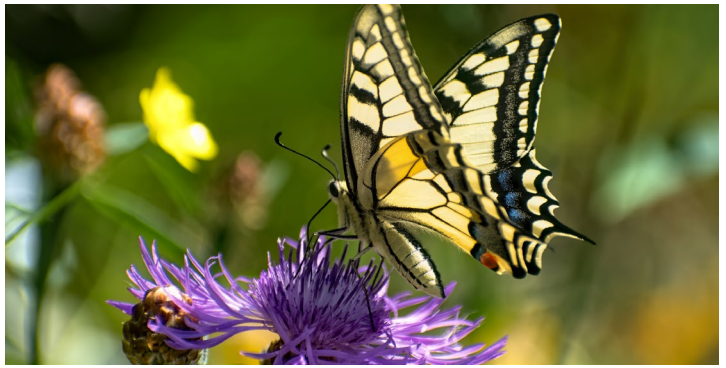
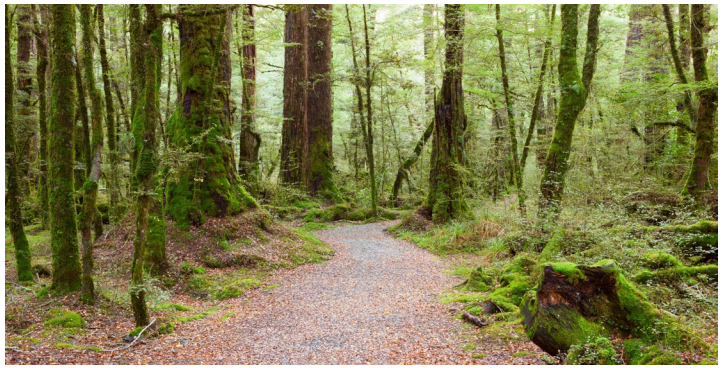
OREGON HEALTH AUTHORITY

Welcome!

Please make sure you are muted.

We will get started in a few minutes.

Chat or email us if you have technical issues.

Oregon Hospital Community Benefit Summit

July 22, 2026

OREGON HEALTH AUTHORITY

Health Policy & Analytics Division
Hospital Reporting Program

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 Nettle Alder**.

- 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
1:05 – 1:15 pm	Introduction	Sarah Grabe, Clare Pierce-Wrobel
1:15 – 1:20 pm	Community benefit reporting	Sarah Grabe
1:20 – 1:45 pm	Fiscal year 2024 data, partial fiscal year 2025 data	Steven Ranzoni
1:45 – 1:55 pm	Fiscal year 2024 Investments Report	Sarah Grabe
1:55 – 2:05 pm	Break	
2:05 – 2:20 pm	HFAR form deep dive	Steven Ranzoni
2:20 – 2:35 pm	HB 4040 Section 1: New prescreening rule	Sarah Grabe
2:35 – 2:50 pm	Question and answer, public comment	Sarah Grabe, Steven Ranzoni
2:50 pm	Adjourn	

Who we are

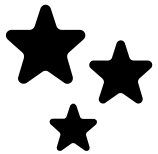
OHA staff

Clare Pierce-Wrobel	Piper Block	Steven Ranzoni	Sarah Grabe	Rachel Higgins	Nettle Alder
Health Policy & Analytics Division Director	Research & Data Unit Manager	Hospital Policy Advisor & Hospital Reporting Program Manager	Hospital Community Benefit Program Analyst	Hospital Finance Analyst	Hospital Reporting Program Analyst

Purpose of the Summit

Summit purpose

- 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

Health Policy & Analytics Division Director

Community benefit reporting

Community benefit reporting is required

- 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
- Hospital Reporting Program webpage

Community benefit reporting forms

- 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

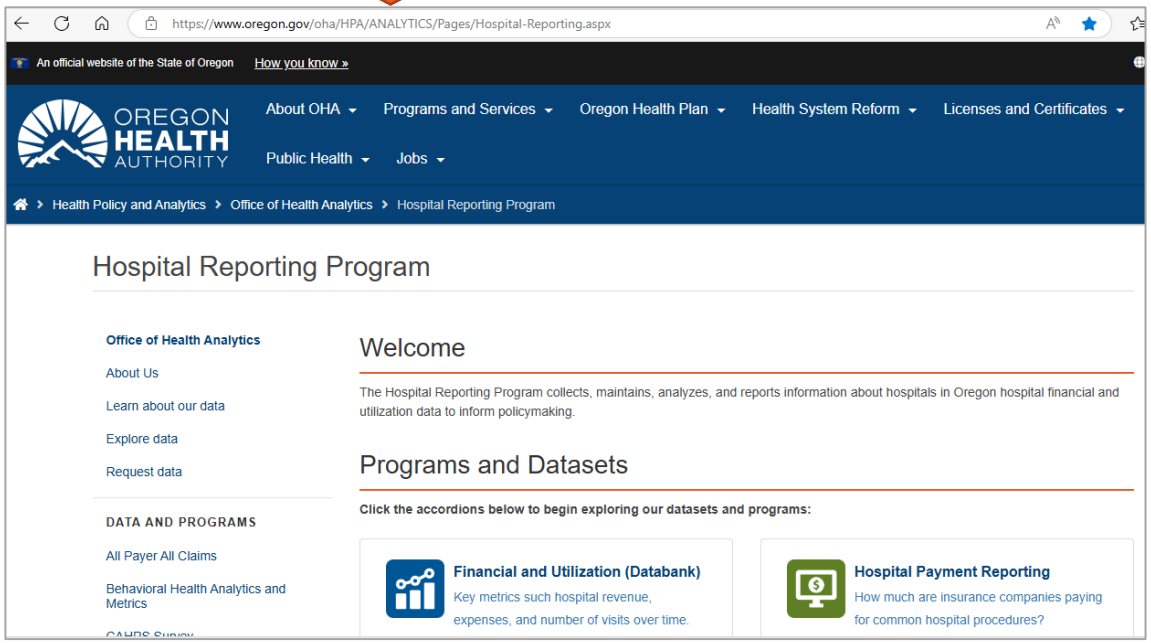
Find blank forms and extension request forms in the “Forms” section of the Hospital Reporting Program webpage

Form due dates

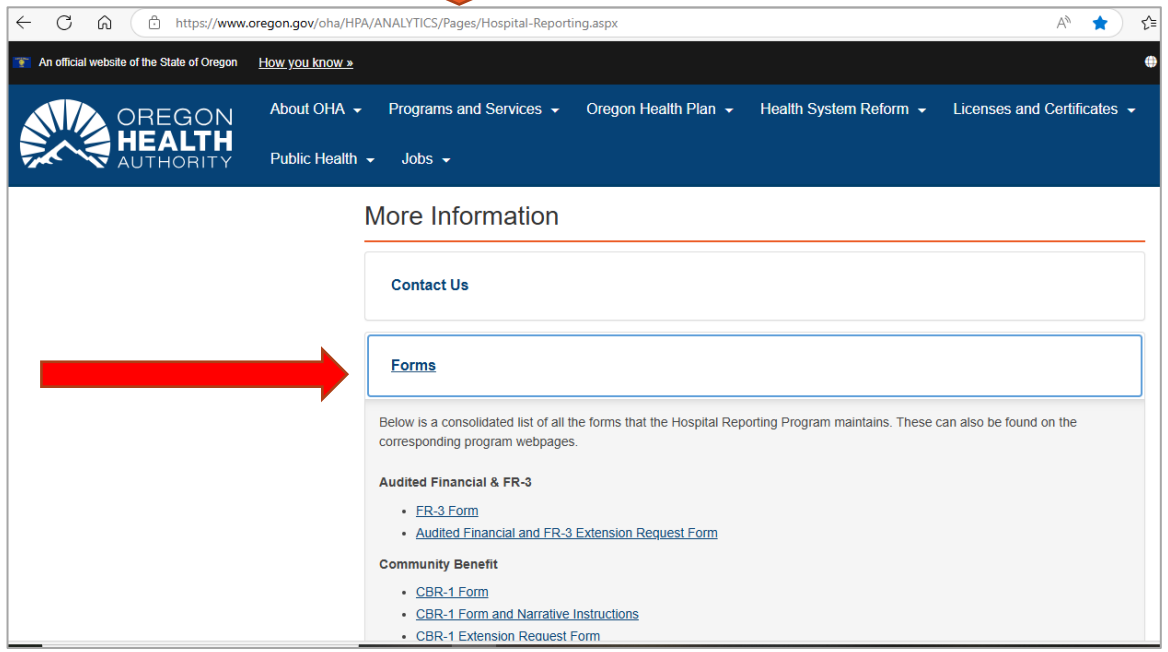
				FY26 Start - 90	FY25 End +120	FY25 End +150	FY25 End +240		FY26 End +120	FY26 End +150	FY26 End +240		FY28 Start - 90	FY27 End +120	FY27 End +150	FY27 End +240
			2025	FY25				2026	FY26			2027	FY27			
FY Start	FY End		HFCR	CBR-3 (odd years)	FR-3 & AFS	HFAR (new)	CBR-1 & Narrative & CHNA & CHIP	HFCR	FR-3 & 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

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



Website changes for digital accessibility

You may notice some changes to OHA's website to comply with new ADA regulations

The Hospital Profiles Archive is no longer in use

- The Hospital Reporting Program used to publish all submitted hospital documents to our Hospital Profiles Archive
- Many of these documents do not meet new ADA digital accessibility requirements so as a government agency, OHA will no longer publish them
- **The documents are still publicly available:**
  - By request (email HDD.Admin@odhsoha.oregon.gov)
  - By searching the Oregon State Library Archive
- **OHA will continue to share, analyze and report on the data**

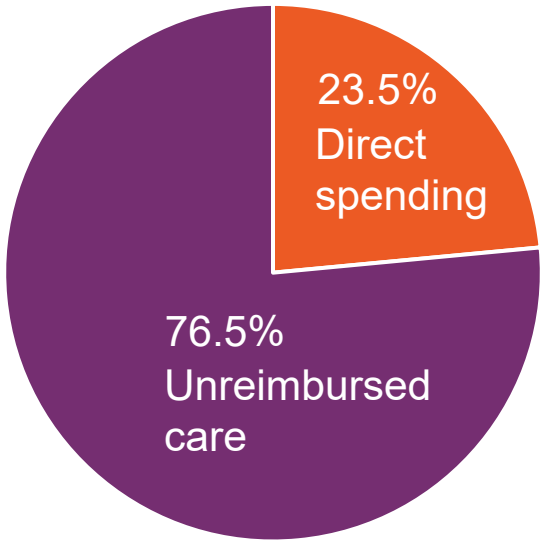
Form or document reporting questions?

