Oregon Health Authority

[Health Policy and Analytics - Chapter 409](https://secure.sos.state.or.us/oard/displayChapterRules.action;JSESSIONID_OARD=dlIk_ozASRm_RUTfSbHVMqEgCHd5IJk0CB2E3bMib_5fU8kujxHv!-1442988785?selectedChapter=34)

Division 23  
COMMUNITY BENEFIT REPORTING

[**409-023-0100**](https://secure.sos.state.or.us/oard/viewSingleRule.action;JSESSIONID_OARD=dlIk_ozASRm_RUTfSbHVMqEgCHd5IJk0CB2E3bMib_5fU8kujxHv!-1442988785?ruleVrsnRsn=81743)  
**Definitions**

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

(1) “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 as the 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, 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 as 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;

(c) Advance generalizable knowledge;

(d) Demonstrate charitable purpose;

(e) Address social determinants of health.

.

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

(7) “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.

(8) “Social Determinant of Health” has the meaning provided in ORS 442.612

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

[**409-023-0105**](https://secure.sos.state.or.us/oard/viewSingleRule.action;JSESSIONID_OARD=dlIk_ozASRm_RUTfSbHVMqEgCHd5IJk0CB2E3bMib_5fU8kujxHv!-1442988785?ruleVrsnRsn=81744)  
**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 complete and error free community benefit report on 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 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) The Authority shall send out a summary file for hospital to review and validate community benefit amounts. Hospitals 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 section or following sections, removes the requirement that hospitals report their individual community benefit report.

(6) If the control or ownership of the hospital changes during the reporting year, each hospital controller shall be required to 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 for the subsequent year by July 1.

(a) A Community benefit activity must be counted in one of the following categories:

(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;

(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.

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

(c) Reporting only includes activities under the direct control and management of hospital management and occurring during the fiscal year of the report except for the case of a single time, large expenditure.

(d) In the event a hospital makes a single time, large expenditure the hospital may allocate qualifying community benefit net cost 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 a description of the investment and a plan for allocation to the Authority.

(e) 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 Authority web site. The Authority must inform each hospital subject to this reporting of any changes in guidelines for the subsequent year by July 1.

(7) A hospital shall identify its affiliated clinics on form CBR-1 and provide the following information:

(a) Clinic name and street address for the practice location;

(b) Attestation that the clinic has distributed the hospital’s financial assistance policy in accordance with ORS 442.610.

(c) Whether the clinic is non-profit or for-profit; and

(d) Whether the clinic’s financial information is incorporated into the hospital’s financial reports or statements.(8) In addition to the reporting requirements of section (6) and (7), a hospital shall submit the most recently updated version of its Community Health Needs Assessment and its Community Health Improvement Strategy as specified in ORS 442.630.

(9) The hospital shall identify the community need or health improvement strategy the community benefit activity addresses and any entities that received funds, grants, or in-kind contributions on form CBR-1

(10) If the hospital is partnering with a CCO or public health agency to address community need(s), the hospital should identify a) the community partner(s) and b) the CHNA/CHIP that identified the community need(s).

(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 produce and publicly report, by hospital, an annual report of the community benefit information submitted to the Authority.

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

**[409-023-011](https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=81744)0**

**Community Benefit Minimum Spending Floor**

(1) Community benefit minimum spending floors shall be based on the fiscal year of the hospital or hospital and affiliated clinic grouping and shall be effective over the next two consecutive fiscal years.

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

(3) Hospitals and their affiliated clinics may organize themselves into groupings for the purposes of assigning a minimum community benefit floor in the manner of their choosing, as specified in ORS 442.624, provided that:

(a) The hospital(s) provide the Authority with necessary financial information related to the affiliated clinic(s) they are choosing to organize with, as determined by the Authority, if such information is not already incorporated into the audited financial reporting of the hospital.

(b) The hospital reports the community benefit net costs that occur in the affiliated clinic(s) they have chosen to organize with on community benefit reporting form (CBR-1).

(c) For grouping of multiple hospitals and affiliated clinics, hospitals are responsible for reporting the community benefit net costs of any affiliated clinic they reported under ORS 442.618, such that each individual hospital total net costs reported on form CBR-1 will sum to be inclusive of all hospitals and affiliated clinics in the chosen grouping.

(d) The hospital(s) informs the Authority of their elected organization grouping and provides necessary information, no later than 90 days prior to the start of their fiscal year.

(e) The elected organization grouping remains the same for the two-year duration of community benefit minimum spending floor assignments unless a facility within the organizational grouping closes or common control of the facility changes.

(4) The Authority shall publish the formula used to calculate community benefit minimum spending floors by January 1st of every odd number year.

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

(6) The hospital, health system or elected organizational grouping shall have 30 days to comment or provide additional information which may be used to modify the proposed community benefit spending floor.

(7) The Authority shall notify the hospital, health system or organizational grouping of the final community benefit spending floors, effective over the next two fiscal years, no later the first business day of the initial fiscal year the spending floors are effective for.

(8) The Authority shall review and update, as necessary, the formula used to calculate the community benefit minimum spending floor at least once every 18 months and prior to January 1st of every odd number year.

(9) The Authority shall allow hospitals to ask for a review of its minimum spending floor if the hospital experiences a change in circumstance, outside their control, that will result in serious financial harm to the hospital if the community benefit minimum spending floor remains unchanged.