

Date: November 24, 2020

From: Steven Ranzoni, Hospital Policy Adviser

Subject: Report on Rulemaking Hearing and Public Comments

Hearing Date: November 17, 2020, 3PM
Hearing Location: Remote Microsoft Teams
Hearing Officer: Pete Edlund, HPA Rules Coordinator
Public Comment Period: November 2nd, 2020 to November 23rd, 2020
Title of Proposed Rules: Changes to hospital community benefit reporting and creation of minimum community benefit spending floor program.
Repeal: none
Amend: OAR 409-023-0100, 409-023-0105
Adopt: OAR 409-023-0110, 409-023-0115

Rules Hearing Attendance Record:

Steven Ranzoni, OHA
Pete Edlund, OHA
Amy Clary, OHA
Chris Holland, OHA
Margie Fernando, OHA
Peter Morgan, Adventist Health
Gina Cole-Plasker, Legacy Health
Kirsten Isaacson, SEIU
Michael Sorensen, Cedar Hills Hospital
Greg Miller, PeaceHealth
Molly McGrew, Cedar Hills Hospital
Rachel Seeder, Santiam Memorial
Rebecca Tiel, OAHHS
Sandy Saylor, Shriners' Children Hospital
Sean Kolmer, OAHHS
Nicole Vertner, Adventist Health

Summary of oral comments presented during November 17th, 2020 Rules Hearing.
Chronological order of presented

Testimony by Kirsten Isaacson, SEIU

General Comments: We are excited to support the draft rules and appreciate the process that lead to them. SEIU reiterates they want to see strong ties to Social Determinants of Health but feel those will be worked out through further definition of reporting requirements outside of rule. SEIU does not have further comments on the rules or requests for changes.

Comment 1: SEIU Supports draft rules. No further changes are requested.

Response 1: OHA appreciates the feedback and thanks SEIU and all the other participants for their engagement in the rules process.

Rebecca Tiel, OAHHS

General comments: OAHHS appreciates the process that lead to these rules, appreciates the consultations of experts and the time spent modelling the impact of spending floors. OAHHS wishes to reiterate for the record that the COVID-19 pandemic has presented numerous challenges for hospitals and strained the capacity to engage in this process.

Comment 2: Newly introduced definitions did not have adequate time for review. Definitions were added between the rule version October 22nd and the final draft proposed rule. Definition of “control” is new. From OAHHS’s perspective it is unnecessary and OAHHS has not had adequate time to vet the definition among hospitals. Addition of the term “nonprofit” raises the same concerns and fails to ensure the definition includes both federal and state designations.

Response 2: OHA will remove the definitions for “Control”, “Nonprofit” and “Outpatient Clinic” from the rules.

Comment 3: Example methodologies provided in rule need to reflect statute language and include nonprofits specifically. We request that the rules include at least the 3 specific examples included in statute are reiterated, verbatim, in rule.

Response 3: OHA will add the three examples from statute. We will modify 409-023-0110(5)(a) – (c) to reflect the methodology choices provided in statute verbatim and will add a fourth category to be used when appropriate and approved by OHA.

While some commenters have asked to have the term “nonprofit” included in all the grouping methodologies, OHA will retain the language in the final methodology option specified in 409-023-0110(5)(d) that refers to any hospital-affiliated clinic. This reflects the language of ORS 442.624(3):

“The authority shall adopt by rule alternative methodologies for hospitals and hospital-affiliated clinics to report data and to apply the community benefit spending floors, including but not limited to....”

HB 3076 includes a definition of hospital-affiliated clinic that is not limited to nonprofit clinics, but rather to clinics that are operated in Oregon under the common control or ownership of a hospital. The statute uses the term “hospital-affiliated clinic,” and does not exclude for-profit clinics. The statute and rules do not apply to a hospital-system-owned or -controlled clinic. If a clinic, or chain of clinics, is not owned or controlled by an individual hospital, it is not subject to the spending floor.

Comment 4: Have questions around what attestation means. OAHHS wants clarification on what this really means and what it means for the hospitals.

Response 4: OHA expects an officer of the hospital to attest to the accuracy of statements made in the report about whether the hospital’s financial assistance policies are posted and available to patients in the hospital facilities and clinics that share the hospital’s brand.

