Hospital Community Benefit Spending Data

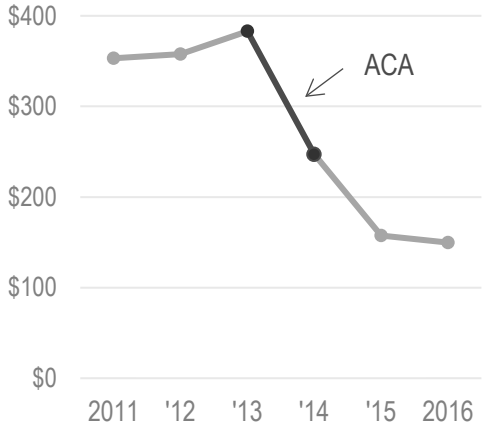
HPA Data Profile

Most hospitals in Oregon are designated as non-profit institutions. In return for their tax-exempt status, non-profit hospitals are expected to provide measurable benefits to the community. Every year, Oregon's 60 acute care inpatient hospitals[1] report the amount of money they contribute toward different categories of community benefit.[2]

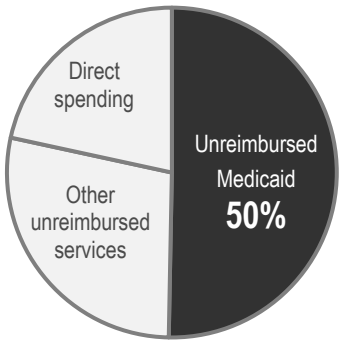
Hospital community benefit spending data can tell us things like:

Hospital charity care fell dramatically after the Affordable Care Act expanded insurance coverage.

Units are in $ billions

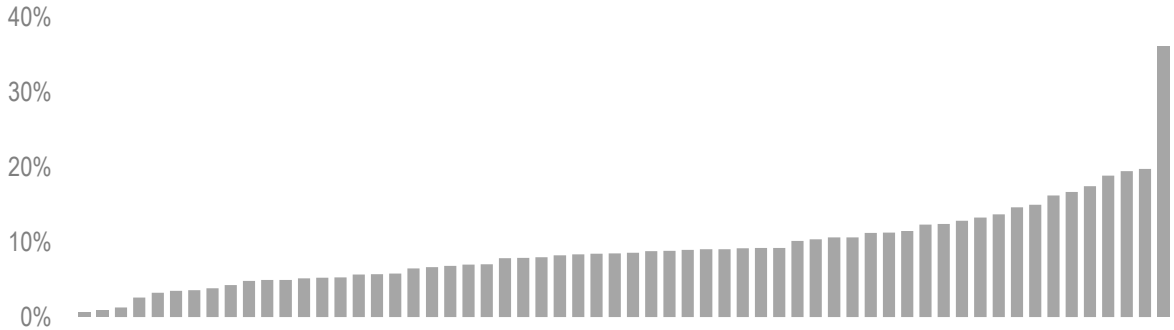


In 2020, the cost of providing *unreimbursed Medicaid* made up half of statewide community benefit spending.



Measured as a percentage of operating expense, total community benefit spending varied greatly across Oregon hospitals in 2019.

Operating expenses are from Audited Hospital Financial Data



[1] Hospitals that provide medical care and other related services for surgery, acute medical conditions or injuries

[2] Fifty-eight of Oregon's 60 hospitals are non-profit institutions. While all 60 are required by Oregon law to *report* community benefit spending, only the 58 non-profits are required to *provide* measurable community benefit. Learn more on page 6.

Regular reporting

Raw data are published annually (typically in late fall) in an Excel file on the Hospital Reporting Program webpage. The file includes data back to 2010. In addition to dollar spending in each of the ten community benefit categories, the file also includes supplemental information such as hospital type,[3] congressional district, and key financial measures[4] for the most recent year.

OHA also annually updates an interactive dashboard which allows users to visually explore trends over time and filter the data by different community benefit spending categories and hospital types. Along with each annual update, a short summary provides key takeaways and high-level policy analysis. These reports are published on the Hospital Reporting Program webpage under the "Community Benefit Reporting" dropdown menu.

Beginning with 2022 data, OHA will also publish a more in-depth, qualitative report each year. The 2022 report is expected to be published around spring 2024.

> ***Analyzing the data***
> When comparing across hospitals, community benefit data should be normalized against hospital financial measures. Learn more on pages 4-5 of this profile.

About the data

This section includes some helpful information about how hospital community benefit data are collected, and important things to remember when interpreting the data.

