August 6, 2025

We will get started in a few minutes

Please make sure you are muted

Chat or email us if you have technical issues

Welcome!

OREGON HEALTH AUTHORITY

August 6, 2025

2025 Hospital Community Benefit Summit

Meeting Functionality

Remain muted when not speaking

When possible, use the “raise hand” function under “reactions” to be recognized prior to speaking

Introduce yourself, your organization, and your pronouns before you speak

Turn on your camera when speaking

Chat is monitored, questions will be addressed along the way and at the end

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 **chat 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
2 – 2:15 p.m.	Introduction	Sarah, Clare
2:15 – 2:25 p.m.	Form due dates	Sarah
2:25 – 2:45 p.m.	FY23 data	Sarah
2:45 – 2:50 p.m.	Community benefit in the news	Sarah
2:50 – 3 p.m.	Break	
3 – 3:05 p.m.	HB 3320 implementation	Steven
3:05 – 3:20 p.m.	HFAR guidance	Steven
3:20 – 3:40 p.m.	HB 3320 discussion	All
3:40 – 4 p.m.	Q & A, public comment	All
4 p.m.	Adjourn	

Who are we?

OHA staff introduction

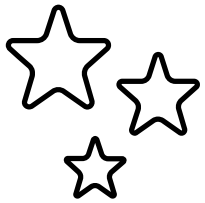
Clare Pierce-Wrobel	Piper Block	Steven Ranzoni	Sarah Grabe	Rachel Higgins	Tiffany Goetz
• Health Policy & Analytics Division Director	• Research and Data Unit Manager	• Hospital Reporting Program Manager and Policy Advisor	• Hospital Community Benefit Program Coordinator	• Community Benefit Research Analyst	• Hospital Reporting Program Analyst

Meeting purpose

Annual community benefit summit

Purpose of the meeting

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



We want to move community benefit toward purposeful, planned programs that address health needs through SDOH and health equity.

Opening remarks

Clare Pierce-Wrobel, HPA Division Director

OREGON HEALTH AUTHORITY

Community benefit forms, documents and due dates

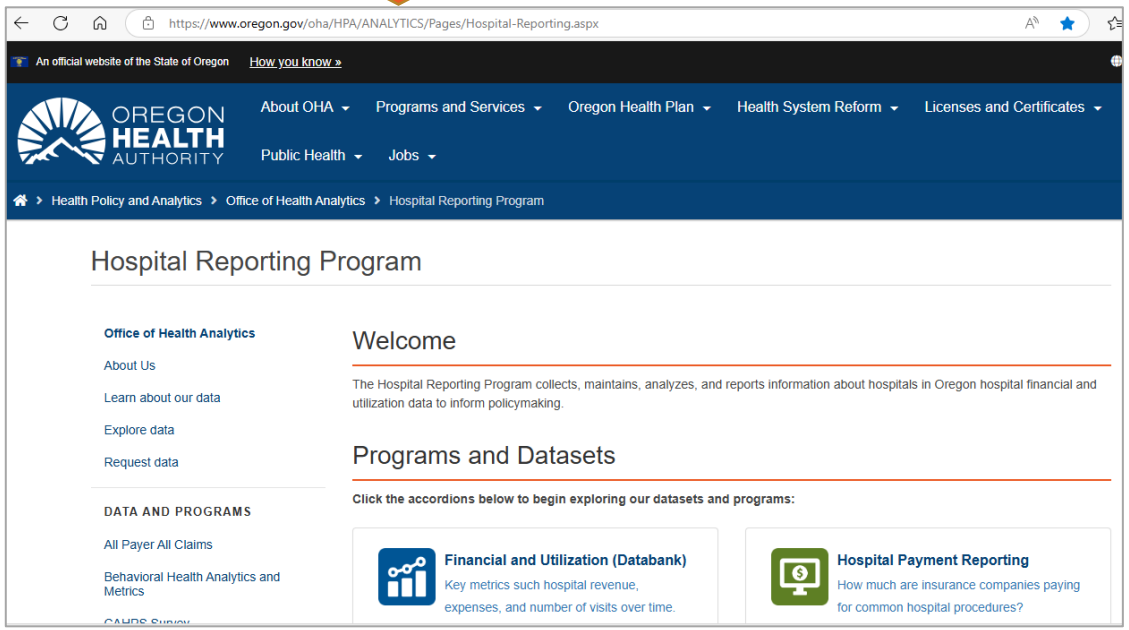
Forms and documents

- Audited Financial Statement (**AFS**)
- Capital Projects Reporting (**CPR-1**) Form
- Financial Report 3 (**FR-3**) Form
- Community Benefit Report 1 (**CBR-1**) Form
- Narrative Report
- Community Health Improvement Plan (**CHIP**)
- Community Health Needs Assessment (**CHNA**)
- Community Benefit Report 3 (**CBR-3**) Form
- Hospital Facility and Clinic Report (**HFCR**) Form
- Hospital Financial Assistance Report (**HFAR**) Form
- Notification of Community Benefit Minimum Spending Floor (**MSF**) and calculations

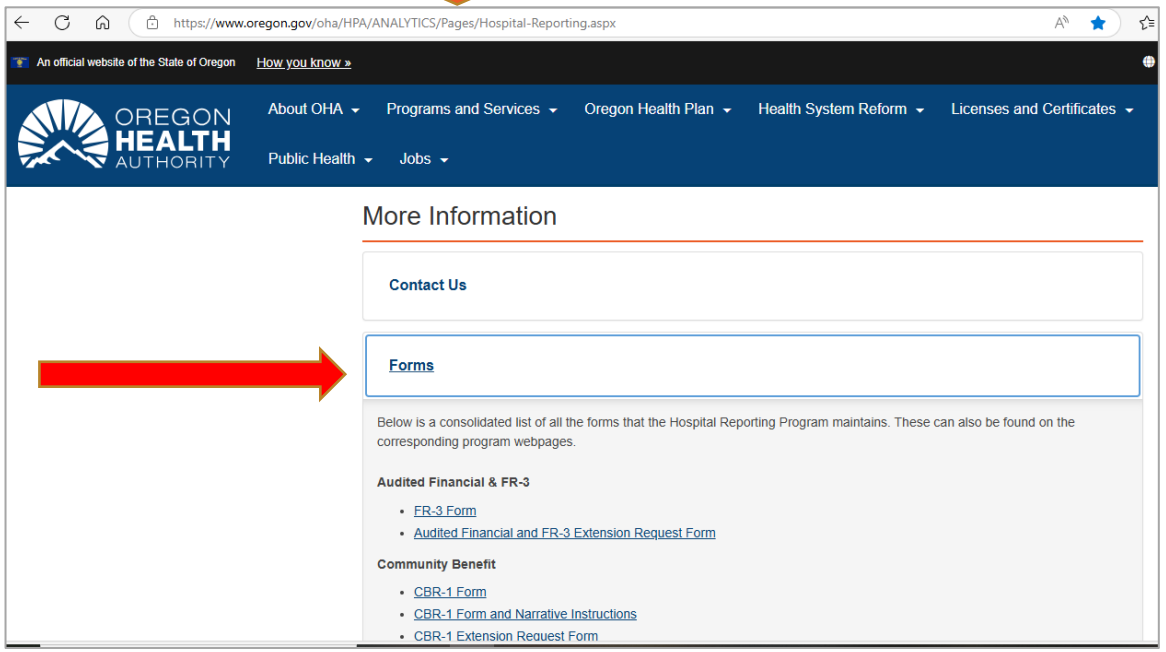
The “Forms” section of the Hospital Reporting Program webpage is where the blank forms and/or extension requests can be obtained. The Hospital Profiles / Index webpage provides short descriptions of these hospital documents and more.

Where to find community benefit forms

On the OHA hospital reporting program website



Scroll to the bottom of the main page
Under “More information”
“Forms”



Anatomy of hospital reporting reminders

CBR-1 +

Due date is group (fiscal year) specific

Link to the form available from the Hospital Reporting webpage.

(Note: all links are rechecked before the reminder email is sent to ensure the most recent version of the form is provided.)

Top part = the specific message

Link to the Oregon Administrative Rule

Greetings,

This is a reminder that the following FY# Community Benefit documents are due on MM/DD/YYYY, per OAR 409-023-0105:

1. Community Benefit Report 1 (**CBR-1 Form**)
2. Community Benefit **Narrative** (instructions are on the first tab of the CBR-1 and on page 17 of the CBR-1 and Narrative instructions)
3. Community Health Needs Assessment (**CHNA**)
4. Community Health Improvement Plan (**CHIP**)

Note: If the CHNA and CHIP are not separate documents, please note if submitted together as one document.

