Hospital Community Benefit Spending Data

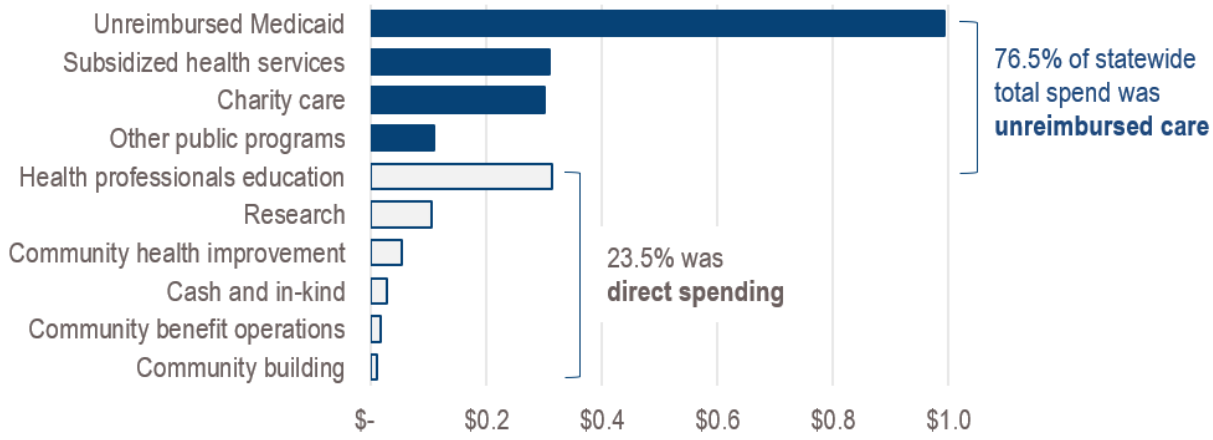
HPA Data Profile

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 58 acute care inpatient hospitals report the amount of money they contribute toward different categories of community benefit.

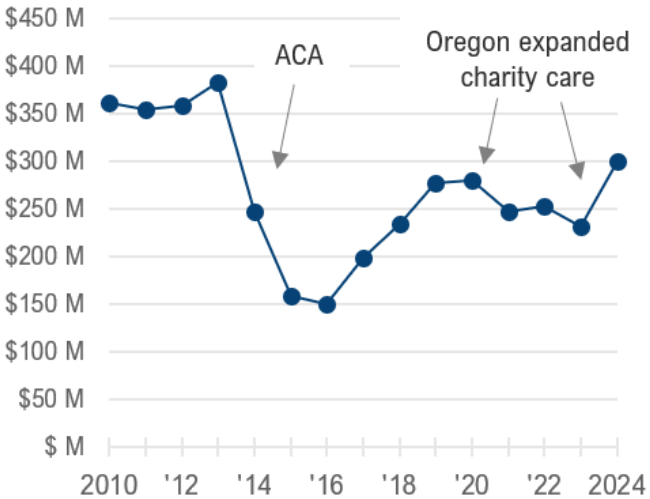
Hospital community benefit spending data can tell us things like:

2024 total community benefit spending by category

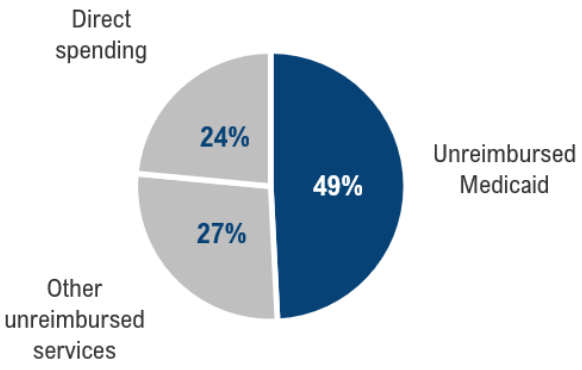
$ billions



Hospital *charity care* fell dramatically after the Affordable Care Act expanded insurance coverage and has varied more recently after Oregon passed laws further expanding charity care.



In 2024, the cost of *unreimbursed Medicaid* made up half of statewide community benefit spending.



Regular reporting

Raw data are published annually (typically in late fall) in an Excel file on the Hospital Community Benefit Reporting 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, congressional district, and key financial measures 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 data brief provides key takeaways and high-level policy analysis.

Since 2024, OHA has published a more in-depth, qualitative annual report called the Oregon Hospital Community Benefit Investments. The report is based on narratives that each hospital and health system are required to report. It presents detailed descriptions of community benefit activities and is intended to complement the quantitatively focused dashboard.

