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Community Benefits of Critical Access Hospitals: A Review of the Data

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The Flex Monitoring Team is a consortium of the Rural Health Research Centers at the Universities of Minnesota, North Carolina, and Southern Maine. With funding from the federal Office of Rural Health Policy (PHS Grant No. U27RH01080), the Flex Monitoring Team is cooperatively conducting a performance monitoring project for the Medicare Rural Hospital Flexibility Program (Flex Program). The monitoring project is assessing the impact of the Flex Program on rural hospitals and communities and the role of states in achieving overall program objectives, including improving access to and the quality of health care services; improving the financial performance of Critical Access Hospitals (CAHs); and engaging rural communities in health care system development.

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The Medicare Rural Hospital Flexibility Program

The Medicare Rural Hospital Flexibility Program (Flex Program), created by Congress in 1997, allows small hospitals to be licensed as Critical Access Hospitals (CAHs) and offers grants to States to help implement initiatives to strengthen the rural health care infrastructure. To participate in the Flex Grant Program, States are required to develop a rural health care plan that provides for the creation of one or more rural health networks; promotes regionalization of rural health services in the State; and improves the quality of and access to hospital and other health services for rural residents of the State. Consistent with their rural health care plans, states may designate eligible rural hospitals as CAHs.

CAHs must be located in a rural area (or an area treated as rural); be more than 35 miles (or 15 miles in areas with mountainous terrain or only secondary roads available) from another hospital or be certified before January 1, 2006 by the State as being a necessary provider of health care services. CAHs are required to make available 24-hour emergency care services that a State determines are necessary. CAHs may have a maximum of 25 acute care and swing beds, and must maintain an annual average length of stay of 96 hours or less for their acute care patients. CAHs are reimbursed by Medicare on a cost basis (i.e., for the reasonable costs of providing inpatient, outpatient and swing bed services).

The legislative authority for the Flex Program and cost-based reimbursement for CAHs are described in the Social Security Act, Title XVIII, Sections 1814 and 1820, available at http://www.ssa.gov/OP_Home/ssact/title18/1800.htm

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EXECUTIVE SUMMARY

There is a growing national interest in the benefits provided by nonprofit and public hospitals to their communities in exchange for the tax benefits or public funding that they receive. The Internal Revenue Service (IRS) and a number of states have implemented mandatory or voluntary *community benefit* reporting standards. Community benefits include a wide range of services and activities that hospitals provide to improve health in communities and increase access to health care. Beginning in tax year 2009, all nonprofit hospitals, including Critical Access Hospitals (CAH), will be required to collect and report on their community benefit activities. As part of its focus on the community impact of CAHs, the Flex Monitoring Team (FMT) has developed a three-tiered framework describing how CAHs impact their communities which includes the delivery of patient care services (Tier 1), community benefits as defined by the IRS (Tier 2), and economic contributions of CAHs as major employers in rural communities (Tier 3). This paper describes a pilot test designed to assess the issues related to the collection of data for a set of indicators for the community benefit activities in Tier 2 of our framework.

To assess the interest and willingness of CAHs to include benefit indicators in their performance monitoring systems and to test the feasibility of collecting the data necessary for using these indicators, the FMT tested a set of community benefit indicators and measures with a small sample of CAHs. The purpose of the test was to determine whether it would be possible for CAHs to collect and report data for the purposes of: a) reporting to the IRS, b) reporting to the federal Office of Rural Health Policy, and c) informing the hospital leadership and board on hospital community benefits.

We worked with the Performance Management Institute of Stroudwater Associates to develop a community benefit module for the RPM system, a web-based performance management tool designed to support the performance improvement activities of small rural hospitals. In early 2008 we recruited four CAHs in each of six states to participate in a pilot test of the indicators and RPM community benefit module.