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

Statewide fiscal year 2024 data, partial fiscal year 2025 data

Community benefit spending categories

Unreimbursed care	Direct spending
Unreimbursed Medicaid	Community building activities
Charity care	Cash and in-kind
Subsidized health services	Community health improvement
Other public programs	Health professions education
	Research
	Community benefit operations



Point in time look at reporting: July 22, 2026

- **Complete**, full year data: Fiscal year (FY) 24
  - View the FY 24 report: data brief and dashboard

- **Incoming**, partial year data: FY 25
  - Groups 1-4 submitted, group 5 will submit August 29, 2026
  - **The data in this deck are from groups 1-3, hospitals with reports submitted before May 1, 2026**
  - **Charts show both full year, all hospitals, and groups 1-3, for comparison**

- **Looking ahead**: FY 28 – 29 spending floors will be assigned in 2027

Community benefit spending floor data - 2024

- The statewide total community benefit spending floor was $1.6 billion
- Total statewide community benefit spending was $2.2 billion
- **Statewide spending exceeded the statewide floor by $612.6 million (137.4%)**
- **79.4% of hospitals met their spending floor**
  - Compliance decreased in 2024, from 92.1% in 2022 and 97.4% in 2023
  - Most lack of compliance can be attributed to unreimbursed care not meeting projected levels
  - The goal of unreimbursed care is to reflect the need, not to incentivize spending. Remember to monitor unreimbursed care costs and to reach out if costs are lower than projections
  - Group 1-3 hospitals have all met their floor in 2025 (with 28/58 hospitals reporting)

Community benefit spending floor formula

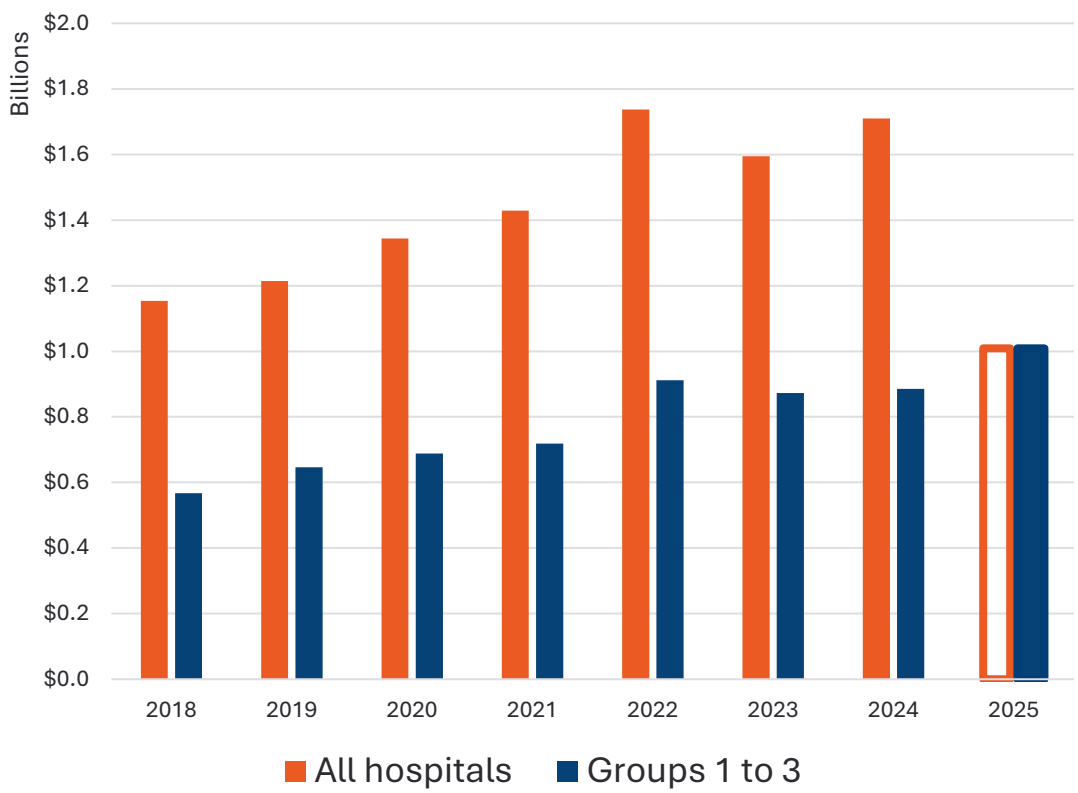
OHA does not currently have recommended changes to the spending floor formula. We recognize uncompensated care forecasting is the biggest current challenge.

OHA is open to feedback related to uncompensated care forecasting

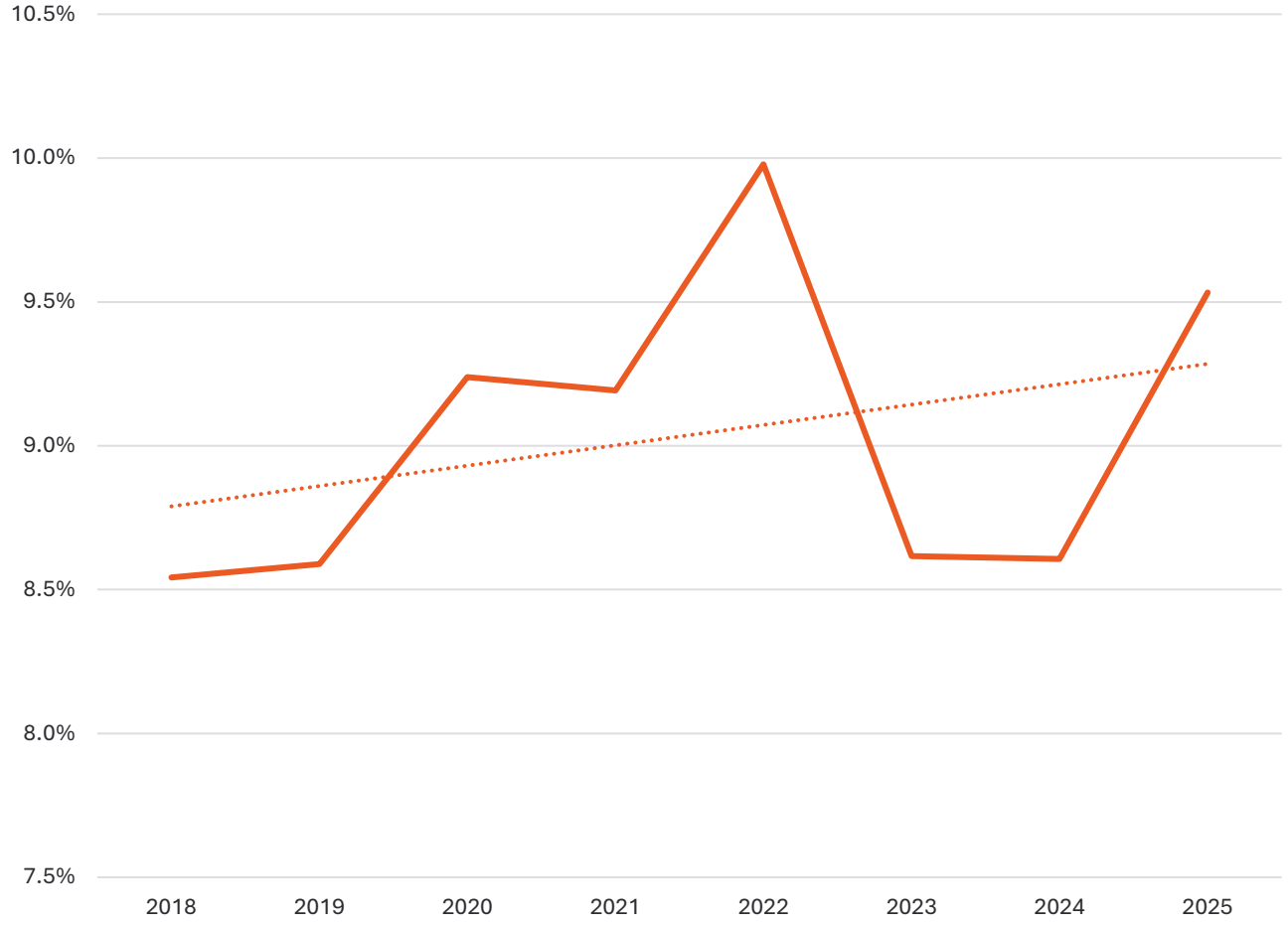
Unreimbursed care cost trend

- Unreimbursed care accounted for 76.5% of community benefit spending in 2024 ($1.7 billion)
- Unreimbursed care grew $115.1 million (7.2%) from 2023 to 2024
- Average growth rate of 6.8% from 2018 to 2024
- Unreimbursed care is on pace to total $1.9 to $2.0 billion in 2025, about a 13% increase from 2024*