ORS 442.618 requires hospitals to make annual reports regarding all health care facilities and affiliated clinics that are owned in part or in full by the hospital or operating under the same brand as the hospital. These reports must include a statement as to whether the hospital’s financial assistance policy is posted in each of the nonprofit health care facilities and affiliated clinics and available to the patients of that facility and/or clinic. The rule operationalizes this requirement as an attestation by an officer because it is unrealistic to think that hospital staff within large systems would have knowledge of postings at all facilities and clinics sharing the brand utilized by their hospital. OHA does not consider such an annual attestation to constitute a significant administrative burden.

Summary of Written Comments received during the public comment period November 2nd, 2020 through November 23rd, 2020.

Chronological order of received

Kamesha Robinson, Legacy Health (Exhibit 1)

Comment 5: Concern with new definitions (similar to comment 2) As stated by Legacy: “Legacy is concerned that the definitions in OAR 409-023-0100 do not reflect statutory definitions. We request that the definitions of "control," "outpatient clinic" and "nonprofit" be removed from the rule.”

Response 5: See response 2.

Comment 6: Correct methodologies to reflect statute and legislative intent (similar to comment 3) As stated by Legacy: “OAR 409-023-0110 should be corrected to reflect legislative intent established in the development of HB 3076. It was clear to all stakeholders that the

community benefit spending floor would only apply to hospitals and their nonprofit affiliated clinic.”

Response 6: See response 3.

Comment 7: Concern with new attestation language (similar to comment #4). As stated by Legacy: “Legacy is concerned with the new language in OAR 409-23-0115 that requires an attestation signed by an officer "under false claims liability." First, we do not believe an attestation related to the Financial Assistance Policy (FAP) is necessary in this rule. Hospitals are already required under IRS Code Sec 501(r)(4) to post and make available the FAP using many different avenues. The FAP information is also required to be disclosed on the hospital's 990, Schedule H which is signed by an officer. Second, while hospitals and health systems regularly attest to agency guidance and/or compliance requirements, tying an attestation to a liability claim is unnecessarily punitive. A posting and distribution requirement, which is generally stated, and (appropriately) not detailed about how the requirement is fulfilled, is not the type of requirement to which "false claims liability" is intended to apply. We request the attestation requirement be deleted from the rule entirely, or at the very least the words "under false claims liability" be removed from the rule.”

Response 7: The phrase “under false claims liability” does not add new liability, as such, it can be and will be deleted.

Kirsten Isaacson, SEIU (Exhibit 2)

Comment 8: Request for adequate transparency. SEIU states: “Currently, there are challenges in representing the statute-required factors of 1.) demographics of the population served and 2.) spending on the social determinants of health (Section 6.(1)(e)and(f)) in the spending floor methodology. We feel strongly that transparency is necessary in these areas and believe that adding clarity is required to realize the intent of the legislation.

The requirement in draft rules 409-023-0105 (9) calls for community benefit reporting to a) identify the community need or health improvement strategy the community benefit addresses; b) disclose the entities to which hospital gave funds, grants, or in-kind contributions; and (c) report activities that address the social determinants of health. While these requirements set in rule are a good start, stopping short of offering clear directives leaves room for unknowns when it comes to how each hospital may choose to report specifics.

Narrowing down the details of the community benefit reporting is being discussed in a separate workgroup. We will continue to participate in that process but will take this opportunity to reiterate our strong desire for detailed transparency.”

SEIU further notes that “Again, we propose alignment with [NASHP’s recommended community benefit reporting](#) template by including additional columns that track, by investment: target

populations and/or regions, partners engaged, outcomes to date, and data used to measure outcomes.”

Response 8:

OHA agrees that it will be important for the agency to collect information sufficient to consider demographics and spending on social determinants of health when setting individual spending floors, as directed by HB 3076. As discussed in the first workgroup meeting on November 17, 2020, OHA intends to add supplemental questions to the CBR-1 reporting form that ask hospitals to identify how their community benefit investments address the social determinants of health and health equity.

OHA also intends to ask hospitals to identify the following for each of their large community benefit investments:

- the target populations served, including demographics and geographic area
- partners engaged, and
- outcomes to date and the data used to measure them.

These changes will align the reporting form with the NASHP reporting template as suggested by the commenter.

Sean Kolmer, OAHHS (Exhibit 3)

Comment 9: Remove new definitions (similar to Comment #2 and #5) OAHHS reiterates comments made orally in the rules hearing, and echoed in written comments by Legacy

Response 9: See response 2.

Comment 10: Correct methodologies to reflect statute language and legislative intent (similar to comment 3 and 6). OAHHS reiterates comments made orally in the rules hearing and echoed in written comments by Legacy about language used for applicable spending floor methodologies.