You may submit **all four** of your community benefit documents on or before the due date to the **Hospital Reporting email: HDD.Admin@odhsoha.oregon.gov.**

***

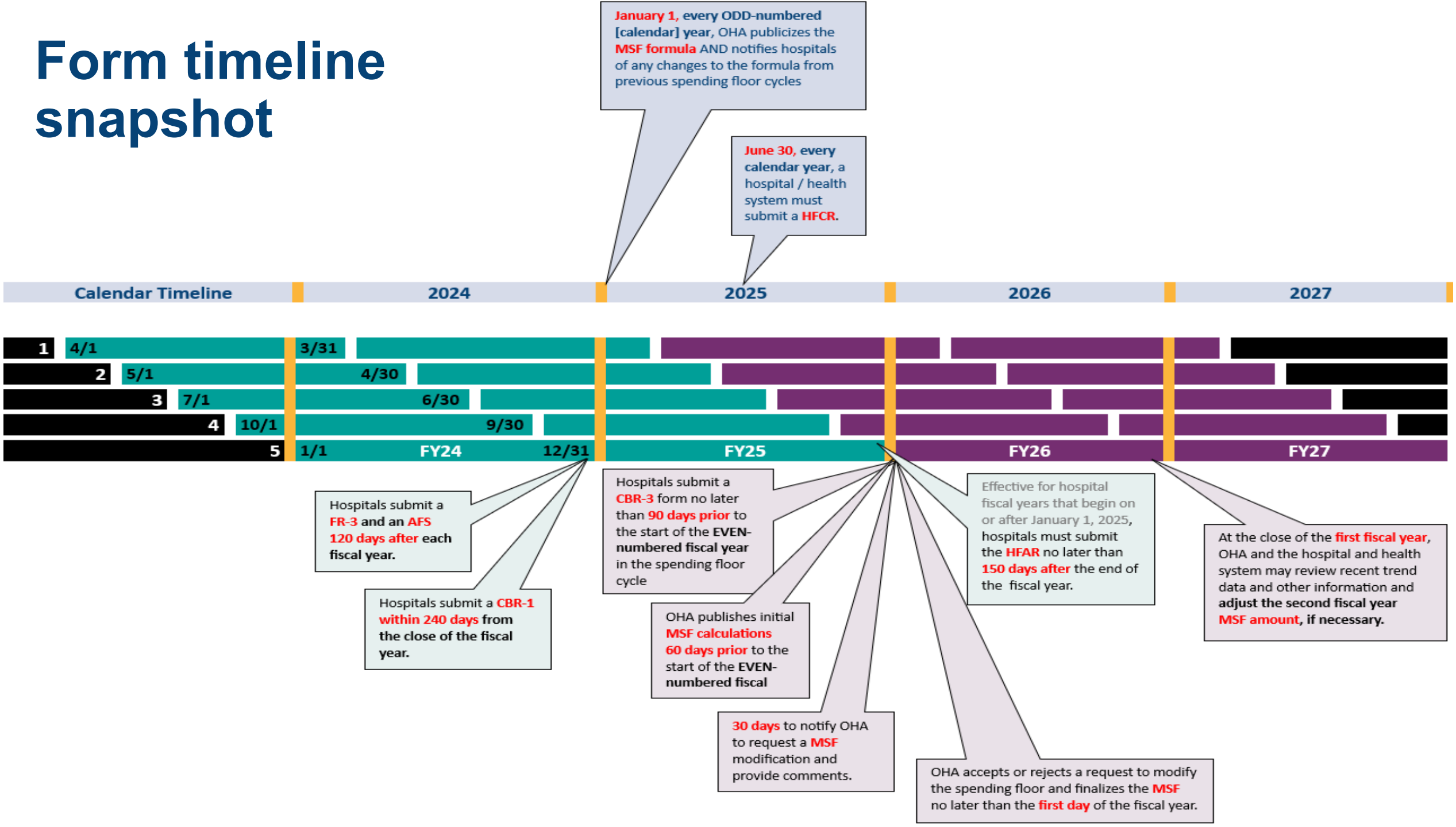
Note: The Hospital Profiles/Index webpage provides form descriptions for convenience. If more time is needed, please complete and return the CBR-1 Extension Request Form (linked here for your convenience). Extension requests, along with other forms, are located on our Hospital Reporting Program webpage (under "Forms"). If needed, please submit the extension request form and all other community benefit documents to the **Hospital Reporting email: HDD.Admin@odhsoha.oregon.gov**.

***

Form due dates

			FY26 Start - 90	FY25 End +120	FY25 End +150	FY25 End +240		FY26 End +120	FY26 End +150	FY26 End +240		FY28 Start - 90	FY27 End +120	FY27 End +150	FY27 End +240
			2025	FY25			2026	FY26			2027	FY27			
FY Start	FY End		HFCR	CBR-3 (odd years)	FR-3 & AFS	HFAR (new)	CBR-1 & Narrative & CHNA & CHIP	HFCR	FR-3 & AFS	HFAR (new)	CBR-1 & Narrative & CHNA & CHIP	HFCR	CBR-3 (odd years)	FR-3 & AFS	HFAR	CBR-1 & Narrative & CHNA & CHIP
4/1	3/31	Group 1	6/30/2025	1/2025	7/2025	N/A	11/2025	6/30/2026	7/2026	8/2026	11/2026	6/30/2027	1/2027	7/2027	8/2027	11/2027
5/1	4/30	Group 2	6/30/2025	1/2025	8/2025	N/A	12/2025	6/30/2026	8/2026	9/2026	12/2026	6/30/2027	1/2027	8/2027	9/2027	12/2027
7/1	6/30	Group 3	6/30/2025	4/2025	10/2025	N/A	2/2026	6/30/2026	10/2026	11/2026	2/2027	6/30/2027	4/2027	10/2027	11/2027	2/2028
10/1	9/30	Group 4	6/30/2025	7/2025	1/2026	N/A	5/2026	6/30/2026	1/2027	2/2027	5/2027	6/30/2027	7/2027	1/2028	2/2028	5/2028
1/1	12/31	Group 5	6/30/2025	10/2025	4/2026	5/2026	8/2026	6/30/2026	4/2027	5/2027	8/2027	6/30/2027	10/2027	4/2028	5/2028	8/2028

Form timeline snapshot



Minimum Spending Floor formula posting

MSF formula published January 1 of odd numbered calendar year (CY)

January 1 every odd numbered calendar year (CY), OHA publishes the **MSF formula AND notifies** hospitals of any changes to the formula from previous fiscal years (FY)

CY 2024	CY 2025	CFY 2026

FY 2025	FY 2026	FY 2027

Community Benefit Reporting Form - 3

CBR-3 form due 90 days prior to even numbered fiscal year (FY)

Hospitals submit a **CBR-3** form no later than **90 days prior** to the start of the **even numbered** fiscal year in the spending floor cycle

FY 2025	FY 2026	FY 2027

Proposed spending floors

Proposed spending floors sent 60 days prior to start of even fiscal year

OHA publishes **proposed MSF calculations** **60 days prior to the start of even numbered fiscal year**

Review and modify proposed spending floor

Hospitals have 30 days to request a change to the proposed spending floor

Hospitals have **30 days** to notify OHA to request a **MSF modification** and provide comments

Assigned spending floor

Assigned spending floors are issued by the first day of hospital's fiscal year

OHA accepts or rejects a request to modify the spending floor and **finalizes the MSF** no later than the **first day of the fiscal year**

Second year spending floor adjustment

Hospitals may request a change to the second year spending floor

At the **close of the first fiscal year** in the MSF biennium, OHA and the hospital or health system may review recent trend data and other information and **adjust the second year MSF, if necessary**.

Hospital Facility and Clinic Reporting Form

HFCR due June 30th every year

June 30 every calendar year, every hospital must submit a **HFCR** form

CY 2024	CY 2025	CY 2026

FY 2025	FY 2026	FY 2027

Audited Financial Reporting

Financial Reporting Form 3 and Audited Financial Statements due 120 days after close of a fiscal year

Hospital Financial Assistance Report

HFAR due 150 days after close of fiscal year

Effective for hospital fiscal years that begin on or after January 1, 2025, hospitals must submit a **HFAR** form no later than **150 days** after the end of the fiscal year

Community benefit reports

Community Benefit Report – 1 (CBR-1), Community benefit narrative, Community Health Needs Assessment (CHNA), Community Health Improvement Plan (CHIP) due 240 days after close of fiscal year

Helpful links

- Hospital Reporting Program webpage
- Oregon Revised Statutes
  - ORS 442.361 to 442.362
  - ORS 442.601 to 442.630
  - ORS 442.991
- Oregon Administrative Rules
  - OAR 409-023
  - OAR 409-024

Form or document reporting questions

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

To update contact lists, submit required forms and documents, share comments, ask questions or obtain more information, please email the Hospital Reporting team at HDD.Admin@odhsoha.oregon.gov

