MEMORANDUM

To: Oregon Health Authority, Health Policy & Analytics Division, Sustainable Health Care Cost Growth Target Program
From: Jodie Mooney, Senior Vice President; Chief Legal & Risk Officer - St. Charles Health System
Date: January 16, 2026
Re: January 26, 2026, Conference, Agency No. CGT-2024-PROV-16

1. **Procedural posture**:

St. Charles requested this conference under OAR 409-065-0050(5), in the context of its request for a contested case hearing. The conference is, thus, an opportunity to review the information on which the Cost Growth Target (CGT) program relied for its "reasonableness" determination, to "correct any misunderstandings of fact," and to "settle the matter." See OAR 409-065-0050(5)(b).

The CGT program informed St. Charles that it would also like to use the conference as the forum for its informal review process on St. Charles' separate request for reconsideration under OAR 409-065-0050(1). St. Charles does not object to that.

2. **What St. Charles does not dispute**:

The data released and used by the CGT program to conclude that St. Charles exceeded the 2023 target is inherently insufficient to reconcile or support the reported Commercial CGT for St. Charles. That is why St. Charles was never able to validate the CGT program's data. St. Charles will nevertheless not dispute that the aggregated data, supplied by insurance companies, reflects an increase from 2022 to 2023 in payments made for health care services provided to persons attributed to St. Charles, and that the increase exceeded 3.4%.

St. Charles shares the CGT program's view that "[m]aking healthcare affordable benefits everyone."[1] It understands the important role that the CGT program can play in ensuring the "long-term

[1] Clare Pierce-Wrobel, Director – OHA, Health policy & Analytics Division, ***KEZI*** – *OHA finds five Oregon Health entities exceed cost growth limits,* November 17, 2025.

affordability and financial sustainability of health care in Oregon." ORS 442.386(1)(c). St. Charles agrees with the CGT program manager's realistic view that achieving those program objectives is not simple because "[h]ealthcare is really complicated, and there are a lot of drivers and a lot of things happening."[2]

3. **What St. Charles does dispute**:

St. Charles disputes the CGT program's proposed determination that its "health care cost growth for the Commercial market from 2022-2023 was not due to acceptable reason(s)."[3]

4. **The Notice of Proposed Determination reveals two misunderstandings of fact**:

Attachment A to the Notice of Proposed Determination (Notice) suggests that the CGT program misunderstood at least two reasons given by St. Charles to explain the increase in payments. First, the CGT program refers to "avoidable delays" which St. Charles believes should be "avoidable days." Second, the number of avoidable days decreased, which resulted in an increase in reimbursable medical services. The following excerpts are taken from the CGT program's attachment containing its characterization of St. Charles' reasons (in the first box) along with the CGT program's comments (in the other boxes):

Acts of God – COVID return to care increasing IP length of stay	Y	N	N/A	Supplemental information showed IP LOS decreasing in 2023
Increase in avoidable delays	Y	N/A	N/A	Insufficient information provided to support given reason

"Avoidable days" is a term that refers to days spent in the hospital for which CMS and many commercial insurance carriers will not provide reimbursement. St. Charles began to successfully reduce avoidable days in 2023 as it began to recover from the effects of COVID. That meant that

[2] Sarah Bartelmann, Program Manager - OHA, Health policy & Analytics Division, Sustainable Health Care Cost Growth Target Program, **Newsweek** – *Oregon Health Authority Enforces Improvement Plans to Cut Health Spending*, November 20, 2025.