*Only reporting groups 1-3 for 2025



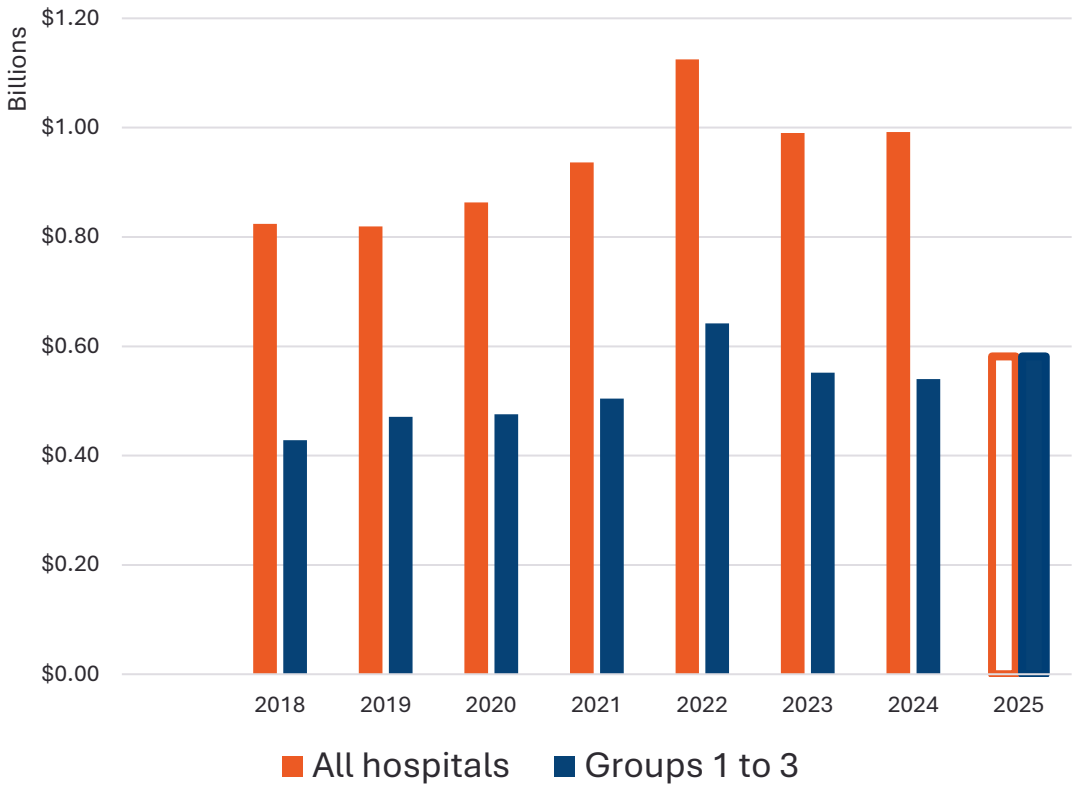
Unreimbursed care expense ratio



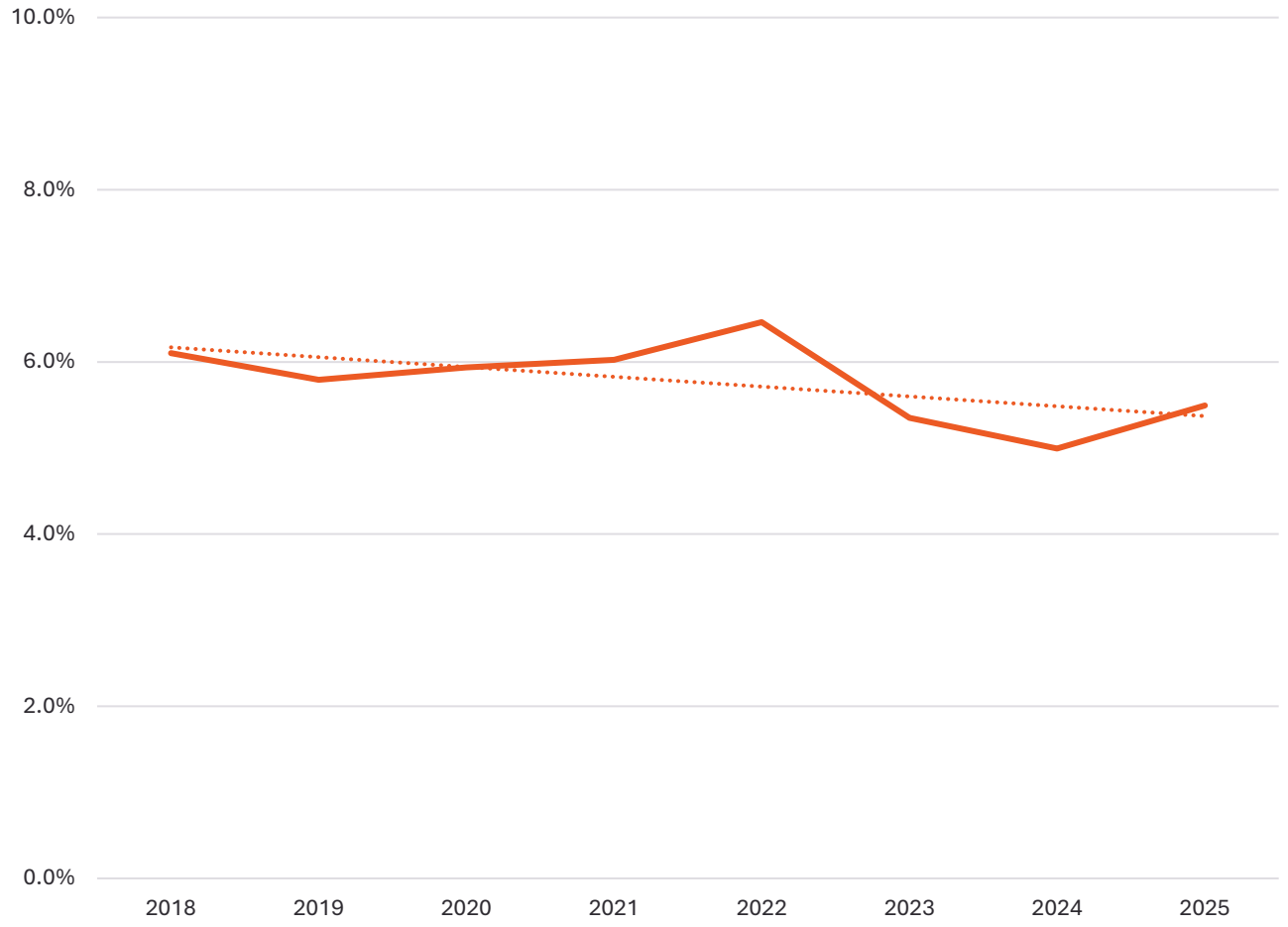
- Unreimbursed care expense ratio = unreimbursed care as a proportion of total operating expense
- Unreimbursed care has shown volatility, and overall growth as a proportion of total operating expenses
- Unreimbursed care expense was 8.6% of total operating expense in 2024 but is projected to grow to 9.5% in 2025

Unreimbursed Medicaid cost trend

- Unreimbursed Medicaid made up 44.4% of community benefit spending statewide in 2024 at $991.9 million and was effectively flat from 2023
- 2022, the first year of the spending floor, was an outlier year of higher spending
- Unreimbursed Medicaid's average annual growth rate is 3.1% from 2018 through 2024
- Unreimbursed Medicaid costs project to be $1.0 to $1.1 billion in 2025, a 7% increase from 2024