Community benefit data

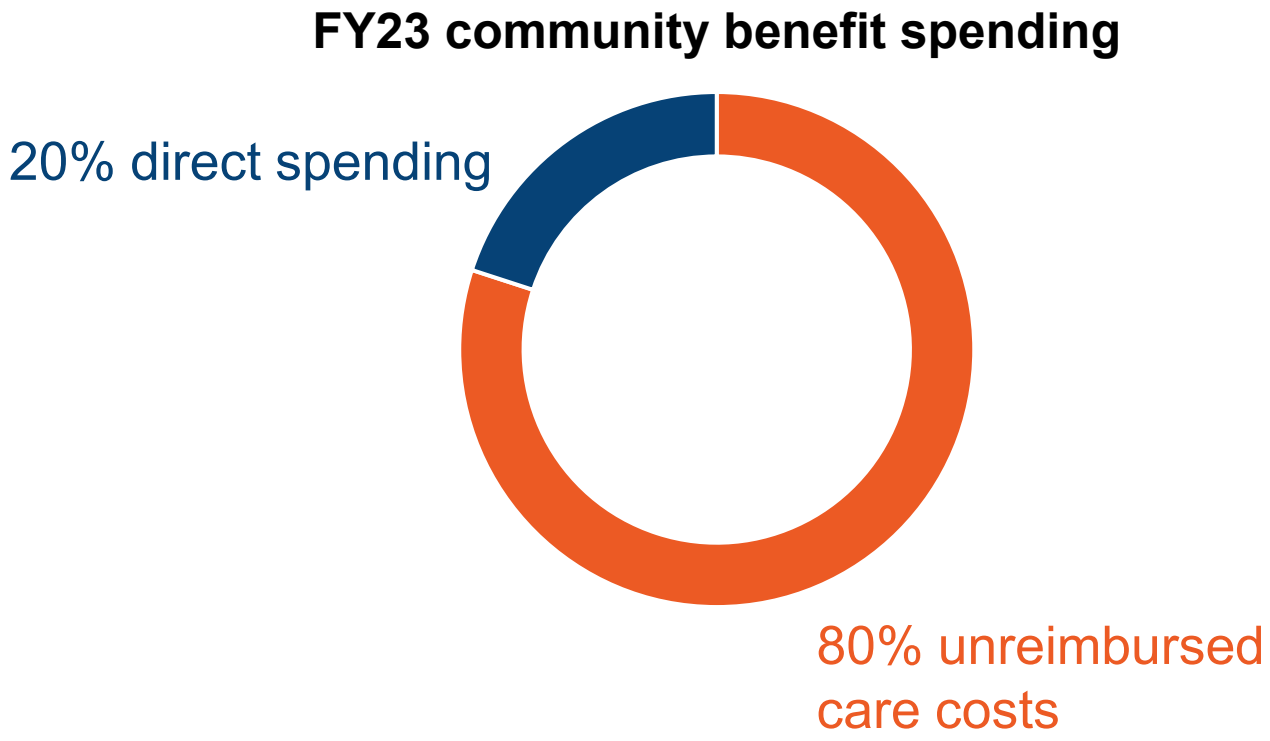
Community benefit spending categories

Direct spending includes:

- Community building activities
- Cash and in-kind
- Community health improvement
- Health professions education
- Research costs
- Community benefit operations

Unreimbursed care includes:

- Unreimbursed Medicaid costs
- Charity care costs
- Subsidized health services costs
- Other public programs costs



Status of community benefit reporting as of August 6, 2025

FY 23 data is current, full data

FY 24

- Final group data due at the end of August 2025
- Dashboards will be refreshed in late fall 2025

FY 26 – 27 spending floors:

- Groups 1 – 3 have been assigned
- Group 4 has been proposed
- Group 5 will be proposed November 1, 2025

FY 23 spending floor data

- Of the 38 spending floors assigned to 58 hospitals or health systems, 37 out of 38 (97.4%) met or exceeded their FY 23 floor.
- Community benefit spending **decreased statewide by 8.7%** ($191.7 million) to $2.0 billion in 2023, the first year-over-year decrease in overall statewide community benefit spending since the Affordable Care Act in 2014.
- New spending floors are primarily based on previous years' spending. As a result, statewide group 1-3 FY 26 spending floors increased 6.7% from group 1-3 FY 25 spending floors – groups 4-5 still to be assigned.

Hospital performance in FY 2023

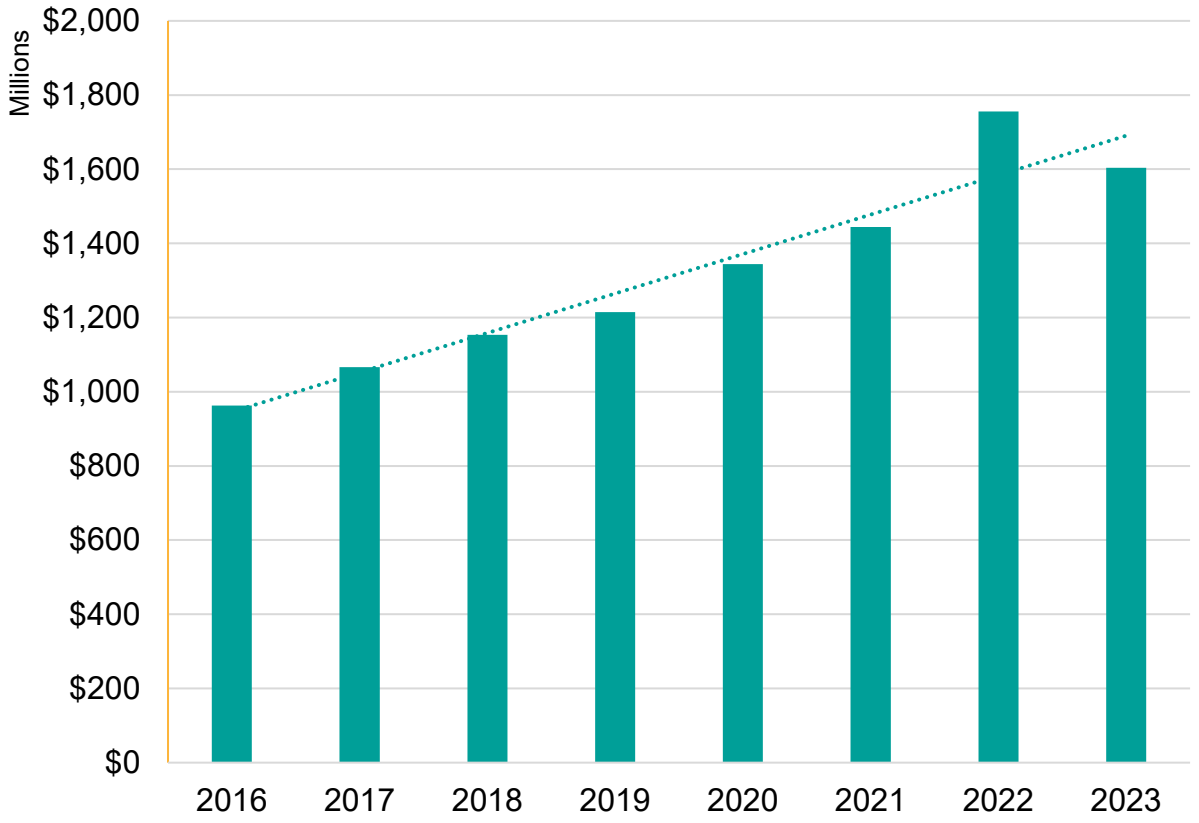
- 37 out of 38 hospitals and health systems met their FY 2023 assigned minimum spending floor
- Statewide total community benefit spending ($2B) exceeded the statewide assigned floor ($1.43 billion) by $514 million (140% of the assigned floor)
- On average, hospitals spent $13M more than their assigned floor
- The median hospital spent 136% of their assigned floor

Spending floor data

Fiscal year	All hospitals' spending floors statewide	Total community benefit spend statewide
2020	N/A	$1,743,577,906
2021	N/A	$1,870,409,154
2022	$1,386,260,083	$2,195,458,810
2023	$1,433,782,658	$2,003,796,858
2024	$1,669,709,940	September 2025
2025	$1,756,718,037	October 2026
2026	January 1, 2026	October 2027
2027	January 1, 2026	October 2028