Response 10: See response 3.

Comment 11: Concern with new attestation language (similar to comment 4 and 7). OAHHS reiterates comments made orally in the rules hearing and echoed in written comments by Legacy about concerns about attestation language use.

Response 11: See responses 4 and 7.

Greg Miller, PeaceHealth (Exhibit 4)

Comment 12: Review rules' application to health systems. As stated by PeaceHealth: "PeaceHealth urges the OHA to review the application of these rules as they apply to hospital systems operating in Oregon. The language in HB 3076 was crafted with input and agreement from a variety of stakeholders who agreed that a spending floor could apply to a hospital system and that system's not-for-profit clinics."

Response 12: Rule and statute language allows, but does not require, a system to coordinate on behalf of its member hospitals and those hospital's affiliated clinics. 409-023-0110(5) provides the option for a health system to apply the spending floor to its hospitals and their nonprofit affiliated clinics. A system may choose to have one single spending floor assigned to all hospitals and their hospital-affiliated clinics, or to have multiple spending floors assigned to different groupings, all while using the existing data collection mechanisms.

The statute and rules do not apply to a hospital-system-owned or -controlled clinic. If a clinic, or chain of clinics, is not owned or controlled by an individual hospital it is not subject to the spending floor.

See response 3 for additional comments.

Comment 13: Correct methodologies to reflect statute language and legislative intent (similar to comment 3, 6, and 10). PeaceHealth reiterated similar comments made by OAHHS and Legacy about language used for applicable spending floor methodologies.

Response 13: See response 3.

Megan McAninch-Jones, Providence Health and Services (Exhibit 5)

Comment 14: Align regulations with legislative intent. As stated by Providence: "Providence is concerned that the proposed regulations do not align with legislative intent and agreements made during the legislative process. HB 3076 was carefully negotiated to address three unique issues: financial assistance, community benefit spending floors and nonprofit status of health care entities. Specific to the spending floor, it is important that the Authority recognize that the spending floor is intended to apply to those entities for which a health system counts toward community benefit. The regulations should establish a standardized process for understanding how a hospital and its nonprofit affiliated clinics' total community benefit compares to the revenue generated from the hospital."

Response 14: See responses 3 and 12. OHA will always consider, and respect, the legislative intention behind statutory language. OHA believes that these rules, as edited through this stakeholder process, remain true to both statutory language and legislative intent.

Comment 15: Maintain continuity between statutory and regulatory definitions (Similar to comment 2, 5 and 9). Providence reiterates comments made by OAHHS and Legacy about concerns with new definitions. Providence further notes that definitions for affiliated clinic or hospital affiliated clinic, community benefits, hospital, and non-profit need to align with HB3076.

Response 15: See response 2.

Comment 16: Methods for reporting and applying community benefit spending floor (similar to comment 3, 6, 10 and 13). Providence reiterates comments made by OAHHS, Legacy and PeaceHealth about language used for applicable spending floor methodologies.

Response 16: See response 3.

Comment 17: Concern with new attestation language (similar to comment 4,7 and 10). Providence reiterated comments made by OAHHS and Legacy with concerns about attestation language use.

Response 17: See responses 4 and 7.



Legacy Health
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November 23, 2020

Steven Ranzoni
Oregon Health Authority
Health Policy and Analytics
500 Summer St NE
Salem, OR 97031

Re: Oregon Administrative Rules 409-23 (Hospital Community Benefit)

Dear Mr. Ranzoni,

Legacy Health is Oregon's only locally owned nonprofit health care provider in the Portland-Vancouver area and mid-Willamette Valley. We are an integrated network of care providers with over 100 primary care, urgent care and specialty care clinics, and seven community-based and nationally recognized hospitals.

Nonprofit hospital community benefit investments and programs are driven by community health needs assessments (CHNAs) and community health improvement plans. The improvement plans guide our community-focused work, including investments and health efforts based on prioritized needs identified in the CHNAs. With limited resources within our communities, it is imperative that we are strategic with our solutions and community benefit resources.

The current community benefit structure allows hospitals the ability to think outside the box, respond to the individual needs of our communities, and collaborate with other systems to combine our resources for a greater impact. The 2019 legislative intent regarding HB 3076 was clear. These new requirements would still allow flexibility and innovation as well as permit continued work as health systems and with community partners to ensure that community benefit programs continue to move the needle on health outcomes.

We appreciate the work and collaboration of the Oregon Health Authority in developing OAR 409-23; however, Legacy still has several concerns with the proposed rule as published for public comment.