Overview of data elements

Broadly, community benefits are activities and services that improve the health of the community and social determinants of health. To be considered a community benefit, hospital spending must be provided at a loss to the hospital and in response to identified community needs; and must NOT be done for the primary purpose of advertising or marketing.

More specifically, community benefit spending is categorized into two main types: **1) unreimbursed care** and **2) direct community benefit spending**. Within each category are several sub-categories.

Unreimbursed care means services the hospital provided but didn't receive full payment to cover the cost of providing that care. Hospitals calculate the amount they spent toward unreimbursed care by 1) estimating the amount it costs to provide the care and 2) subtracting the amount they were reimbursed. Within the broader category of unreimbursed care are several sub-categories of spending. A few examples include:

- *Charity care:* The amount the hospital forgave from bills because patients were unable to pay
- *Unreimbursed Medicaid:* The difference between the amount the hospital estimates it cost to provide care to Medicaid members, and the amount that the Medicaid program paid for the care

[3] Hospital types: **DRG** hospitals are large and typically urban; **Type A** hospitals are small (fewer than 50 beds) and located more than 30 miles from another hospital; **Type B** hospitals are also small but located within 30 miles of another hospital.

[4] Financial measures come from hospital-reported Audited Financial Data

- *Subsidized health service:* Money the hospital lost for providing services that are needed by the community, and that otherwise wouldn't exist (or would be provided by government) if the hospital didn't provide the service. Examples include emergency and trauma services and newborn care.

Direct community benefit spending is when a hospital contributes money or activities toward certain causes. Within this category are several sub-categories. A few examples include:

- *Cash and in-kind contributions:* Direct donations toward programs or activities that are operated by a community partner and align with the mission and goals of the hospital
- *Community health improvement:* Costs incurred for providing programs or activities intended to improve community health
- *Health professional education:* Costs incurred for providing educational programs to the health care workforce

Full definitions of these and other sub-categories of unreimbursed care and direct community benefit spending can be found in the online dashboard. More detailed descriptions, including specific examples of what hospitals can and cannot count toward each category, are in Community Benefit Reporting Program documentation such as the CBR-1 form (available to download on the program webpage) and the accompanying form instructions.

How the data are collected

Each hospital submits a completed CBR-1 form, which itemizes spending amounts toward different community benefit categories during the hospital's most recent fiscal year.

Beginning with 2022 fiscal year reporting, hospitals are also required to submit the most recent version of their Community Health Assessment[5] (CHA) and Community Health Improvement Plan (CHIP), as well as a supplemental narrative describing how their community benefit spending addresses the needs and strategies identified in those documents. The narrative must also describe community partners the hospital partnered with, and how the spending addressed social determinants of health.

Timing and frequency

Hospitals submit their CBR-1 form and accompanying documents annually, within 240 days (about eight months) of their fiscal year ending. Hospitals in Oregon do not all follow the same fiscal year. Some end as early as March (beginning in April of the prior year) or as late as December (beginning in January).

OHA publishes annual data for all hospitals in late fall of each year. The data in each annual report are based on when the hospitals' fiscal years ended. For example, the 2022 data file and summary report (published in 2023) cover all fiscal year data that ended in 2022. Since hospitals use different

CHAs and CHIPs

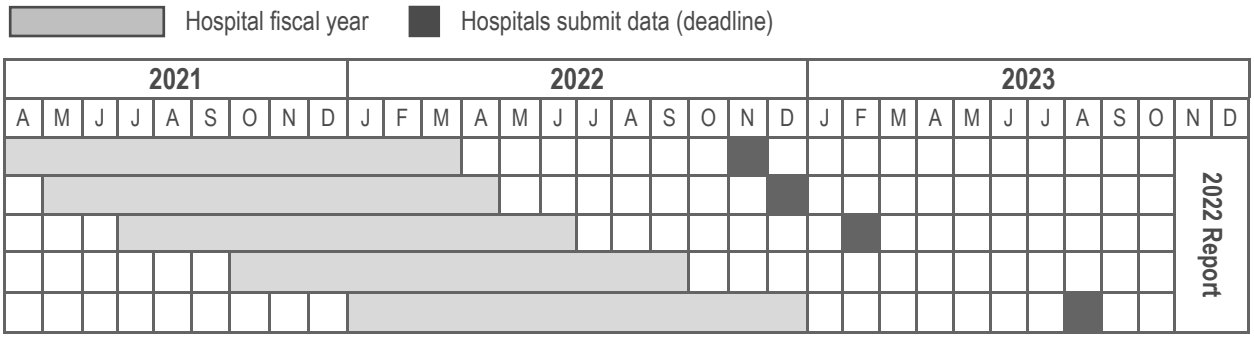
To maintain their tax-exempt status, non-profit hospitals are required by the federal government to prepare a Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) every three years. CHAs identify the key health needs of a community. CHIPs are plans for how the hospitals will address the needs identified in the CHA.