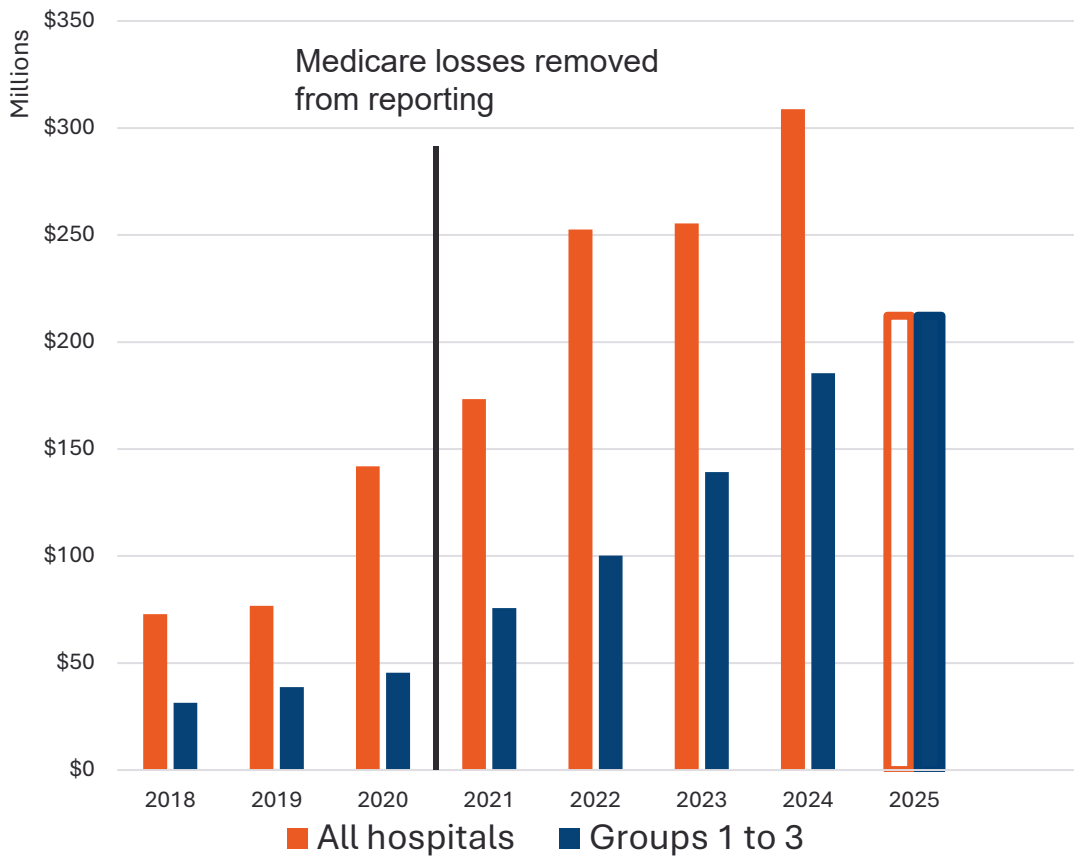
Unreimbursed Medicaid expense ratio



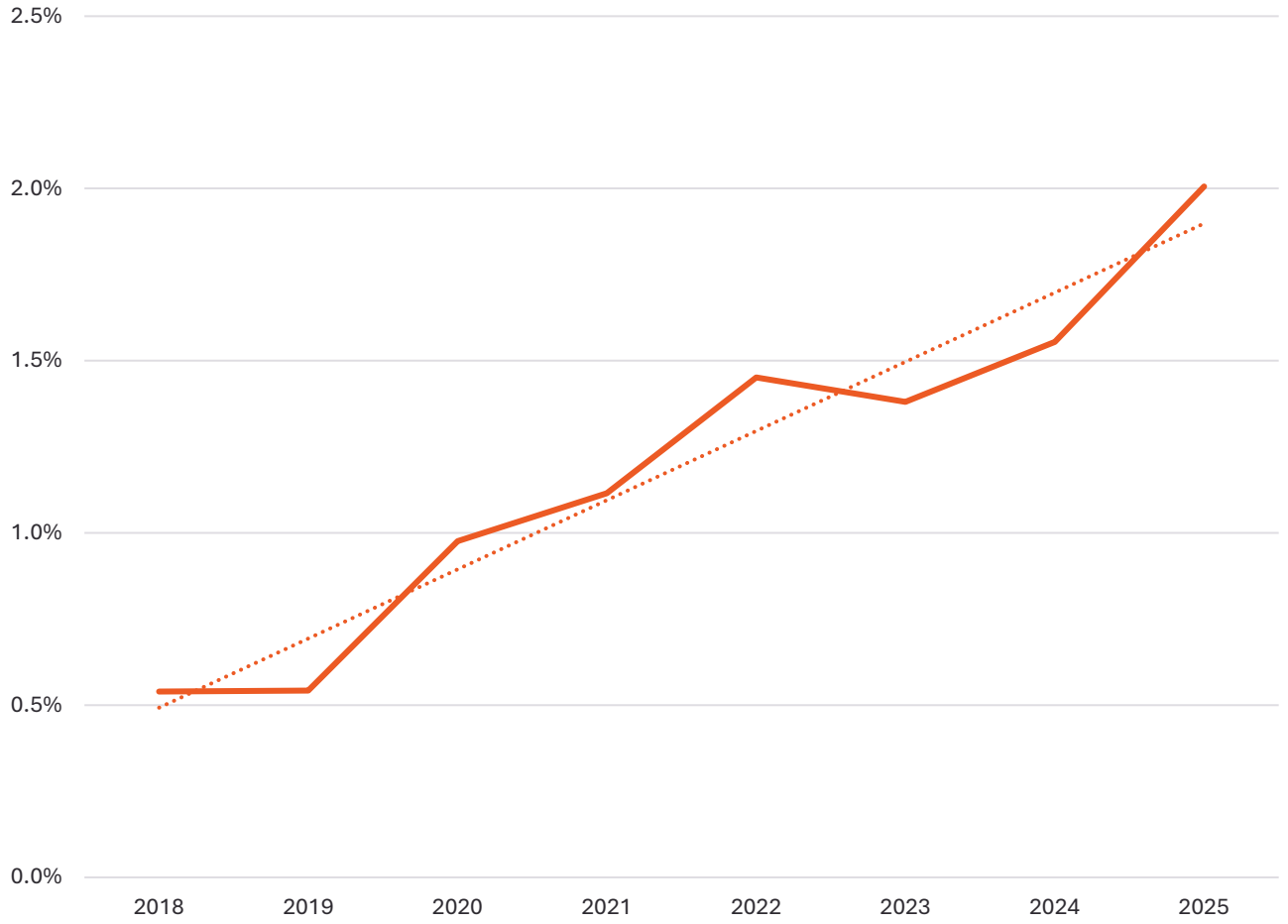
- Unreimbursed Medicaid expense ratio = unreimbursed Medicaid as a proportion of total operating expense
- Unreimbursed Medicaid has slightly decreased as a share of total operating expense
- Unreimbursed Medicaid was 5.0% of total operating expense in 2024 and is projected to be 5.5% in 2025

Subsidized health services cost trend

- Subsidized health services (SHS) made up 13.8% of community benefit spending statewide in 2024 at $308.7 million
- SHS costs increased significantly since the removal of Medicare losses from reporting in 2020
- SHS average annual growth rate is 27.2% from 2018 through 2024
- SHS projected to be $385 million in 2025, a 25% increase from 2024



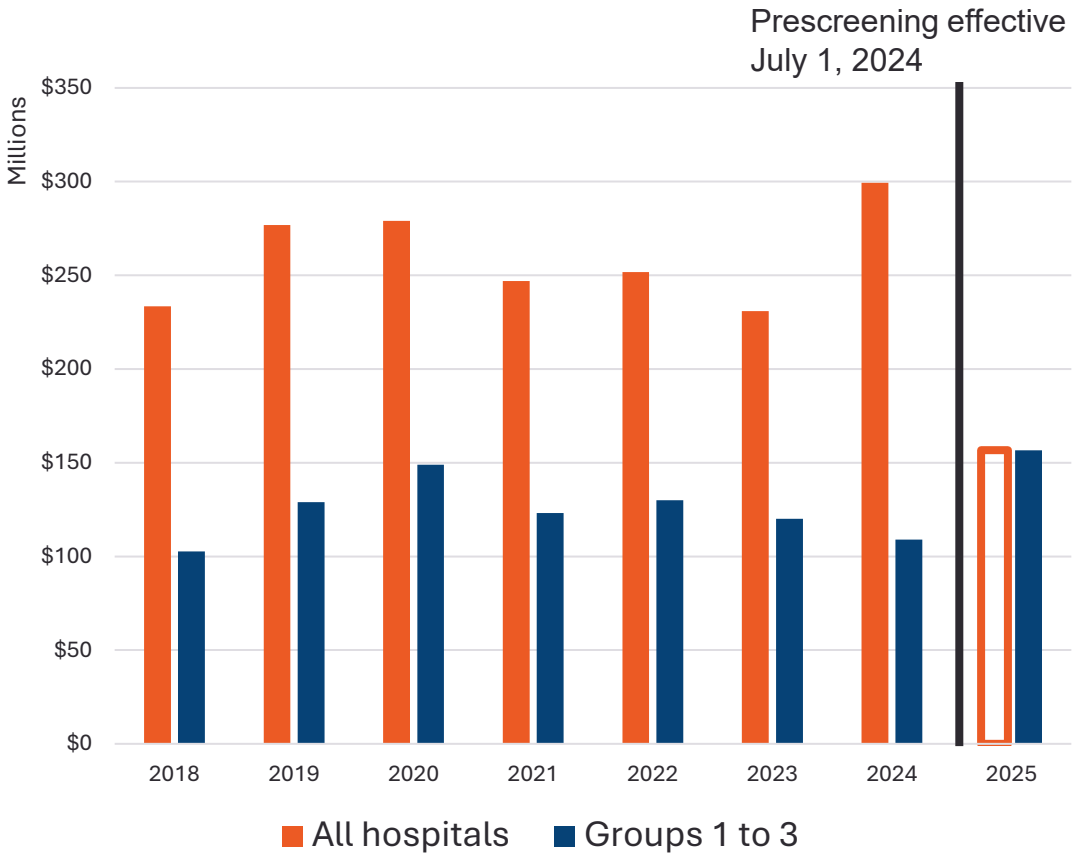
Subsidized Health Services expense ratio



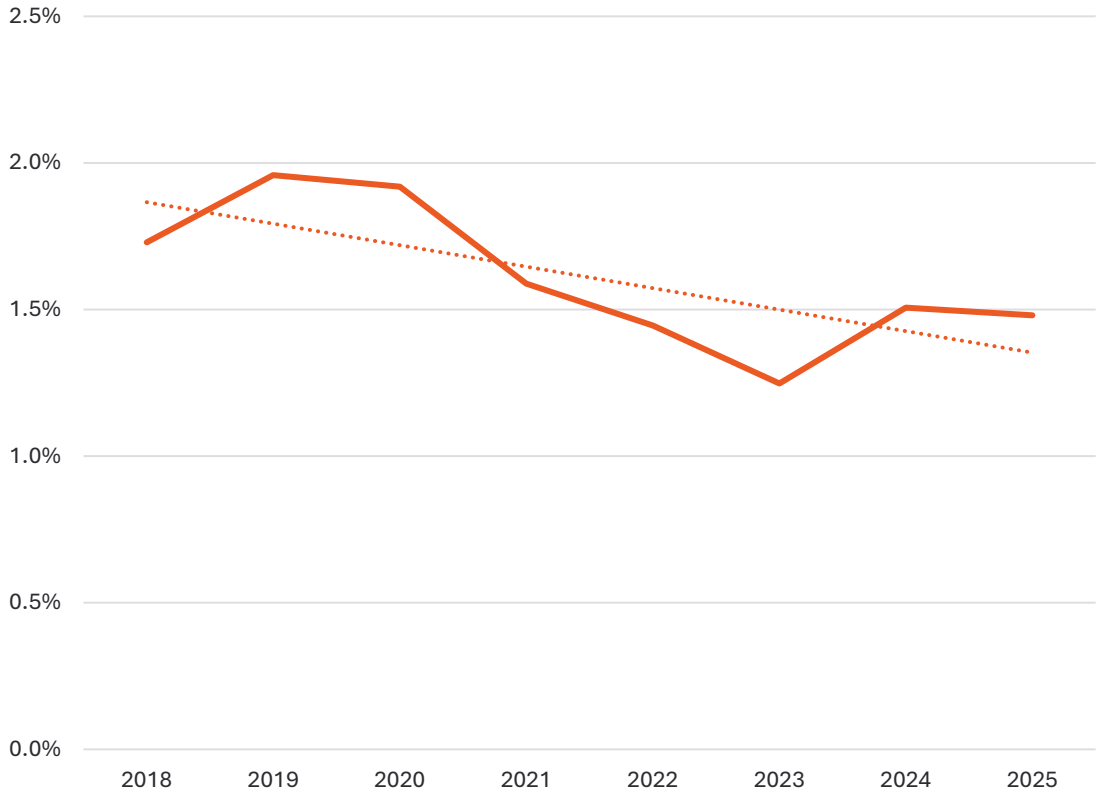
- SHS expense ratio = SHS as a proportion of total operating expense
- SHS has grown sharply as a share of total operating expenses
- SHS made up 1.6% of total operating expense in 2024 and is projected to be 2.0% in 2025

