HEALTH POLICY AND ANALYTICS
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Policies Governing Spending Floor Modification Requests

This document outlines the Oregon Health Authority's policies governing requests to modify a hospital community benefit minimum spending floor. Requests must be made in writing and submitted to the program mailbox: hdd.admin@dhsoha.state.or.us. Formal modification requests and supporting documents are subject to public posting.

**Considerations related to COVID-19 and other Pandemics**
In 2021 OHA established criteria originally developed for the COVID-19 pandemic response. These categories will remain for future emergencies or pandemic responses, with ability to be altered. These policies are in addition to – not in place of – the guidance governing requests for spending floor recalculations and financial hardship waivers. The policy also highlights COVID-19 and future potential pandemic or emergency-related expenses that can be considered community benefit.

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## Requesting Spending Floor Recalculations

As allowed for in rule, hospitals may request a modification of the proposed spending floor within 30 days of receipt.

- Hospitals may provide updated figures and request a recalculation if they discover an error in OHA's data that does not match their records,

- Hospitals may also provide updated figures and request a recalculation if more recent data indicates their financial position will be lower than the formula assumes.

Hospitals may request a recalculation of the year two amount prior to the start of the second fiscal year in the two-year cycle. A year two recalculation request must be made in writing, 90 days prior to the start of the second year. With the exception of financial hardship waivers and the temporary COVID-19 policies, OHA will not accept requests for spending floor calculation modifications outside these two windows.

***If OHA or the hospital makes an error:***

If OHA makes an error, such as by using a figure that differs from a correctly submitted figure, OHA will correct the formula with no further action from the hospital.

If the hospital makes an error, such as by submitting a figure that differs from hospital records, OHA will require the hospital to resubmit the data on the relevant form (FR-3 or CBR-1) prior to OHA's correcting the formula.

***If the hospital believes future financial metrics will be below the averages in the formula:***

The spending floor formula assumes a hospital will perform *at least* as well as the figures used in the calculations and does not assume an expected level of growth between the years used to calculate the floor and the year to which the floor is applied.

The spending floor uses the most recent data available to OHA from FR-3 and CBR-1 reporting. This results in a data lag of one full fiscal year. A hospital may elect to submit more recent data for use in calculating the spending floor. For example, OHA uses data through FY2020 to calculate the FY2022 spending floor. A hospital may submit preliminary FY2021 data for consideration. Any submitted FY2021 data must not include more than one quarter of trended or projected data. Depending on the basis of the request, OHA may request additional projections for future years. OHA may consider the following modifications to the spending floor calculation:

1. A change in the calculated amount of unreimbursed care that the formula considers. This request must be well-supported with evidence to support the projection. The intention of the unreimbursed care potion of the formula is to maintain constant performance in response to community needs. If OHA deems the hospital's predicted value to be well-supported, OHA may elect to replace the formula's value of unreimbursed care with a hospital-provided value.
2. A change in the net patient revenue amount used to calculate the direct spending portion of the formula. OHA will only allow a net patient revenue value replacement if it can be shown the fiscal year the spending floor applies to will be lower than the reference year used – not lower than the hospital's expectation for the year the floor applies to.
3. A more recent operating margin year. OHA's formula uses the three most recent fiscal year operating margins based on FR-3 reporting. A hospital may elect to provide their most current operating margin available, if well supported with documentation. OHA would use the most recent operating margin as the last data point in the series of three to establish the operating margin average. For example, a hospital may supply a FY2021 operating margin allowing OHA to use FY 2019, FY2020 and FY2021 to determine average operating margin.
4. When calculating the second-year floor, OHA will consider a more recent value for net patient revenue, if well supported with documentation. OHA would use the more recent figure as the last

value in the series to establish the 4-year change in net patient revenue. Similar to the above, using FY2021, OHA would then use the percent change from FY 2018 through FY2021 to determine the average year over year change.

These situations will always be handled on a case-by-case basis, but will be considered with the following general guidelines:

1. Any modification of the spending floor is at OHA's discretion.
2. The burden of proof is on the hospital, and the hospital must provide the rationale and justification for any figures they wish to provide.
3. Hospital must, at minimum, show they will be below the formula's current assumptions.
4. In evaluating the request for modification, OHA will consider all resources available to the hospital and consider the entire financial picture of the hospital. This includes but is not limited to other operating revenue amounts, investment income amounts, cash on hand, or any other metric which may inform if the hospital risk financial harm from the current spending floor.

