| | |
|---|---|
| To: | Sarah Bartelmann – Manager -- Oregon Health Authority, Health Policy and Analytics Division, Sustainable Health Care Cost Growth Target Program |
| From: | Jodie Mooney, Senior Vice President; Chief Legal & Risk Officer – St. Charles Health System |
| Date: | March 4, 2026 |
| Re: | Response to OHA's January 30, 2026, Conference Summary and Request for Information, CGT-2024-PROV-16 |

---

Thank you for hosting us in your Portland offices on January 26th. As the four of us travelled back to Central Oregon, we had the shared sense that the informal conference with you and your team went well and that we had begun a productive discussion. To be candid, we were more than a bit surprised when we received your twelve-page letter a week later. Let me explain.

Your summary of the conference is incomplete. For example, other than "confirm[ing] that market share was not a factor," you did not mention St. Charles' due process argument or that we discussed it at length during the conference. You did not mention that, when pressed, you would not deny your media statement that St. Charles' dominance in the region played a major role in driving up cost. Those two things – (1) your claim that market share was not a factor in your cost growth determination, and (2) your refusal to deny your statement to the media that regional dominance was a cost growth factor – are in conflict. Your failure to explain the conflict was notable and has significant implications. You did not need to create a summary of our conference, but you did. And because you are a State Agency, it is important that your summary be accurate and complete. It is not.

Your conference summary is misleading when it states that "St. Charles confirmed that it was not challenging the calculation of 26.3% commercial cost growth." To be clear, St. Charles "does 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%." See Memorandum dated January 16, 2026, submitted by St. Charles for the January 26, 2026, informal conference. At the conference, St. Charles confirmed several times that it was not there to "check the Cost Growth Program's math," but instead to discuss the reasonableness determination made by OHA. St. Charles has been absolutely steadfast in stating that it has not been able to validate the data used against it by OHA. In an effort to validate your numbers, we commissioned Milliman to evaluate St. Charles' 2022-23 cost growth target performance. Milliman was not able to do so because key information is missing. The insurer-driven attribution method did not yield sufficient attribution detail or cost data to make it possible to identify who to include or exclude from a cost growth trend analysis. St. Charles would need access to all insurance member-level cost data for attributed members to verify the CGP results. A copy of the Milliman report can be made available to the Cost Growth

Program if it is willing to agree to keep the report confidential. But the bottom line is that St. Charles does not concede that the calculation of its commercial cost growth at 26.3% is accurate.

Your request for additional data and documents is extensive and exceeds the Cost Growth Program's authority. "Cost growth" is defined by ORS 442.385(3) as the annual percent change in "health expenditures." Cost is thus measured by what insurers say they paid for health care; not by what St. Charles spent to provide that care. The level of detail you seek about subsidies, community stabilization, and the like strongly suggest that OHA is now attempting to measure cost in a way not defined by statute. The irony, of course, is that St. Charles was placed in the impossible position of having to defend itself against data that it cannot examine by offering business information that may or may not have anything to do with the increase reflected in the insurers' blinded claims data.

Our responses to your specific requests for more information are set forth below. But your requests confuse apples with oranges and highlight the flaws built into Oregon's cost growth program. Affordable healthcare, like affordable groceries, is a laudable goal and makes for snappy campaign slogans and promises. But to develop sound policy supporting the goal takes work. Capping what insurers pay healthcare providers will not make healthcare affordable, because if payment does not adequately fund what it costs to provide healthcare, services will simply disappear.

Respectfully submitted,

*/s/ – J. Mooney*

Jodie Mooney
Senior Vice President
Chief Legal and Risk Officer
jhmooney@stcharleshealthcare.org

**Requested Information**

a. Avoidable Days

i. This request incorrectly presumes there is a formulaic relationship between Medicare payments and commercial health insurance payments that is uniform among commercial insurance payers. To provide the detailed narrative you seek and to quantify the differences in reimbursement you are requesting, St. Charles would have to review each commercial contract to determine the various lengths of stay the payer was obligated to pay under various circumstances and compare that information to patient records. The development of that data and analysis would require St. Charles to commit a significant amount of time and resources and would have a negative impact on operations. Additionally, this request could result in the disclosure of St. Charles' patients' personal health information.

Again, St. Charles offered the information about the decrease in avoidable days to explain one reason that reimbursement may have increased during the 2022-23 time period. Whether that increased reimbursement has any connection to the increased payment data that the insurers gave the Cost Growth Program is unknown.

ii. As discussed at the conference, St. Charles was among the several health care organizations in the state that experienced delays in discharging patients to long-term care, skilled nursing, assisted living, nursing home, and other facilities during the COVID-19 pandemic. In many circumstances, those facilities were at capacity and were unable to accept additional patients. For patients that required ongoing medical care and treatment at such facilities, St. Charles was unable to discharge them until space was available, or they were medically cleared for another type of discharge. As you have acknowledged, other organizations experienced the same challenges which impacted their discharge rates and, in turn, their reimbursement rates.