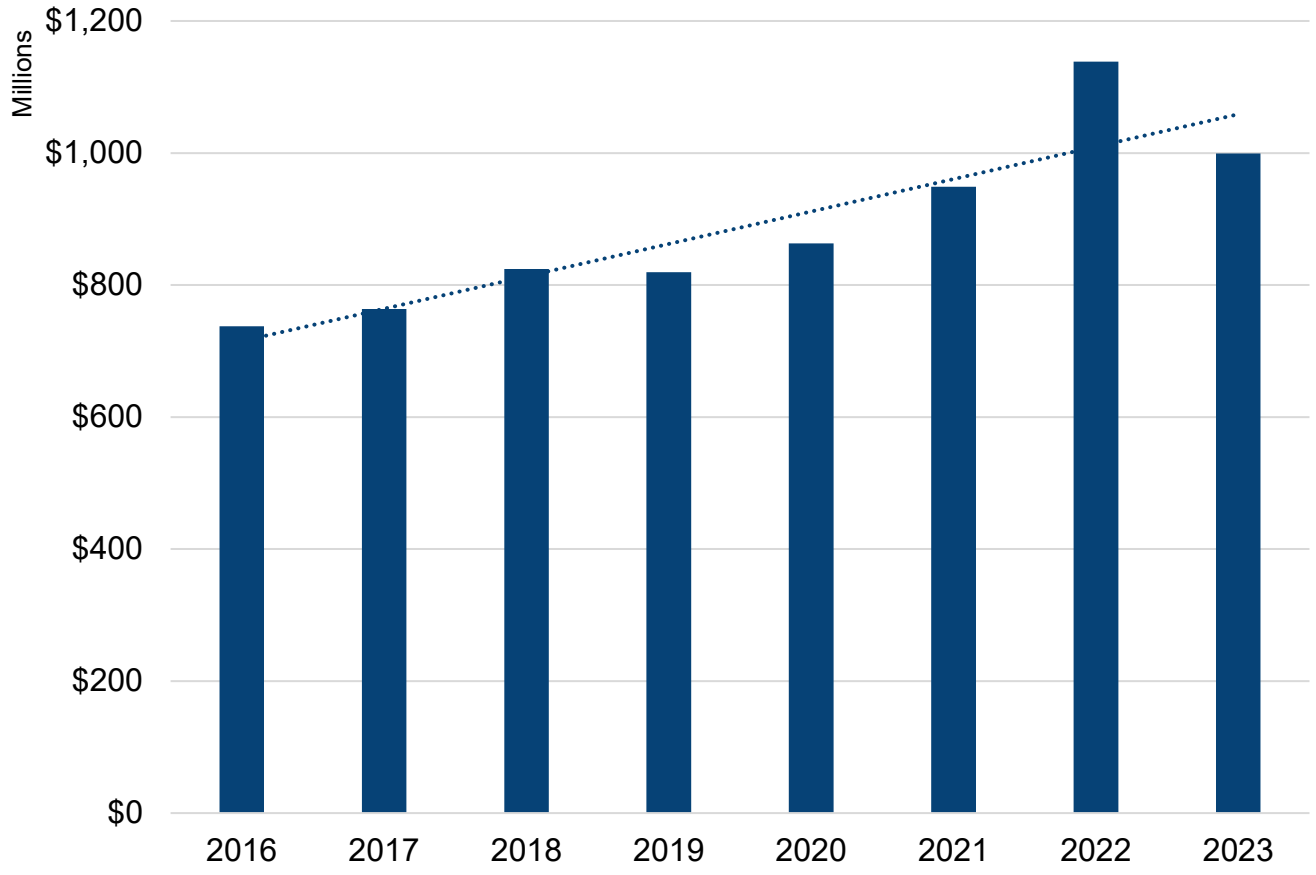
Unreimbursed care trends

- Unreimbursed care **fell $151.9 million** (8.6%) in 2023, following a 21.5% increase in 2022
- Unreimbursed care spending accounted for 80% of community benefit spending
- Unreimbursed care and operating expenses historically trend closely and have identical long term annual growth rates
- FY 22 was an outlier year that saw a drastic increase in unreimbursed care after an upward trend since 2016



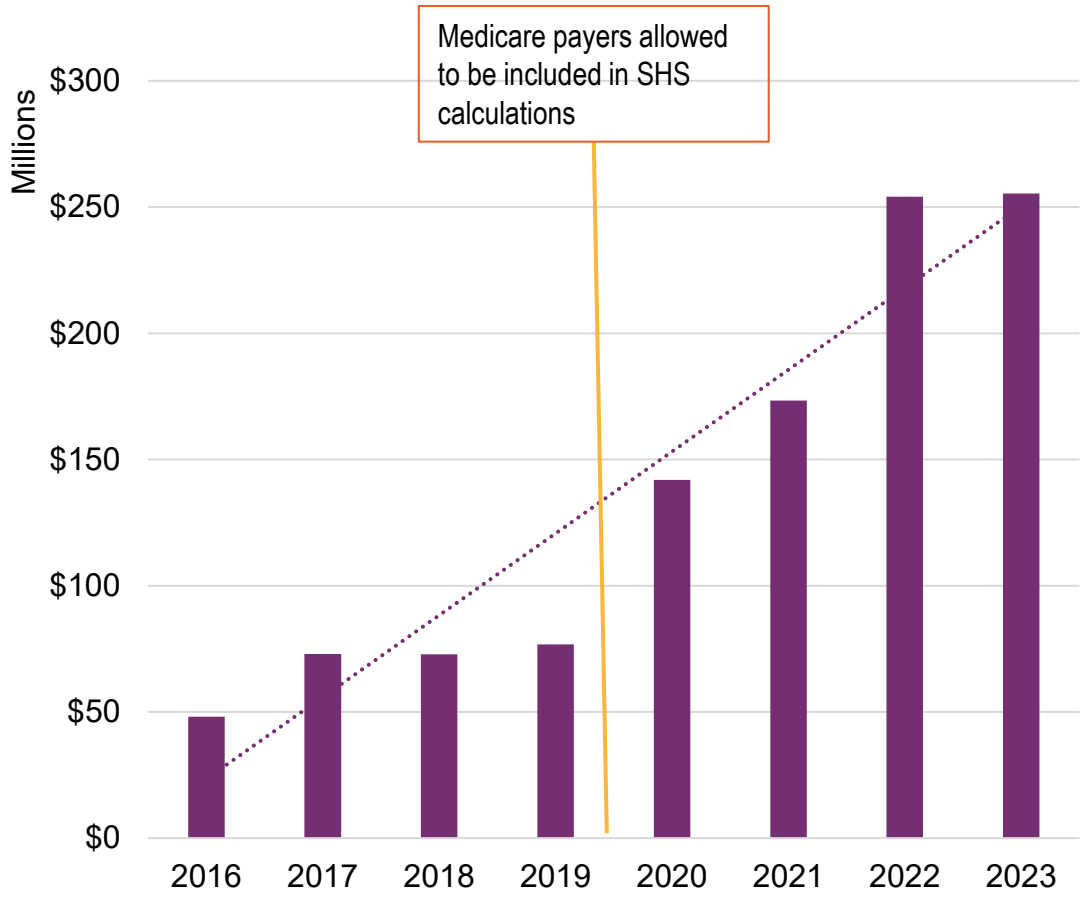
Unreimbursed Medicaid trends

- Unreimbursed Medicaid **fell 12.2%** in 2023**.** This decrease follows the jump in unreimbursed Medicaid from FY 22.
- A contributing factor to the drop is the participating provider (PAR) rate increase for DRG hospitals in calendar year 2023