### Requesting Financial Hardship Waivers

At any time, a hospital may submit a written request for a waiver of a portion of their spending floor obligation if the hospital experiences a change in circumstance outside its control that causes financial hardship. If approved, OHA may waive all or some of the direct spending portion of the spending floor, thus lowering the overall spending floor amount. Because most unreimbursed care is specified in statute, OHA will not lower any amounts associated with unreimbursed care. However, hospitals may pursue a modification to that portion of the formula, as specified above. Financial hardship waivers are subject to the following guidelines:

1. The hospital must provide evidence of current or imminent financial instability, including, but not limited to, data on current days cash on hand, current cash to debt ratio, capital spending ratio, and trend information that may inform future projections for revenue and expense.
2. Hospitals that are members of health systems must provide system-wide figures for the system's Oregon activities in addition to hospital's own figures. This could include data on health system-owned clinics or hospital foundation resources not captured in the existing reporting made to OHA.
3. Hospital must disclose any future expected sources of revenue, including but not limited to grants, subsidies, gifts, or other support that may inform the financial security of the hospital.
4. OHA may reduce the direct spending portion depending on the severity of the financial instability.
5. OHA will not reduce unreimbursed care amounts because financial assistance requirements are specified in statute. Unreimbursed care assumptions may be addressed according to the guidelines specified in formula recalculations.
6. Reductions will be applied and reassessed quarterly.

### Public Disclosure

Any formal request made to OHA will be posted on the website for a 30-day public comment period, regardless of whether the request is approved or denied. Any information provided to OHA to support the request may also be subject to public posting.

OHA welcomes informal requests for information from any hospital wishing to better understand this program and their options. However, no agreement on a spending floor will be reached without a formal request submitted to OHA for public posting.

## Accounting for COVID-19 in the Community Benefit Reporting and Community Benefit Minimum Spending Floor Programs

OHA's Hospital Community Benefit Program has launched in the midst of a pandemic that has highlighted health inequities and the vital link between health and the conditions in which we live, grow, work, and age. It also highlights the role hospitals play in addressing their communities' needs. Oregon Health Authority will consider the impact of COVID-19 on community benefit programs according to the following guidelines.

### *Reporting COVID-19 Related Community Benefit Costs*

Many hospital costs associated with the COVID-19 response can count toward the community benefit spending floor, typically in the categories of Community Health Improvement Services or Cash and In-Kind Contributions.

As with all other community benefit reporting, the services must not require admission or referral by the hospital in order to count as community benefit, and hospitals must also deduct any offsetting revenue prior to reporting.

The following is a non-exhaustive list of examples of COVID-19-related community benefit investments.

### *Personal Protective Equipment*

Hospitals may claim PPE expenses if masks or other PPE were provided to community organizations or groups or used in vaccination clinics, drive-up testing sites, or other public events.

**Count:**

- Donated masks, gloves, shields or gowns to community groups or organizations such as childcare providers, social service workers, unaffiliated long-term care, or senior living establishments.
- PPE used during operation of public testing sites or vaccination sites as long as the testing or vaccination was not related to patients otherwise admitted to the hospital

**Do Not Count:**

- PPE purchased for hospital staff and used during normal operation of the hospital or any hospital affiliated clinic
- PPE purchased and provided to any other health care entity that shares a common owner or brand with the hospital.

### *COVID-19 Testing Sites*

Hospitals may count expenses related to operating a public COVID-19 testing site if the facility did not require admission to the hospital or treatment by the hospital as a condition of testing. Hospitals may not count testing expenses related to the care of patients admitted to the hospital or being treated at a hospital affiliated clinic.

**Count:**

- Staff time for employees
- PPE, as noted above
- Materials and supplies (tents, signs, traffic control devices)
- Testing supplies

**Do Not Count:**

- Testing costs associated patients of the hospital or hospital affiliated clinics
- Testing costs associated with screening patients for elective procedures

***Vaccination Sites***

Hospitals may count expenses related to providing COVID-19 vaccines if the site was open to the general public or the priority groups specified by OHA. Hospital may not count expenses related to the vaccination of patients under their care.

**Count:**

- Staff time for employees
- PPE, as noted above
- Materials and supplies
- Information Technology expenses related to maintaining vaccine scheduling software

**Do Not Count:**

- Vaccination costs association with patients admitted to the hospital
- Vaccination costs associated with worksite only vaccination clinics only open to hospital staff and employees