

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~~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) “Patient cost” has the meaning provided in ORS 442.612.

(9) “Prescreen” or “Prescreening” means the process a hospital uses to proactively screen a patient for presumptive eligibility for financial assistance in accordance with ORS 442.615.

(10) “Presumptive eligibility” refers to a decision by the hospital that, based upon the hospital’s prescreening, the patient qualifies for financial assistance.

(811) “Net ~~Cost~~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.

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

(13) “State medical assistance program” means a program for payment of health services provided to eligible Oregonians, including Medicaid and CHIP services under the OHP Medicaid Demonstration Project and Medicaid and CHIP services under the State Plan, or Healthier Oregon, or Bridge Program, or any other programs that may be prescribed by the Authority from time to time, in accordance with ORS 414.025(17).

Statutory/Other Authority: ORS 442.602, 442.618 & 442.624

Statutes/Other Implemented: ORS 442.602, ORS 442.601 & 442.612

History:

OHP 5-2020, amend filed 12/21/2020, effective 12/21/2020

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: ORS 442.602

Statutes/Other Implemented: ORS 442.630

History:

OHP 5-2020, amend filed 12/21/2020, effective 12/21/2020

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: ORS 442.602 & 442.624

Statutes/Other Implemented: ORS 442.601, ORS 442.602, 442.612, 442.624 & 442.630

History:

OHP 5-2020, adopt filed 12/21/2020, effective 12/21/2020

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) Effective for hospital fiscal years that begin on or after January 1, 2025, hospitals must submit the Hospital Financial Assistance Report form (form HFAR) no later than 150 days after the end of the hospital's fiscal year, for certain financial assistance data from the most recently completed fiscal year. Data on form HFAR must include:

(a) Total number of financial assistance applications received in the fiscal year, and of the received applications, the number approved and denied by the following payer types:

(A) Uninsured;

(B) Medicare and Medicare Advantage;

(C) State medical assistance programs including out-of-state Medicaid;

(D) Commercial or private health insurance; and

(E) All other payers.

(b) Total number of patients that received cost adjustments based on:

(A) Completing a hospital's financial assistance application; and

(B) Without completing a hospital's financial assistance application, but instead as a result of the hospital's presumptive eligibility process as specified in OAR 409-023-0120.

(c) Total number of patient accounts referred to a debt collector or collection agency.

(d) Total number of patient accounts in which extraordinary collection activities (ECA) occurred, listed by the following categories, as described in 26 C.F.R. 1.501(r)-6(b):

(A) Selling of an individual's debt to another party (except for those sales not considered an ECA as described in 26 C.F.R. 1.501(r)-6(b)(2));

(B) Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus;

(C) Deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under the hospital's financial assistance policy, as described in 26 C.F.R. 1.501(r)-6(b)(iii); and

(D) Taking actions that require a legal or judicial process including, but not limited to, liens, judgements, garnishments, foreclosures, or other action related to collection of a debt owed to the hospital as described in 26 CFR 1.501(r)-6(b)(iv)(A)-(G).

(e) The average and median per person debt, as well as the total amount of debt owed to the hospital by patients whose accounts were either placed in collections or referred to a collection agency during the reporting period.

(4) The Authority shall provide the necessary data reporting templates and make them available on its website no later than September 30th of each year for the upcoming fiscal year reporting.

(5) Data collected on form HFCR and form HFAR shall be made publicly available on the Hospital Reporting Program of the Authority's website.

(36) 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:

OHP 5-2020, adopt filed 12/21/2020, effective 12/21/2020

[409-023-0120](#)

Requirements for prescreening patients for presumptive eligibility for financial assistance

(1) Prescreening and presumptive eligibility rules are effective July 1, 2024.

(2) Hospitals must document their prescreening process in their financial assistance policy. Process documentation must disclose the software products and all other third-party services used to evaluate patient household income for prescreening.

(3) The prescreening process and presumptive eligibility determination is not considered an application for financial assistance and does not disqualify a patient from seeking financial assistance.

(4) The prescreening process must use the financial assistance eligibility standards published in the hospital's financial assistance policy and in accordance with the minimum standards specified in ORS 442.614. Any adjustment to patient cost due to the prescreening process must meet the minimum standards specified in ORS 442.614.

(5) Hospitals must complete prescreening for financial assistance and make any resulting adjustments to patient cost prior to sending the patient a billing statement.