[3] Oregon Health Authority's Notice of Proposed Determination and Right to Request a Hearing, CGT-2024-PROV-16, p. 4.

inpatient lengths of stay were decreasing. As that happened, St. Charles was able to fill those days with medical services for which CMS and private insurers would pay. See declaration of Matthew Swafford, submitted herewith. The CGT program's characterization of an "increase in avoidable delays" and its oblique reference to the decreasing "IP LOS" suggests that a typo and a misunderstanding likely combined in a way that caused it confusion. Simply put, St. Charles decreased the services for which it could not be paid and increased the services for which it could be paid. In other words, it became better at complying with CMS and private insurance company billing requirements, increased its capacity to serve more patients and, not surprisingly, was paid more when it did so. Correctly understood, this was work St. Charles did to recover from the impact of the pandemic on hospital operations and qualifies as an acceptable reason for exceeding the cost growth target under OAR 409-065-0035(2)(e) ("natural disasters or pandemics").

5. **St. Charles Bend and Redmond were merged under a single CMS Provider Number when CMS granted it Sole Community Hospital and Rural Status Designations in 2022**[4]:

Some of St. Charles' Medicare Advantage and Commercial contracts were impacted by this change which resulted in reimbursement increases beginning in 2023. This designation is highlighted in a publication titled Oregon Hospital Types located on the Oregon Health Authority's website. *See* attachment – *Oregon Hospital Types.* This would qualify as an acceptable reason for exceeding the cost growth target under OAR 409-065-0035(2)(d) ("[c]hanges in . . . administrative requirements[.]").

6. **St. Charles did not have notice that the CGT program was considering market share or market "dominance" in its reasonableness determination**:

After the Notice was issued and made public, media coverage revealed that the CGT program relied on its belief that "St. Charles' dominance in the region" played "a major role in driving up prices" when it issued its proposed determination. When asked about St. Charles in particular, the CGT program manager responded that -

[4] The Centers for Medicare and Medicaid Services (CMS) designate Sole Community Hospitals through Section 1886(d)(5)(D)(iii) of the Social Security Act.

> "[t]he payers in central Oregon have to contract with (St. Charles) if they want their members to have access to hospital care … because they're the only game in town[.] We see that both health plans and the primary care patients who end up needing hospital services are paying more. It affects costs all the way through the system."[5]

Prior to that press release, St. Charles did not know that the CGT program considered market share in its reasonableness determination. St. Charles did not know that the program had formed an opinion about St. Charles' market share, or that it had concluded there were relevant implications of that market share with respect to cost growth. St. Charles was entitled to notice and an opportunity to be heard on the CGT program's view of market share as a "major" driver of cost growth.

In fact, traditional American views about market share, monopoly, and antitrust theory do not apply to St. Charles and the economic reality in which St. Charles operates its hospitals and clinics in Central Oregon. See attached declaration. Traditional antitrust legal theory was designed to protect economic competition for the ultimate benefit of the downstream consumer. But the fundamental tension between (1) healthy competition that fosters creativity and innovation and (2) successful competition that results in dominant market share and creates concern for the potential abuse of that dominant market share is not present in Central Oregon.

St. Charles is the largest provider of health care services in the region. But that is not because St. Charles squeezed competitors out of the market, exploited its size, or engaged in anti-competitive conduct to the detriment of Central Oregonians. To the contrary, St. Charles' intention to keep its hospital doors open and to sustain necessary medical services for Oregonians east of the Cascades has required it to be innovative in its business practices. Other providers have reached out to St. Charles and asked it to employ their physicians and to assume the financial risks associated with providing healthcare in this increasingly complex and uncertain era. St. Charles responds not by quelling competition but by subsidizing local businesses and by entering into employment agreements with physicians to enable them to stay in the market. Consider, for example, the Material Change Transaction (Transaction ID: 035) approved by OHA's Cost Programs Manager, on December 18, 2024. That transaction resulted in St. Charles making employment offers to all of the

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[5] Sarah Bartelmann, Program Manager - OHA, Health policy & Analytics Division, Sustainable Health Care Cost Growth Target Program, ***The Oregonian***, *Oregon flags 3 health insurers, a hospital group and a clinic for unexplained surge in costs*, **November 19, 2025**.

providers and the majority of staff then employed by The Center (an independent, physician-owned orthopedic, neurosurgical, physical medicine and rehabilitation services practice in Bend) and purchasing substantially all of the practice assets. St. Charles does what it can to respond to such requests to ensure that licensed providers of essential medical specialty services remain in the region and continue to provide those services.

