Oregon Hospital Community Benefit Report Fiscal Year 2021

This report accompanies OHA's interactive 2021 Oregon Community Benefit Dashboard. These data are self-reported and may be subject to change.

Key Takeaways

- ↑ Statewide total community benefit increased 12.9 percent from 2020 to $1.97 billion.
- ↑ Unreimbursed care increased 14.8 percent to $1.54 billion.
- ↑ Direct spending increased 6.5 percent to $426 million.
- Community benefit was 12.7% of total operating expenses, an increase from 12.0% in 2020.
- Spending on areas related to social determinants of health was 2.2% of all community benefit in 2021

Community benefit increased to $1.97 billion in 2021

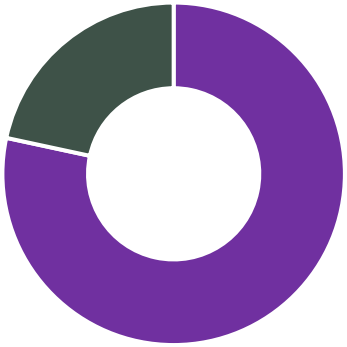
In 2021, hospitals in Oregon provided $1.97 billion in total community benefit, which was 12.9% higher than 2020. Overall, community benefit was 12.7% of hospitals' operating expenses. Growth in community benefit was primarily due to unreimbursed care, which increased 14.8% when compared with 2020.

What is community benefit?

Community benefit refers to services, activities, or programs that hospitals provide to improve the health and wellbeing for their local community. Nonprofit hospitals are required to provide and report their community benefit activities in lieu of paying certain taxes.

Community benefit may be reported in up to ten different categories. OHA groups these into two types of costs, unreimbursed care and direct spending. Of all community benefit costs, $1.54 billion (78%) was unreimbursed care, or health care services provided to patients where the hospital was not reimbursed enough to cover their costs. The remaining $426 million (22%) is direct spending, or specific proactive activities the hospital engages in to improve the health and wellbeing of their community.

Direct spending was 22% of all community benefit spending.



Unreimbursed care was 78% of all community benefit spending.

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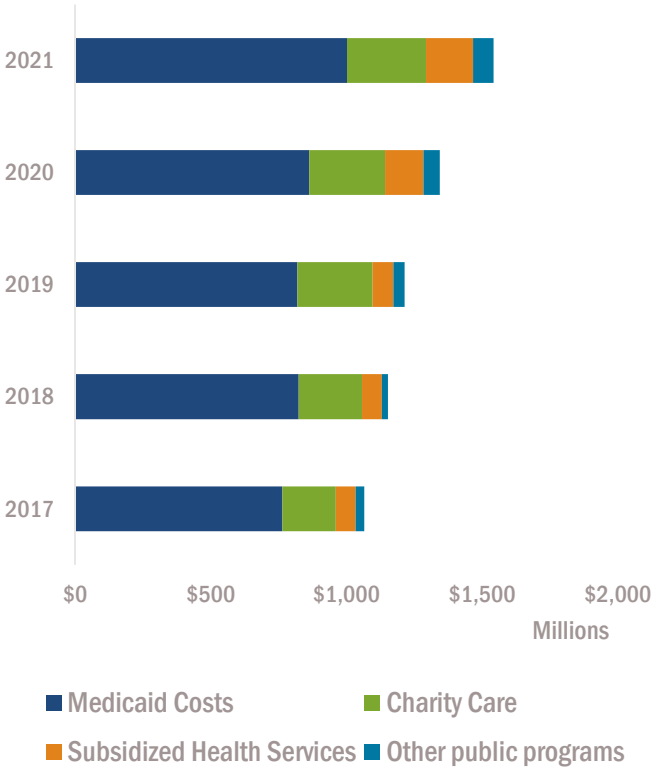
Unreimbursed care continues to dominate community benefit

Unreimbursed care continues to be the leading source of community benefits. It is comprised of charity care, Medicaid unreimbursed costs, other public programs, and subsidized health services. Unreimbursed care grew 14.8% in 2021 to $1.54 billion.