Charity care cost trends

- Charity care made up 13.4% of community benefit spending statewide in 2024 at $299.3 million
- The amount of charity care spending grew in 2024, in part due to new financial assistance laws
- The first full year of charity care prescreening data will be available once fiscal year 2025 is complete
- Charity care is projected to be $325 million in 2025, an increase of 9% from 2024



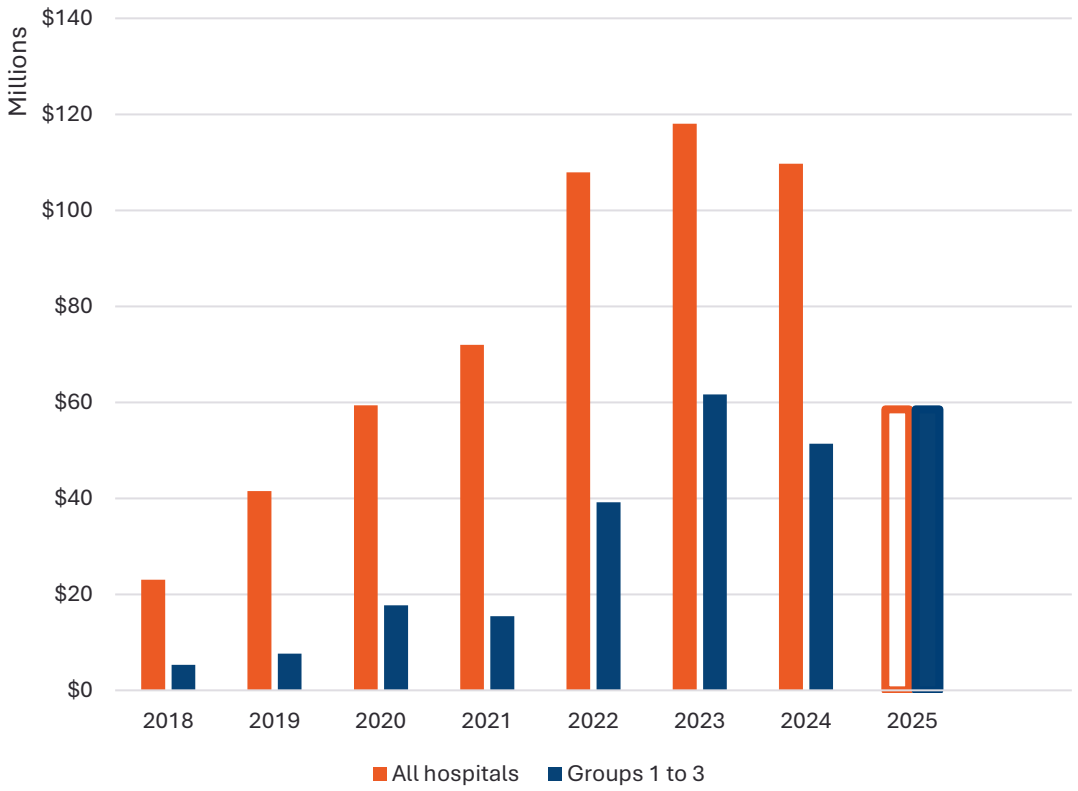
Charity care expense ratio



- Charity care expense ratio = charity care as a proportion of total operating expense
- Charity care has decreased as a share of total operating expense overall, though it increase in 2024 to 1.5% from 1.2% in 2023
- Charity care is projected to remain flat at 1.5% of total operating expense in 2025

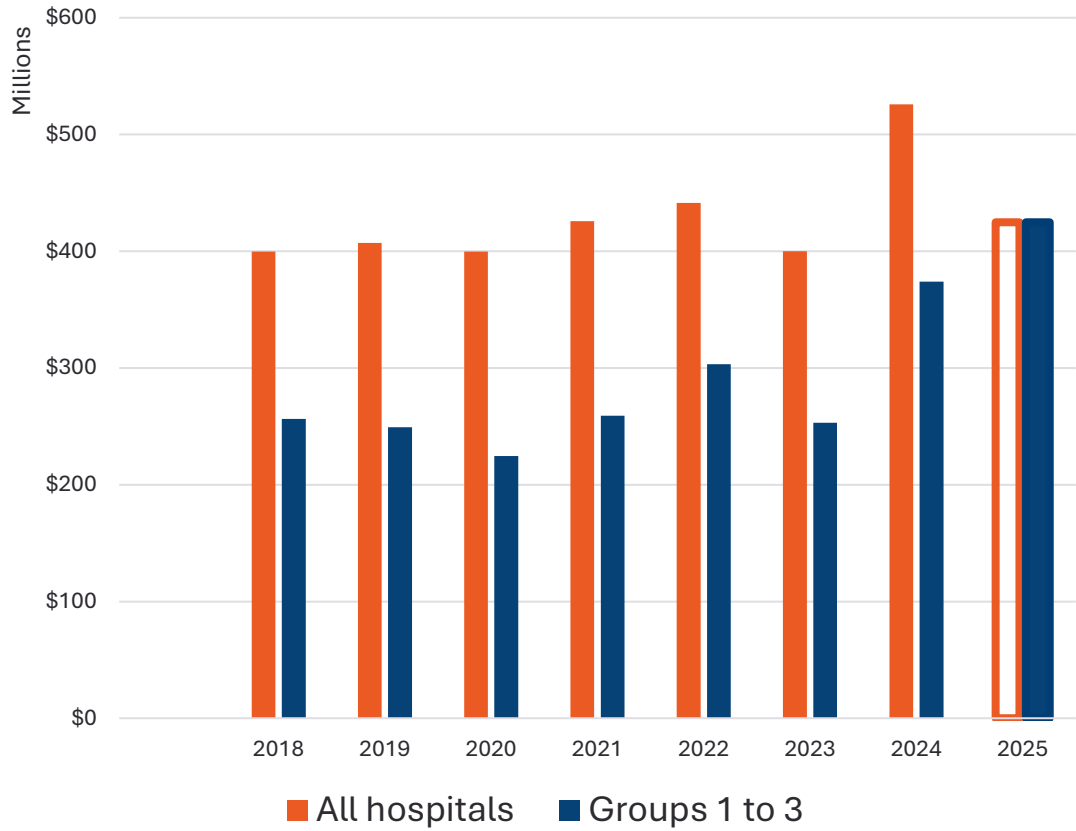
Other public programs cost trend

- Other public programs cost was 4.9% of community benefit spending statewide in 2024
- Spending peaked in 2023 and fell back in 2024 at $109.7 million

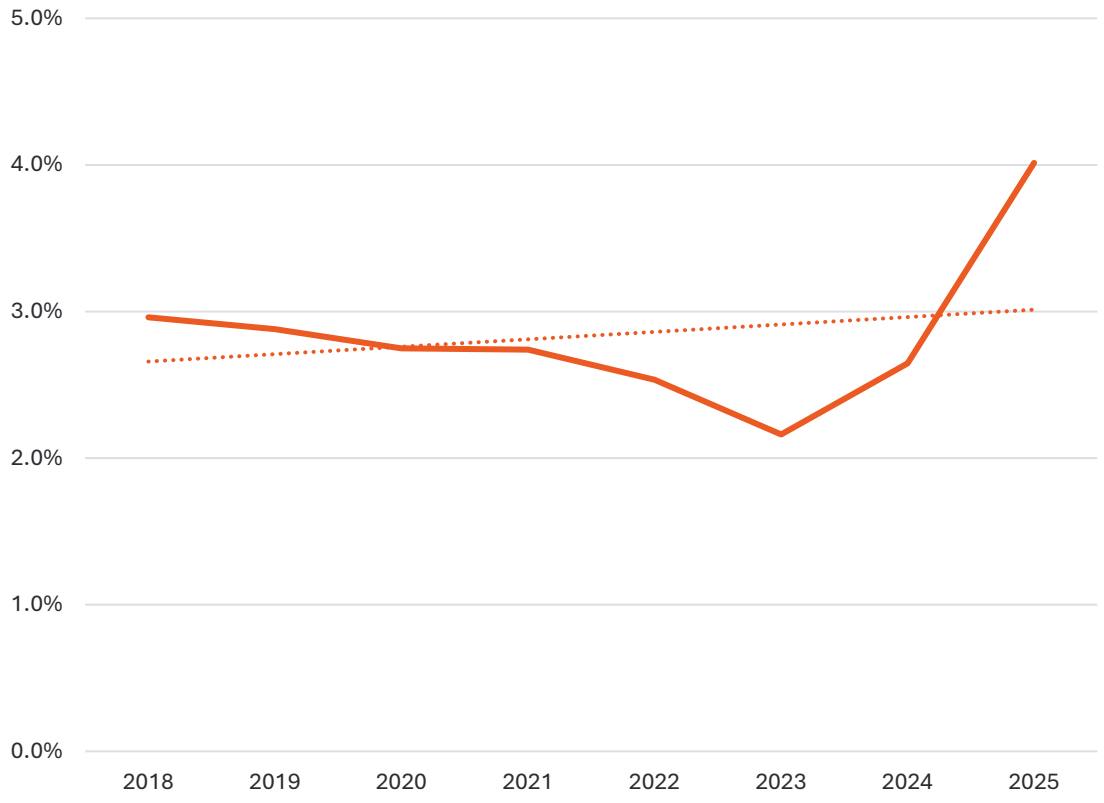


Direct spending trend

- Direct spending accounted for 23.5% of community benefit spending in 2024
- Direct spending grew from $400 million in 2023 to $525.9 million in 2024
- OHSU accounted for most of the direct spending growth, $105.7 of the $125.9 million increase, mostly in Health Professions Education and Research
- Spending increases varied by hospital size: smaller, individual hospitals increased their direct spending 48.5% compared with larger health systems that increased just 3.1% on average