St. Charles questions the CGT program's finding that it had insufficient information to support "community stabilization" as a reason for cost increase. In response to the program's request for additional information about physician and other practices that St. Charles subsidizes, St. Charles explained that it is contractually bound to keep the terms of such agreements confidential. Given the shared goal of continuing high-quality, affordable health care in Central Oregon, it is surprising that the CGT program opted to discount the existence of such agreements and instead penalize St. Charles for complying with its contractual obligations. St. Charles' subsidization agreements qualify as an acceptable reason to exceed the target under OAR 409-065-0035(2)(f) ("entity investments to improve population health or address health equity…"). The contemporary landscape against which St. Charles operates its hospitals and clinics is peppered with requests from other providers to assume more legal and financial responsibility for aspects of care that have historically been absorbed by physician groups and other healthcare providers. See attached declaration.

St. Charles provides care to all people who seek care in its hospitals and clinics, regardless of their reason for being in Central Oregon. We ask the CGT program to consider that much of the care St. Charles provides is for those who work hard to support the recreation industry – by waiting tables, servicing hotel rooms, and providing bedside nursing care. Central Oregon is largely rural. St. Charles also serves farmers, ranchers, displaced and aging timber workers, and those who reside on the Warm Springs Indian Reservation. Its remote location is undeniable. Recruitment of new providers, and retention of existing providers, can be challenging and has never been more important. The sole community hospital designation described in #5, above, is itself evidence that market "dominance" can be misinterpreted. Being the sole provider of hospital services in the region – and, thus, the dominant provider – means that St. Charles provides access to essential medical services for otherwise underserved populations. The sole community hospital designation creates higher rates of reimbursement for St. Charles to allow it to continue providing those services. Characterizing that increased revenue as unacceptable "cost growth" would place Oregon's CGT program directly at odds with the federal government's Sole Community Hospital program.

St. Charles provides millions of dollars in charity care each year to Oregonians and others who seek medical care east of the Cascades. Like other healthcare organizations – non-profit and for-profit alike -- St. Charles must balance its budget. That budget is based upon total expenses and total revenue across the entire range of payers – commercial insurance companies, federally funded programs (i.e. – Medicare), state funded programs (i.e. – Oregon Health Plan), and private-pay patients. Because St. Charles' ability to negotiate rates of payment are not the same across that spectrum of payers, the cost of providing care to its patients is more accurately reflected in the total systemwide expenses incurred, as reported in St. Charles' audited financial statements. The per member/per month (PMPM) calculation used by the CGT program skews the "cost growth" rate by inflating its value based on the more limited scope inherent in the primary-care based CGT attribution methodology. St. Charles not only does not -- it also cannot -- balance its budget in that artificial way. As a charitable, nonprofit organization, St. Charles is duty-bound to balance the entire budget in a way that allows it to carry out its corporate mission for everyone it serves.

Assumptions that St. Charles' market share is due to calculated dominance and intentional anticompetitive conduct are incorrect and ignore the reality of the healthcare landscape in Central Oregon. That economic and regulatory environment has, in fact, made St. Charles smarter and more dedicated than ever to its mission. We ask the CGT program to consider the value that St. Charles brings to Central Oregon in terms of its ability to help keep healthcare services local. Viewed in that way, it is not accurate that the "cost growth" attributed to St. Charles was "not due to acceptable reasons." Any increase in reimbursement from 2022 to 2023 reflects prudent and tireless planning on the part of St. Charles that allowed it to keep its doors open and to continue its substantial charity work in Central Oregon.