Definitions

Legacy is concerned that the definitions in OAR 409-023-0100 do not reflect statutory definitions. We request that the definitions of "control," "outpatient clinic" and "nonprofit" be removed from the rule.

First, the definition of "hospital-affiliated clinic" was carefully crafted with stakeholders, in statute, as a key element of the legislative process. The proposed rules now include new definitions for "control" and "outpatient clinic" as sub-definitions of "hospital-affiliated clinic." These definitions are not needed, and they are inconsistent with the legislative intent. Second, the definition for "nonprofit" is also not needed as this term is already defined in state statute. Having two different definitions is not only unnecessary but also causes confusion.

The addition of these new definitions could lead to inclusion of services not intended to be included in the program, such as private-public partnerships or for-profit care settings, which are not included in community benefit reporting.

Community Benefit Minimum Spending Floor

OAR 409-023-0110 should be corrected to reflect legislative intent established in the development of HB 3076. It was clear to all stakeholders that the community benefit spending floor would only apply to hospitals and their nonprofit affiliated clinic. Legacy requests that (5) (a-d) include the word "nonprofit" as shown below.

(5) Each hospital may select among the following methodologies, as applicable to the hospital's organizational structure, for the purpose of applying a minimum community benefit floor:

(a) By an individual hospital combined with all its **nonprofit** affiliated clinics as a single entity;

(b) By an individual hospital as one entity and all its **nonprofit** affiliated clinics grouped as a second entity;

(c) By all hospitals in a health system and all of their hospital **nonprofit** affiliated clinics grouped as a single entity;

(d) By any other grouping of hospitals and **nonprofit** affiliated clinics that accounts for all of a hospital's or hospital system's hospitals and **nonprofit** affiliated clinics subject to the floor and is approved by the Authority.

Hospital Facility and Clinic Report

Legacy is concerned with the new language in OAR 409-23-0115 that requires an attestation signed by an officer "under false claims liability." First, we do not believe an attestation related to the Financial Assistance Policy (FAP) is necessary in this rule. Hospitals are already required under IRS Code Sec 501(r)(4) to post and make available the FAP using many different avenues. The FAP information is also required to be disclosed on the hospital's 990, Schedule H which is signed by an officer. Second, while hospitals and health systems regularly attest to agency guidance and/or compliance requirements, tying an attestation to a liability claim is unnecessarily punitive. A posting and distribution requirement, which is generally stated, and (appropriately) not detailed about how the requirement is fulfilled, is not the type of requirement to which "false claims liability" is intended to apply. We request the attestation requirement be deleted from the rule entirely, or at the very least the words "under false claims liability" be removed from the rule.

Legacy Health appreciates the opportunity to comment on the proposed rule and look forward to collaborating toward final consensus language in OAR 409-23.

Sincerely,



Kamesha Robinson
Director, Community Benefit

Ranzoni Steven

From: Kirsten Isaacson <KirstenI@seiu49.org>
Sent: Monday, November 23, 2020 1:07 PM
To: Edlund Peter M
Cc: Ranzoni Steven
Subject: SEIU49 comments re HB3076 published draft rules

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Hello Mr. Edlund-

Before diving into the comments, we would like to express our gratitude to OHA staff for running an efficient rule-making process, making changes clear at each step, and facilitating thoughtful discussion with ample opportunity for input. We recognize that OHA is balancing many priorities and have appreciated the thoughtful, inclusive approach.

The intent and purpose of this bill was to offer clarity, install protections, and promote investments that will improve the health and lives of Oregonians. We believe the published draft rules continue to move in that direction. Specifically, the rules concerning public disclosure, reporting, and opportunity for comment are clear and in alignment with the legislative directive to provide for a robust and transparent process. In addition, the definitions proposed in the draft rules offer important clarity that will help drive a program that realizes the legislation.

Our only concern is centered in a single topic area: adequate transparency regarding the intent of the reported spending. Currently, there are challenges in representing the statute-required factors of 1.) demographics of the population served and 2.) spending on the social determinants of health (Section 6.(1)(e)and(f)) in the spending floor methodology. We feel strongly that transparency is necessary in these areas and believe that adding clarity is required to realize the intent of the legislation.

The requirement in draft rules 409-023-0105 (9) calls for community benefit reporting to a) identify the community need or health improvement strategy the community benefit addresses; b) disclose the entities to which hospital gave funds, grants, or in-kind contributions; and (c) report activities that address the social determinants of health. While these requirements set in rule are a good start, stopping short of offering clear directives leaves room for unknowns when it comes to how each hospital may choose to report specifics.

