HOK LAW LLC

Draft Requests to the Legislative Offices

To: Representative Emily McIntire and the member who joins her, Oregon House of Representatives
From: HOK Law, LLC, preparer
Matter: Systemically Important Rural Hospital Project
Date: November 15, 2026
Version r12.5
Status: Draft for Representative McIntire's review

Prepared for Representative Emily McIntire and the member who joins her on requests 1 and 2. That member is hers to choose and is not yet named. The language below is proposed for the members to adopt or change. It has not been approved or sent, and it selects no funding commitment or payment entitlement.

Requests 1 and 2 are written for two members to send together, so they say "we." If Representative McIntire sends them alone, "we" becomes "I." Request 3 is hers alone, because LC 1969 is her request. The voice belongs to a member only if that member adopts it. The requests seek an initial factual inventory from LFO and LRO and drafting advice from Legislative Counsel; the scope, contacts and disclosure remain under the members' control.

1. Legislative Fiscal Office

We would like an initial inventory of existing analyses and data on Oregon hospital financing and state fiscal exposure, covering acute-care hospitals statewide. The purpose is to understand how payment and support programs interact before we select a small number of options for further analysis.

Please begin with existing reports, spreadsheets, program inventories and assumptions. Links and native files are sufficient. Please do not recreate available material or build a new statewide claims model at this stage. Where records are held elsewhere, please identify the custodian and the most efficient route.

The first priorities are:

- State spending on hospital payment and support, and its funding sources. This covers Medicaid fee-for-service and managed care, supplemental and directed payments, disproportionate share hospital payments, graduate medical education payments, grants and public financing. Please separate appropriations or awards from amounts actually paid. Please show match assumptions and their denominators, and distinguish General Fund, Other Funds and Federal Funds.

- Non-state public funds already used as the non-federal share of Medicaid payments. Please include any existing inventory of intergovernmental transfers and certified public expenditures, and how expenditure limitation is provided for them.
- Enacted federal changes. Please include existing estimates of their timing and of Oregon's budget exposure, including the limits on directed payments and provider taxes, and any existing estimate of how current hospital payments compare with those limits.
- Implementation needs. Please identify the administrative, staffing, systems, data and federal-approval steps needed to evaluate or implement alternative payment approaches.

Where existing work is available, please identify analyses of full or partial cost-based reimbursement, targeted support for essential services or access, and financing interactions. Please distinguish direct state and local budget consequences from broader community effects, which require separate work.

The approach under consideration excludes diverting existing CCO capitation or margin, education funds or resources, OHP services, or frontline pay and jobs. A new, separately financed payment through CCOs can be evaluated on its own terms.

After we select options, we may ask for each option's fiscal effects shown separately:

- agency administration and systems;
- rulemaking and federal-approval work;
- payments by fund;
- timing and cash flow;
- expenditure limitation;
- contingent liabilities, such as a federal disallowance;
- displacement of existing payments.

Please state the assumptions for each government fiscal effect and identify overlaps or offsets once. Keep this analysis separate from the hospital net-benefit calculation, which hospital finance and OHA would support by reconciling contributions, assessments, displaced receipts and new costs.

The most useful first product would be the initial inventory, major gaps, responsible offices, a recommended sequence, and feasible timing for a first installment, all before substantial new extraction or modeling. Our offices will coordinate this work with LRO's revenue work and OHA's operational data. This request selects no payment formula, hospital class or financing route.

Timing. By Wednesday, November 25, 2026, if feasible, please send a good-faith estimate of turnaround for each priority above. Staged delivery is welcome: please send each piece as it is ready, beginning with material already in hand.

2. Legislative Revenue Office

We would like an initial inventory of existing statewide tax and public-finance information relevant to hospital stability and access. The purpose is to compare financing choices after establishing the current baseline, without selecting a particular revenue source or hospital class.

Please begin with existing reports, native tables, models and assumptions. The initial priorities are:

- The hospital assessment and related financing. Bases, rates and exclusions (including the lower rates the statute permits for certain small rural hospitals), collections, uses, enacted changes and existing forecasts. Please include the effect of federal provider-tax limits.
- Local public finance statewide. For counties, cities, and health or hospital districts: tax bases, permanent and local-option rates, compression, receipts, obligations and material restrictions.
- Restricted local revenues that may support local health services, with their legal limits and key dates. Examples are transient lodging tax allocations as changed by Oregon Laws 2026, chapter 121 (operative January 1, 2027), and opioid settlement receipts under Oregon's allocation agreements.
- Classification of transfers. How transfers or certified expenditures from local governments, special districts and Tribes for Medicaid purposes are classified and recorded, and the local-finance consequences of using local revenues in that way.