Although hospital CHAs and CHIPs are a federal requirement, Oregon passed a law (HB 3076) in 2019 that includes additional reporting requirements.

[5] Also known as Community Health *Needs* Assessment, or CHNA

fiscal years, the time periods covered by the data will differ and include months from the prior calendar year. See Figure 1 below.

Figure 1. Oregon's 60 acute care hospitals follow different fiscal years, as shown by the gray bars below. Data are submitted by hospitals within 240 days of their fiscal year ending. Data for all hospitals are published annually, in late fall of the calendar year following the close of all fiscal years. The example below shows the range of fiscal year data included in the "2022" data report.



READ and SOGI

READ and SOGI[6] are types of standardized demographic information. READ stands for: Race, Ethnicity and Language, Disability. SOGI stands for: Sexual Orientation and Gender Identity.

Since hospital community benefit data do not include information about people, READ and SOGI do not apply.

Things to remember when interpreting hospital community benefit data

There are different types of community benefit spending

As described in the *Overview of data elements* section on page 2 of this profile, there are two main types of hospital community benefit spending: 1) unreimbursed care and 2) direct community benefit spending. When analyzing the data, it's important to remember the distinction between these two types of community benefit spending. **Unreimbursed care** is the amount of money that hospitals lost for providing care without being fully reimbursed for the cost of care. Rather than money going "out" the door, it's money that *didn't come in*. **Direct spending**, by contrast, is when hospitals donate or spend money toward community causes.

Some people in Oregon believe that non-profit hospitals should contribute more toward *direct* community benefit spending. Learn more in *Community benefit data in action* on page 6.

Hospitals vary greatly by size (and budgets)

Hospitals vary greatly by size and budgets. As a result, the dollar amounts that different hospitals spend on community benefits vary greatly – from a few thousand dollars, to a few hundred million. The reason OHA's reporting categorizes hospitals by type (DRG, Type A, and Type B) is that hospitals within each category share similar characteristics in terms of size and budgets.

However, there is still wide variation even within a single hospital type. When comparing spending between two or more hospitals, it's best to normalize the data by looking at percentage

[6] As of this publication, only draft SOGI data collection standards have been released

rates rather than raw dollar amounts. This is *especially* true if you want to compare hospitals that are different types (for example, a Type A and a DRG hospital).

Two ways to normalize community benefit spending are:

1. **Analyzing the *proportions* each hospital spends toward different categories of community benefit.** In the online dashboard, users can select to view how much individual hospitals spent on each category of community benefits *as a percentage of their total community benefit spending*.

2. **Calculating percentages using key financial metrics.** OHA includes supplemental financial information[7] about each hospital in the raw data files. That way, users can calculate the amount that hospitals spent toward community benefits *as a percentage* of their patient revenue or other financial metrics.

"Charity care" is reported in two other OHA datasets, but those are calculated differently than charity care in community benefit data

OHA also collects and publishes annual *audited hospital financial reporting* data and quarterly *hospital financial and utilization* data. Like community benefit data, both of those datasets include a field called "charity care." However, those two datasets use a different definition and way of calculating charity care than the way it's defined in community benefit data:

- In community benefit reporting, hospitals calculate their ultimate **cost** of charity care. For example, suppose a hospital fixed a patient's broken arm and forgave the bill as part of charity care. The hospital would calculate how much it actually cost them to fix that broken arm (in staff time, equipment/materials, and so on).

- In the two other datasets, on the other hand, hospitals report the amount they would have **charged** the patient and their insurance for fixing the broken arm (that is, the amount that would have appeared on the bill or invoice).

Since hospitals charge higher amounts than the actual cost for providing care, **charity care amounts reported in audited hospital financial data will be much higher than charity chare amounts reported in community benefit data.**

Learn more about *audited hospital financial reporting* data and *hospital financial and utilization data* on the Hospital Reporting Program webpage, or read their data profiles.

Because of an accounting adjustment, spending toward *subsidized health services* grew in 2020 onward

As described in the *Overview of data elements* section on page 2 of this profile, there are two main categories of community benefit spending: 1) unreimbursed care and 2) direct spending. One category of unreimbursed care is "unreimbursed Medicaid" spending. Before 2020, there was a similar category for unreimbursed **Medicare** spending.