7. **The CGT program should not have refused to consider relevant economic factors occurring outside the 2022-2023 timeframe that impacted reimbursement rates during the 2022-2023 timeframe**:

St. Charles engages in financial planning, like any other business or financial unit, by looking back and looking forward. The family that budgets for the coming year without considering that two children will enter college three years down the road is a family that will fall short when tuition is due. Maintenance deferred in tight budget years must eventually be done to preserve the physical

integrity of the family home. St. Charles asks the CGT program to consider the negative financial impacts of COVID on hospital operations and the planning it took to increase revenue for the years in which St. Charles needed to recover from the financial challenges of the pandemic. With that broader view, the work St. Charles did to plan for and achieve financial recovery from the pandemic qualifies as an acceptable reason for exceeding the cost growth target under OAR 409-065-0035(2)(e) ("natural disasters or pandemics").

8. **The CGT program did not consider that reimbursement rates were set through arms-length negotiations between St. Charles and the insurance companies obligated to cover their insureds' medical expenses**:

For the reasons described in #6, above, St. Charles asks the CGT program to reconsider its view about rate negotiations. There is no evidence that bargaining power between St. Charles and the insurance companies is not competitive. In fact, rate negotiations are rigorous and hard fought in every cycle. Given that the insurers who supplied the aggregated data on which the CGT program is based agreed to the rates of payment – which tend to be less than the actual charges – St. Charles requests the CGT program provide insight into the impact of its view about negotiations on its determination of unreasonableness.

9. **Conclusion**:

The CGT program is charged with reviewing each case through "analyses to understand potential systematic causes, market conditions" and other factors that might reasonably result in an entity exceeding the target. OAR 409-065-0035(1). St. Charles submits that such an analysis was not done here. If it was done, it has not been explained. The only substantive information St. Charles has about the CGT program's analysis and findings is the information it later gleaned from media coverage indicating that the program regards market dominance to have been a major driver of cost.

OAR 409-065-0035(2) lists several reasons for exceeding the target that the CGT program must presumptively conclude were reasonable. In St. Charles' case, the CGT program concluded that the factors related to changes in behavioral health directives, pharmaceuticals, and frontline compensation were reasonable causes for excess growth under OAR 409-065-0035(2)(b), (c), and (h). As we explained in sections #4 and #7, hereinabove, the CGT program was incorrect when it

concluded that OAR 409-065-0035(2)(e) ("natural disasters or pandemics") did not apply. In fact, St. Charles' work to recover from the effects of the pandemic does qualify as acceptable. Macro-economic influences – such as the fact that Central Oregon is rural – and micro-economic influences – such as the overall budgeting process St. Charles employed to grapple with the larger macro-economic factors that were beyond its control – were acceptable reasons to have exceeded the target in 2023. OAR 409-065-0035(2)(g) ("[m]acro-economic factors). When those factors are viewed together, they support a finding of reasonableness on the part of St. Charles.

In the end, the CGT program appears ready to penalize St. Charles for employing prudent business and mission-focused practices designed to keep its doors open under difficult circumstances in order to continue delivering health care services to the rural populations it serves. Respectfully, that cannot possibly be what the Legislative Assembly had in mind when it created the CGT program and charged the State with the incredibly complex task of keeping health care affordable.

RESPECTFULLY SUBMITTED this 16th day of January 2026.

Josephine H. Mooney, OSB No. 882738

Declaration

I, Matthew Swafford, make the following declaration in support of St. Charles Health System, Inc.'s Memorandum submitted to the Oregon Health Authority, Health & Policy Analytics Division, Sustainable Health Care Cost Growth Target Program on January 16, 2026, in anticipation of the January 26, 2026, Conference.