Narrowing down the details of the community benefit reporting is being discussed in a separate workgroup. We will continue to participate in that process, but will take this opportunity to reiterate our strong desire for detailed transparency.

We believe detailed reporting requirements are needed to understand the quality and impact of community benefit investments. Comprehensive information on the population(s) served by an investment and how the investment(s) is tied to addressing an identified health need or social determinant of health is important. The population intended to benefit from an investment is not always the same as the population residing in a hospital's service area. Again, we propose alignment with [NASHP's recommended community benefit reporting](#) template by including additional columns that track, by investment: target populations and/or regions, partners engaged, outcomes to date, and data used to measure outcomes.

We look forward to working to achieve this clarity in the workgroup and again reiterate our appreciation for the well-organized process by which these rules and related reporting forms were generated.

Sincerely,

Kirsten Isaacson
Research Director

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November 23, 2020

Oregon Health Authority
Health Policy and Analytics
500 Summer St NE
Salem, OR 97031

Re: Oregon Administrative Rules 409-23 (Hospital Community Benefit)

Dear Mr. Ranzoni,

Thank you for the opportunity to comment on proposed rules to codify the community benefit spending floor program and health care facility reporting sections of House Bill 3076 (2019). We appreciate the efforts to develop a transparent and novel methodology for calculating the minimum spending floor program and establishing a reporting system to capture financial assistance policy information at a facility-level. HB 3076 was a carefully crafted bill that was the result of over three years of discussions with stakeholders on modernizing Oregon's community benefit program. We have concerns that some areas of the rules steer away from legislative intent and agreements among partners on the development of the program. Specifically, we have concerns in the following areas:

New Definitions

The definitions in OAR 409-23 must mirror the definitions in statute. The proposed rules include new definitions for 'control' and 'outpatient clinic', both of which are used in the definition of 'hospital-affiliated clinic' as well as a new definition for 'nonprofit'. The definition of 'hospital-affiliated clinic' was as an important part of the policy development process. Adding sub-definitions for 'control' and 'outpatient' clinic will create confusion and potential unintended consequences of capturing, or not capturing, appropriate facilities which are accountable for community benefit.

There is a robust definition of 'nonprofit' included in HB 3076 which is different from the proposed new definition of 'nonprofit' in rule. These definitions were not discussed during the rules advisory committee process and have not been a part of public meeting discussions. The definitions of 'control', 'outpatient clinic' and 'nonprofit' should be stricken from the proposed rule.

Hospital and Health System Organization

As reflected in our comments from Oct. 22nd, the manner in which hospitals and health systems organize themselves for purposes of the program must reflect the reality of how community benefit programs and expenditures are delivered. During policy development, it was clear to all stakeholders that the spending floor program would apply only to hospitals and their nonprofit affiliated clinics. It is the reason the explicit examples are in provided in statute. OAHHS recommends the following language:

(5) Each hospital may select among the following methodologies, as applicable to the hospital's organizational structure, for the purpose of applying a minimum community benefit floor:

- (a) By each individual hospital and all of the hospital's nonprofit affiliated clinics;
- (b) By a hospital and a group of the hospital's nonprofit affiliated clinics;
- (c) By all hospitals that are under common ownership and control and all of the hospitals' nonprofit affiliated clinics; or
- (d) By any other grouping of hospitals and nonprofit affiliated clinics that is approved by the Authority.

This would provide clarity to hospitals as the examples listed in statute should be carried over into rule language. Overall, our expectation is that the spending floor program will capture community benefit expenditures that align with the audited financial information for hospitals and clinics responsible for delivering community benefit programs and activities.

Hospital Facility and Clinic Report

We appreciate the separate and distinct section of rule to align with Section 7 of HB 3076 which serves a different policy goal than Section 6. The reporting structure looks appropriate, however, the language related to the attestation requiring signature by an officer under false claims liability is new. Hospitals and health systems comply with various requirements without attestation and this level of 'officer under false claim liability' is even further than what is commonly in rule. We request attestation be removed.

Thank you for your consideration of these important rule revisions to align with legislative intent.

Sincerely,



Sean Kolmer
Senior Vice President of Policy and Strategy
Oregon Association of Hospitals and Health Systems



November 23, 2020

Oregon Health Authority
Health Policy and Analytics
500 Summer St NE
Salem, OR 97031

RE: HB 3076 Rule Making - Community Benefit

Mr. Ranzoni,

PeaceHealth has a proud history of providing compassionate healthcare services to all who are in need in the communities we serve. Community benefit is an integral part of our mission and is a cornerstone of our dedication to providing health care services to all who are in need regardless of their financial situation.

