# Oregon Health Authority

## Health Policy and Analytics - Chapter 409

### Division 23
### COMMUNITY BENEFIT REPORTING

**409-023-0100**
**Definitions**

The following definitions apply to OAR 409-023-0100 to 409-023-0115:

(1) “Affiliated Clinic” or “hospital affiliated clinic” mean an outpatient clinic located in Oregon that is operating under the common control or ownership of a hospital.

(2) “Authority” means the Oregon Health Authority.

(3) “Charity care” means free or discounted health services provided to persons who cannot afford to pay and from whom a hospital has no expectation of payment. Charity care does not include bad debt, governmentally set fees, contractual allowances, or discounts for quick payment.

(4) “Community” means the geographic service area and patient population that the health care institution serves as defined by the hospital.

(5) “Community benefits” mean programs or activities that provide treatment or promote health and healing, address health disparities or address the social determinants of health in a response to identified community needs. They are not provided primarily for marketing purposes or to increase market share. Community benefit must generate a negative margin and meet at least one of the following criteria:

(a) Improve access to health services;

(b) Enhance population health or improve health disparities;

(c) Advance generalizable knowledge;

(d) Demonstrate charitable purpose; or

(e) Address social determinants of health.

(6) “Health System” means an organization that delivers health care services through hospitals, facilities, clinics, medical groups and other entities that are under common ownership or control.

(7) “Hospital” has the meaning provided in ORS 442.612.

(8) “Net Cost” means the total expense incurred by the hospital minus any offsetting revenue such as grants, donations, or payments for service. Net costs may be provided using either a cost-to-charge ratio methodology or a cost accounting methodology.

(9) “Social Determinants of Health” has the meaning provided in ORS 442.612.

**Statutory/Other Authority:** 442.602. 442.618, 442.624
**Statutes/Other Implemented:** ORS 442.601, 442.602, 442.442.612,
**History:**
OHP 2-2008, f. & cert. ef. 7-1-08

**409-023-0105**
## Community Benefit Reporting

(1) Hospital reporting required pursuant to this rule must be consistent with generally accepted accounting principles (GAAP).

(2) The hospital must submit a completed Community Benefit Report form CBR-1 to the Authority within 240 days from the close of the hospital’s fiscal year. The report will be deemed submitted as of the date the report is postmarked or electronically delivered to the Authority, whichever is first.

(3) Form CBR-1 must be completed in accordance with instructions published by the Authority in the Community Benefit Reporting Guidelines (CBR-2). The Authority has 30 days to review and request clarification or corrections to form CBR-1.

(4) No later than October 31 of each year, the Authority shall send out a summary file for hospitals to review and validate. Hospitals shall have 14 days to review the summary file and submit corrections.

(5) Hospitals that are part of a multi-hospital system may submit reports for all system hospitals in one submission, but each hospital must be separately reported and clearly identified in any submission. Nothing in this rule removes the requirement that hospitals report their individual community benefit activities.

(6) If the ownership or control of the hospital changes during the reporting year, each hospital owner or controller must submit a community benefit report for the hospital for the portion of the year it owned or controlled the hospital.

(7) The Authority shall inform each hospital subject to reporting of any changes to the Community Benefit Report (CBR-1) or Community Benefit Reporting Guidelines (CBR-2) for the subsequent year by July 1. Community Benefit Reporting Guidelines shall be posted on the Authority’s website.

(a) Hospitals may report a community benefit activity in only one of the following categories as defined by the authority’s Community Benefit Reporting Guidelines (CBR-2):

(A) Charity care;

(B) Losses related to Medicaid and State Children’s Health Insurance Program;

(C) Losses related to other publicly funded health care programs, excluding Medicare;

(D) Community health improvement services;

(E) Health professionals’ education;

(F) Subsidized health services;

(G) Research;

(H) Financial and in-kind contributions to the community;

(I) Community building activities; or

(J) Community benefit operations.

(b) Community benefit activities must be reported as net costs.

(c) Only activities that occur during the fiscal year of the report and are under the control or management of the hospital can be reported, except in the case of a large one-time expenditure.

(d) Large one-time expenditures for qualifying community benefit activity that is under the control or management of the hospital may be allocated across multiple fiscal years, provided that:

(A) The expenditure is a single-transaction contribution;

(B) The expenditure exceeds the lesser of $1 million or 0.5% of annual net patient revenue;

(C) The expenditure is made in the community benefit categories of cash and in-kind contributions, community health improvement activities, or community building activities, as defined in the Community Benefit Reporting Guidelines (CBR-2);

(D) Net costs are not allocated across more than five fiscal years; and

(E) The hospital provides the Authority with a description of the investment and a plan for allocation.

(8) In addition to the reporting requirements of sections (6) and (7), a nonprofit hospital shall submit the most recent version of its Community Health Needs Assessment and its Community Health Improvement Strategy as specified in ORS 442.630.

(9) Beginning with a hospital's fiscal year 2022 community benefit reports, the hospital shall report additional information, as prescribed in the Community Benefit Reporting Guidelines (CBR-2), relating to:

(a) The community need or health improvement strategy the community benefit activity addresses;

(b) Entities to which the hospital gave funds, grants, or in-kind contributions; and

(c) Activities that address the social determinants of health.

(10) Beginning with a hospital's fiscal year 2022, a hospital that works with a CCO or public health agency to address community need(s) shall identify:

(a) The community partner(s), and

(b) The community health needs assessment or community health improvement plan that identifies the community need(s) on either form CBR-1 or in supplemental documentation.

(11) Any information provided to the Authority pursuant to this reporting will be publicly available and may be included in the annual report produced by the Authority.