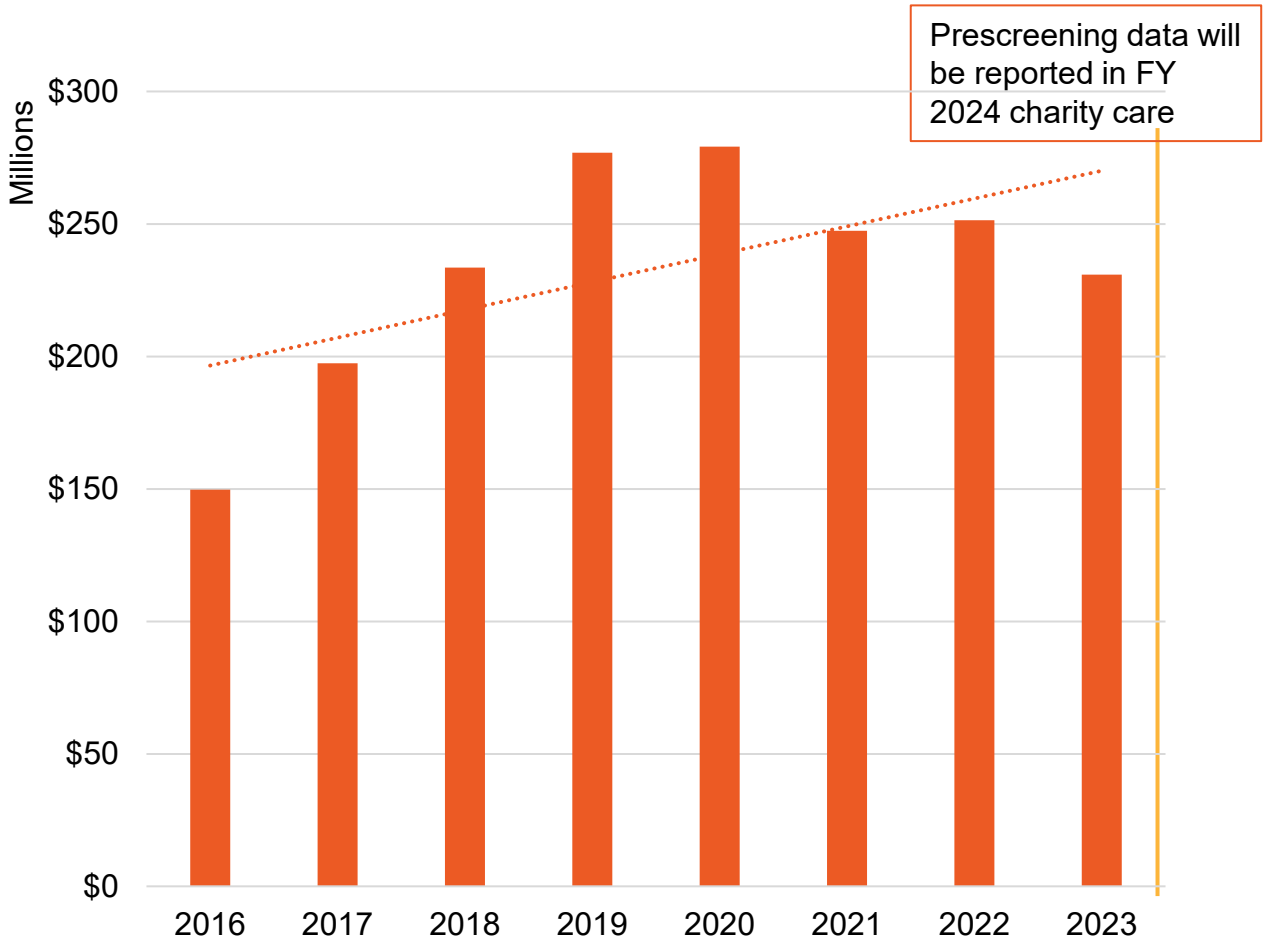
Subsidized health services (SHS) trends

- SHS spending **grew just 0.5%** in 2023. In contrast, between 2020-2022, SHS year-over-year spending increased 85%, 22% and 47%, respectively
- Statewide SHS spending now **exceeds** total charity care spending by $24.5 million
- DRG hospitals have the largest increase in SHS spending: $126 million (256%) since 2019
- Including Medicare payers in the calculation in 2020 is a major factor the growth in SHS



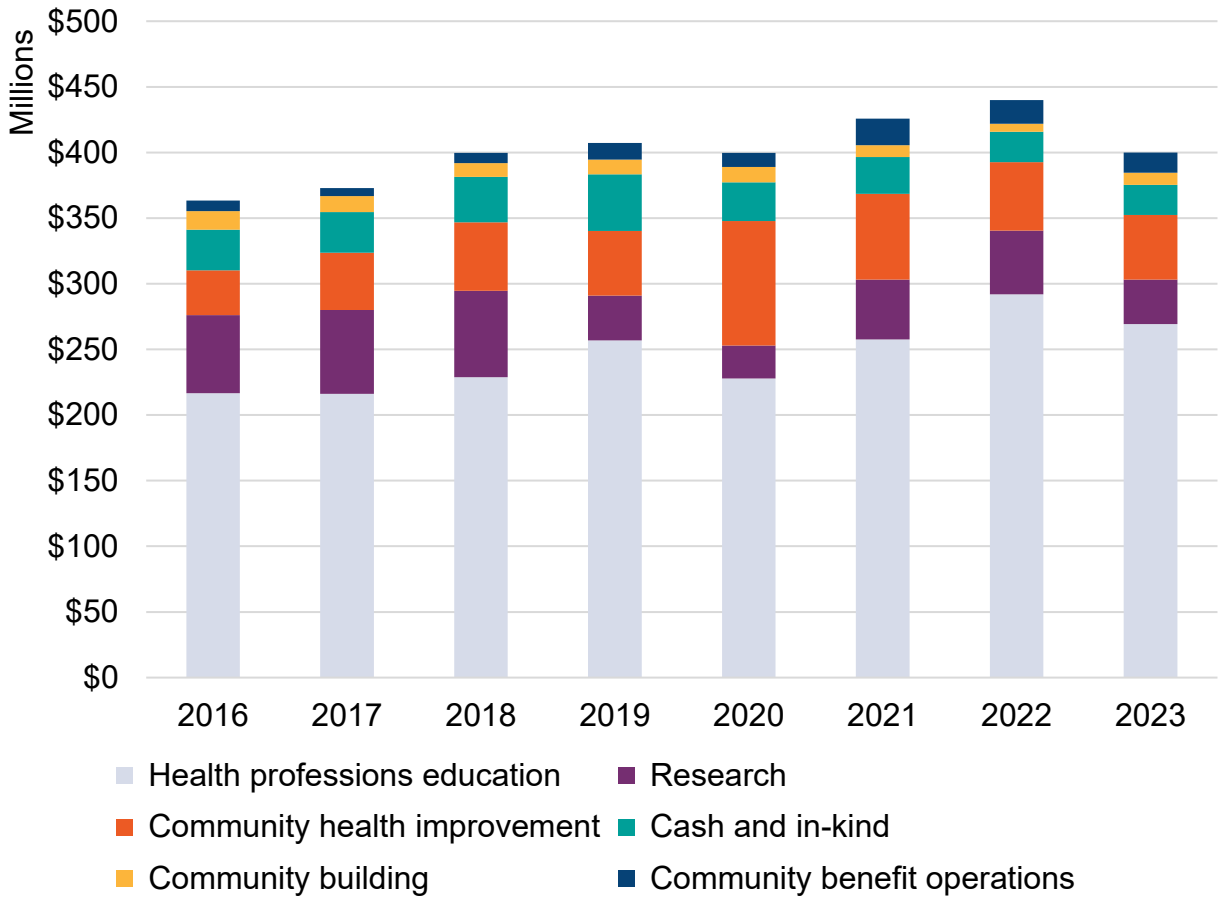
Charity care (financial assistance) trends

- Since implementation of minimum financial assistance tiers – expanding charity care – on January 1, 2020, statewide charity care spending has **decreased**
- Charity care **fell 8.2%** in 2023, continuing an almost $50 million decrease since its peak of $280 million in 2020
- The public health emergency and redetermination pause has kept OHP enrollment high, reducing the need for financial assistance
- **HB 3320 presumptive eligibility data will be included in 2024 data**



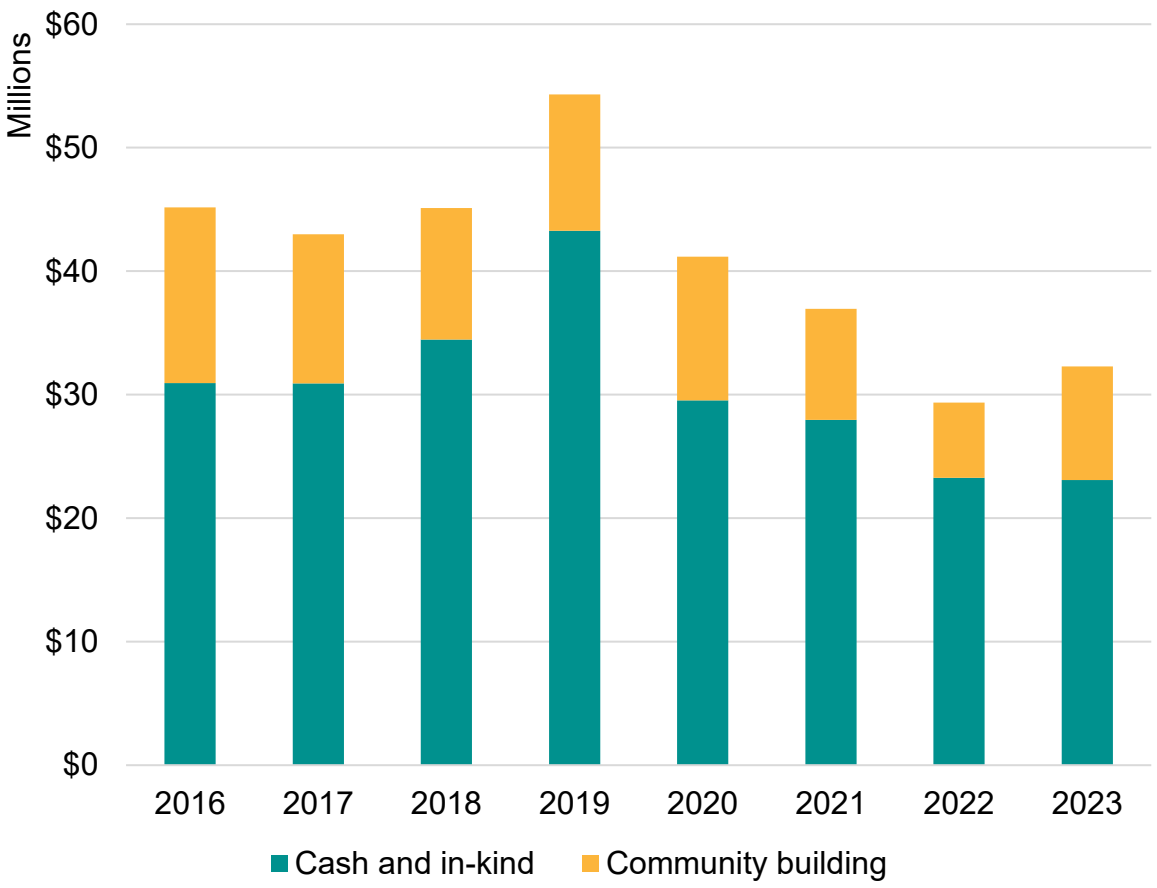
Direct spending trends

- Health professions education accounted for 61% of all direct spending in 2023
- Direct spending **fell 9%** ($40 million) in 2023
- Community building and cash and in-kind **grew slightly**, while direct spending **fell in all other categories**