It was a pleasure to work with you and the OHA team in drafting first-of-a-kind rules setting charity care spending floor, a state financial assist policy, and adding clarifications to not-for-profit hospital status. PeaceHealth was part of the legislative process that negotiated HB 3076, and therefore feel it is important to ensure that all the elements of the legislative agreement are captured in the final rules that will be considered.

- 1) PeaceHealth urges the OHA to review the application of these rule as they apply to hospital systems operating in Oregon. The language in HB 3076 was crafted with input and agreement from a variety of stakeholders who agreed that a spending floor could apply to a hospital system and that systems not-for-profit clinics.
- 2) In supporting the comment above, we simply ask that the 3 grouping examples that are enumerated in HB 3076 be added to section 5 of the proposed rules. Those grouping options are:
 - a. By each individual hospital and all of the hospital's nonprofit affiliated clinics;
 - b. By a hospital and a group of the hospital's nonprofit affiliated clinics;
 - c. By all hospitals that are under common ownership and control and all of the hospitals' nonprofit affiliated clinics.

Thank you, we appreciate the opportunity to comment and continue to contribute to this important work.

Greg Miller

Greg Miller, Director of Government Affairs



November 23, 2020

Oregon Health Authority
Health Policy and Analytics
421 SW Oak St, Ste 850
Portland, OR 97204

Via email: peter.m.edlund@dhsosh.state.or.us

RE: Rules Advisory Committee – House Bill 3076 (409-23 hospital community benefit)

Dear Mr. Edlund,

Providence Health & Services has a long tradition of compassionate care and dedication to our communities. Community benefit is integral to our Mission as a not-for-profit Catholic health care organization, and is one of the many ways Providence demonstrates our commitment to serving the poor and vulnerable. We appreciate the opportunity to participate on the rules advisory committee to implement House Bill 3076, and the Authority's openness to stakeholder feedback.

In response to the draft final rules, dated November 2, 2020, Providence would request consideration for the following:

Align regulations with legislative intent

Providence is concerned that the proposed regulations do not align with legislative intent and agreements made during the legislative process. HB 3076 was carefully negotiated to address three unique issues: financial assistance, community benefit spending floors and nonprofit status of health care entities. Specific to the spending floor, it is important that the Authority recognize that the spending floor is intended to apply to those entities for which a health system counts toward community benefit. The regulations should establish a standardized process for understanding how a hospital and its nonprofit affiliated clinics' total community benefit compares to the revenue generated from the hospital.

Maintain continuity between statutory and regulatory definitions

In order to limit confusion and align with legislative intent, Providence would request that all definitions in rule align with statutory definitions in HB 3076 and that the Authority not further define terms used in those definition. Specific definitions for consideration include:

- Definitions for "affiliated clinic or hospital affiliated clinic," "community benefits," "hospital," and "nonprofit" need to align directly with HB 3076.
- Definitions for "control" and "outpatient clinic" need to be deleted.

Methods for reporting and applying community benefit spending floor

During the development of HB 3076 and throughout the rule making process, there was a shared understanding among stakeholders that the community benefit spending floor program would apply to hospitals and their nonprofit affiliated clinics. While HB 3076 does allow the Authority to adopt alternative methodologies to apply the community benefit spending floor, Providence requests that the methodologies explicitly outlined in statute be included in 409-023-0110 (5). This would include:

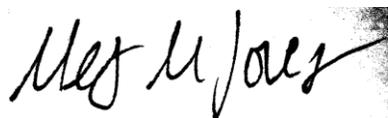
- By each individual hospital and all of the hospital's nonprofit affiliated clinics;
- By a hospital and a group of the hospital's nonprofit affiliated clinics;
- By all hospitals that are under common ownership and control and all of the hospitals' nonprofit affiliated clinics.

Annual reports of financial assistance policies and nonprofit status

Providence appreciates that the Authority created a distinct section to achieve the intent of HB 3076, Section 7. We would request that 409-023-0115(2)(d) related to attestation under false claims liability be removed from the regulation, this language is unnecessary as health systems regularly attest to various statements and compliance requirements.

Thank you for the opportunity to comment on this important issue.

Sincerely,



Megan McAninch-Jones, MSc, MBA
Director, Data Integration, Community Health Investment
Providence Health & Services