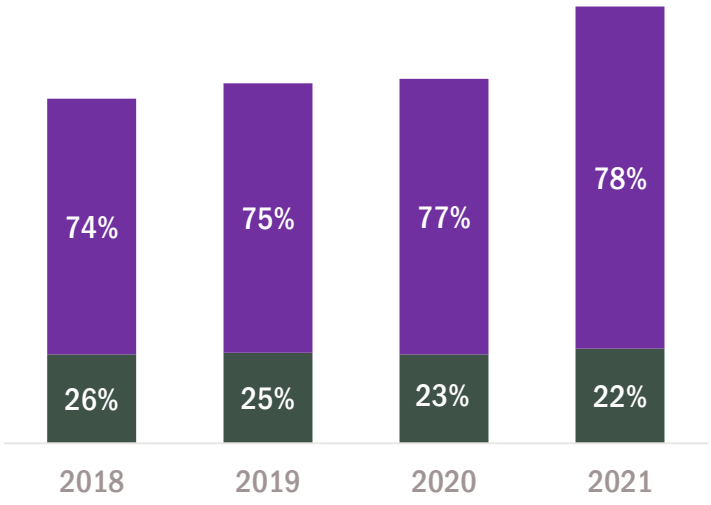


Unreimbursed Medicaid and subsidized health services are the leading causes of overall unreimbursed care cost growth. Unreimbursed Medicaid grew 16.1% in 2021, exceeding $1.0 billion. Subsidized health services (SHS) has seen rapid growth as well, increasing 22% in 2021 to $173.3 million. Much of the growth can be attributed to definitional changes to the SHS category, which now allows for certain Medicare related expenses to be counted that were previously excluded.

Charity care that hospitals provide at a discount or for free based on the financial assistance policies of the hospitals grew 4.5% to $291.6 million in 2021.

Other public programs, which are government run programs that are not Medicaid or Medicare, grew 26.6% in 2021. While this is the greatest increase of any category, proportionally it is the smallest unreimbursed care category, accounting for just over $75 million in 2021.

Unreimbursed care is not only the leading source of community benefit but is a growing proportion as well. The share of total costs due to unreimbursed care has grown annually. At the same time, the share of total costs due to direct spending has decreased. Unreimbursed care costs grew 14.8% in 2021 compared with 6.5% for direct spending costs. This trend is reflective of overall high rate of growth in health care costs.



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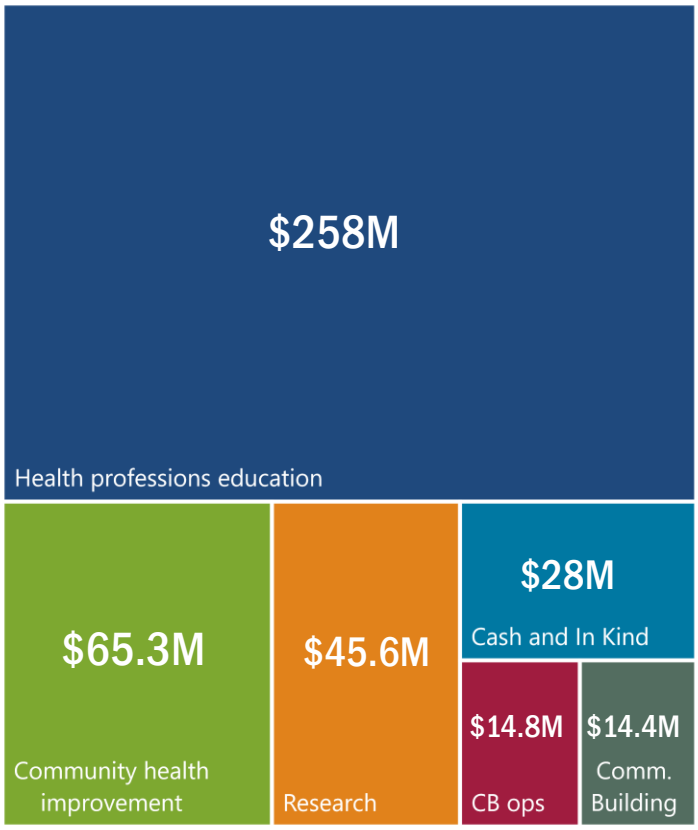
Direct spending on social determinants of health are a small percentage of all community benefit spending.