Where available, please identify existing inventories of public financing programs, hospital-related public assets or service arrangements, and analyses of their receipts or spending effects. Please separate gross receipts, restricted funds, net available revenue and actual redirectable savings, and identify questions that need separate legal review. Please use only lawfully available data and aggregates; this request does not presume access to confidential taxpayer information.

Please coordinate with LFO so that financing receipts and spending exposure use compatible periods and assumptions. Hospital payment receipts and retained net hospital benefit require separate hospital and OHA analysis, and should be kept distinct from public revenue.

The most useful first product would be an initial inventory, data gaps, custodians, a recommended sequence, and feasible timing for a first installment. No new assessment, tax, transfer or financing commitment is requested.

Timing. By Wednesday, November 25, 2026, if feasible, please send a good-faith estimate of turnaround for each priority above. Staged delivery is welcome: please send each piece as it is ready, beginning with material already in hand.

3. Legislative Counsel

Please review possible revisions to LC 1969, dated November 5, 2026, and advise on the scope and timetable for revisions under the existing request. I would like to compare the five levels and their eligibility choices before selecting drafting instructions.

The class in section 1(1). Please review:

- the phrase "outside of a metropolitan area";
- the method and date for establishing both CMS classifications—sole community hospital and rural referral center;
- the licensed-bed measure;
- the consequences of later changes in a hospital's status or capacity.

Please also advise how this class relates to the rural hospital definitions in ORS 442.470, including the type C definition ("is not a referral center") and the exclusion in ORS 442.470(6)(b). Please distinguish the state referral-center term from CMS's classification rather than assuming they are interchangeable. Please flag any mismatch between the defined class and the policy problem described in the supporting materials I authorize.

The five levels. Please compare the working drafts for (1) designation alone, (2) designation and an OHA study reporting in 2028, (3) a payment pilot supported by a willing public entity, (4) targeted payment protection limited to appropriated funds, and (5) an allowable-cost payment target with a first-biennium General Fund formula. These are options for my review; this request selects none of them.

For each level, please distinguish the two eligibility versions: federal classifications alone, or federal classifications with an additional service-based route. Please identify the definition of the designated class, the OHA application and renewal process, and any mismatch with the existing Oregon classifications.

Study design at level 2. Please compare a study that permits recommendations with one that requires actionable options. The analysis should distinguish existing payments from changes, define allowable costs and credited receipts, identify offsets, compare retained net benefit and timing, and identify financing, implementation and required federal review. Please distinguish direct state fiscal effects from broader community effects, and advise on staged deliverables, the report date and the study's repeal.

Payment design at levels 3 through 5. Please identify:

- whether a willing county, special district or federally recognized Tribe is a funding participant, an eligibility criterion or an optional partner;
- any additional OHA authority needed to accept and administer eligible public transfers or certified expenditures, subject to ownership, allowable-cost, provider-class and payment-limit rules;

- the appropriation, expenditure limitation and required federal approvals for the selected payment tool;
- reporting, accountability, commencement and sunset, separately from the study's repeal;
- how the designation remains distinct from Type A, Type B and critical access classifications, hospital assessments, existing directed payments and federal grandfathering.

Levels 1 and 2 should imply no payment obligation. The designation should not redirect enhanced federal match governed by ORS 413.241 or any existing Tribal arrangement. The twelve payment variants in the policy menu are tools to test within levels 3 through 5, not twelve funding sources.

Optional payment provisions. Please draft two bracketed alternatives, for my decision after fiscal review:

1. A fee-for-service provision for designated hospitals, modeled on ORS 414.728.
2. Direction to OHA to seek a state plan graduate medical education pathway for documented rural training costs.

Please do not insert any percentage, appropriation, tax, eligibility change or deadline that I have not selected.

Procedure and coordination. Please advise whether these changes can proceed within LC 1969 or need another route. Please also advise how your office would coordinate confidential draft review with LFO and LRO. My office will identify authorized technical contacts, and will approve any instructions or disclosure before they are treated as mine.