

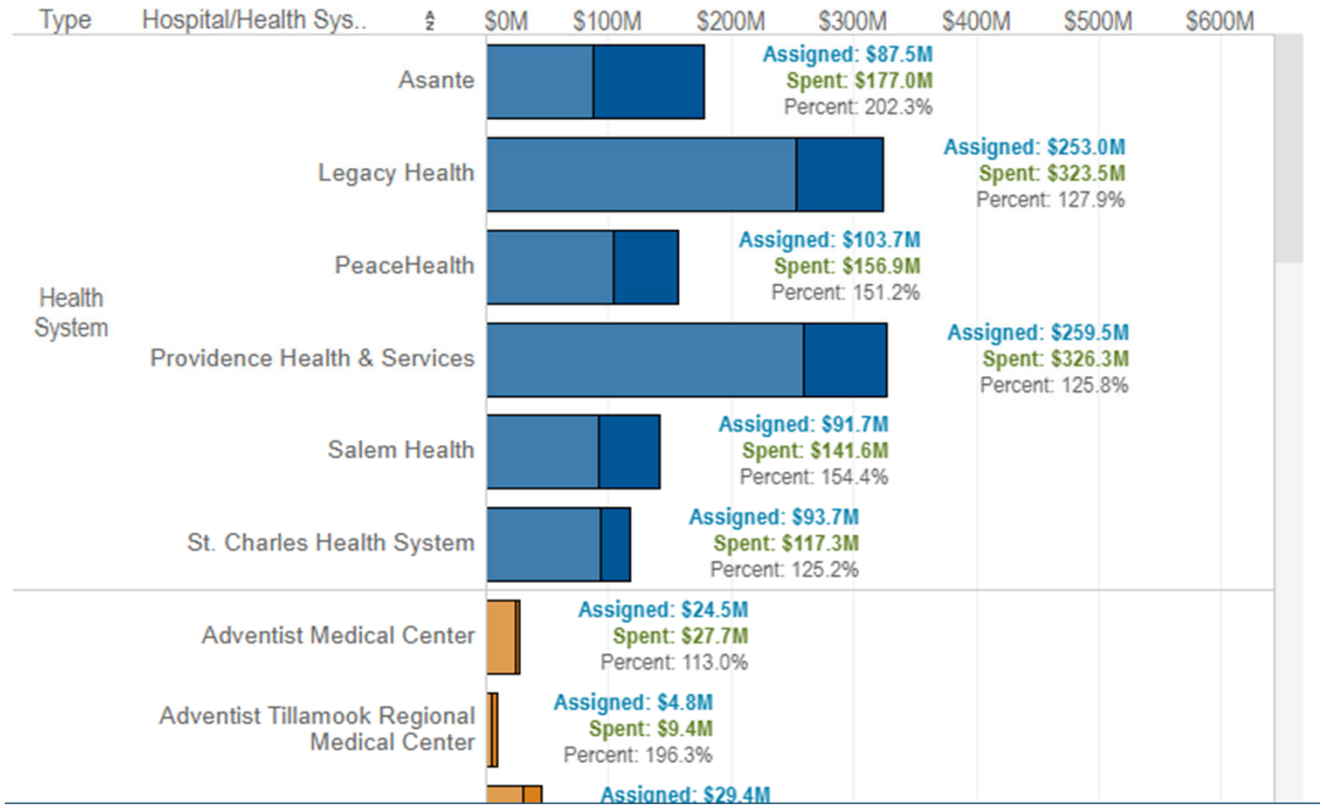
FY24 spending floor = **3-year average of unreimbursed care** + (**Direct Spending Net Patient Revenue Percentage** x **3-year average operating margin multiplier**)
FY25 spending floor **= FY24 spending floor** + (**FY24 spending floor** x **4-year average percent change in net patient revenue, capped at +/=10%**)

Spending floors reflect a hospital or health system's financial situation. Hospitals can request modification for increased efficiency, financial insecurity, or other reasons.

- OHA published updated spending floor modification guidance December 2023.