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 (SDOH). To be considered community benefit, hospital spending must be provided 1) at a loss to the hospital and 2) 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: **unreimbursed care** and **direct community benefit spending**. Within each spending type there are several 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 spending type of unreimbursed care there are several categories of spending. They are:

- *Charity care:* The amount the hospital forgave from bills because patients were unable to pay
- *Unreimbursed Medicaid:* The difference between the amount the hospital estimated it cost to provide care to Medicaid members, and the amount that the Medicaid program paid for the care
- *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 an emergency room, trauma services and newborn care.

- *Other public programs:* The difference between the amount the hospital estimated it cost to provide care to other public program members such as Indian Health and Tricare, and the amount that those programs paid for the care

Direct spending is when a hospital provides money or programming to improve the health of their community, with an emphasis in SDOH. Within this spending type there are several categories. They are:

- *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
- *Community building activities*: Providing money or programming addressing SDOH and root causes of health problems
- *Research:* Costs incurred for conducting research that is publicly available and is consistent with community need
- *Community Benefit Operations:* Costs for staffing and coordinating community benefit reporting

Further definitions and information on community benefit spending can be found on the dashboard webpage (under "Definitions and Terminology"). More detailed descriptions, including specific examples of what hospitals can and cannot count toward each category, are in community benefit documentation such as the CBR-1 form and instructions (available on the main Hospital Reporting Program webpage under "Forms") .

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[1] (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.

> **CHAs and CHIPs**
> To maintain their tax-exempt status, non-profit hospitals are required by the federal government to prepare a CHA and 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.

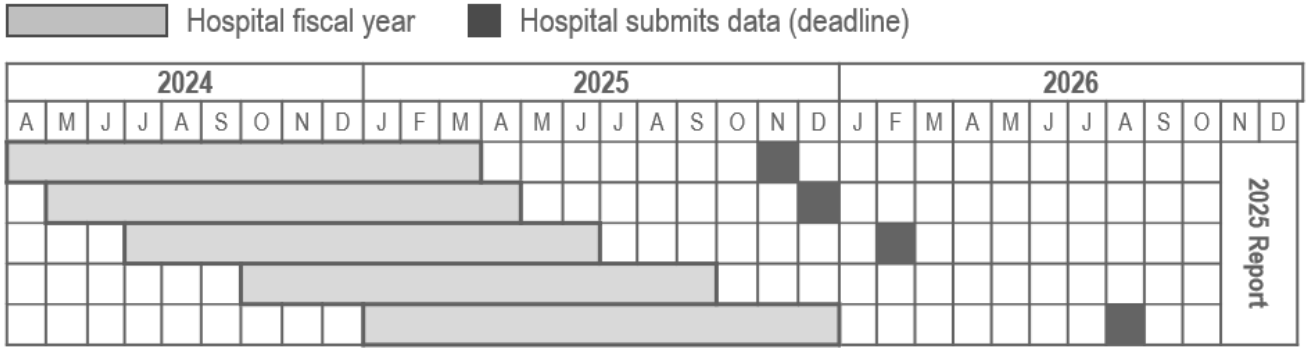
[1] Also known as Community Health *Needs* Assessment, or CHNA

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 2025 data file and data brief (published in late 2026) cover all fiscal year data that ended in 2025. Since hospitals use different 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 58 acute care hospitals follow different fiscal years, as illustrated 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 "2025" data report.



REALD and SOGI

REALD and SOGI are types of standardized demographic information. REALD 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, REALD 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 earlier in 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* section on page six.

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 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 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 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 they are calculated differently than charity care in community benefit data

OHA also collects and publishes annual Audited Financial data and quarterly 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.**

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 types 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 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 care. 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 spending.**

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 Archive webpage.

Hospital community benefit spending data in action

Helping policymakers understand the current landscape and establish new expectations

Fifty-six of the 58 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 2019 and 2023, hospitals categorized a greater share of total community benefit spending as *unreimbursed care*, while the share of *direct spending* fell. In 2024, 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 2024 ranged from 0.3 to 27.5 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 were reported on for the first time in early 2024. Learn more on the Hospital Community Benefit Minimum Spending Floor webpage.

You can get this document in other languages, large print, braille, or a format you prefer. Contact HPA.IDEA.Team@odhsoha.oregon.gov.

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 data brief, published annually
Website	https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Hospital-Community-Benefit-Reporting.aspx
To request data	n/a (available online)
General contact	HDD.Admin@odhsoha.oregon.gov
Security level	Level 1 “Published” (low-sensitive information) (Learn about data security levels)
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]