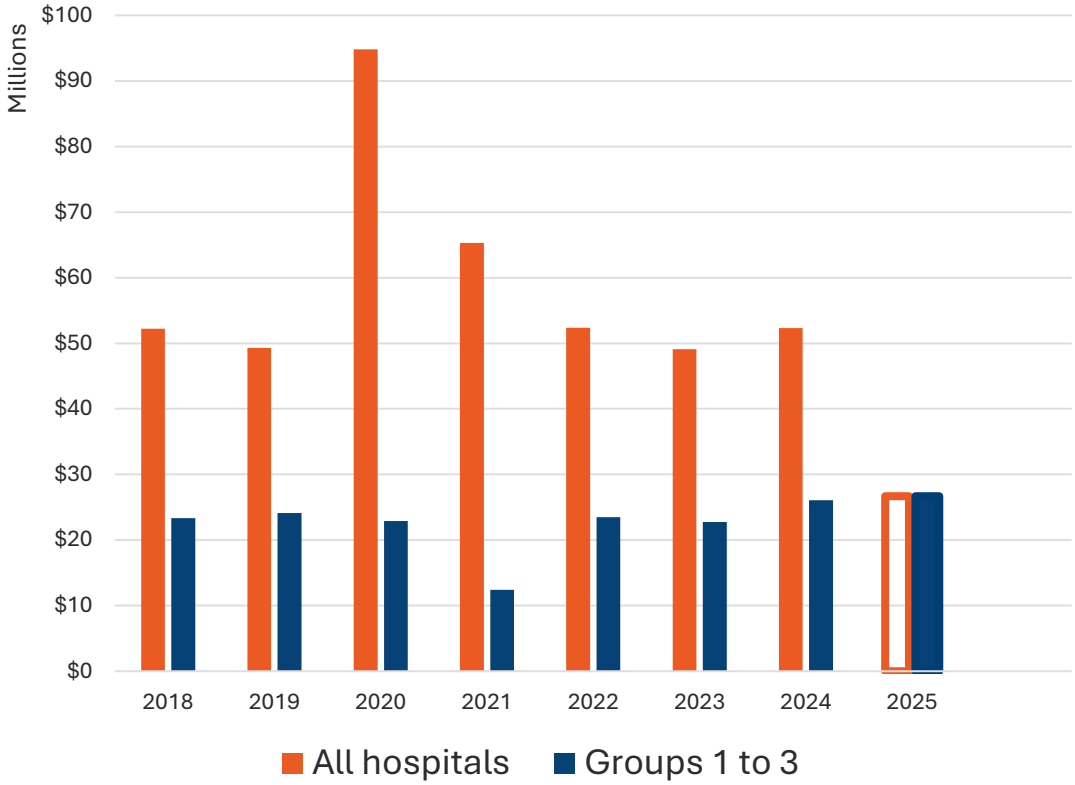
Direct spending expense ratio



- Direct spending expense ratio = Direct spending as a proportion of total operating expense
- Direct spending increased from 2.2% of total operating expense in 2023 to 2.6% in 2024. It is projected to jump to 4.0% in 2025
- Much of the increase is due to health professions education and research

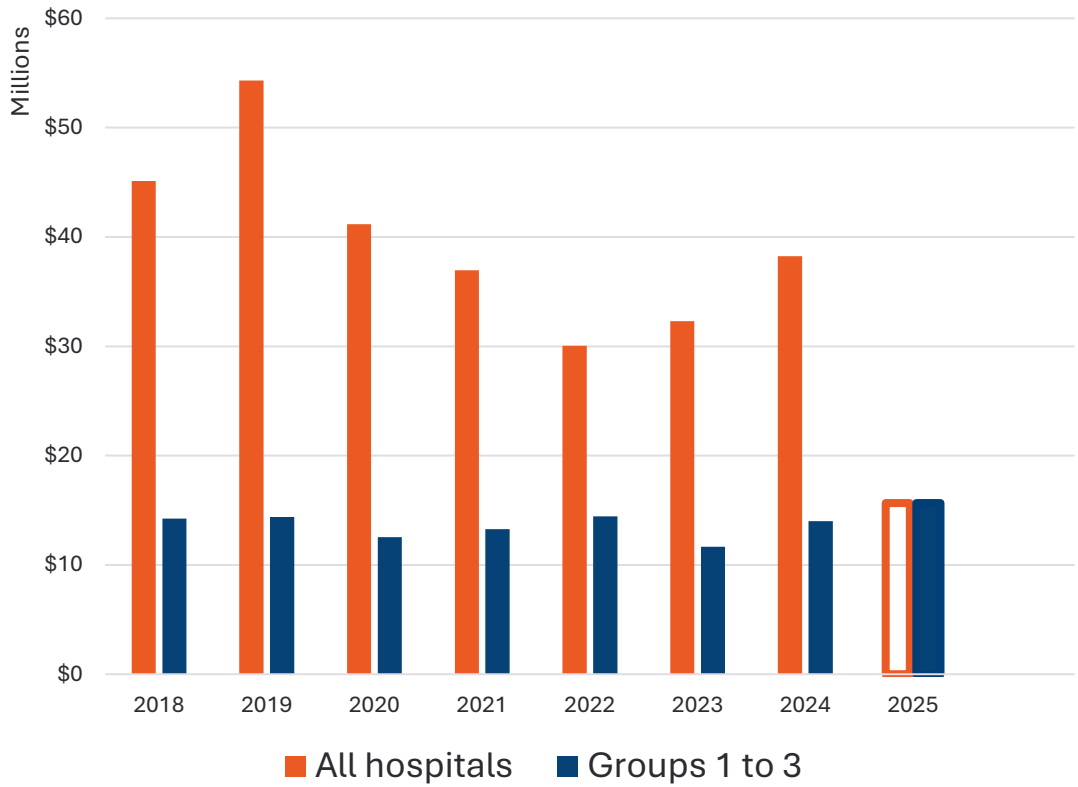
Community health improvement trend

- Community health improvement made up 2.3% of community benefit spending statewide in 2024
- It grew from $49.1 million in 2023 to $52.3 million in 2024



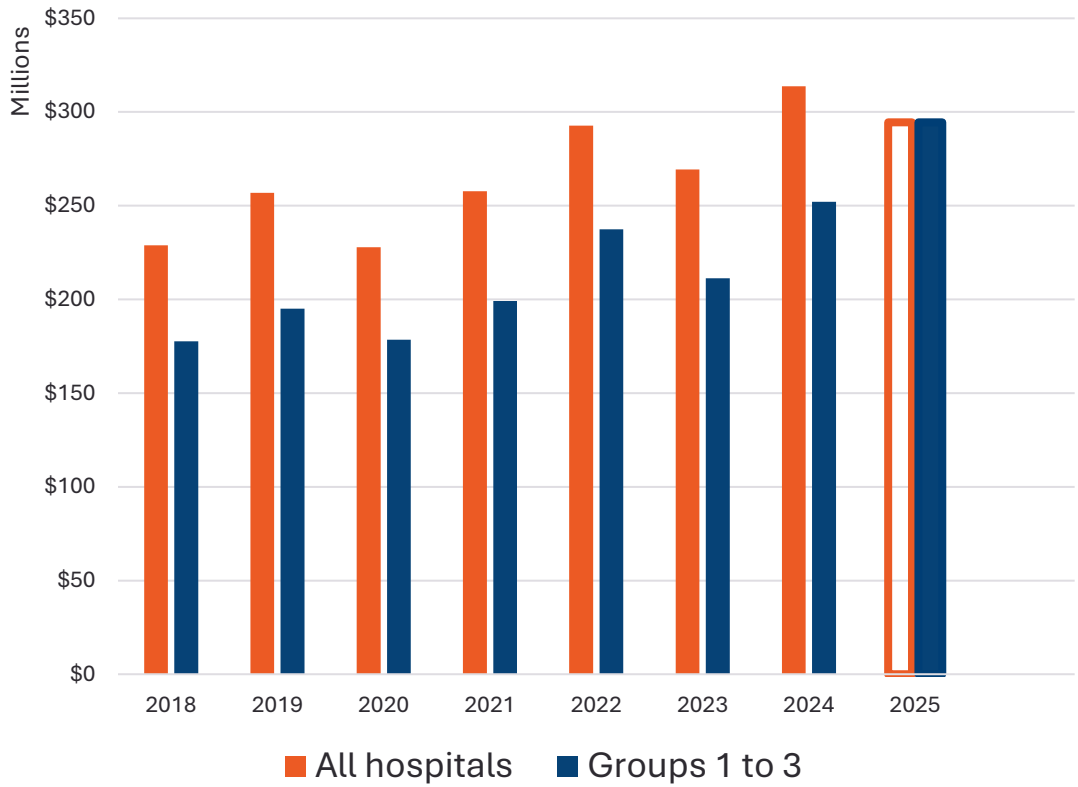
Social determinants of health trend

- Social determinants of health (SDOH) is comprised of community building activities and cash and in-kind
- SDOH are part of the definition of community benefit in Oregon, and an integral piece of community benefit spending
- SDOH made up just 1.8% of community benefit spending statewide in 2024 ($38.2 million)