The FY2022 community benefit dashboard includes minimum spending floor performance

- Compares **assigned minimum spending floor** amounts to **total community benefit spending** amounts



CBR-1 Reporting Tips

Documents Required for Submission to OHA

Annually by June 30th	1. Hospital Facility and Clinic Report (HFCR)
120 days after end of each FY	1. Audited Financial Statement (AFS) 2. Financial Report 3 (FR-3)
150 days after end of each FY	1. Hospital Financial Assistance Report (HFAR) – first due is FY25
240 days after end of each FY	1. Community Benefit Report 1 (CBR-1) 2. Narrative Report 3. CHNA and CHIP
No less than 90 days before the start of even numbered FY	1. Minimum Community Benefit Spending Floor Hospital Grouping Worksheet (CBR-3)*

*No less than 90 days prior the start of an odd numbered fiscal year, hospitals must submit the Minimum Community Benefit Spending Floor Hospital Grouping Worksheet (Form CBR-3) to the OHA to begin the minimum spending floor assignment process.

Subsidized health services calculation

Reporting provider tax

If hospitals report provider taxes as an expense, they must report QDPs as offsetting revenue.

Line		Amount	Sample
1	Number of Medicaid patients, including managed Medicaid and SCHIP		2,000
2	Gross patient charges from Medicaid programs, including managed Medicaid and SCHIP		23,000,000
3	Cost-to-charge ratio	0.0%	48.6%
4	Medicaid Expenses	**0**	**11,185,349**
5	Medicaid Provider Taxes		1,000,000
6	**Total Medicaid Expenses**	**0**	**12,185,349**
7	Net patient service revenue from Medicaid programs, including managed Medicaid and SCHIP		7,000,000
8	Other revenue (Ex: HRA payments, Provider Tax Reimbursement, Qualified Directed Payments)		1,000,000
9	Total direct offsetting revenue	**0**	**8,000,000**
10	**Net community benefit expense**	**0**	**4,185,349**
Note: If net community benefit expense is negative, indicating a gain, do to report results on form CBR-1, as gains are not reportable.			

If you report provider taxes here,

You must report QDP amounts received here.

CBR-1 reporting questions?

Ask us any questions you have about the specifics of reporting.

10 Minute Break

Oregon Hospital Community Benefit Investments Report

A first-of-its-kind look at how hospitals invested in direct, proactive community benefit activities in Oregon, the CB Investments Report was published in July using qualitative data from the FY22 hospital narratives.

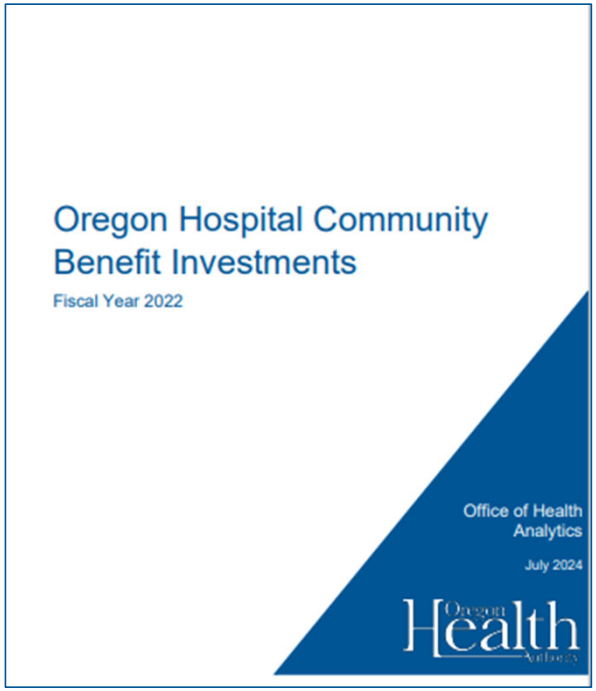
Purpose of the CB Investments Report

To answer the question, **"How are nonprofit hospitals fulfilling their charitable obligations through proactive community benefit?"**

To **compare community benefit programs with identified statewide needs.**

To **highlight innovative work** that nonprofit hospitals and health systems are doing across the state to:

- **Raise awareness for patients and community members** about what programs and services are available in their communities.
- Provide opportunities for hospitals, CCOs, and local organizations to **learn from each other's work**.
- Showcase work that hospitals do **above and beyond patient care**.