1. I am above the age of 18 and I make this declaration based on personal belief and knowledge on the facts related to St. Charles herein.
2. I am currently the Senior Vice President of Finance Strategy and Chief Financial Officer for St. Charles Health System, Inc.
3. St. Charles is incorporated in Oregon as a nonprofit corporation, organized as a charity, and recognized by the Internal Revenue Service as a §501(c)(3) organization exempt from Federal income tax since 2001.
4. St. Charles maintains a Financial Assistance Policy that ensures free or discounted health services are provided to patients who meet eligibility criteria and who are unable to pay for all or a portion of the services.
5. In 2023, St. Charles provided (1) a community benefit of over $3.7M across its health system and four hospital campuses in the form of grants, donation of medical supplies and in-kind donations of time; (2) $10M in free or reduced charges to patients for medical care; and (3) total unreimbursed care in the amount of $98M.
6. *Avoidable days* is a term that refers to days spent in the hospital for which CMS and many commercial insurance carriers will not provide reimbursement. St. Charles began to successfully reduce avoidable days in 2023 as it began to recover from the effects of COVID. That meant that inpatient lengths of stay were decreasing. As that happened, St. Charles was able to fill those days with medical services for which CMS and private insurers would pay.
7. Some of St. Charles' Medicare Advantage and Commercial contracts were impacted by the May 2022 Sole Community Hospital and Rural Status designations which resulted in reimbursement increases beginning in 2023.
8. In response to the State's request for additional information about physician and other practices that St. Charles subsidizes, we explained that we are contractually bound to keep the terms of such agreements confidential. In fact, such agreements exist and we are contractually bound not to disclose the terms of such agreements.
9. It is not unusual for St. Charles to receive requests from other providers to assume more legal and financial responsibility for aspects of care that have historically been absorbed by physician groups and other healthcare providers. We step up to assist whenever we can.

1/15/2026

Matthew Swafford/Date

Oregon Hospital Types

Oregon Health Authority (OHA) categorizes hospitals by size, distance from another hospital, and reimbursement level. OHA's Hospital Reporting Program primarily uses three hospital type designations: DRG, Type A, and Type B. All 58 acute care inpatient hospitals fall into one (and only one) of these three categories. However, there are several other state and federal designations that can impact a hospital's financial and utilization measures.

The following tables provide details and definitions for all hospital categories, as well as counts for the number of each type of hospital in Oregon. These counts are not cumulative, as some hospitals may be categorized in multiple ways.

	Designation	Number	Description
Oregon Designations	DRG	26	DRG hospitals are typically large urban hospitals that receive standard Medicare Diagnostic Related Group (DRG) based reimbursement.
	Type A	12	Type A hospitals are small hospitals (with 50 or fewer beds) that are located more than 30 miles from another hospital.
	Type B	20	Type B hospitals are small hospitals (with 50 or fewer beds) that are located within 30 miles of another hospital.
	Type C	2	Type C hospitals are rural hospitals with more than 50 beds that are not a referral center. These hospitals are also uniformly DRG hospitals.
	Health District	13	Health district hospitals are hospitals under the control of a formal health district. In most cases the controlling entity is the local county government. Being a part of a health district allows these hospitals access to additional funds from tax sources to contribute to operations. This allows many hospitals to continue to operate in rural areas when they otherwise could not afford to do so.
Federal Designations	Critical Access Hospital (CAH)	25	Critical access hospitals are designated by the Centers for Medicare & Medicaid Services (CMS). This designation impacts the reimbursement hospitals receive from Medicare. There are a number of specific criteria a hospital must meet to be considered a critical access hospital, but in general it must be located in a rural area and serve patients with limited access to other hospitals. In exchange for providing additional services that it might not otherwise provide due to cost. Medicare will reimburse the hospital at a higher rate than other hospitals receive for the same services. These services mostly relate to expanded emergency services such as a 24-hour emergency room and ambulance transportation.
	Sole Community Hospital (SCH)	8	Sole community hospitals are rural hospitals located at least 35 miles from another hospital, in which no more than 25% of Medicare beneficiaries are admitted to other like hospitals.
	Rural Referral Center (RRC)	8	Rural referral centers are hospitals located in a rural area (with a few exceptions) in which at least 50% of Medicare patients are referrals, and 60% of Medicare patients live at least 25 miles away.
	Frontier Hospital	7	Frontier hospitals are hospitals located in a frontier county, defined as a county with a population density of six or fewer people per square mile.
	Non-Profit Hospital	56	State and federal governments grant non-profit status, which exempts hospitals from most property and income taxes. Since most hospitals in Oregon are non-profit, hospitals with for-profit status are indicated on the following page.