(12) The Authority shall annually report on community benefit activity to the Oregon Health Policy Board and produce a public report detailing community benefit activities performed by individual hospitals.

(13) A hospital that fails to report as required in these rules may be subject to a civil penalty not to exceed $500 per day.

**Statutory/Other Authority:** 442.602,
**Statutes/Other Implemented:** 442.630
**History:**
OHP 2-2008, f. & cert. ef. 7-1-08

## 409-023-0110
## Community Benefit Minimum Spending Floor

(1) The community benefit minimum spending floor program is effective January 1, 2021.

(2) The Authority shall calculate community benefit minimum spending floors for each hospital and its affiliated clinics in Oregon based on the fiscal year of the hospital, with each floor effective over the next two consecutive fiscal years. The Authority shall recalculate the spending floor every two years.

(3) The Authority will collect the data and criteria enumerated in ORS 442.624 on form CBR-3, if it is not already provided by hospitals on forms CBR-1 or FR-3, and from the general public for consideration in establishing hospital minimum community benefit floors. The Authority will post the spending floors for comment from the hospitals and general public as required under OAR 409-023-0110 (9).

(4) Community benefit minimum spending floors shall apply to all community benefit net costs reported to the Authority on Community Benefit Reporting Form (CBR-1).

(5) Each hospital may select among the following methodologies, as applicable to the hospital's organizational structure, for the purpose of applying a minimum community benefit floor:

(a) By each individual hospital and all of the hospital's nonprofit affiliated clinics;

(b) By a hospital and a group of the hospital's nonprofit affiliated clinics;

(c) By all hospitals that are under common ownership and control and all of the hospitals' nonprofit affiliated clinics; or

(d) By any other grouping of hospitals and their hospital affiliated clinics that is approved by the Authority.

(6) The Authority will utilize the methodology selected by the hospital from among those listed in OAR 409-023-0110 (5) to assign each hospital's community benefit minimum spending floor, subject to the following requirements:

(a) Hospitals shall include audited financial statements and other objective data describing the overall financial positions of the hospitals and their affiliated clinics as grouped in the selected methodology on form CBR-3, if such information is not already incorporated into the audited financial reporting of the hospitals.

(b) Hospitals shall report the community benefit net costs that occur in their affiliated clinic(s) as grouped in the selected methodology on CBR-1.

(c) Hospitals choosing methodologies with multiple groupings shall report objective financial data and community benefit net costs for each facility such that the group totals, taken together, sum to be equal to the cumulative financials and net community benefit costs of all hospitals and affiliated clinics referenced in the chosen methodology.

(d) Each hospital shall inform the Authority of its elected organization groupings on form CBR-3 and provide all information requested on CBR-3 no later than 90 days prior to the start of their fiscal year.

(e) The elected organization grouping shall be maintained for the two-year duration of the community benefit minimum spending floor assignment, unless a facility within the organizational grouping closes or undergoes a change in ownership or control.

(7) The Authority shall publish the formula used to calculate hospitals' community benefit minimum spending floors by January 1 of every odd numbered year.

(8) The Authority shall provide a proposed community benefit spending floor applicable to a hospital and its elected organization grouping no later than 60 days prior to the start of the hospital's fiscal year.

(9) The proposed community benefit spending floor shall be posted to the Authority's website, and a public comment period of 30 days shall begin the day of posting. All subsequent changes or amendments to the spending floor shall also be posted to the website for comment.

(10) The hospital and its affiliates shall have 30 days from receipt of the proposed spending floor to comment or provide additional information which may be used to modify the proposed community benefit spending floor.

(11) The Authority shall notify each hospital of the final community benefit spending floor no later than the first business day of the initial fiscal year of the two-year period for which the spending floors are effective.

(12) A hospital may ask for a review of its minimum spending floor if the hospital experiences a change in circumstance outside its control that will result in serious financial harm to the hospital if the community benefit minimum spending floor remains unchanged.

(13) The authority may amend the formula, if necessary, based on review of community benefit reports and feedback from stakeholders and the general public.

**Statutory/Other Authority:** 442.602, 442.624,
**Statutes/Other Implemented:** ORS 442.601, 442.602, 442.612, 442.624, 442.630
**History:**

## 409-023-0115

## Annual reports of financial assistance policies and nonprofit status

(1) For purposes of this rule:
(a) "Health care facility" means:

(A) A hospital;

(B) An ambulatory surgical center;

(C) A freestanding birthing center;

(D) An outpatient renal dialysis facility; or

(E) An extended stay center.

(b) "Reportable affiliated clinic" means an outpatient clinic located in Oregon that:

(A) Is operating under the common control of a hospital; or

(B) Is owned in whole or part by the hospital; or

(C) Is operating under the same brand of the hospital.

(2) A hospital or health system designee must submit a health care facility and reportable affiliated clinic report using the Hospital Facility and Clinic Report form (form HFCR) to the Authority, annually, by June 30 of each calendar year. The report shall identify its health care facilities and reportable affiliated clinics on form HFCR and provide the following:

(a) The health care facility name and street address for the facility location;

(b) The reportable affiliated clinic name and street address for the clinic location;

(c) The non-profit status of each health care facility or reportable affiliated clinic; and

(d) An attestation, signed by an officer of the hospital, that the hospital's financial assistance policy as developed under ORS 442.614 has been posted in the health care facilities and reportable affiliated clinics, and has been made available to patients of the facility and reportable affiliated clinic.

(3) A hospital that fails to report as required in OAR 409-023-0115 may be subject to a civil penalty not to exceed $500 per day.

**Statutory/Other Authority:** ORS 442.618
**Statutes/Other Implemented:** ORS 442.618
**History:**