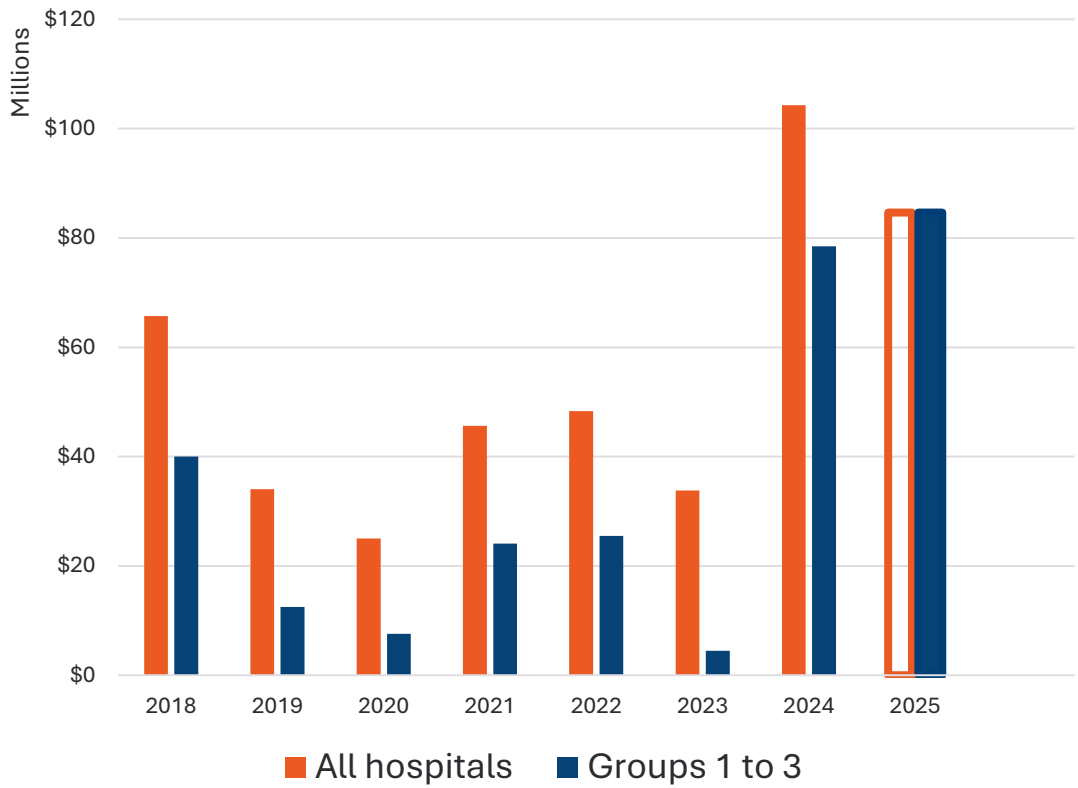
Health professions education trend

- Health professions education made up 14% of community benefit spending statewide in 2024
- HPE increased from $269.4 to $313.7 million from 2023 to 2024
- OHSU spent $213.2 million of the $313.7 million statewide total



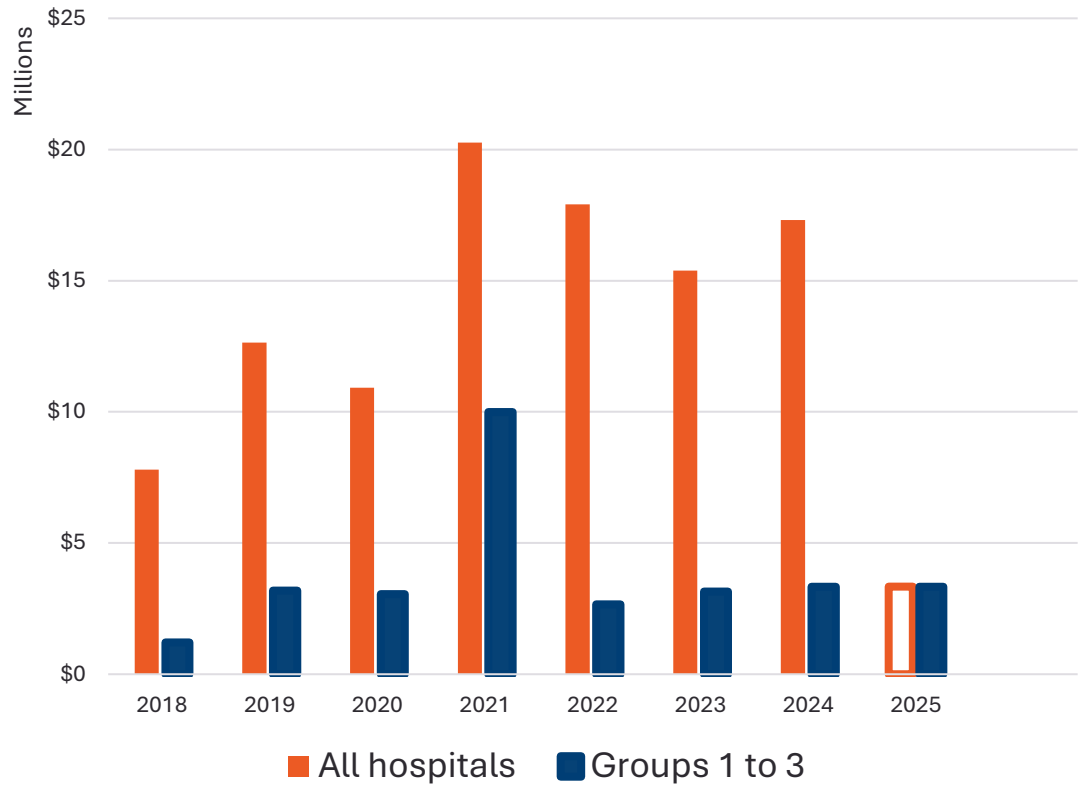
Research trend

- Research made up 4.7% of community benefit spending statewide in 2024
- It increased $33.8 million from 2023 due to OHSU not reporting research in 2023 but reporting in 2024
- Excluding OHSU, research spending would have decreased from $33.8 to $30.3 million



Community building operations trend

- CBO made up 0.8% of community benefit spending statewide in 2024
- **Reminder**: hospitals can count staff time towards completing community benefit reporting, and time and/or payments towards completing a CHNA and CHIP

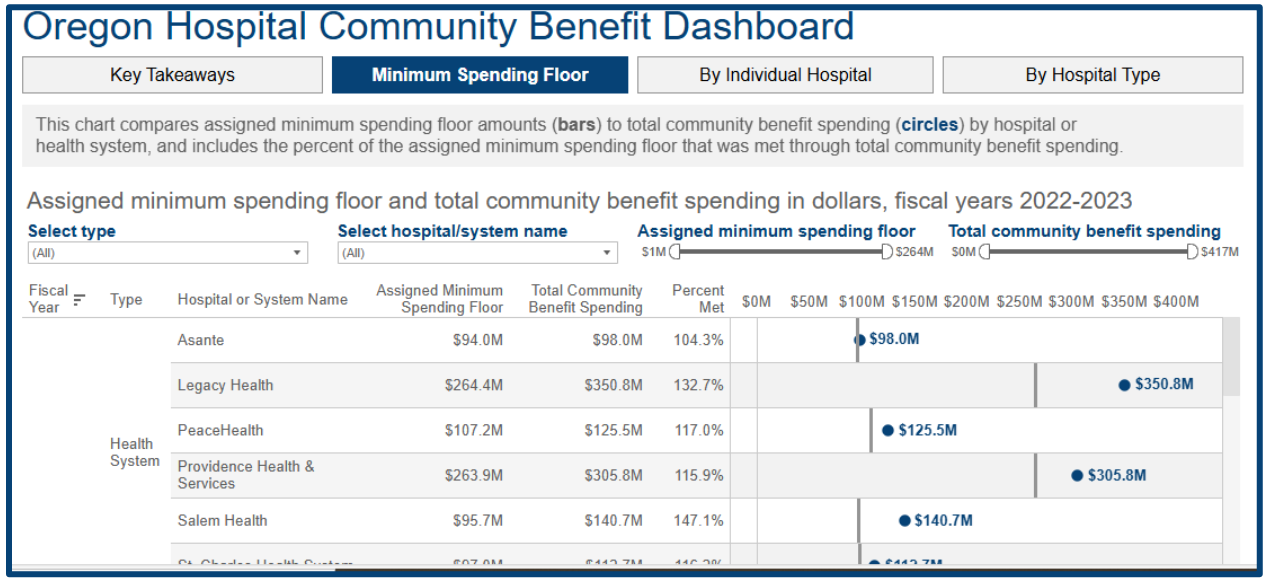


Community benefit reporting tips

- Community health worker/traditional health worker hours dedicated to work beyond standard patient care or discharge planning are **reportable community benefit costs**
- Staff time spent completing community benefit reporting, writing the narrative, and working on CHNA/CHIP are all **community benefit operation** costs
- **Subsidized health services are not for general losses**. They must be a service that is an identified community need in your community health needs assessment, and one the community would be without if your hospital didn't offer the service
- Reporting **consistently** in each category each year allows for more accurate data and analysis
- Reporting in **cash and in-kind** and **community building activities** are most closely tied to SDOH, a key priority for community benefit

Visit our website to learn more

- Community benefit dashboard



- Spending floor information

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%*)

Fiscal year 2024 Investments Report

Purpose of the report

OHA publishes this report for the following reasons:

- To answer the question, “How are nonprofit hospitals fulfilling their charitable obligations through proactive community benefit?”
- To highlight innovative work that nonprofit hospitals and health systems are doing across the state to:
  - Raise awareness for patients and community members about what programs and services are available in their communities
  - Provide opportunities for hospitals, CCOs, and local organizations to learn from each other’s work
  - Showcase work that hospitals do above and beyond patient care

FY24 top identified health priorities

86% identified access to care and transportation:

Investments to support individuals gaining access to necessary health services

74% identified behavioral health and substance use:

Investments to promote access to improved infrastructure for behavioral health and substance use support

57% identified housing:

Investments to help Oregonians attain an affordable, safe, and secure place to live

53% identified food security:

Investments to support healthy, available, and affordable foods for all

Spotlight on an investment in access to care

Good Shepherd Health Care System

Good Shepherd ran ConneXions services, a team of community health workers who provide services and resources to patients in-house, in the community, and in patients' homes. ConneXions services include education and safety on a variety of topics as well as assisting patients with access to health care issues: transportation, SDOH, language barriers, finding a provider, food and nutrition procurement/cooking classes/recipes and more. Additionally, they provided CareVan Medical Transportation, free transportation for any patient utilizing a Good Shepherd service.