House Bill 3076, passed by the Oregon Legislature in 2019, removed "unreimbursed Medicare" as a sub-category of unreimbursed care beginning in 2020. When OHA reported hospitals' 2020

[7] The source for this information is Hospital Audited Financial data. Learn more: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Hospital-Reporting.aspx

data, we removed the unreimbursed Medicare category of spending from historical data in the raw data files and online dashboard so that the overall unreimbursed care category can still be compared over time.

However, when unreimbursed Medicare was removed as a category, hospitals could begin reporting *some* of the amount of money they lost providing care to Medicare patients as a "subsidized health service" which is another category of unreimbursed service. As a result, the spending on subsidized health services appeared to grow in 2020 – but that was due mostly to the accounting change. **When looking at trends over time, spending toward subsidized health services from 2020 onward should not be directly compared to 2010-2019 results.**

Requesting data

Hospital community benefit spending data back to 2010 are available for download on the Hospital Reporting Program webpage. If users want assistance with analysis, email HDD.Admin@odhsoha.oregon.gov.

In addition to the summarized data, PDF copies of hospitals' CBR-1 forms are published on the Hospital Document Library webpage.

Hospital community benefit spending data in action

Helping policymakers understand the current landscape and establish new expectations

Fifty-eight of the 60 acute care inpatient hospitals in Oregon are considered non-profit institutions. As non-profits, these hospitals are exempt from paying state and federal taxes. The intent behind this tax exemption is that hospitals will invest their tax savings back into the community so everyone benefits.

In 2007, seeking better insight into the different ways – and amounts – that non-profit hospitals were giving back to their communities, the Oregon Legislature passed House Bill 3290 establishing requirements for hospital community benefit reporting.

Over the years, the data provided valuable insights. Just a few examples include:

- When insurance coverage increased in Oregon with the passage of the Affordable Care Act, the amount that hospitals spent toward charity care fell dramatically (see chart on page 1). Meanwhile, financial data showed that hospitals were earning higher profits.
- Every year between 2015 and 2019, hospitals categorized a greater share of total community benefit spending as *unreimbursed care*, while the share of *direct spending* fell. In 2019, direct spending made up less than a quarter of total spending.
- The amount that hospitals spent toward community benefits varied greatly. Measured as a percentage of operating expense, total community benefit spending in 2019 ranged from 0.6 to 36.2 percent (see chart on page 1).
- The quality of reporting was also inconsistent between hospitals, and the connection to identified community needs wasn't always clear.

The hospital community benefit reporting program established by HB 3290 provided new transparency. For the first time, policymakers and the public had a view into the investments that hospitals were obligated to make to improve the health and wellbeing of communities they serve in exchange for their tax-exempt status.

With this transparency, policymakers were able identify the ways hospitals were (or were not) meeting community expectations. Advocates proposed ways that Oregon's Community Benefit Reporting could further improve transparency, increase accountability, and support genuine community priorities. To that end, in 2019 the Oregon Legislature passed House Bill 3076 which transforms hospital community benefit in important ways, such as:

- ✓ Establishing a target (minimum floor) for each hospital's annual community benefit spending; and
- ✓ Requiring hospitals to identify and describe how the programs and activities they are supporting will improve social determinants of health and other needs identified in their Community Health Assessment.

Minimum spending floors were introduced with hospitals' 2022 fiscal year reporting and will be reported on for the first time in early 2024.

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Quick Facts

Name	Oregon Hospital Community Benefit Reporting
Acronym	None (occasionally "CBR")
Summary	Every year, hospitals report the amounts they spend toward different types of community benefits
Data type	Administrative
Populations	Level of analysis is hospitals in Oregon
Frequency	Annual
Available since	2010
Required?	Yes: Oregon Revised Statute 442.601 to 442.630 and Oregon Administrative Rule 409-023. Established by HB 3290 (2007) and HB 3076 (2019)
Regular reporting	Interactive dashboard and summary report, published annually
Website	https://www.oregon.gov/oha/hpa/analytics/pages/hospital-reporting.aspx
Lead staff	Steven Ranzoni
To request data	n/a (available online)
General contact	HDD.Admin@odhsoha.oregon.gov
Security level[8]	Level 1 "Published" (low-sensitive information)
Data dictionary?	Detailed definitions can be found in program documentation available on the Hospital Reporting Program webpage
REALD	n/a
SOGI	n/a
Suggested citation	Oregon Health Authority, Hospital Community Benefit Reporting [Year]

[8] Learn more: https://www.oregon.gov/das/policies/107-004-050.pdf