In February 2009, the IRS released the Final Report of its 2006 Hospital Compliance Study, which includes community benefit data from 489 hospitals, including 68 CAHs. The results suggest several conclusions: (1) CAHs had the lowest reported spending for community benefits (when measured as a percentage of revenues); (2) lower spending is in part tied to differences in the composition of community benefit spending in CAHs (e.g. most CAHs are not engaged in medical research or medical education and training and therefore cannot claim spending in these areas), and (3) lower spending may be tied to difficulties CAHs have tracking community benefits spending related to uncompensated care and community health programs.

CAHs and other hospitals may have difficulties developing and/or changing their accounting and reporting systems to collect and report the required community benefits data. This is a significant task that requires sophisticated cost accounting and extensive data collection. At the same time, more information is needed about the types of community benefit activities CAHs are engaged in and how they are tracking and reporting this information. Our study sought to assess the utility and feasibility of tracking and reporting community benefit information.

The findings of this pilot test echo the results of the IRS Hospital Compliance Project. Our survey of the participating hospitals indicated a moderate degree of satisfaction with both the usefulness and feasibility of collecting community benefit data using either RPM or other software tools. It is unclear, however, whether CAHs are tracking and reporting all of the community benefit activities in which they are engaged. Using community benefit data as a management tool requires that data be entered in a timely and consistent manner into a single tracking system or tool, or into a set of integrated tools. Our results, with a number of indicators excluded from the tracking tools and mixed ratings on the usefulness and feasibility of tracking a number of other indicators, suggest that some CAHs have not yet determined whether and how to use the available tools to manage their community benefit activities.

Participants in the pilot test gave mixed ratings for the usefulness and feasibility of tracking charity care and bad debt costs using RPM and other software programs. A clearer understanding of how, where, and when to report bad debt and charity care might encourage CAHs to use community benefit tools to track and report this information.

Software tools can help CAHs track all community benefit activities on an ongoing basis using a single tool. Our pilot test revealed that CAHs were successfully tracking some programs and services using these tools but not others. In general, the tools seemed best suited to tracking community-based programs and services rather than hospital-based activities.

It appears from this pilot test and data from the Flex Monitoring Team's 2007 survey that CAHs may be falling short of conducting formal, periodic community needs assessments on a periodic and regular basis as recommended by the Catholic Health Association and IRS guidelines. The use of a community benefit management tool that ties community benefit activities and their effects (e.g., numbers or people served, reductions in barriers to access, and improvements in community health) to a current assessment of community needs could help CAHs strategically develop and manage their community benefit activities, thereby improving their effect on the health of their communities.

Accurate tracking and reporting of CAHs' community benefit activities is important to assist the Flex Program and ORHP in understanding how CAHs are benefiting their communities. We know from the IRS study that the community benefit profiles of CAHs are different than those of other hospitals. Not only do CAHs appear to be providing lower levels of community benefits when measured as a percentage of total revenues, but the types of community benefits are different as well. Understanding how and why the community benefit profiles of CAHs are different could be helpful in advocating for community benefit standards that do not disadvantage CAHs, perhaps by considering their broader community impact as well as their size and location. In addition, such an understanding may inform Flex Program funding priorities as ORHP seeks to ensure that CAHs are providing the most appropriate benefits to the rural communities they serve.

INTRODUCTION

The Flex Monitoring Team (FMT) is charged with developing performance indicators and measures to monitor the financial health of CAHs, the quality of services they provide, and their community impact and benefit activities. With regard to community impact and benefit, the Office of Rural Health Policy (ORHP) has established expectations for states and CAHs to:

- Promote and support CAH engagement with their communities;
- Help CAHs undertake collaborative efforts to identify and address unmet community health and health system needs;
- Assist CAHs to develop collaborative delivery systems with CAHs as the hub of those systems of care; and
- Assist CAHs and their community partners in improving the health status of their communities (Office of Rural Health Policy, 2003).