Spotlight on an investment in behavioral health or substance use

Samaritan Lebanon Community Hospital

Samaritan Lebanon provided $5,000 in funding to Faith, Hope, and Charity. The funding provided support to youth exiting the juvenile justice system experiencing substance use challenges. These youth received access to community organizations and public education resources, life and employment skill-building, recreation, art, fitness, civic engagement, and self-advocacy opportunities. Thirty-six youths participated in workshops, group sessions and individual mentoring.

Spotlight on a housing investment

Providence Medford Medical Center

Providence provided a $75,000 grant to help restore Latinx and indigenous neighborhoods that were destroyed by wildfires and to create pathways to home ownership in the form of resident-owned communities. In partnership with CASA of Oregon, Coalición Fortaleza will restore the Talent Mobile Estates (TME) mobile home park and turn it into the first resident-owned communities in southern Oregon. Eighty percent of previous TME households engaged in community development with 140 individuals ultimately being served.

Client Success Story: One success story from the TME community is of R. and his family. R. is indigenous from Mexico and his family lived at TME before the fire and they are currently living in an RV. He has been very involved in community engagements and is an IDA Program saver. His wife gave birth during the fires, and the Coalición has been able to see his daughter grow and grow every year. In July 2023, R. was selected to receive one of the first two units (made of mass timber) and he accepted! The Coalición are so excited that he and his family will transition to permanent housing this year.

Spotlight on a food security investment

Legacy Silverton Medical Center

Legacy Health primary care clinics screen patients during clinic visits for food insecurity and other social needs and provide shelf-stable food bags to those patients who need them. Among patients who visited a Legacy Medical Group (LMG) clinic in the quad county region during FY24, 85,486 (67% of total patients) were screened and, of those, 6% were identified as food insecure. Among 14,564 LMG patients who were Oregon Health Plan/Medicaid members in this region, 64.8% of the 9,438 patients were screened and 25% identified as food insecure. Approximately 250 food bags were distributed to these food insecure patients.

3 takeaways from this year's reported information:

1. Third year reporting shows hospitals are dedicated to the health of their communities beyond providing health services.

2. There is opportunity for hospitals to collaborate more with Coordinated Care Organizations.

3. There is opportunity for hospitals to invest, and invest more, in housing.

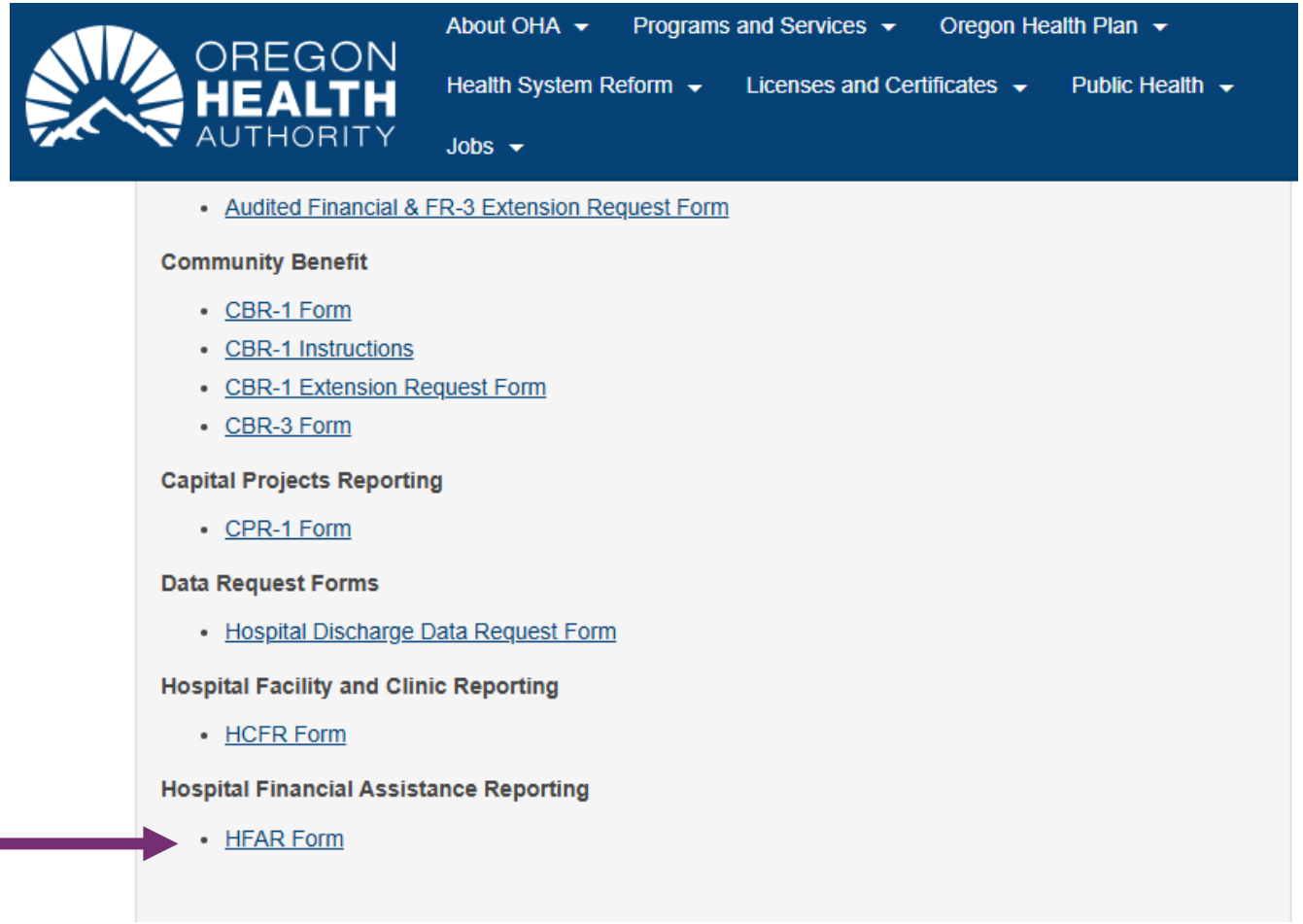
10-minute break

HFAR form deep dive

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

- Section 2 is a count of actual applications. It is not an account of instances of providing financial assistance or number of adjustments to accounts. The unit (denominator) is an application submitted, regardless of how many people it applies to in the family.

HFAR guidance, section 2

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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 2

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	Total denied:	0

- Following a patient's application, during the 9-month approval period, if their payer changes, report the initial payer as listed on their application. If they submit another application, list it as a separate application and separate payer.

HFAR reporting is by hospital

- Community benefit reporting, including HFAR reporting, is by hospital
- If your hospital does not have a way to track applications by hospital, then submitting the **system total divided and allocated to each hospital so that they add up to your system total** would be permissible.
- **Do not submit the same system total for each hospital**, as this could result in data users in the future mistakenly summing the amounts for your hospitals and having an incorrect amount for your Oregon hospitals.
- You may allocate in a reasonable manner you see fit. This may be proportionate to patient volume, to expenses, revenue or another means that appropriately distributes the applications and amounts to your hospitals.

HFAR reporting discussion

- Can we establish best practices for how to allocate applications, so everyone is using the same method?
- The goal is for reporting to be consistent across hospitals so data users can make sense of the numbers when comparing hospitals around the state

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.

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.

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

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- 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.

What HFAR questions can we answer?

HB 4040 Section 1: New prescreening rule

What to know about HB 4040, Section 1

- HB 4040 (2026) Section 1 made a change to existing financial assistance law increasing the amount a patient owes a hospital before they are automatically prescreened.
- HB 4040 was a stakeholder bill, not an agency bill. OHA has no position on the bill.
- OHA has existing rulemaking authority over the effected statute and is obligated to update administrative rules to comply with statutory changes.
- The law had an emergency clause, so it was **effective upon the governor's signature on April 7, 2026**.
- OHA held public comment from June 1st to June 21st and held a rule hearing on June 17th.
- Hospitals complying with the initial statute (prescreening patients with bills of >$500) are still in compliance with the new law. Hospitals are required to screen any patient that will owe the hospital more than $1,500 in a single encounter; however, they are free to prescreen any amount under that which they choose.

Change to minimum prescreening criteria

HB 4040 (2026) Section 1 changed Oregon Revised Statute 442.615(2). OHA completed a conformity rule change to Oregon Administrative Rule 409-023-0120:

(7) Hospitals must prescreen for presumptive eligibility for financial assistance whenever the patient meets any of the following criteria:
(a) Is uninsured; or
(b) Is enrolled in a state medical assistance program; or
(c) Will owe the hospital ~~$500 or more~~ **more than $1,500 for a single hospital encounter** after all adjustments from insurance or third-party payers, if applicable, have been made.

The rest of the criteria is unchanged. The rest of the law is unchanged: financial assistance tiers, applications, automatic reduction in bills, and the appeals process.

Single hospital encounter

NOTE: OHA cannot provide legal advice. The following is not legal advice. All hospitals should consult their own legal counsel prior to making any policy changes.

OHA interprets a single hospital encounter to be a single visit, admission, or continuous episode of care for which the patient receives a hospital bill.

A single encounter is not each separate charge, lab, image, or other line item on a bill.

Effective dates

- Prescreening for financial assistance became effective on July 1, 2024.
- As of July 1, 2024, services rendered on or after that date require hospitals to prescreen patients with bills of $500 or more and automatically apply financial assistance before a bill is sent.
- HB 4040 (2026) had an emergency clause, so it was **effective upon the governor's signature on April 7, 2026**.
- Thus, beginning on April 7, 2026, for services rendered on or after that date, hospitals may prescreen patients with bills of $1,500 or more for a single hospital encounter.
- Hospitals may always prescreen patients with bills that are less than $1500; **hospitals may always provide more financial assistance than the law requires**. The law is the minimum required amount.

Question and answer, public comment

Thank you!

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.

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