Social determinants of health (SDOH) and health equity trends

- **Cash and in-kind contributions** and **community building** are the categories that most closely align to **SDOH**-type activities
- These combined SDOH categories **increased 10%** ($2.9 million) in 2023, following at 20% decrease ($7.6 million) in 2022
- **The 2023 increase follows a steady decline in SDOH spending since 2019**



Community benefit spending considerations

- The increase in total community benefit spending in FY 22 was driven by unusually large increases in unreimbursed care, not direct spending
  - Unreimbursed care **decreased by 8.6%** in FY 23
- SDOH and direct spending remain a small portion of overall community benefit spending. Hospitals are encouraged to continue to find ways to invest more in SDOH and direct spending.

Spending floor calculation

OHA recommended retaining the current spending floor methodology for FY 2026 – 2027.

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.

FY26 spending floor = *3-year average of unreimbursed care spending* + (***Direct Spending Net Patient Revenue Percentage*** x *3-year average operating margin multiplier*)

FY27 spending floor = ***FY26 spending floor*** + (***FY26 spending floor*** * *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.

FY23 spending floor data is in the community benefit dashboard

Community Benefit

How much are hospitals giving back to their local communities?

Oregon Hospital Community Benefit Dashboard

Key Takeaways | **Minimum Spending Floor** | By Individual Hospital | By Hospital Type

This chart compares assigned minimum spending floor amounts (**bars**) to total community benefit spending (**circles**) by hospital or health system, and includes the percent of the assigned minimum spending floor that was met through total community benefit spending.

Assigned minimum spending floor and total community benefit spending in dollars, fiscal years 2022-2023

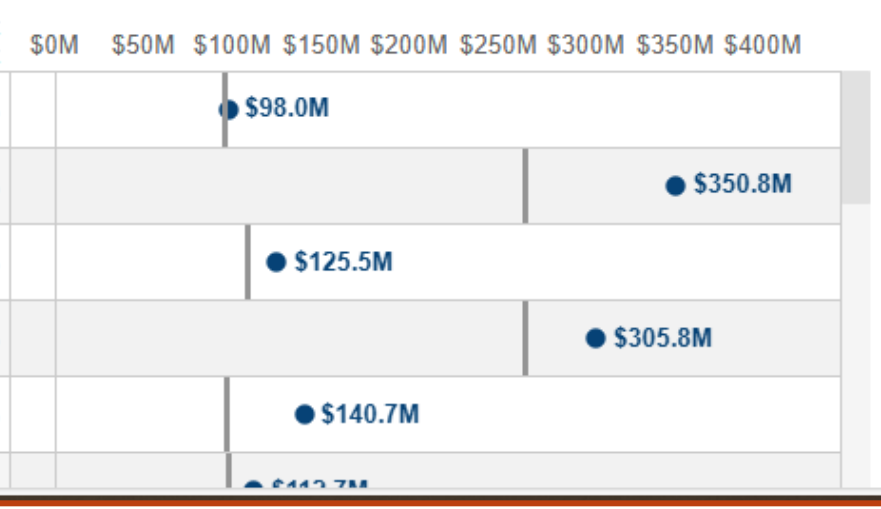
Select type: (All)

Select hospital/system name: (All)

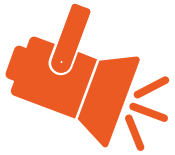
Assigned minimum spending floor: $1M – $264M

Total community benefit spending: $0M – $417M

Fiscal Year	Type	Hospital or System Name	Assigned Minimum Spending Floor	Total Community Benefit Spending	Percent Met
	Health System	Asante	$94.0M	$98.0M	104.3%
		Legacy Health	$264.4M	$350.8M	132.7%
		PeaceHealth	$107.2M	$125.5M	117.0%
		Providence Health & Services	$263.9M	$305.8M	115.9%
		Salem Health	$95.7M	$140.7M	147.1%
		St. Charles Health System	$97.0M	$112.7M	116.2%



Community Benefit Investments Report



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

Recommendations for future reporting:

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

- FY 2023 CB Investment Report was just published last week
- All hospitals' narratives are available on the Hospital Profiles Page

Oregon community benefit in the news

Oregon community benefit in the news

HealthAffairs

[Oregon Community Benefit Reform Influenced Not-For-Profit Hospitals' Charity Care and Medical Debt Write-Off]

Articles on FY 2023 statewide community benefit data

KATU 2 abc

the Lund Report

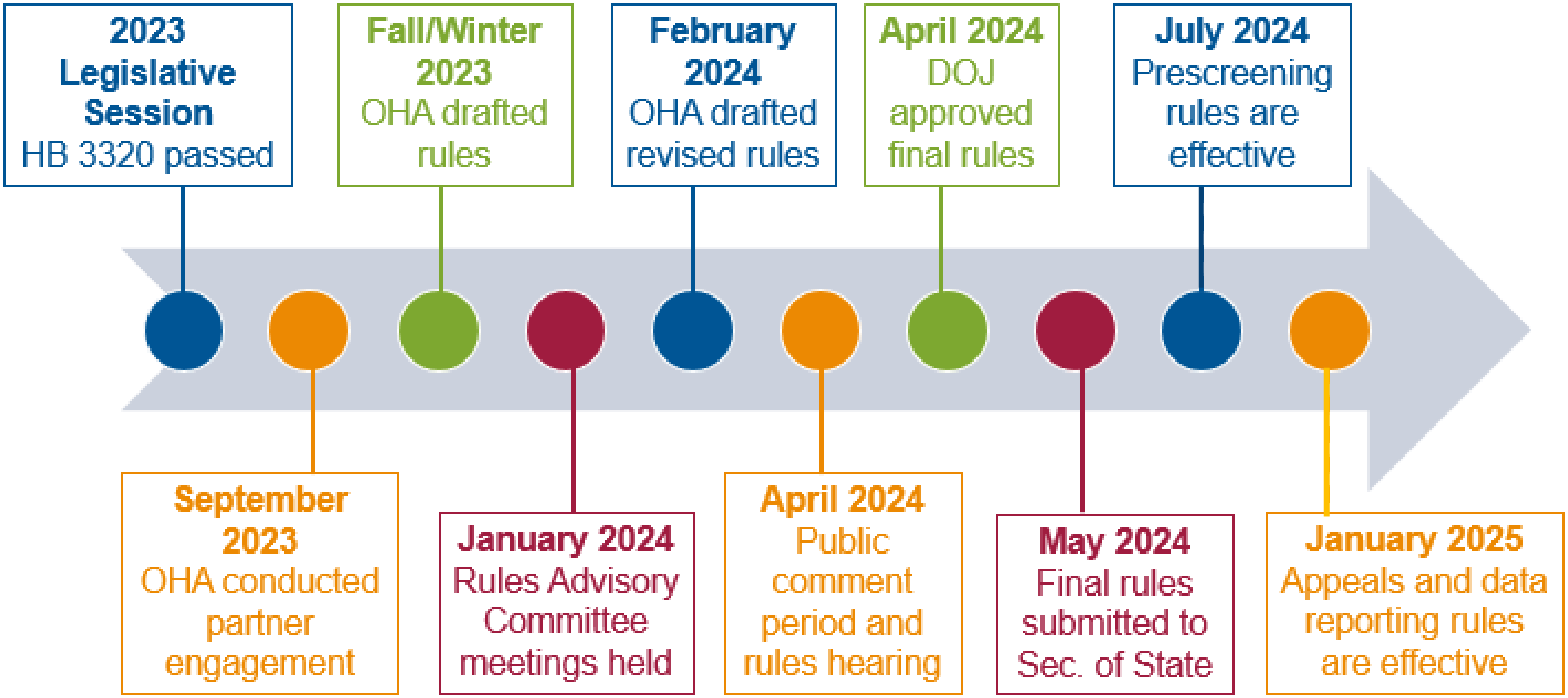
OREGONLIVE The Oregonian

PORTLAND BUSINESS JOURNAL

10-minute break

HB 3320 implementation

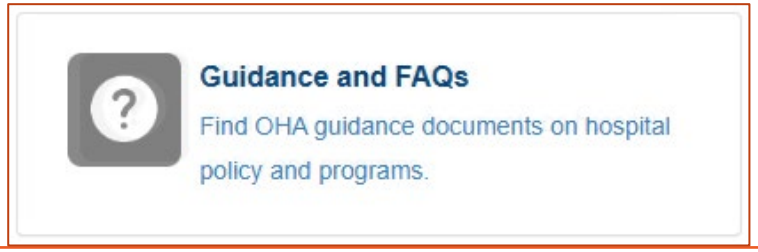
HB 3320 implementation timeline



HB 3320 implementation - 2025 updates

- At hospitals' request, OHA published Hospital Prescreening Implementation Interviews Summary
- In the 2025 legislative session, HB 3561 was proposed as a placeholder bill to make changes to HB 3320 but the bill did not make it to the first hearing