In addition to the community health and health system development priorities of the Flex Program, there is growing national interest in the benefits provided by nonprofit and public hospitals to their communities. The Internal Revenue Service (IRS) and a number of states have implemented mandatory or voluntary community benefit reporting standards. In recognition of the value of this information, a number of state hospital associations have implemented statewide voluntary community benefit reporting systems. Critical Access Hospitals (CAHs), which are typically the hubs of rural health systems, are not immune to the pressure to report their community benefit activities. CAHs are predominantly nonprofit or public hospitals that are accountable to their communities for their performance and impact. Given the rural nature of the communities in which they are located and the economic environment, CAHs are under pressure to respond to community needs including caring for the uninsured and indigent, addressing public health needs, and supporting the local health care infrastructure. As small hospitals with limited resources, CAHs need to be strategic about how they respond to community needs.

Working with a group of community benefit and rural hospital experts, the FMT developed a proposed set of community-focused performance indicators. These indicators will be calculated from a variety of data sources including the annual survey of hospitals conducted by the American Hospital Association and, when they become available, data from the IRS Form 990. A limited subset of these indicators will be entered annually into ORHP's Performance Improvement and Measurement System (PIMS) reporting tool by the FMT (See Appendix A).¹

These community-focused indicators will serve multiple purposes. The first is to monitor the effect of Flex Program activities on the performance of CAHs, including their use by the Office of Rural Health Policy (ORHP) in reporting on the impact of the Flex Program under the requirements established by the Government Performance and Results Act (GPRA) and the Office of Management and Budget's (OMB's) Program Assessment Rating Tool (PART). The data required to fulfill these reporting requirements will be collected through PIMS (Morris, 2009). It is also expected that State Flex Programs will use these indicators and measures to target program activity. Finally, CAHs may use them to manage and assess their community impact and benefit activities and benchmark their performance against other CAHs.

¹ The data collected through Form 990 for tax year 2009 is not expected to be available until late 2010.

In 2008-2009, the FMT pilot tested the collection of hospital-level data for a subset of our indicators focusing on community benefit activity with 24 hospitals in six states. The primary purpose of this pilot test was to assess CAHs' interest in and willingness to include community benefit indicators in their performance monitoring systems and to test the feasibility of collecting the data necessary for using these indicators.

This paper reports on the findings from this pilot test. In the following sections, we review the background of this project, examine the available evidence on differences in the community benefits provided by CAHs compared to larger hospitals, and discuss the issues for CAHs in complying with the IRS's community benefit reporting requirements.

BACKGROUND

Community Impact and Benefit

The FMT has undertaken a series of projects and studies to identify and measure how CAHs address the health care needs of rural communities. Based on this work, the FMT has developed a three-tiered community impact framework to identify and categorize the activities and programs that improve the health and well-being of rural communities including:

1. The services provided by CAHs that have a source of reimbursement and are expected to be self-sustaining;
2. Activities, the focus of the pilot test and this paper, that fall into the more tightly defined category of community benefit activities as defined by Catholic Health Association (CHA) and the IRS; and
3. The economic benefits of CAHs as major employers and economic engines in the community.

Tier 1 includes the activities that comprise the day-to-day services provided by CAHs to residents of the community, including inpatient and outpatient services. The development of economically sustainable services is the primary obligation of all hospitals, with the goal of developing services appropriate to the needs of the community and within the resources and capacity of the hospital to provide safely, effectively, and efficiently. Without a stable and self-sustaining base of services that are used by members of the community, CAHs will be unable to address and improve the health of their communities. The primary source of data to measure the service offerings of CAHs is the American Hospital Association's Annual Survey of Hospitals.

Tier 2 is a more tightly defined category of activities defined by CHA and adopted by the IRS as community benefits. Tier 2 includes activities through which hospitals address specific needs within the community or of vulnerable populations. In accordance with community benefit reporting's goal of identifying and quantifying activities that support the nonprofit status of hospitals, the activities in Tier 2 are typically not self-sustaining. As defined by CHA, community benefit activities include programs or initiatives that provide treatment or promote health in response to identified community need and meet one or more of the following criteria:

- Generates a low or negative margin;
- Responds to the needs of special population, such as the uninsured;

- Supplies a service or program that would likely be discontinued if based solely on financial criteria;
- Responds to public health needs; or
- Involves education or research that improves overall community health.