(6) Prior to taking any other prescreening actions, the hospital must determine if the patient has already qualified for financial assistance based on the hospital qualifying the patient during the previous nine (9) month period. Patients determined to have already qualified for financial assistance during the previous nine (9) months, fulfills the prescreening requirement and the patient must receive a patient cost adjustment in accordance with ORS 442.614, prior to receiving a billing statement.

(7) Hospitals must prescreen for presumptive eligibility for financial assistance whenever the patient meets any of the following criteria:

(a) Is uninsured; or

(b) Is enrolled in a state medical assistance program; or

(c) Will owe the hospital \$500 or more after all adjustments from insurance or third-party payers, if applicable, have been made.

(8) Hospitals may prescreen patients who do not meet any of the criteria in (7) above at the hospital's discretion or as established in the hospital's financial assistance policy.

(9) A hospital must not require a patient to present documentation or other verification related to any eligibility criteria as a condition of prescreening or a requirement for adjustment to the patient costs as a result of prescreening. A hospital may accept voluntary submission of information or documentation that would assist the hospital in the prescreening process provided the hospital does not compel the patient to provide the information.

(10) Hospitals may use existing patient data in the prescreening process, including but not limited to:

(a) Existing patient records;

(b) Information routinely collected during patient registration or admission;

(c) Information voluntarily supplied by the patient;

(d) Previous financial assistance adjustments; and

(e) Existing eligibility for assistance programs. Examples include, but are not limited to: Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Women, Infants and Children (WIC), free lunch or breakfast programs, low income home energy assistance programs, or any other program which are means tested and would reasonably reflect the approximate patient household income.

(f) If a method described in this subsection fails to return information about the patient, the hospital must consult at least one additional method specified in (10) or (11) and make a good faith effort to determine the patient's presumptive eligibility status.

(11) A hospital may use third party income verification software tools or services or contract with a third party to conduct the prescreening if:

(a) The process does not cause any negative impact on the patient's credit score;

(b) Evaluations must be based on eligibility criteria established in the hospital's written financial assistance policy. Evaluations by non-profit hospitals must be based on household income only, and cannot consider household assets or any assessment, evaluation or score that predicts the patient's propensity or ability to pay; and

(c) If a third-party service or software tool fails to return information about the patient, or specifies the patient's income is unknown, the hospital must consult one or more of the data sources specified in (10) and make a good faith effort to determine the patient's presumptive eligibility status.

(13) Hospitals must document methods utilized under (10) and (11) they took to prescreen the patient.

(14) A hospital must notify the patient in writing of the results of the prescreening process, regardless of outcome. The notification must meet the following standards:

(a) Be written in plain language and either the preferred language of the patient or otherwise in alignment with the translation standards specified in ORS 442.614;

(b) Delivered by a minimum of one of the following means:

(A) Letter;

(B) Email, if agreed to by the patient as an acceptable form of communication;

(C) Message or notification on an online patient portal if the patient is a registered user of the patient portal;

(D) A distinct notice on the billing statement;

(E) An insert accompanying a billing statement; or

(F) In-person acknowledgement signed by the patient.

(c) Clearly state the outcome of the prescreening as one of the following:

(A) "prescreening process has found you are presumptively eligible for full financial assistance";

(B) "prescreening process has found you are presumptively eligible for partial financial assistance";

(C) "prescreening process has found you are not presumptively eligible for financial assistance; or

(D) "prescreening process was unable to determine if you are presumptively eligible for financial assistance".

(d) If the prescreening process determines that the patient is not presumptively eligible, or their eligibility cannot be determined, or the patient cost adjustment was less than 100% of the patient cost amount, the hospital must further state the following information:

(A) That the patient may still apply for financial assistance, or additional financial assistance, by using the standard hospital financial assistance application;

(B) How a patient may request and receive a physical application or access an online application;

(C) How a patient may request assistance in completing the financial assistance application; and

(D) That the patient is eligible to apply for financial assistance for at least 240 days following the first billing statement for the services provided or at least 12 months after the patient pays for the services provided, or for any additional time period beyond these minimums as specified in the hospital's financial assistance policies.

Statutory/Other Authority: ORS 442.615

Statutes/Other Implemented: ORS 442.615, 442.614

409-023-0125

Requirements for a Process for Patient Appeals of Financial Assistance Determinations

(1) Requirements for patient appeals of financial assistance determination are effective January 1, 2025.

(2) Hospitals must document their financial assistance appeals process in their financial assistance policy.

(3) A patient may only appeal determinations based on applications for financial assistance.