CB Investments Report methodology

Framework of priority health needs:

1. The 2023-2025 Governor's State Budget, State of Oregon
2. "Healthier Together Oregon" 2020 – 2024 State Health Improvement Plan (SHIP)

	Access to care	Behavioral health	Social Determinants of Health	Child and school health
Governor's State Budget Priorities		✓	✓	✓
SHIP	✓	✓	✓	

OHA then reviewed the hospitals' top health needs based on the **response to questions two and three** on the submitted Hospital Community Benefit Narratives. These narrative responses were **grouped into common themes**, including those that aligned to the identified statewide priority health needs.

CB Investment Report findings

Access to care was the most frequently addressed priority.

Almost 75 percent of hospitals are investing in Social Determinants of Health.

Two-thirds of hospitals are focusing on behavioral health programs as Oregon's behavioral health needs continue to grow.

There is opportunity for hospitals to invest more in housing.

There is opportunity for hospitals to collaborate more with Coordinated Care Organizations.

There is opportunity to report on impact and outcomes.

Future CB Investments Report

Give us content! Let us shine the spotlight on your work.

OHA will publish the CB Investments Report **each summer.**

Recommendations for future reporting:

- **Explicitly show the connections between CB and your CHNA and CHIP**
- **Impact of investments:**
    - **# served,**
    - **$ or time invested,**
    - **Health outcomes.**

Hospitals may review the CB Narrative Report and other hospitals' narratives, available on the Hospital Profiles Page, to improve their reporting.

Strong narrative examples

Kaiser Westside granted Tribal Technology Training (T3) almost **$25,000** to increase capacity for their Native Financial Empowerment Training program to address the legacy of intergenerational trauma and poverty. T3 embeds culture in training and provides a safe place for participants to share and **build financial confidence to leverage capital investments** to buy a house, car, or other consumer goods.

 $ spent  program goals

Adventist Portland runs the Market Street Garden, which provided **27 refugee families** with 42,000 square feet of growing space. Gardeners emphasized producing hard to find, culturally specific produce from around the world. They hosted a Free Celebration of Thanksgiving event where they collected **850 pounds of food** for Portland Adventist Community Services. Other community garden partnerships are in the works for 2023.

 # served  outcome measurement

Strong narrative examples

St. Charles Madras provided **$7,500** to organizations addressing housing for people experiencing houselessness, including funding for the Winter Shelter which completed its fifth year of operation on March 15, 2023. A **grantee described** the shelter program: “there was a **23% increase year-over-year of the number of individuals served** with overnight accommodation and/or meals (**123 this shelter season compared to 100 during 2021-2022**). As has been typical, the Winter Shelter received widespread support from a variety of individual, business, and church donors, with significant support from state Out of the Cold (OOTC) funding administered through Neighbor Impact, as well as the continuing generosity of the St. Charles Health System. This **resulted in a funding surplus** to be taken forward to the 2023-2024 season, when **the operation transitioned from solely winter shelter to year-round operations** providing additional services will require increased funding.”

- $ spent on the specific program or priority
- Quotation from a grantee that provides insight and detail
- Outcome measurement

