

Community Benefit Minimum Spending Floor Development Whitepaper

Background

House Bill 3076 (2019) introduced significant changes to hospital community benefits policy. The bill created new standards for financial assistance to patients, limited medical debt collection and interest, instituted new data reporting requirements, and introduced a new community benefit minimum spending floor program. Under the spending floor program, the Oregon Health Authority (OHA) must every two years set the minimum amount each hospital must spend on community benefits. The legislature directed OHA to develop a methodology for determining this spending floor in consultation with hospitals, health care economists, and the general public.

Methodology Requirements

The bill allows hospitals to choose the grouping the spending floor is applied to, including but not limited to:

- Each individual hospital and all the hospital's nonprofit affiliated clinics
- A hospital and a group of the hospital's nonprofit affiliated clinics
- All the hospitals that are under common ownership and control and all of the hospitals' nonprofit affiliated clinics

The bill further requires OHA to consider several factors when developing the spending floor, including but not limited to:

- Historic and current community benefit expenditures by the hospital and the hospital's affiliated clinics.
- Demographics of the population served
- Spending on social determinants of health by the hospital and affiliated clinics
- Identified community needs
- The hospital's need to expand the health care workforce

- The overall financial position of the hospital and affiliated clinics based on audited financial statements
- Taxes paid to federal, state, or local municipalities

OHA is required to apply the spending floor every two years. However, the bill does not specify whether the spending floor must be the same for both years or calculated separately for each of the next two years. OHA is opting for the latter approach and calculating the spending floor for each year, two years at a time.

Methodology Guiding Principles

In developing the minimum spending floor methodology, OHA adopted several guiding principles that go beyond the direct requirements of the bill. These principles were informed through conversations with key stakeholders and legal analysis of the bill. One such principle is that “minimum” really means “minimum.” All hospitals should exceed their minimum spending floor, and the spending floor should not be a disincentive for hospitals with robust spending to maintain those levels. OHA considered adopting a methodology that codified that principle by requiring hospitals to expend community benefit amounts that equaled or exceeded historic practice. Instead, OHA proposes a methodology that achieves a similar end, but with greater transparency, nuance and responsiveness to financial trends. For example, the methodology:

- Links the minimum spending floor to operating margin. Hospitals in robust financial health (as defined in the methodology, below) will have their spending floor adjusted upward, even if they are already making strong community benefit investments. Hospitals that are financially struggling will have their spending floor adjusted downward.
- Breaks out hospitals’ spending on direct community benefit services -- such as spending to address the social determinants of health and health equity – from their unreimbursed care obligations and expects greater spending from urban hospitals than rural. This more granular approach also allows for fine-tuning when there are fluctuations in the need for unreimbursed care.
 - While hospitals can meet their spending floor through spending on any on any of the ten categories mentioned below, the methodology reflects the

importance of both types of spending by breaking out unreimbursed care from direct spending when calculating the overall spending floor.

- Is responsive to fluctuations in net patient revenue. The community benefit spending floor adjusts up or down in response to prolonged trends in revenue.

The methodology is also guided by the following principles:

- Comprehensive. Spending against the established floor will include all 10 categories of community benefit spending recognized by Oregon statutes including financial assistance spending categories such as charity care and Medicaid.
- Prospective defined amount. The spending floor is a known dollar amount given at the start of the fiscal year.
- No new data reporting systems. While some new data points are required, OHA will continue to utilize the Community Benefit Reporting (form CBR-1) and the Audited Financial Report (form FR-3).
- Simple and scalable. The formula should be objective and straightforward. All hospitals should be able to readily calculate their own minimum spending floor for each spending cycle.
- Flexible. Processes will be established to allow for modifications needed by hospitals experiencing financial challenge or significant changes in circumstance.
- Does not create negative trends. The formula should not negatively affect community benefit trends or be incentive to reduce spending.

Spending floor Methodology

OHA will use the following formula for assigning the Community Benefit Minimum spending floor for the two-year cycle of 2022-2023:

Year 1 spending floor = **3-year average of unreimbursed care spending** + (**Direct Spending Net Patient Revenue Percentage** x **3-year average operating margin multiplier**)

Year 2 spending floor = **Year 1 spending floor** + (**Year 1 spending floor** * **4-year average percent change in net patient revenue, capped at +/- 10%**)

Where:

Three-year average of unreimbursed care is the arithmetic mean of the sum of unreimbursed Medicaid net costs, charity care net costs, other public programs net

costs, and subsidized health services net costs for the most recent three years reported to OHA on the CBR-1 form.

Direct Spending Net Patient Revenue Percentage is a percentage of the most recently reported net patient revenue amount on form FR-3. The percent amount is based on hospital type. For DRG hospitals, the amount is 1.5% of net patient revenue, for Type A and Type B hospitals it is 1.0% of net patient revenue.

Three-year average operating margin multiplier is a multiplying factor applied to the direct spending net patient revenue portion of the formula based on the arithmetic mean of the three most recently reported operating margins, expressed as a percentage of operating revenue, as reported to OHA on form FR-3. The factors are:

- 1.05 for three-year average operating margins of 6% or more
- 1.0 for three-year average operating margins between 3% and 6%
- 0.9 for three-year average operating margins between 0% and 3%
- 0.8 for three-year average operating margins between -2% and 0%
- 0.75 for three-year average operating margins less than -2%

Four-year average percent change net patient revenue is the arithmetic average of year over year change in net patient revenue for the most recent 4-year period. The percent change adjustment is capped at + or – 10%.