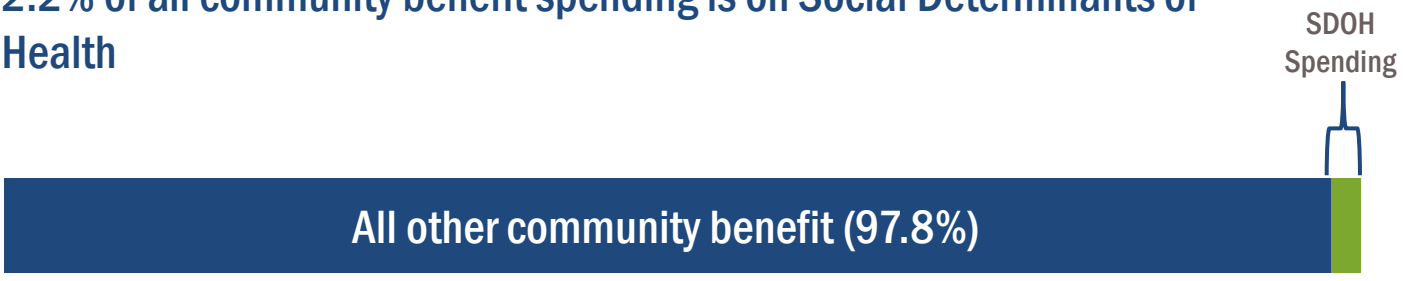
Direct spending is community benefit activities that represent proactive actions to improve health and wellbeing in the community, particularly as they relate to the **social determinants of health (SDOH).** SDOH means the social, economic and environmental conditions in which people are born, grow, work, live and age that may influence health. In 2021, direct spending was $426 million, or 22% of the $1.97 billion in community benefits. There are six categories of community benefit that make up direct spending. Health professions education, which are costs incurred to educate doctors, nurses and other health professionals, is the largest category of direct spending at $258 million. Community health improvement activities, which are programs that provide health services such as preventative screening or vaccine clinics to anyone who shows up, are the next largest at $65.3 million in 2021.



Community benefit operations, administrative costs incurred by hospitals running a community benefit program, were $14.8 million in 2021, and have been growing in recent years. This is reflective of hospitals expanding the size and scope of their community benefit programs in order to better serve their communities.

The categories that most closely target SDOH are community building activities and cash and in-kind. These are programs and investments made in prioritized SDOH needs in a hospital's community. In 2021, these impactful categories accounted for $42.4 million, or 2.2% percent of total community benefit spending. As detailed on the following page, changes to community benefit laws in 2019 has put a focus on community benefit activities that address the social determinants of health.

2.2% of all community benefit spending is on Social Determinants of Health



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In 2019, House Bill 3076 was implemented

- Expanding hospital financial assistance tiers
- Expanding medical debt policies
- Creating a hospitals community benefit minimum spending floor
- Updating community benefit's definition and reporting to focus on SDOH

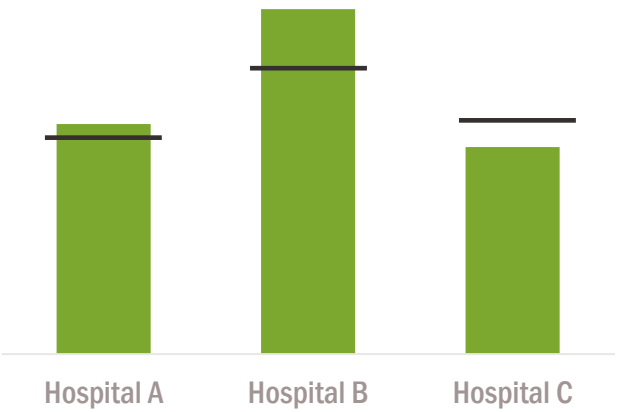
Financial assistance and medical debt policies were implemented by January 1, 2021. The minimum spending floor and reporting on SDOH will begin in fiscal year 2022.

The new program looks to emphasize direct spending and the social determinants of health as they represent factors hospitals can proactively change, and the area that has the most impact in their communities.

The Future of Community Benefit Reporting

House Bill (HB) 3076 created the community benefit minimum spending floor, a requirement that OHA assign a minimum amount of money each hospital must spend on community benefit. This program became effective January 1, 2021, and OHA assigned the first spending floors effective for hospitals' 2022 fiscal years. OHA will begin reporting on individual hospital performance relative to their spending floor next year.

Example of possible spending floor reporting



As the example chart illustrates, hospitals spend different amounts on community benefit. Hospitals received individualized floors specific to their past community benefit spending and overall financials. After fiscal year 2022, OHA will report on data submitted on how hospitals performed compared to their assigned floors.

Additionally, OHA will use fiscal year 2022 data to produce a new report on the importance of community benefit spending in SDOH. The report will highlight those hospitals that are making the biggest and most impactful investments in their communities.

OHA's mission is to eliminate health disparities, and hospital community benefit spending in SDOH is integral in achieving the state's goal. To achieve this goal, hospitals will need to further target programs and actions that prioritize the social determinants of health among Oregon's communities.

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