HB 3320 Implementation

HB 3320 rules in a nutshell

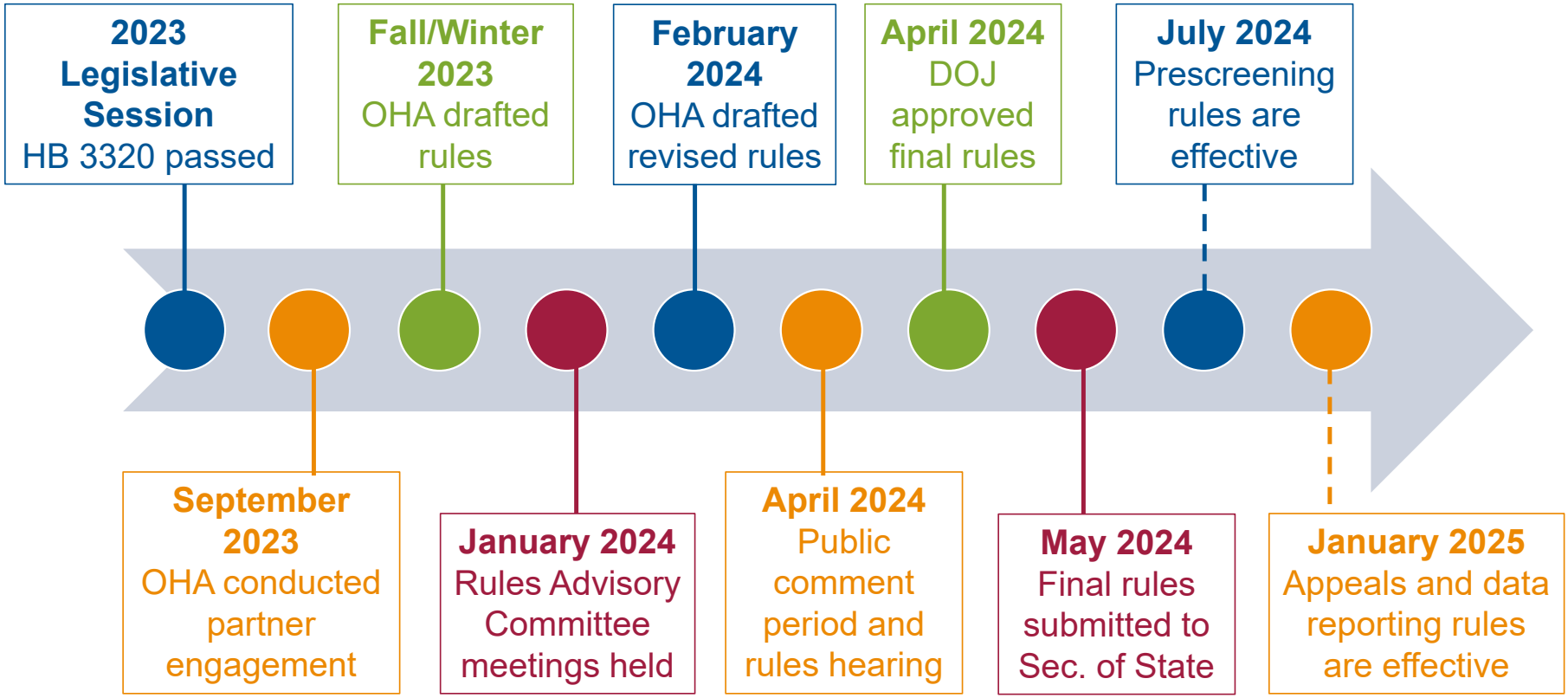
Hospitals must:

Screen a patient for presumptive eligibility of financial assistance (prescreening)

Provide a process for a patient to appeal a denial of financial assistance, in whole or in part

Report new data on financial assistance applications, approvals, denials and collection activities

HB 3320 implementation timeline



Prescreening

Effective July 1, 2024

Prescreening overview

"Using the process prescribed by the Oregon Health Authority under subsection (3) of this section, a hospital licensed under ORS 441.025 shall screen a patient for presumptive eligibility for financial assistance…"

OHA established rules for prescreening in **OAR 409-023-0120.**

Prescreening is a **new and separate** process from an application for financial assistance.

Hospitals are free to **develop their own process** that complies with requirements in rules.

Prescreening is intended to **use readily available information** or services to provide **automatic financial assistance adjustments** without the patient taking action.

Prescreening overview

ORS 442.614 requirements for financial assistance policies

The prescreening process and any resulting adjustment to patient costs must meet the same financial assistance standards as ORS 442.614:

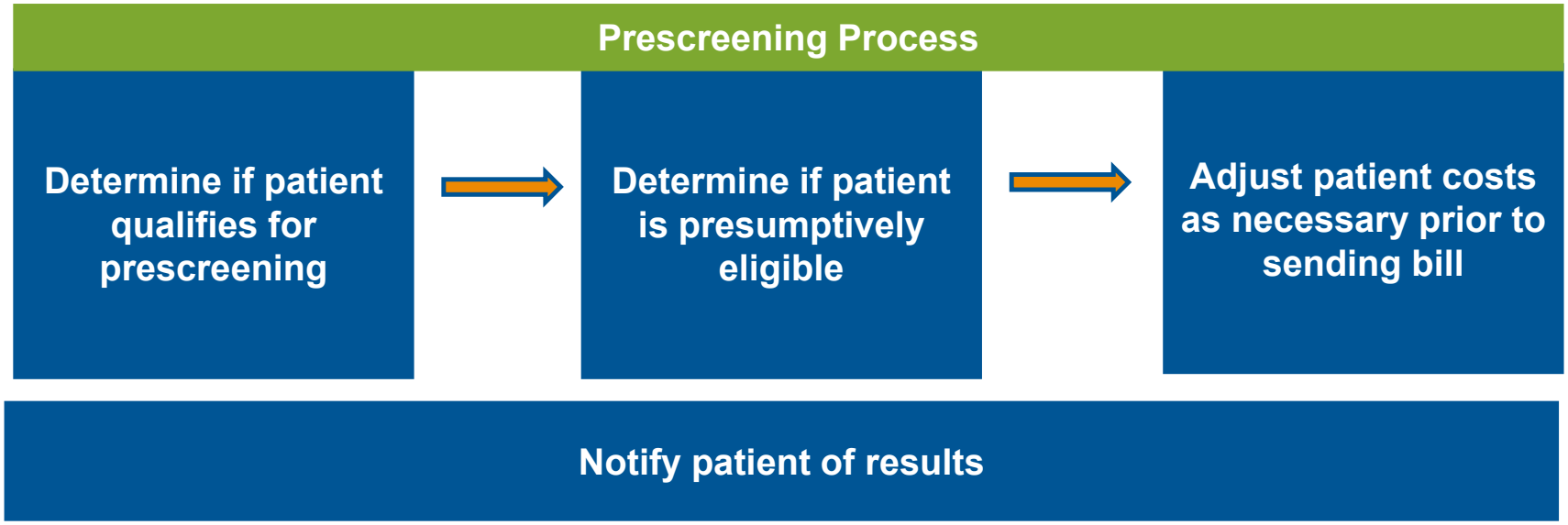
- Evaluated on **household income**, and
- In alignment with **minimum financial assistance tiers**.

Any resulting adjustment to patient costs must be **applied before a patient receives a bill.**

Prescreening **cannot require a patient to provide documentation** or verification and cannot negatively impact the patient's credit.

Before any prescreening actions, the hospital must determine if the patient has existing financial assistance eligibility

ORS 447.615(7) If a patient applies for financial assistance and the hospital determines that the patient is eligible for financial assistance based on documentation provided by the patient, the patient's eligibility for financial assistance continues for nine months following the hospital's determination, and the patient may not be required to reapply for financial assistance for services provided during that nine-month period.



Who to prescreen

Uninsured	Any patient without public or private health insurance coverage
Enrolled in a state medical assistance program	Any type of OHP including CCO or open card or any other state-provided coverage such as CHIP, Healthier Oregon, or Bridge program (basic health plan)
Will owe the hospital $500 or more	Any time the patient will be responsible for $500 or greater on a single statement

Any other qualifying conditions at the hospital's discretion

Hospitals can use information they have available to conduct the prescreening

A hospital may use any of the following means to establish presumptive eligibility:

- Existing patient records,
- Information routinely collected during registration or admission,
- Information voluntarily supplied by the patient,
    - Hospitals **may ask** but **cannot compel** or require patients to report information
- Previous financial assistance adjustments, or
- Existing eligibility for assistance programs like OHP, SNAP, TANF, WIC, free food programs, low-income energy assistance programs, other means tested programs, and
- Third party tools, software, or services.

When used by a non-profit, any third-party software tools or services must use household income, and cannot use an ability to pay score

"**409-023-0120(11)(b)** Evaluations must be based on eligibility criteria established in the hospital's written financial assistance policy. Evaluations by non-profit hospitals must be based on household income only, and cannot consider household assets or any assessment, evaluation or score that predicts the patient's propensity or ability to pay;"

Evaluations **cannot use asset information** for Oregon patients.

Evaluations **cannot result in a negative credit impact** for the patient.

Hospitals must make good faith efforts to determine presumptive eligibility and make use of information available to the hospital

If any chosen method fails to return usable information on the patient, the hospital **must attempt to use other available information** prior to declaring that the patient's presumptive eligibility cannot be determined.