OHA guidance on HB 3320



OHA published guidance documents available on the Hospital Reporting Program website under Guidance and FAQs:

- Hospital Financial Assistance Information for Patients: guidance hospitals can share with patients in English and Spanish
- OHA Guidance to Hospitals Regarding Patients Interested in Declining Financial Assistance: Patients may not opt out of prescreening. However, a patient may decline the financial assistance (FA) determination and opt to pay their full bill. Hospitals must document patients' declination.
- Prescreening and Presumptive Eligibility Award FAQs

This guidance does not, and is not intended to, constitute legal advice. It does not absolve hospitals from potential future litigation or risk under state or federal law. Hospitals should consult with their own legal counsel prior to taking any action under this guidance.

OHA guidance on HB 3320 cont.

- An insured patient must provide all third-party payer information prior to a FA determination. If a patient refuses to provide information, the hospital may deny FA.

- A patient who qualifies for OHP, Medicaid, SNAP, or TANF is presumptively eligible to automatically receive 100% FA as their household income is already verified by the state; these patients do not require additional screening steps.

- Hospitals should consult with their legal counsel about providing FA to non-Oregon residents and have the associated information written in their FA policy.

This guidance does not, and is not intended to, constitute legal advice. It does not absolve hospitals from potential future litigation or risk under state or federal law. Hospitals should consult with their own legal counsel prior to taking any action under this guidance.

FA application appeals effective January 1, 2025

- Appeals process must be documented in hospital FA policy
- Patients may appeal an FA determination **based on an application**, not based on a prescreening result
- Based on an application, if a patient does not receive 100% FA, the hospital has 10 business days to notify the patient of all of the following:
  1. Their ability to **take corrective action** (e.g. fix a mistake or supply documentation) or **appeal the determination**
  2. **Instructions on how** to take corrective action or appeal the determination
  3. **Direct contact information** for a hospital representative who can answer questions about the patient's FA application

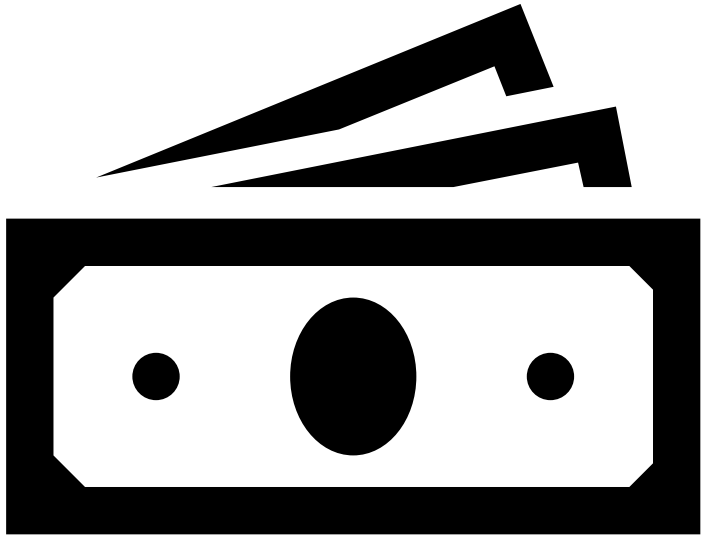
Handling an appeal

- Appeals are effective for **services rendered on or after January 1, 2025**
- Patients have 240 days after the first billing statement or 45 days from notification of FA determination to correct an application, **whichever is greater**
- Hospitals may conduct standard billing practices during this period if there is not a standing appeal. However, hospitals will have to **reimburse** a patient if the patient is found to be eligible for FA

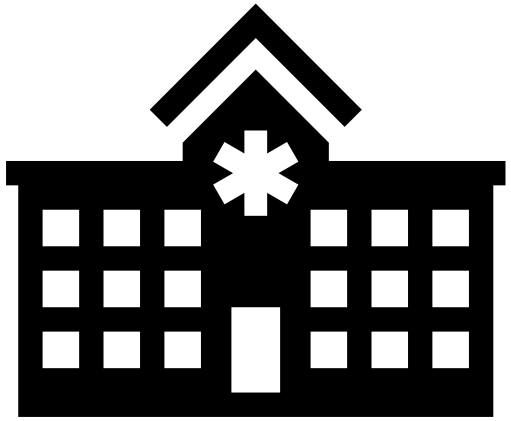
Collection activities during an appeal

During an appeal, a hospital must:

- Suspend all collection activities
- Notify collection agencies to suspend collection activities on any sold debts currently under appeal
- Confirm receipt of the patient's appeal, notify patient the hospital has suspended all collection activities and has instructed collection agencies to suspend their collection activities



Handling an appeal, cont.



- Patient has 45 days to provide additional information the hospitals needs for the appeal
- Hospital may allow multiple meetings to decide on the appeal
- An acting third party with consent is allowed to act on the behalf of the patient
- Hospital must issue a written determination within 30 days of either the final appeals meeting or receipt of corrections to application deficiencies, whichever is later
- If the appeal is denied, a hospital must notify the patient of the date any suspended collection activities will resume

