

Community Benefit Reporting Program
409-023-0100
Definitions

The following definitions apply to OAR 409-023-0100 to 409-023-0105:

(1) “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, contractual allowances, or discounts for quick payment. Charity care is reported on the basis of cost, not gross charges by adjusting charges by a ratio of cost to charges (RCC).

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

(3) “Community benefits” mean programs or activities that provide treatment or promote health and healing as a response to identified community needs. They are not provided primarily for marketing purposes or to increase market share.

(a) Community benefit must meet at least one of the following criteria:

- (A) Generate negative margin;
- (B) Improve access to health services;
- (C) Enhance population health;
- (D) Advance knowledge;
- (E) Demonstrate charitable purpose.

(b) Community benefit activities must be counted in only one of the following categories:

- (A) Charity care;
- (B) Losses related to Medicaid, Medicare, State Children’s Health Insurance Program, or other publicly funded health care program shortfalls;
- (C) Community health improvement services;
- (D) Health professionals’ education;
- (E) Subsidized health services;
- (F) Research;
- (G) Financial and in-kind contributions to the community;

(H) Community building activities;

(I) Community benefit operations.

(4) “Cost” means the total expense incurred by the hospital minus any offsetting revenue (e.g. grants, payments).

(5) Hospital” has the meaning provided in ORS 442.015.

(6) “Office” means the Office for Oregon Health Policy and Research.

Stat. Auth.: ORS 442.205

Stats. Implemented: ORS 442.205, 442.011, 442.200, 442.425 & 442.445

Hist.: OHP 2-2008, f. & cert. ef. 7-1-08

409-023-0105

Reporting

(1) Hospital reporting required pursuant to this rule shall begin with hospital fiscal years beginning on or after January 1, 2008 and must be consistent with generally accepted accounting principles.

(2) The hospital must submit a community benefit report to the Office 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 Office, whichever is first.

(3) Hospitals may submit an amended report after submission of original report to the Office within 30 days of the report submittal deadline. The amended report must include a written explanation for the reason for the amendment.

(4) 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 section removes the requirement that hospitals report their individual community benefit report.

(5) If the ownership of the hospital changes during the reporting year, each hospital owner shall be required to submit a community benefit report for the hospital for the portion of the year owned.

(6) Each hospital must submit, on an annual basis, a community benefit report on form CBR-1 as defined by the Office. The report must be completed in accordance with instructions published in the Community Benefit Reporting Guidelines (CBR-2). The Office shall inform each hospital subject to reporting of any changes for the subsequent year by July 1.

(a) Reporting only includes activities under the direct control and management of hospital management and occurring during the fiscal year of the report.

(b) Hospitals must not include a community benefit cost in more than one category as defined by the Community Benefit Reporting Guidelines (CBR-2). These guidelines shall be posted on the Office web site. The Office must inform each hospital subject to this reporting of any changes in guidelines for the subsequent year by July 1.

(7) A hospital may submit, in addition to the reporting required in section (6), its financial assistance policy or any additional qualitative documents it deems appropriate. Any submission should be clearly identified for explanation of one of the community benefit categories defined in CBR-1.

(8) A parent company or academic health center may submit quantitative and qualitative information about the community benefit provided by the parent company or academic health center and should comply with the definition of community benefit as defined in this rule. Any information provided should clearly identify the hospitals included.

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

(10) The Office shall produce and publicly report, by hospital, an annual report of the community benefit information submitted to the Office.

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

Stat. Auth.: ORS 442.205

Stats. Implemented: ORS 442.205, 442.011, 442.200, 442.425 & 442.445

Hist.: OHP 2-2008, f. & cert. ef. 7-1-08