A hospital may use a single source of information if it provides affirmative information on the patient's income status.

Hospitals must **document the methods** they use.

"**409-023-0120(13)** A hospital must notify the patient in writing of the results of the prescreening process, regardless of the outcome. The notification must meet the following standards:"

Hospitals may notify patients by:

- Letter;
- Email, if the patient has agreed to receive communications this way;
- Message on an online patient portal that the patient is a registered user of;
- Notice prominently displayed on the billing statement;
- An insert accompanying the billing statement; or
- In-person acknowledgement signed by the patient.

Notifications must be in plain language and the preferred language of patients and in alignment with translation standards in ORS 442.614.

Notices need to be clear, plain language, and provide specific and actionable information

OHA released sub-regulatory guidance with suggested language for prescreening notifications.

The notification must clearly state the outcome of the prescreening in plain language for one of the following outcomes:

1. Presumptively eligible for full financial assistance;
2. Presumptively eligible for partial financial assistance;
3. Not presumptively eligible for financial assistance; or
4. Unable to determine presumptive eligibility status.

Any notice for presumptive eligibility for less than full reduction of patient costs must include information on how to apply for additional financial assistance

- ✓ That the patient may apply for further financial assistance
- ✓ How a patient may request and receive a financial assistance application and assistance in completing it
- ✓ That the patient is eligible to apply for financial assistance for at least 240 days following the first billing statement or 12 months after the patient pays for services, or any additional time period beyond these minimums that the hospital financial assistance policies specify.

Provide specific, direct phone numbers, email addresses, and web links whenever possible. Avoid general numbers, inboxes and websites.