(4) If a hospital denies an application for financial assistance, finds the application to be incomplete or missing documentation, or provides a patient cost adjustment for less than 100% of the patient costs, the hospital must, within ten (10) business days, notify the patient of their ability to take corrective action or appeal the determination. The notification must meet the following criteria:

(a) The notification must be written in plain language and either the preferred language of the patient or otherwise in alignment with the translation standards specified in ORS 442.614.

(b) The notification may be delivered by mail, email, in person, or through an online portal, if the patient is a registered user of the hospital's portal. The notification must be delivered separately and in addition to any financial assistance statements included on billing statements.

(c) The notification must clearly specify whether the application was incomplete or if the patient was denied due to not meeting eligibility criteria.

(A) If the application is found to be incomplete, missing documentation, or containing errors, the notification must designate the application as incomplete and requiring further action by the patient. The notice must further clearly describe the deficiencies and the actions the patient can take to complete the application by correcting the deficiencies.

(B) If the application was denied based on a failure to meet eligibility criteria, the notification must specify the relevant eligibility criteria and provide contact information so that the patient can request further information about the relevant eligibility criteria and the information that was used by the hospital to reach its determination.

(d) The notification must include a clear description of how the patient may submit corrections or additional documentation and how the patient may request an appeal. At a minimum, a patient must be able to submit corrections or additional documentations and request an appeal through email, mail, and in-person delivery.

(e) The notification must inform the patient that if the patient chooses to appeal, the patient may request a meeting, virtual or in person, with the hospital's Chief Financial Officer or a designee of the hospital's Chief Financial Officer who has been delegated decision-making authority over the appeal.

(f) The notification must inform the patient that the patient may also submit an appeal through a written statement or other supporting documentation.

(5) A hospital must allow a patient the duration of the 240-day application period, specified in 26 CFR 1.501(r)-1(b)(3), from the date the patient was notified of the financial assistance determination to correct deficiencies in the application or request an appeal.

(6) During the pendency of an appeal a hospital must:

(a) Suspend all collection activities if the hospital has initiated collection activities; and

(b) If the hospital has sold the debt under appeal to a collection agency or has authorized a collection agency to collect debts on behalf of the hospital, the hospital must notify the collection agency to suspend collection activities; and

(c) Provide the patient with a written statement, delivered by the same method used under OAR 409-023-0125(4)(b), unless the patient has requested a different delivery method, that contains:

(A) Confirmation of receipt of the patient's appeal request;

(B) Notice that:

(i) The hospital has suspended all collection activities that they have initiated; and

(ii) If the hospital has sold debt to a collection agency or authorized a collection agency to collect debts on behalf of the hospital, that the hospital has notified the collection agency to suspend collection activities.

(C) Information on how to schedule a meeting, including information for both in-person and virtual meetings, if a patient has requested a meeting with the hospital's Chief Financial Officer or a designee.

(7) A hospital may deny a request for an in-person meeting with the hospital's Chief Financial Officer or a designee as part of an appeal if the patient has a documented history of violence or has made threats against the hospital or staff. In this circumstance, the hospital must document its records accordingly and the patient must be provided with an opportunity for a virtual meeting or to submit appeal documentation via mail or electronic means.

(8) If it is determined by the hospital officer with the authority to determine the appeal that the patient must provide additional information, the patient must be allowed an additional 45 days, minimum, to provide the requested information. This additional time period runs from the date the hospital officer with the authority to determine the appeal informs the patient that they must supply additional information.

(9) A hospital may allow for multiple meetings to make a decision about the appeal.

(10) A hospital must allow for a third party acting with consent and on behalf of the patient to take action on a patient's application and/or represent the patient on appeal. A hospital may require documentation of consent to representation from the patient.

(11) A hospital must issue a written determination on the appeal within 30 days of either the date of the final appeals meeting or the date of receipt of corrections related to application deficiencies, whichever is later. The hospital must communicate its determination in accordance with plain language and preferred language requirements established in OAR 209-023-0125(4)(a) and it must be delivered through the same method used under OAR 409-023-0125(4)(b), unless the patient has requested a different delivery method.

(a) If the final determination results in a denial of financial assistance, the hospital must also notify the patient of the date on which suspended collection activities, if any, will resume.

(b) A hospital may not resume suspended collection activities until a patient is notified of the final determination.

(12) A patient who has taken corrective action on an application that was determined to have deficiencies may request an appeal if the application is subsequently denied based on a failure to meet the hospital's eligibility criteria.

Statutory/Other Authority: ORS 442.615

Statutes/Other Implemented: ORS 442.615, 442.614