Oregon Association of Hospitals and Health Systems

March 6, 2017

Oregon State Legislature
House Revenue Committee
900 Court St. NE
Salem Oregon 97301

Re: House Bills 2115 and 2047 – Relating to Community Benefit (CB) and Nonprofit Hospital/Health System Property Tax Exemption

Dear Chair Barnhart and Members of the Committee:

Thank you for the opportunity to testify. I am Jenn Welander, chief Financial Officer of St. Charles Health System and a member of the hospital association's healthcare finance policy advisory committee.

Like my colleagues on the panel, On behalf of Oregon's 62 hospitals, health care systems, and the patients they serve, the Oregon Association of Hospitals and Health Systems (OAHHS) appreciates the opportunity to comment on bills 2115 and 2047. While we oppose both bills as written I want to highlight a specific issue with HB 2047 and why we believe the solution we are putting forward for community benefit reporting and accountability makes sense in achieving the intent of the bill. HB 2047 calls for at least 40 percent of a hospital-owned clinic's utilization to be Medicaid recipients, uninsured or those in need of financial assistance to qualify for an exemption of real property tax. First a couple of points:

- Hospitals and outpatient clinics do not dictate who walks through their doors to receive care. At St. Charles, and Oregon's other hospitals and health systems, we provide service and care to whomever needs it , regardless of their health status, or ability to pay. In addition, our own financial assistance policy and charity care programs extend from our hospitals to our outpatient settings covering both uninsured and under-insured. This has been a critical component of transformation as we have seen care migrate from inpatient to outpatient care settings.

- When a hospital or health systems acquires a local health clinic in a community, many times it is to save the health care service at a local level. Due to our nonprofit status, we often see increased utilization by Medicaid and Medicare populations than when the clinic was a standalone facility. This provides increased access to care for those who need it the most.

- Finally, from a system perspective, we are moving to a more integrated health care delivery system in Oregon and that is very true for Central Oregon through St. Charles. We do not silo our accounting and financial workflows based on the care delivery setting whether it be inpatient or outpatient. All of our financials are reported to the parent organization. So, when we propose minimum thresholds for community benefit reporting, we would capture all of the activity across the health system, both inpatient and outpatient.

These realities are why we believe that we should not create two standards of community benefit activity for different delivery settings. This would only add to the confusion of hospitals seeking to

comply with the rules, local officials seeking to determine various exemptions and the community in determining where they would like to receive care. This would not create a clear bright line.

We think from a policy perspective; it would be best to look at the community benefit program in our state holistically. We are on the cusp, working through amendments for HB 2115, to provide increased transparency and enhanced community benefit reporting that will accomplish this goal by:

- including minimum thresholds for total community benefit spending;
- including continuous improvement for hospitals and health systems going forward;
- aligning with the federal definition of community benefit; and
- providing a clear bright line.

Thank you for your consideration.

Jenn Welander, Chief Financial Officer
St. Charles Health System