Community benefits comprise two broad categories of activities. The first category includes community benefits that arise from the day-to-day delivery of services, including the provision of charity care and shortfalls in revenues over expenses of government-sponsored health care programs. Charity care includes free and discounted services provided to people who cannot afford to pay for their care and meet criteria established by the hospital for the provision of charity care. Charity care does not include bad debts, which are uncollectible charges for care delivered to individuals who fail to pay for services. Shortfalls from government-sponsored, means-tested health care are the unpaid costs for care provided to beneficiaries covered by Medicaid, state children's health insurance programs (SCHIP), and local or state means-tested public or indigent care programs. Government-sponsored program shortfalls exclude contractual adjustments, which are the differences between the hospital's charges for a service and the payment received from a third-party payer, as they do not measure the true cost of providing the services. Based on the CHA framework, shortfalls related to Medicare are not considered a community benefit.

The second category of community benefit activities includes community programs and/or activities developed and provided by the hospital, such as:

- Community health improvement services including health fairs, screening programs, community health education, health care support services, and support groups and self-help programs;
- Health professions education involving the training of health professionals, including medical students, residents, nurses, and others, through internships, residencies, job sharing, etc.;
- Subsidized health services that are not expected to be self-sustaining, such as emergency and trauma care, behavioral health services, burn units, neonatal intensive care units, etc.;
- Clinical and community health research activities whose benefits extend beyond the hospital;
- Financial and in-kind contributions made by the hospital to community groups and nonprofit organizations;
- Community building activities supporting community needs related to health care, economic development, workforce enhancement, leadership development, coalition building, etc.; and
- Community benefit operations including the cost associated with planning, implementing, and managing the hospital's community benefit strategies.²

Tier 3 captures the economic benefits of CAHs as major employers and consumers of goods and services in rural communities. CAHs are often among the largest employers in rural communities, alongside municipal government and school systems. The National Center for Rural Health Works at Oklahoma State University has developed the Rural Health Works

² See Appendix B for a more detailed discussion of concept and history community benefits.

program that states, counties, and communities can use to measure the economic impact of their health care services. Rural Health Works also includes tools to identify and develop new services that are needed by the community.

As mentioned earlier, our pilot test focused on testing indicators for the Tier 2 community benefit activities of CAHs.

COMMUNITY BENEFITS ACTIVITIES: DO CAHS DIFFER FROM OTHER HOSPITALS?

The IRS 2006 Hospital Compliance Project

In May 2006, the IRS surveyed a sample of nonprofit hospitals (the 2006 Hospital Compliance Project) to study the community benefit activities of these hospitals and determine how they establish and report executive compensation. The IRS mailed a comprehensive compliance check questionnaire to 544 nonprofit hospitals (including Critical Access Hospitals) and analyzed their responses (Internal Revenue Service, 2009). In July 2007, the IRS released its Interim Report on the Hospital Compliance Project, which recommended revisions to IRS Form 990, *Return of Organization Exempt from Income Tax*, including the development of a separate schedule to report hospital community benefit expenditures. (Internal Revenue Service, 2007a) Subsequent to the release of the interim report, the IRS undertook revisions of Form 990 and the development of Schedule H to collect hospital community benefit data. These revisions were completed in December 2008. Using the revised Form 990 and related Schedule H for Hospitals, the IRS began phasing in implementation of mandatory hospital reporting of community benefit activities starting in tax year 2008 (beginning January 1, 2008 with returns filed in 2009), with full implementation beginning in tax year 2009 (beginning January 1, 2009 with returns filed in 2010) (Internal Revenue Service, 2007b).

