Oregon Association of Hospitals and Health Systems

March 27, 2019

Oregon State Legislature
House Committee on Health Care
900 Court St. NE
Salem, OR 97301

Re: House Bill 3076 – OAHHS Opposes

Chair Salinas and members of the House Health Care Committee:

On behalf of Oregon's 62 community hospitals and the patients they serve, the Oregon Association of Hospitals and Health Systems (OAHHS) **opposes House Bill 3076.** As introduced, HB 3076 threatens the critical role hospitals play in communities and does not reflect the year-long stakeholder process to modernize Oregon's hospital community benefit programs.

The broad and sweeping new requirements expected of hospitals and health systems not only does not reflect the stakeholder process, it also does not acknowledge the significant amount of expertise and resources this new process would require.

Components of this bill will put critical services in jeopardy and could potentially create unintended negative consequences for community programs aimed at improving the health of our communities.

OAHHS and its members have acknowledged that as the health care landscape has changed there is a need to adjust how we interact with our patients and their families. For this reason, we proposed and helped pass HB 4020 in 2018 to standardize communications around financial assistance policies for all hospitals. We began the stakeholder process on community benefit with that same mindset, but unfortunately, the product you have in front of you does not reflect any of the conversations.

Standardizing how charity care policies, as a component of the state's Community Benefit program, are applied is a policy concept we proactively addressed with the stakeholder workgroup. This legislative concept would ensure there is no wrong door for low-income patients in seeking care. Unfortunately, the introduced version of HB 3076 under consideration today does not reflect any of the conversations. Instead it includes many policy elements that jeopardize business operations, facility licensing or interfere with federal regulations, which could create additional regulatory compliance challenges for the state down the road.

Below you will find:

- An overview of federal requirements for hospitals;
- The current state of community benefit in Oregon;
- Our objections to specific provisions of this bill; and
- Hospitals' policy proposals relating to this topic which were not included in this bill.

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AFFORDABLE CARE ACT – FEDERAL REQUIREMENTS OF TAX-EXEMPT HOSPITALS

To fully grasp the ways HB 3076 threatens the viability of hospitals, it is important to recognize federal requirements under the Affordable Care Act (ACA) for tax-exempt hospitals. The ACA materially changed the requirements hospitals must meet to obtain or maintain tax-exempt status under 501(c)(3). The ACA created Section 501(r) in the Internal Revenue Code, which requires each tax-exempt hospital facility to[i]:

- Conduct a community health needs assessment (CHNA) every three years
- Adopt an implementation strategy to meet the needs identified through the CHNA
- Establish a written financial assistance policy (FAP) that includes eligibility criteria and the method for applying for financial assistance
- Establish a written emergency medical care policy that requires the provision of care for emergency medical conditions regardless of eligibility for financial assistance
- Limit amounts charged for emergency or other medically necessary care provided to individuals eligible for financial assistance to not more than amounts generally billed to insured patients
- Refrain from engaging in extraordinary collection actions before making efforts to determine whether individuals are eligible for financial assistance

Community Health Needs Assessment and Implementation Strategies – 501(r)(3)

Hospitals define 'community' based on the geographic area and target populations (e.g., children, women, older adults) served by the hospital facility, and on the hospital's principal functions (e.g., specialties). In defining community, hospitals may not exclude medically underserved, low-income, or minority populations, and must consider all patients regardless of payer source and eligibility for financial assistance.

The CHNA must identify significant health needs, prioritize those needs, and identify resources potentially available to address them. Hospitals must solicit and consider input received from:

- At least one governmental public health department
- Representatives of medically underserved, low-income, and minority populations
- Written comments received on the most recently completed CHNA and most recently adopted implementation strategy

The CHNA report must be adopted by an authorized body, such as a board of directors. It must identify the community and how it was determined, describe the process and methods used to conduct the CHNA, describe how the hospital solicited and took into account community input, include a prioritized description of significant community health needs, describe resources potentially available to address those needs, and include an evaluation of any actions taken to address needs since the hospital conducted its immediately preceding CHNA. The report also must describe data used in the assessment and how the data were collected and analyzed, identify any collaborators and contractors that were involved, and explain the process and criteria used in identifying and prioritizing significant needs.

CHNA reports must be posted on a website and paper made copies available upon request. Each hospital must prepare a separate CHNA report, but a joint CHNA report is allowed under certain conditions: All collaborating hospitals must be identified in the report, and the same community must be defined for all the hospitals. CHNA reports for hospitals collaborating with other facilities or organizations may contain substantively identical material regarding overlapping areas.

The required implementation strategy is a written plan that describes how the hospital intends to address each significant health need identified through the CHNA. For each identified health need, the implementation strategy must describe actions the hospital intends to take and their anticipated impact, identify resources the hospital plans to commit to address the need, and describe any planned collaborations to address the need. The implementation strategy also must identify any significant needs the hospital does not intend to address and provide a brief explanation regarding why not. Implementation strategies are public documents to be attached to IRS Form 990 or posted on a website (or both).

