Systemically Important Rural Hospital Project — Policy Brief

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Protect the care a region depends on

Some rural hospitals carry a regional responsibility that existing classifications may not fully capture. Which services must remain available, what would happen if capacity declined, and what support would sustain them?

Pair an objective hospital designation with evidence and a workable financing design. Define the regional role, measure the payment gap and test lawful support. Develop the study and legal framework together to produce choices the Legislature can act on.

Five levels for review

The working drafts pair a proposed designation and OHA certification with five levels: (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. Each has two eligibility versions: federal classifications alone, or those classifications with an additional service-based route. Levels 1 and 2 imply no payment obligation. These are alternatives for review, not adopted policy.

Four tests for a workable design

1. Regional need. Identify essential services, the people served and realistic alternatives, including travel and receiving capacity. Define the class around those regional functions.

2. A comparable baseline. Compare allowable costs and existing payments for the same services and period. Identify missing records, existing subsidies and the fiscal effects if capacity declines.

3. Lawful funding and payment. A qualifying public source may finance Medicaid's nonfederal share. It does not itself authorize the hospital payment. The source, eligible recipient, payment method and required approvals must each work.[1]

4. A result worth pursuing. Compare additional resources retained, public costs, implementation risk and the first feasible payment date. Report avoided expense separately from new cash.

[1] 42 C.F.R. § 433.51(a)–(c), Public funds as the State share of financial participation

The designation must connect to the right payment route

Oregon's rural cost-based reimbursement statute covers specified fee-for-service services. A new designation would not automatically extend that rule to care covered by CCOs.[2] The managed-care payment rules are separate. Covered non-grandfathered hospital state-directed payments in Oregon face a total-payment-rate ceiling tied to Medicare, with a state-plan or waiver-rate fallback where the specified Medicare rate does not exist. The arrangement and approval history matter.[3]

Seven packages to test, grouped by what they can do

Package	Useful role and the condition that unlocks it
County public funds	Potential public contribution. Identify available unrestricted funds and the actual transaction; county counsel must address local authority and constitutional limits.
Health district	Potential recurring public revenue. Test boundaries, tax capacity, permitted uses, governance, formation and voter approval where required.
Public-hospital expenditures	Potential certification of eligible public costs. Verify the governmental provider's costs and existing arrangements; these costs are not a common pool for private hospitals.
Tribal partnership	Potential qualifying public contribution or coordinated-care arrangement. Establish eligible services, agreements and the distinct recipients of hospital payments and enhanced federal funds. No hospital supplement is automatic.
Behavioral-health partnership	Potential purchased services, restricted project support or measured cost avoidance. Identify the purchaser, eligible payee and deliverables; avoid counting existing reimbursement twice.
Residency and GME	Potential education payments under an approved method. Map the claimant, costs, resident allocations and existing receipts before testing a new rural design and its federal treatment.
Other public resources	Potential targeted local accounts, grants or service contracts. Verify ownership, permitted uses, existing commitments and actual capacity. Philanthropy can support care without becoming public Medicaid match.

The principal source categories have been screened. Availability, scale and transaction design remain to be tested. The seven packages are possible source categories; the twelve payment variants in the project's policy menu are payment tools. Neither list is a set of amounts that can simply be added together.

[2] Oregon Revised Statutes § 414.728, Reimbursement of rural hospitals on fee-for-service basis

[3] 42 C.F.R. § 438.6(a), (c)(1) and (2), Special contract provisions related to payment; CMS, Section 71116 Guidance, pp. 1–4 (February 2, 2026)

Federal timing and payment limits

Affected adults face federal work or activity requirements from January 1, 2027, subject to statutory exclusions and exceptions. Oregon's September 25 waiver defers six-month renewals through September 30, 2027 for adult-group members covered by expanded continuous eligibility.[4]

Provider-tax threshold reductions begin October 1, 2027. Qualifying grandfathered directed payments step down for rating periods beginning on or after January 1, 2028. The 100-percent Medicare limit for covered non-grandfathered hospital payments in Oregon already applies to rating periods beginning on or after July 4, 2025; a specified state-plan or waiver rate applies where no Medicare rate exists.[5]

Two precedents for different parts of the design

Washington's longstanding sole community hospital class uses historical qualification dates, Level III adult trauma status, fewer than 150 acute-care licensed beds in fiscal 2011, and public ownership and operation. It sets 125 percent of Medicaid fee-for-service rates, including managed care, with an inpatient exclusion for certified-public-expenditure hospitals. Its eligibility cannot be inferred from a hospital's current bed count.[6]

Texas CHIRP increases managed-care hospital payment rates and uses intergovernmental transfers toward the nonfederal share. It illustrates financing and payment mechanics, subject to federal limits; it does not establish an Oregon hospital's eligibility or guarantee cost reimbursement.[7]

Turn the concept into a decision

Use legislative-office requests, hospital records and OHA data to answer three connected questions. These requests are proposed; no submission or office commitment is represented here.

Legislative Fiscal Office: establish the baseline. Establish what existing records show about payments, allowable costs, public spending and fiscal exposure. Identify gaps and the study work needed to compare practical options.

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[4] CMS, Oregon Health Plan Demonstration Approval, pp. 1, 9 (September 25, 2026)

[5] Public Law 119-21, §§ 71107, 71115–71116, 71119 (July 4, 2025); CMS, Section 71116 Guidance, pp. 1–4 (February 2, 2026)

[6] Revised Code of Washington § 74.09.5225(3), Sole community hospitals

[7] Texas HHSC, Comprehensive Hospital Increase Reimbursement Program (CHIRP); Texas HHSC, Non-Federal Share Funding for Certain Medicaid Payments

Legislative Revenue Office: test the sources. Identify each source's lawful uses, controlling body, actual capacity, tax restrictions and timing. Distinguish possible revenue from authorized funds.

Legislative Counsel: build the legal structure. Define the class objectively and connect it to evidence and financing authority. Distinguish fee-for-service, managed-care and education-payment routes; preserve approvals and accountability.

Compare two or three designs on the same terms

For the strongest candidates, identify services, allowable costs, credited payments, contribution source, eligible recipient, risk bearer, approvals and implementation owner. Compare alternatives such as a service-specific payment, a capped gap pool and a prospective cost-informed rate against the same baseline.

Net new cash = new receipts − new costs and contributions − replaced payments.

A state saving, public contribution and hospital payment may describe different parts of the same dollar. Show who receives each amount and what the hospital retains. Keep actual results distinct from forecasts.

A disciplined proposal for discussion

The aim is durable support for the regional function. No class, participant, contribution, formula or implementation date is agreed by this brief. Evidence and drafting should identify choices that are legally workable, fiscally credible and useful to the region.



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