In the case of the two for-profit hospitals in Oregon, the spending floor shall be the remaining amount after subtracting the net sum of state income and property taxes paid in the most recent tax year.

Spending Floor Process Outline

OHA will establish the formula for annual spending floors in two-year cycles. For example, beginning in January of 2021, OHA will assign a spending floor for hospitals' 2022 and 2023 fiscal years. The formula for the 2022-2023 cycle will generate a specific spending floor for each year. In January of 2023, a new cycle will be initiated. Hospitals will have the opportunity to change their choice of organizational structure for the methodology and the formula established for the next two-year cycle will generate specific spending floors for 2024 and 2025 for each hospital.

An issue arises in that hospital fiscal years vary in Oregon, with five different years in use. Fiscal year 2022 starts as early as April 1st, 2021 with additional start dates on May 1st, July 1st, October 1st, and finally January 1st, 2022.

OHA will define its spending floor cycles in terms of when OHA performs the administrative work that supports assigning the spending floor. A two-year spending floor cycle starts on January 1st of an odd number year and ends on December 31st of an even number year. For example, the first spending floor cycle will begin January 1, 2021 and end December 31st, 2022. In that cycle, spending floors for hospital fiscal years of 2022 and 2023 are assigned on April 1st, May 1st, July 1st, October 1st and January 1st. The next cycle will start January 1, 2023, assigning spending floors to fiscal years 2024 and 2025, and so forth.

The general two-year process is summarized as follows:

Step 1: OHA publicizes the spending floor formula by January 1st of every odd numbered year and notifies hospitals of any changes to the formula from previous spending floor cycles.

Step 2: Hospitals or Health systems notify OHA of their elected organizational grouping(s) 90 days prior to the start of their fiscal year in the first year of the two-year spending floor cycle.

Step 3: OHA computes the spending floor and provides it to the hospital or health system 60 days prior to the start of their fiscal year

Step 4: The hospital or health system has 30 days to notify OHA if they wish to challenge the spending floor based on projections or information that indicates a significant change in trend from the computed three-year average, or if projections or other information indicate the hospital or health system would experience significant hardship achieving the minimum spending amount.

Step 5: OHA accepts or rejects a request to modify the spending floor and finalizes the floor no later than the first day of the hospital or health system's fiscal year.

Step 6: At the close of the first fiscal year, OHA and the hospital and health system may review recent trend data and other information and adjust the year 2 amount, if necessary.

Step 7: OHA collects feedback, consults with stakeholders, and reviews performance of the spending floor formula, updating as necessary.

Reporting on Community Benefit Spending

OHA produces a report on Community Benefit Spending every year. OHA will include spending reported by each hospital against its spending floor in this report and envisions highlighting the following types of spending as the data becomes available:

1. Reporting all hospitals' actual spending in comparison to their minimum floors
2. Highlighting spending that is significantly above the hospital's spending floor
3. Highlighting spending on community level spending, particularly spending that addresses community need identified in partnership with CCOs and/or local public health

Formula Modelling Results

The spending floor was modelled using historic community benefit spending data. Data for 2015-2017 was used to assign a floor to compare with actual spending in 2018. The formula assigned a spending floor that was an average of 90% of actual 2018 community benefit spending, and a median of 81% of actual spending. In 2018, 13 (22%) of hospitals had actual spending lower than the assigned floor.

The formula has a notable outlier in the case of Oregon Health Sciences University, due primarily to the disproportionately high amount of health professions education and research spending compared with other hospitals. The formula sets a spending floor nearly \$150 million below actual spending in 2018. It is reasonable that OHA should make special modifications for OHSU, due to its status as the only public academic medical school in the state, and as a hospital that does nearly double the patient service of the next-largest hospital.

The impact of the COVID-19 pandemic on net patient revenue is a concern. Net patient revenue was forecasted for 2019 through 2023 using 2011-2018 data to fit a linear forecasting model. A variety of assumptions for the drop in 2020 net patient revenue were tested to determine if a short-term drop produces an unintentional downward adjustment of the spending floor in 2023 or 2025. The 4-year average of net patient revenue can absorb significant year over year drops in net patient revenue, up to approximately 20% statewide, if at least partial recovery to predicted trends occurs in the following years. If net patient revenue does not return to trend, the year 2 adjustment does run the risk of decreasing from the year 2 amount, however, it is likely that such a downward adjustment would be appropriate because the true trend in net patient revenue was decreasing.

Formula Limitations

The key limitation of the formula is it relies on historic trend data for spending that lags by two years. As a result, the formula cannot account for sudden spikes in spending either up or down. When modelling the formula against historic data, hospitals that failed to meet the spending floor all had sharp drops in unreimbursed spending compared to previous year's trends. Likewise, hospitals that greatly exceeded the spending floor amount had significant increases. The Affordable Care Act introduced significant disruptions to the ongoing trends of unreimbursed care spending hospitals, in many cases drastically reducing the amount of unreimbursed care expenditures. This trend disruption reinforces the need to have a manual review of the data, and reasonably adapt to spikes or drops in the data.

The operating margin multipliers could be drawn from more current data sources to blunt the effect of older spending data, if the organizational grouping allows. As referenced above, hospitals will also have the opportunity to challenge assigned minimum spending floors by introducing projections or information that indicates a significant change in trend from the computed three-year average (see Step 4 in the Process Outline).