Financial Assistance Policy (FAP) Regulations – 501(r)(4)

Each tax-exempt hospital must establish a written FAP that applies to all emergency and medically necessary care. The policy must be adopted by an authorized body and include:

- All eligibility criteria that an individual must satisfy to receive each type and level of financial assistance (i.e., all available discounts and free care)
- Whether and how the hospital uses any information from sources other than the applicant to grant financial assistance on a presumptive basis
- A list of any providers delivering care in the hospital facility (other than the hospital facility itself) that specifies which are covered by the FAP and which are not
- A statement that eligible individuals will not be charged more for emergency or other medically necessary care than amounts generally billed to insured individuals
- A statement that the hospital will not apply gross charges to FAP-eligible individuals
- A description of how an individual applies for financial assistance
- Hospital contact information for obtaining assistance with the application process
- A description of actions the hospital or an authorized party may take in the event of nonpayment, unless those actions are described in a separate billing and collections policy
- An explanation of how individuals may obtain a copy of the billing and collections policy, if collections actions are described that policy

Hospitals must widely publicize the FAP in the following ways:

- Making the FAP, the application, and a plain-language summary available on a website
- Making paper available upon request, in public locations, and by mail
- Notifying and informing hospital patients about the FAP by offering a paper copy of the plain language summary as part of the intake or discharge process, including written notice on billing statements and public displays about the availability of financial assistance in public locations in the hospital
- Notifying and informing members of the community served by the hospital about the FAP

The FAP, application form, and plain language summary must be translated for populations with limited English proficiency (for any group that constitutes the lesser of 1,000 individuals or 5 percent of the community served or likely to be affected or encountered by the hospital facility).

Regulations that Limit Charges to FAP-Eligible Individuals – 501(r)(5)

Hospitals must limit the amounts charged to FAP-eligible individuals for emergency or other medically necessary care to no more than amounts generally billed to insured patients, and to less than gross charges for all other medical care. Hospitals may choose between the "look-back" method and the "prospective Medicare/Medicaid" method for calculating charges.

Billing and Collections Regulations – 501(r)(6)

Hospitals may not engage in extraordinary collection actions against an individual before making reasonable efforts to determine whether the individual is FAP-eligible. Extraordinary collection actions include:

- Taking actions that require legal or judicial process (liens, foreclosures, garnishments, seizure of bank accounts or property, civil action, arrest, body attachment)
- Reporting adverse information to credit agencies or bureaus
- Deferring or denying (or requiring a payment before providing) medically necessary care because of nonpayment for previously provided care that is covered under the FAP

BENEFIT OF TAX-EXEMPT STATUS

Tax exemptions are valuable to hospitals and the communities they serve. Unlike for-profit hospitals, tax-exempt hospitals retain any earnings as community assets, rather than having these recourses paid out as returns on investment. Tax-exempt hospitals invest these resources in fulfilling their missions and in honoring the reasons why they were established in the first place. Tax exemptions allow hospitals to receive philanthropic donations that may bolster or maintain essential programs and leverage resources for clinical and community research.

In fulfilling their missions, tax-exempt hospitals:

- Absorb financial losses when taking care of low-income people through financial assistance programs and Medicaid services
- Provide programs and grants focused on community health improvement
- Offer specific clinical programs at financial loss (e.g., substance abuse, mental health, trauma programs) because communities need them, and
- Devote resources to health professional education and research.

COMMUNITY BENEFIT IS MORE THAN CHARITY CARE

Community benefit is catch-all term for a variety of robust activities and regulations, as demonstrated above, that range from community health needs assessments to billing and collections regulations. At the heart of community benefit is a mission-driven commitment to communities.

In 2017, Oregon's community hospitals provided **$2.32 billion in community benefit activities**. In the same year hospitals experienced 347,000 inpatient stays, 1.4 million emergency department visits, 11.8 million outpatient visits and welcomed 42,000 new babies to the world.