We decline to name the facilities associated with our inability to discharge commercial patients during that difficult time because that identifying information does not bear on the question of reasonableness that is before you now. There can be no doubt that as we recovered from the COVID-19 pandemic, the ability to discharge patients increased. This was likely due to a decreased need for social distancing between patients and staff, an increase in providers and staff, and patient improvement, among other factors.

iii. Avoidable days decreased as the need to reserve bed space for pandemic-related, emergent, and "medically necessary" treatment decreased. As a result, medical specialties were able to increase the number of primary elective procedures. That is

supported by the data on Attachment 1. It shows the top 20 elective procedures at St. Charles, the average reimbursement, and the number of procedures from 2019 through 2023. The data shows the number of elective procedures and reimbursement decreased significantly between 2019 and 2020, and again between 2020 and 2021. Then, as recovery from the Covid-19 pandemic began, the number of elective procedures increased in 2022 and again in 2023. These trends support St. Charles' position that the reimbursement increase in the 2022-2023 period was due, at least in part, to fewer avoidable days.

iv. Data showing the top 20 elective procedures for commercial patients between 2019 to 2023 is provided on Attachment 1.

v. St. Charles' commercially insured patients experienced higher acuity post-COVID-19 during the 2022-2023 measurement period. This is shown through the chart on Attachment 1.

vi. Data showing length of stay for commercially insured patients between 2019 – 2023 is provided on Attachment 2. Attachment 2 includes the average length of stay for commercial inpatients. It reflects a decrease in both inpatient commercial discharges and inpatient commercial patient days between 2022 and 2023. This supports the data in Attachment 1, which shows a 29% increase in inpatient procedures between these years. As the Covid-19 pandemic waned, St. Charles carefully managed commercial Medical DRG stays which enabled the backlog of elective commercial inpatient Surgical DRGs (procedures) to increase because beds were now available for those patients.

Again, St. Charles offered the information about its efforts to recover from the challenges of COVID-19 to explain another reason why reimbursement may have increased during the 2022-23 time period. Whether that increased reimbursement has any connection to the increased payment data the insurers gave the Cost Growth Program is unknown. The information supplied in response to your requests is submitted subject to all of St. Charles' objections as stated throughout this letter and memo, including without limitation, relevance.

b. Sole Community Hospital Status

St. Charles received Sole Community Hospital and Rural Status Designation in 2023 after it applied for the designation with the federal government. The timing of St. Charles' application and the federal government's approval of the application are not relevant to the reasonableness analysis before the Cost Growth Program. The idea that a

citizen could be penalized by the State for participating in a federal program, especially one that benefits the People of the State of Oregon, does not ring true. Notwithstanding the complete lack of relevance, St. Charles has included additional information relevant to its sole community hospital designation in the attached declaration.

c. Level 2 Trauma Designation and Community Stabilization

i. This request seeks information far beyond what was discussed at the informal conference.

As discussed in significant detail at the conference, St. Charles is contractually obligated to maintain confidentiality with the community organizations it provided subsidies to, including one that is essential to maintain St. Charles' Trauma 2 designation. The community in Central Oregon is small. Even the identification of the type of specialty care provided by these community organizations would identify the organizations and cause St. Charles to be in breach of its contractual obligations. The reality is that St. Charles provided these subsidies and the identity of the community organizations does not give weight to whether community stabilization is an acceptable or reasonable cause.

OHA's concern that St. Charles may be subsidizing entities it has ownership interest in is unfounded. St. Charles provided verbal confirmation that it has no such ownership interests and agreed to sign a declaration to the same. The Cost Growth Program is without authority to require St. Charles to breach its contractual obligations, and its insistence that St. Charles do so anyway reflects a surprising lack of insight into the role of the program.

1. St. Charles previously provided OHA with the amounts of the two community subsidies and community investments, and a declaration supporting the amounts. Attached hereto is an updated declaration.

2. Not applicable.

ii. Attached is an updated declaration that provides additional information with language that aligns with St. Charles' contractual obligations. St. Charles reiterates its objections contained herein, including those in section c(i) highlighting the coercive nature of this request.

iii. This request implies that St. Charles' Level 2 Trauma designation is related to clinics, facilities, or lines of service that were new in the 2022 to 2023 measurement period. St. Charles has not made such argument and does not intend to do so.

d. Additional Information on Encounter Mix Changes

i. St. Charles provides the additional context and data in support of the following.

ii. Higher Acuity Surgical Volumes

1. See the narrative in response to a(iii-iv) above. See also the data on Attachment 1.

iii. Commercial Case Mix

1. See the narrative in response to a(iii-v) above. See also the data on Attachment 1.

iv. COVID Vaccinations

1. The $100,000 reimbursement amount includes all payers. St. Charles' cost increased for the Covid-19 vaccines in 2023, and insurers paid more. While St. Charles cannot confirm a reason, this increase may represent when St. Charles began purchasing vaccines rather than being provided them free of cost by the government.

**Conclusion**

The information submitted herein and herewith compromises dozens of hours of work spent by numerous St. Charles employees. Most, if not all, of that time was spent chasing down information that may or may not have any connection to the payment data submitted by the insurers. We request that OHA reconsider its reasonableness determination.

## Declaration

I, Matthew Swafford, make the following declaration in support of St. Charles Health System, Inc.'s Response to the Oregon Health Authority, Health & Policy Analytics Division, Sustainable Health Care Cost Growth Target Program's Request for Information dated January 30, 2026.

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. In addition to the community investments identified in paragraph 5, St. Charles provided the following funding to aid community partners in 2023: (1) $6,500,000 to a community partner who provides services essential to maintain St. Charles' Level 2 Trauma designation; and (2) $450,000 to a community partner who provides essential access for the community to St. Charles' hospitals. St. Charles does not have any ownership interest or financial stake in these community organizations.
7. *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.
8. 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.
9. 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.

10. 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.

3/3/2026

Matthew Swafford / Date