OREGON HEALTH AUTHORITY

Facility Name	Oregon Designations					Federal Designations				
	DRG	Type A	Type B	Type C	Health District	CAH	SCH	RRC	Frontier Hospital	For-Profit
Adventist Health Columbia Gorge Medical Center			✓				✓	✓		
Adventist Health Portland Medical Center	✓									
Adventist Health Tillamook Medical Center		✓				✓				
Asante Ashland Community Hospital			✓				✓			
Asante Rogue Regional Medical Center	✓							✓		
Asante Three Rivers Medical Center	✓			✓						
Bay Area Hospital	✓				✓		✓	✓		
Blue Mountain Hospital		✓			✓	✓			✓	
Columbia Memorial Hospital			✓			✓				
Coquille Valley Hospital			✓		✓	✓				
Curry General Hospital		✓			✓	✓				
Good Samaritan Regional Medical Center	✓							✓		
Good Shepherd Health Care System		✓				✓				
Grande Ronde Hospital		✓				✓				
Harney District Hospital		✓			✓	✓			✓	
Hillsboro Medical Center	✓									
Kaiser Sunnyside Medical Center	✓									
Kaiser Westside Medical Center	✓									
Lake District Hospital		✓			✓	✓			✓	
Legacy Emanuel Medical Center	✓									
Legacy Good Samaritan Medical Center	✓									
Legacy Meridian Park Medical Center	✓									
Legacy Mount Hood Medical Center	✓									
Legacy Silverton Medical Center			✓							
Lower Umpqua Hospital			✓		✓	✓				
McKenzie-Willamette Medical Center	✓									✓
Mercy Medical Center	✓			✓			✓	✓		
Oregon Health & Science University Hospital	✓									
PeaceHealth Cottage Grove Community Medical Center			✓			✓				
PeaceHealth Peace Harbor Medical Center			✓			✓				
PeaceHealth Sacred Heart Medical Center - Riverbend	✓									
Pioneer Memorial Hospital - Heppner		✓			✓	✓			✓	
Providence Hood River Memorial Hospital			✓			✓				
Providence Medford Medical Center	✓							✓		
Providence Milwaukie Hospital	✓									
Providence Newberg Medical Center			✓				✓			
Providence Portland Medical Center	✓									
Providence Seaside Hospital			✓			✓				
Providence St. Vincent Medical Center	✓									
Providence Willamette Falls Medical Center	✓									
Saint Alphonsus Medical Center - Baker City		✓				✓			✓	
Saint Alphonsus Medical Center - Ontario		✓					✓		✓	
Salem Health West Valley Hospital			✓			✓				
Salem Hospital	✓									
Samaritan Albany General Hospital	✓									
Samaritan Lebanon Community Hospital			✓			✓				
Samaritan North Lincoln Hospital			✓		✓	✓				
Samaritan Pacific Communities Hospital			✓		✓	✓				
Santiam Memorial Hospital			✓							
Shriners Children's Portland	✓									
Sky Lakes Medical Center	✓						✓	✓		
Southern Coos Hospital & Health Center			✓		✓	✓				
St. Anthony Hospital		✓				✓				
St. Charles Medical Center - Bend	✓						✓	✓		
St. Charles Medical Center - Madras			✓		✓	✓				
St. Charles Medical Center - Prineville			✓			✓				
Wallowa Memorial Hospital		✓			✓	✓			✓	
Willamette Valley Medical Center			✓							✓
Count:	**26**	**12**	**20**	**2**	**13**	**25**	**8**	**8**	**7**	**2**

OREGON HEALTH AUTHORITY