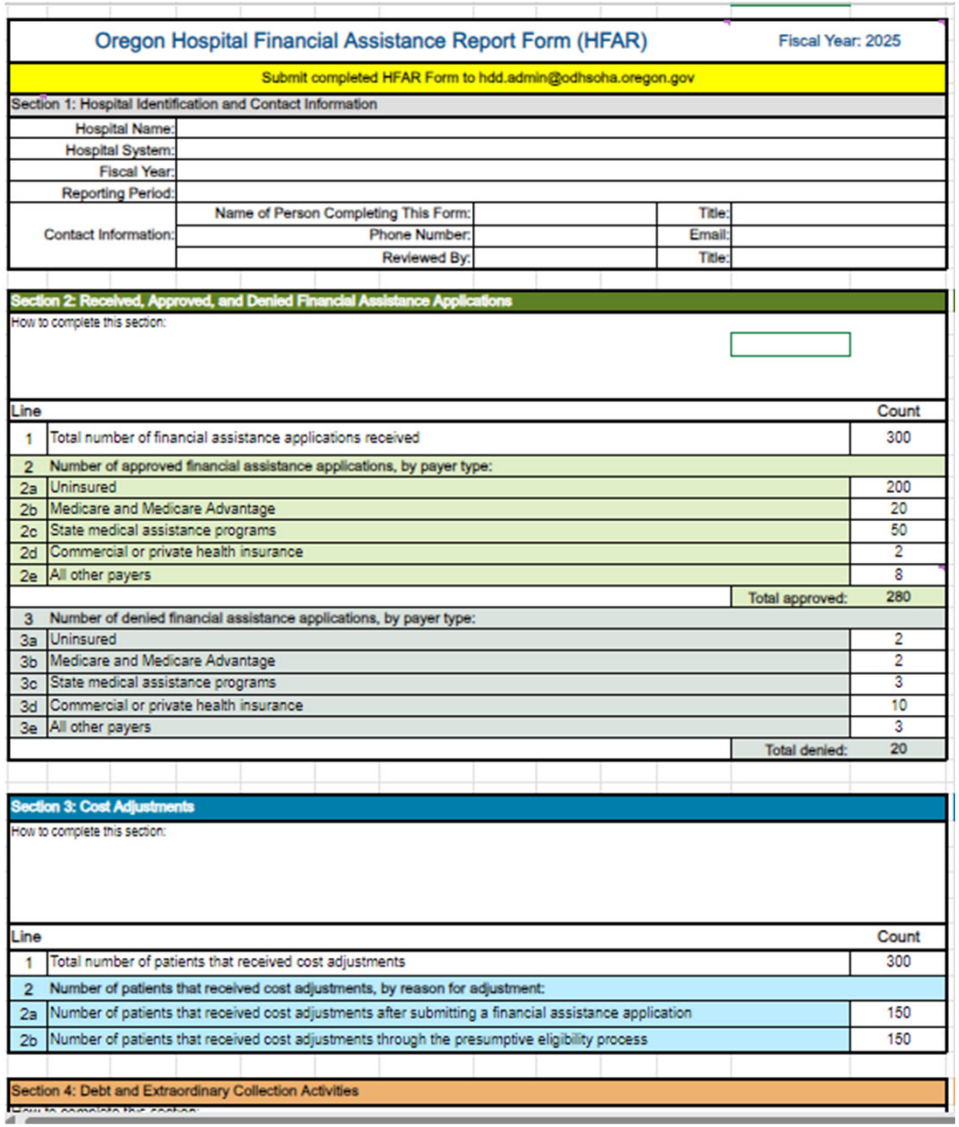
Data Reporting

Effective January 1, 2025

HFAR form

OHA has drafted the new form Hospital Financial Assistance Report (HFAR) and will publish the final HFAR by **September 30, 2024**.

The reportable fields are determined by law, but are there any thoughts OHA should consider while the HFAR is still in draft form?



Oregon Hospital Financial Assistance Report Form (HFAR) — Fiscal Year: 2025

Submit completed HFAR Form to hdd.admin@odhsoha.oregon.gov

Section 1: Hospital Identification and Contact Information

Hospital Name:				
Hospital System:				
Fiscal Year:				
Reporting Period:				
Contact Information:	Name of Person Completing This Form:		Title:	
	Phone Number:		Email:	
	Reviewed By:		Title:	

Section 2: Received, Approved, and Denied Financial Assistance Applications

How to complete this section:

Line		Count
1	Total number of financial assistance applications received	300
2	Number of approved financial assistance applications, by payer type:	
2a	Uninsured	200
2b	Medicare and Medicare Advantage	20
2c	State medical assistance programs	50
2d	Commercial or private health insurance	2
2e	All other payers	8
	Total approved:	280
3	Number of denied financial assistance applications, by payer type:	
3a	Uninsured	2
3b	Medicare and Medicare Advantage	2
3c	State medical assistance programs	3
3d	Commercial or private health insurance	10
3e	All other payers	3
	Total denied:	20

Section 3: Cost Adjustments

How to complete this section:

Line		Count
1	Total number of patients that received cost adjustments	300
2	Number of patients that received cost adjustments, by reason for adjustment:	
2a	Number of patients that received cost adjustments after submitting a financial assistance application	150
2b	Number of patients that received cost adjustments through the presumptive eligibility process	150