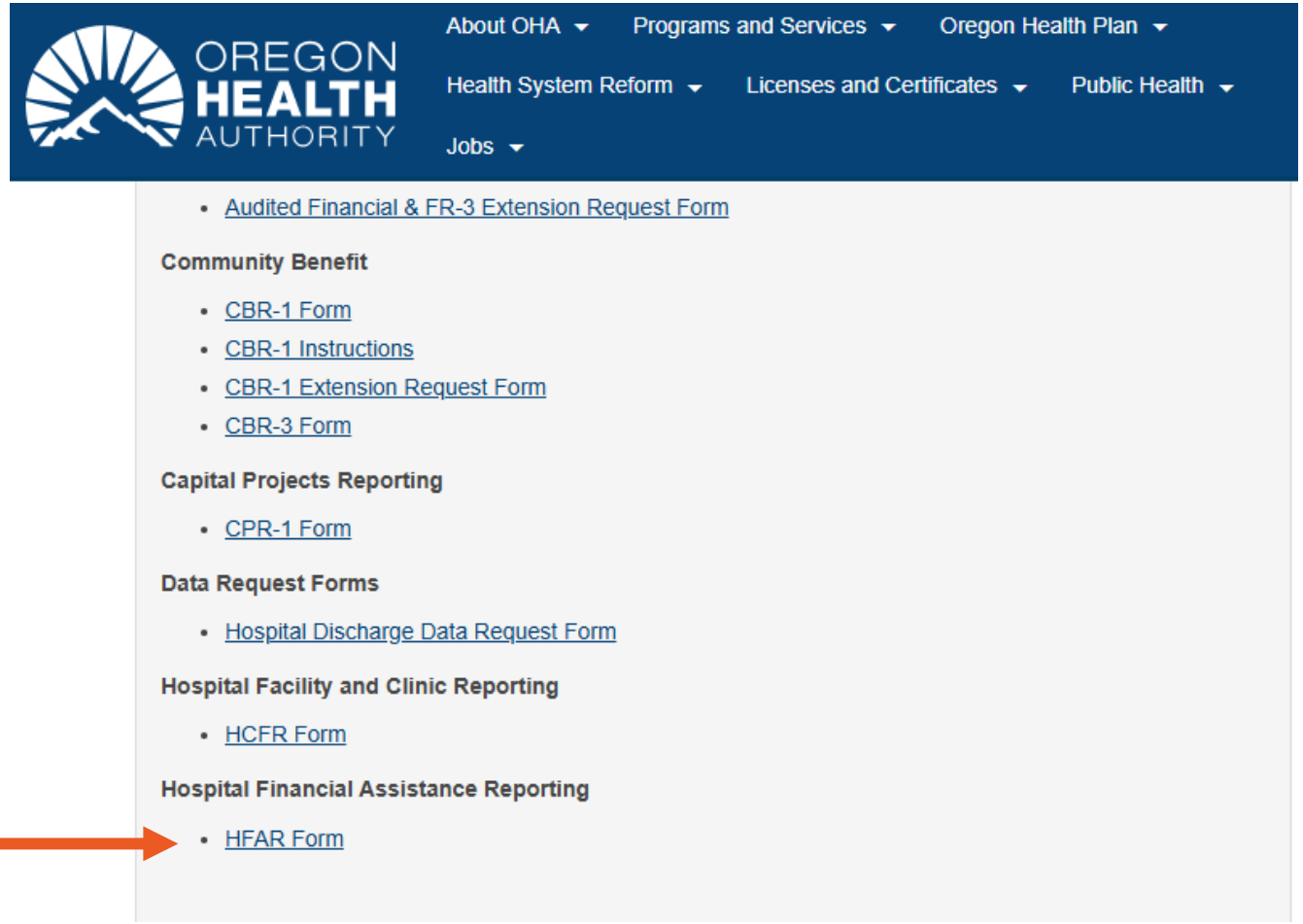
HFAR guidance

The Hospital Financial Assistance Reporting (HFAR) Form

- A new reporting requirement from HB 3320
- Requires hospitals to report:
  - Applications received, approved and denied by payer type
  - Patients who received cost adjustments with and without an application
  - Debt collections activities
- Reporting period began with fiscal years starting on or after January 1, 2025
- HFAR is due 150 days after the close of the fiscal year

Where to find the HFAR form

How to locate the form: scroll to the bottom of the OHA Hospital Reporting website to the “Forms” section, find the Hospital Financial Assistance Reporting Form (HFAR)



HFAR guidance, section 2

Section 2: Received, Approved, and Denied Financial Assistance Applications		
How to complete this section:	Enter the total number of financial assistance applications received, the number of pending applications (optional) (including incomplete applications requiring patient correction, applications in the appeals process, both within the 45-day corrective action window for patients, and completed applications that are in the review process), and the number of approved and denied financial assistance applications received, by payer type, in the reporting period.	
Line		Amount
1	Total number of financial assistance applications received	
2	Number of pending financial assistance applications (optional)	
3	**Number of approved financial assistance applications, by payer type:**	
3a	Uninsured	
3b	Medicare and Medicare Advantage	
3c	State medical assistance programs (Medicaid, Healthier Oregon, Basic Health Plan)	
3d	Commercial or private health insurance	
3e	All other payers	
	Total approved:	**0**
4	**Number of denied financial assistance applications, by payer type:**	
4a	Uninsured	
4b	Medicare and Medicare Advantage	
4c	State medical assistance programs (Medicaid, Healthier Oregon, Basic Health Plan)	
4d	Commercial or private health insurance	
4e	All other payers	
	Total denied:	**0**

- Applications means the **actual number of applications** received. Patients might submit multiple applications within the reporting period.
- Reporting **pending applications** is optional. Pending includes those that are in progress, being revised by patients or under hospital review.

HFAR guidance, section 3

Section 3: Cost Adjustments	
How to complete this section:	**Enter the total number of patients that received cost adjustments, the number of patients that received cost adjustments *through the hospital's presumptive eligibility process* *without submitting an application*, and the number of patients that received cost adjustments *after submitting a financial assistance application* in the reporting period.**

Line		Amount
1	Total number of patients that received cost adjustments	
2	Number of patients that received cost adjustments through the presumptive eligibility process	
3	Number of patients that received cost adjustments after submitting a financial assistance application	

Patients and patient accounts are two different metrics. Both are used on the HFAR form.

Total number of patients is the count of actual unique people who received cost adjustments.

- One singular patient who holds multiple accounts would be counted as one patient.
- For accounts that have a patient and guarantor, such as with minor children, only count the guarantor.
- If an account has multiple guarantors, count all unique persons. (2 guarantors= 2 people received a cost adjustment).

HFAR guidance, sections 4 – 5

Patients and patient accounts are two different metrics. Both are used on the HFAR form.

Section 4: Debt Owed		
How to complete this section:	Enter the the total number of patient accounts referred to a debt collector or collection agency, the total dollar amount of debt owed to the hospital by patients with accounts in collections or reffered to a collection agency, and the average and the median dollar amount of per-person debt owed to the hospital by patients with accounts placed in collections or referred to a collection agency in the reporting period.	
Line		Amount
1	Total number of patient accounts referred to a debt collector or collection agency	
2	Total debt owed by patients with accounts placed in collections or referred to a collection agency	
3	Average per-person debt owed by patients with accounts placed in collections or referred to a collection agency	
4	Median per-person debt owed by patients with accounts placed in collections or referred to a collection agency	

Section 5: Extraordinary Collection Activities		
How to complete this section:	Enter the total number of patient accounts in which extraordinary collection activities occurred, and the number of patient accounts in which extraordinary collection activities occurred, by extraordinary collection activity type, in the reporting period.	
Line		Amount
1	Total number of patient accounts in which extraordinary collection activities occurred	
2	**Number of patient accounts in which extraordinary collection activities occurred, by activity type:**	
2a	Selling of an individual's debt to another party	
2b	Reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus	
2c	Deferring, denying, or requiring payment before providing medically necessary care due to an individual's non-payment of any bills for previously provided care covered by the hospital's financial assistance policy	
2d	Taking actions that require a legal or judicial process including (but not limited to) liens, judgements, garnishments, foreclosures, or other action related to collection of a debt owed to the hospital	

Patient accounts means Hospital Accounting Record (HAR) or similar depending on EHR.

When asked for patient accounts, enter the HAR count or actual number of accounts, which could be more than one per patient.

There is not a direct comparison between people and accounts in this reporting

HFAR guidance, sections 4 – 5

Patients and patient accounts are two different metrics. Both are used on the HFAR form.

Section 4: Debt Owed		
How to complete this section:	Enter the the total number of patient accounts referred to a debt collector or collection agency, the total dollar amount of debt owed to the hospital by patients with accounts in collections or reffered to a collection agency, and the average and the median dollar amount of per-person debt owed to the hospital by patients with accounts placed in collections or referred to a collection agency in the reporting period.	
Line		Amount
1	Total number of patient accounts referred to a debt collector or collection agency	
2	Total debt owed by patients with accounts placed in collections or referred to a collection agency	
3	Average per-person debt owed by patients with accounts placed in collections or referred to a collection agency	
4	Median per-person debt owed by patients with accounts placed in collections or referred to a collection agency	

Section 5: Extraordinary Collection Activities		
How to complete this section:	Enter the total number of patient accounts in which extraordinary collection activities occurred, and the number of patient accounts in which extraordinary collection activities occurred, by extraordinary collection activity type, in the reporting period.	
Line		Amount
1	Total number of patient accounts in which extraordinary collection activities occurred	
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2d	Taking actions that require a legal or judicial process including (but not limited to) liens, judgements, garnishments, foreclosures, or other action related to collection of a debt owed to the hospital	

- Section 4 line 2 means **the grand total, cumulative amount of debt placed into or referred to collections in the reporting period**, not the standing balance at the end of the year.
- Do not report bad debt amounts without review. Based on the requirements of the bill, this question is specific to **bad debt with collection actions taken**. A hospital could deem amounts uncollectable without taking actions. A simple reporting of cumulative bad debt may overstate this value.

HB 3320 discussion

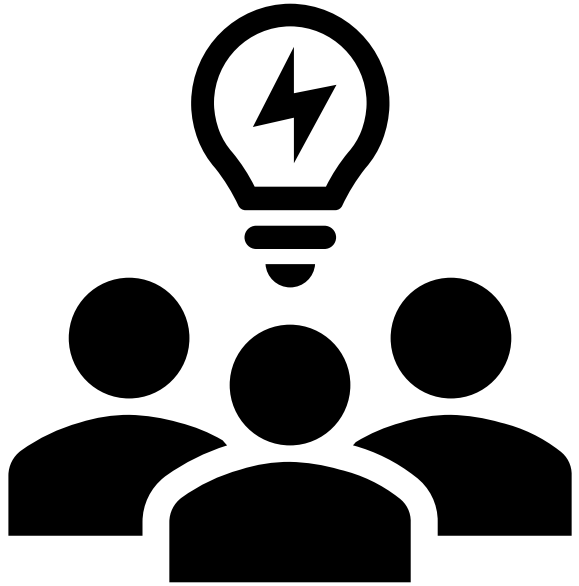
HB 3320 discussion

Prescreening has been live for 13 months.

Appeals and data reporting/tracking have been live for 7 months.

How can we foster collaboration between hospitals?

- Hospitals share out good ideas
  - What has been going well?
  - How have hospitals been increasing accuracy and reducing burden to provide necessary financial assistance?
- Potential for EHR collaborative?



Public comment, Q&A

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Hospital Reporting Program at HDD.Admin@ODHSOHA.Oregon.gov.

Health Policy & Analytics
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