In addition to federal ACA and Internal Revenue Service reporting requirements, community benefit is reported annually to the Oregon Health Authority (OHA) (HB 3290 (2007)) in the following categories:

- **$196 million in charity care**: free or discounted health services provided to people who cannot afford to pay and who meet the eligibility criteria of the hospital's financial assistance policy; does not include bad debt or discounts to self-pay patients
- **$1.6 billion in underpayment**: the shortfall created when a hospital receives payments that are less than the cost of caring for patients on Medicaid, Medicare, State Children's Health Insurance Program (CHIP) and other public programs
- **$43 million in community health improvement services**: activities that improve community health based on an identified community need, including but not limited to support groups, health screenings, transportation services, and smoking cessation; does not include education that is part of a patient care plan or employee wellness programs
- **$63 million in research**: clinical and community health research, as well as studies on health care delivery, that are shared outside the hospital; does not include market research or research that yields propriety knowledge
- **$216 million in health professions education**: educational programs that are available to physicians, medical students, interns, residents, nurses and nursing students, and other health professionals that are not available exclusively to the hospital's employees
- **$74 million in subsidized health services:** clinical service lines that would not be available in the community if the hospital stopped providing them, including but not limited to air ambulance, neonatal intensive care, burn units, mobile units, or palliative care
- **$30 million in cash and in-kind contributions**: funds and services donated to the community, including contributions to nonprofit community organizations, grants, or meeting room space for nonprofit groups
- **$11 million in community building activities**: programs that are not directly related to health care, but provide opportunities to address root causes of health outcomes such as poverty, homelessness, and environmental problems; does not include facility construction or costs associated with housing for employees
- **$6 million in community benefit operations**: costs associated with staffing and coordinating the hospital's community benefit activities

HOSPITALS OBJECTIONS TO HB 3076

As introduced, HB 3076 creates complexity and proposes to set arbitrary policy to an already heavily regulated component of hospital operations. Specifically, the following are just a few of the sections of critical concern for our members.

Section 1 – Financial assistance provisions for up to 600% FPL
HB 3076 requires financial assistance discounts for up to the 600% federal poverty level population. This could lead to negative unintended consequences of people forgoing coverage altogether to rely on hospital financial assistance, bringing the health care system back to a pre-ACA reality with less people covered.

Section 2 – Debt collection and billing requirements
As described above, the ACA provides robust guidance on debt collection and billing activities for hospital financial assistance policies. Specifically, hospitals must refrain from engaging in extraordinary collection actions before making reasonable efforts to determine financial assistance eligibility.

Section 3 – Community health need assessment requirements
Section 3 is duplicative of federal requirements for community health needs assessments (as described above) and includes an out-of-scope reporting requirement for governing body information.

Section 4 – Community benefit spending floor
The spending floor concept poses immense risk to hospitals and communities as community benefit programs are tailored to community needs. Section 4 gives OHA the authority to set arbitrary spending goals for each hospital. If the floor is not met, the Attorney General may revoke nonprofit status and deny tax deductions for donations to the hospitals.

Section 5 – Clinic-level reporting
Requiring hospitals and health systems to report at the facility-level would be administratively complex not just for reporting but would likely require custom methodology depending on the hospital or system based on their own financial and accounting systems.

OAHHS POLICY PROPOSALS
The hospital community underwent a significant policy development process during the interim that culminated in three key policy areas that support transforming the way hospitals meet the needs of their patients and families. These three areas were offered for discussion at the workgroup but not included in HB 3076.

- **HOSPITAL-AFFILIATED CLINICS:** Hospitals offered to require not-profit hospital-affiliated clinics have a financial assistance policy that meet the recently passed requirements under HB 4020 (2018): plain language, adequate notification, public displays
- **CHARITY CARE STANDARD:** Hospitals offered to require policies cover emergency and medically necessary services, in full, for patients with a household income at or below 200% of the federal poverty level, as payer of last resort, inclusive of not-profit hospital-affiliated clinics

- **COMMUNITY BENEFIT REPORTING:** Hospitals offered to require hospitals identify activities and expenditures that address the social determinants of health; remove losses related to Medicare as a reportable community benefit category

CNHAs, SPENDING TARGETS, BILLING AND COLLECTIONS

Understanding that policy related to community needs assessments, community benefit spending, billing and collections occurs at the federal and local level, OAHHS has proposed several iterations of an OHA committee model to accomplish portions of policy work from this bill with the following accountabilities:

- Study and recommend best practices for financial assistance policy discounts, billing and collections including specific recommendations like the best practice approach from other successful legislation;
- Develop a method, or methods, to evaluate the impact of community benefit programs in communities considering different approaches that aim to enhance community benefit programs ability to improve population health;
- Evaluate the impact community benefit programs have on access, health outcomes, health disparities and health equity, response to community need, collaboration with community partners and how investments align with Community Health Improvement Plans.

Unfortunately, these concepts did not make it into the introduced version of the bill. OAHHS and member hospitals stand committed to work on this concept but urge you to oppose the introduced version of HB 3076 and any version that threatens the health of community hospitals serving to improve the health of its communities.

Thank you,

Sean Kolmer
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Oregon Association of Hospitals and Health Systems

[i] Hearle, Keith. "Responding to final 501(r) regulations for tax-exempt hospitals: requirements in the newly released rules will have major impacts on community health needs assessments and on policies relating to financial assistance, emergency medical care and billing and collections." Healthcare Financial Management, April 2015, p.84.