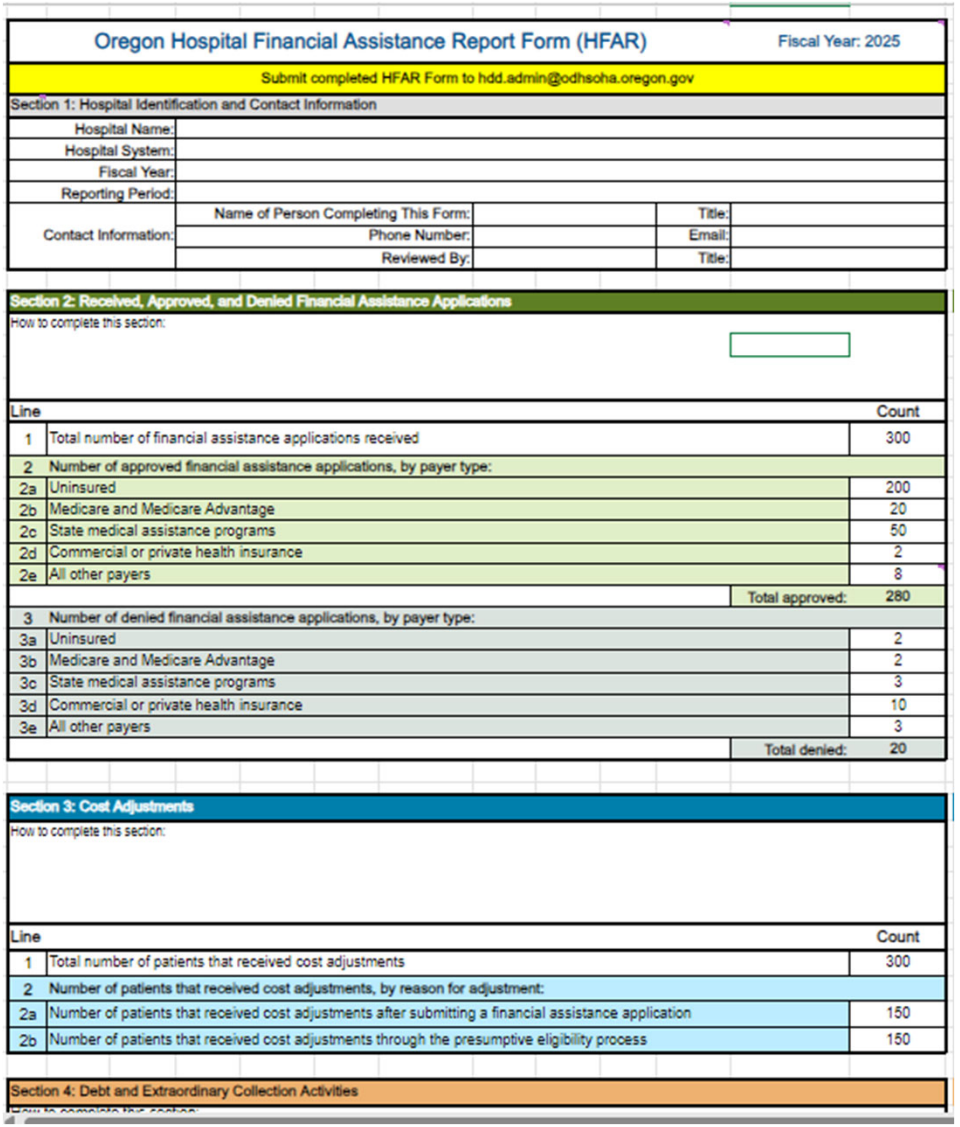
Section 4: Debt and Extraordinary Collection Activities

HFAR form

Hospitals will begin reporting for **fiscal years starting on or after January 1, 2025**.

HFAR is due **no later than 150 days after the close of the fiscal year**.

Call for hospitals to pilot test the form.



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Section 4: Debt and Extraordinary Collection Activities

Data reporting elements

Hospitals will publicly report on:

- Total # of financial assistance applications received, approved and denied by payer type.
- Total # of patients who received cost adjustments with and without completing a financial assistance application.
- Total # of patient accounts referred to a debt collector or collection agency.
- Total # of patient accounts in which extraordinary collection activities occurred, listed by 26 C.F.R. 1.501(r)-6(b) category.
- Average and median per-person debt, and total amount of debt owed by patients whose accounts were in collections or referred to a collection agency.

Resources

Answers to questions from the webinar

- There is no provision for opting out of prescreening.
- Patients are required to share their third-party payer information and use available third-party payers. If they refuse to do so, then financial assistance can be denied.
- If insurance premiums are not paid or insurance payments are requested to be refunded to the insurer, the patient is treated as uninsured and financial assistance is applied.
- Financial assistance requirements apply to Oregon residents.

Remember to always consult your in-house legal counsel.

Troubleshooting together

Open forum for hospitals to share challenges and successes in implementing the new laws.

If your hospital had challenges or complaints, share whether they are one-offs or repeat issues.

If your hospital has advice to share in response to another hospital, please speak up!

Resources

Oregon Health Authority Hospital Reporting Program website, under Hospital Financial Assistance

Steven Ranzoni Steven.Ranzoni@OHA.Oregon.Gov

Sarah Grabe Sarah.Grabe@OHA.Oregon.Gov

General Program Inbox HDDAdmin@DHSOHA.Oregon.Gov

Oregon Administrative Rules 409-023-0100 to 0125

Sub-regulatory Guidance on Financial Assistance Applications

HB 3320 Implementation Webinar for HAO Slide Deck

Open forum for Q&A

Public comment period

Thank You

Oregon Health Authority