In February 2009, the IRS released the Final Report of the Hospital Compliance Study, which included community benefit data from 489 hospitals classified by community type. Respondents to the IRS survey included 94 “high population” hospitals (19%), 249 “other urban and suburban” hospitals (51%), 68 Critical Access Hospitals (14%), and 78 “rural (non-CAH)” hospitals (16%). The high population hospitals were located in the 26 largest urban areas in the United States with populations of 1.5 million or more people based on the 2000 Census. The other urban and suburban hospitals were located in United States Census Bureau–defined urban areas that had a population of less than 1.5 million. The rural (CAH and non-CAH) hospitals were located in areas defined by the Census Bureau as non-urbanized.

Hospital Context: To provide a context for understanding hospital community benefit activities, the IRS report presented data on the total revenues and excess revenues (over expenses) of responding hospitals by community type. Not surprisingly, the revenue and excess revenue amounts were much smaller in CAHs compared with other hospitals. The report also examined excess revenues as a percentage of total hospital revenues. CAHs reported the lowest levels of excess revenues as a percentage of total revenues at 3.5% compared to all hospitals at 4.6%. More CAHs (34%) reported deficits or zero excess revenues than hospitals overall (21%). These data reveal that the CAHs in the study are more vulnerable and suffer from higher levels of financial distress than the other responding hospitals. The data from the IRS report also indicate

that CAHs are more dependent on Medicare and other public programs than other hospitals and have fewer privately insured patients.

Community Benefit Spending and Activity by Hospital Type: CAHs reported spending the lowest average and median levels of community benefit spending (when measured as a percentage of total revenues) at 6% and 3% respectively. This compares to 9% and 6% respectively for all hospitals. High population hospitals report the highest average and median levels of community benefit spending at 14% and 10% respectively. These differences can largely be explained by the composition of community benefit spending (Table 1) and the level of spending (Table 2) by CAHs. CAHs reported that 77% of their overall community benefit spending was for uncompensated care, 4% for medical education and training, and 19% for community programs, with no spending on medical research. This compares to all hospitals with 56% of their overall community benefit spending for uncompensated care, 23% for medical education and training, 15% for medical research, and 6% for community programs. These spending patterns are not surprising in light of the size, patient volumes, and other characteristics of CAHs compared to larger hospitals.

Table 1: Composition of Community Benefit Spending (as a Percentage of Overall Community Benefit Expenditures) by Type of Hospital

	High Population	Rural CAH	Rural Non-CAH	Other Urban and Suburban	Aggregate
Uncompensated Care	42%	77%	76%	69%	56%
Medical Training and Education	26%	4%	17%	21%	23%
Medical Research	25%	0%	1%	5%	15%
Community Programs³	7%	19%	6%	5%	6%
Total	100%	100%	100%	100%	100%

Source: IRS Exempt Organizations (TE/GE) Hospital Compliance Project Final Report, 2009

The limited ability of CAHs to participate in medical training and education and medical research activities, however, accounts for only a portion of their lower spending community benefit spending levels. CAHs reported spending a lower percentage of their revenues on all but one category of category of community benefit spending: community programs (Table 2). CAHs reported the lowest average and median percentage of total revenues spent on uncompensated care, medical education and training, and medical research. CAHs spent higher average and median percentages of their revenues on community programs compared to rural non-CAH hospitals, but a lower percentage than high population hospitals.

³ Community programs include: community health improvement services such as health fairs, screening programs, community health education, health care support services, and support groups and self-help programs; subsidized health services that are not expected to be self-sustaining, such as emergency and trauma care, behavioral health services, burn units, neonatal intensive care units, etc.; financial and in-kind contributions made by the hospital to community groups and nonprofit organizations; community building activities supporting community needs related to health care, economic development, workforce enhancement, leadership development, coalition building, etc.; and community benefit operations including the costs associated with planning, implementing, and managing the hospital's community benefit strategies.

Uncompensated Care: As indicated in Table 2, CAHs reported the lowest percentage of patients receiving uncompensated care compared to other types of hospitals and the group overall. It is important to note, however, that variation in how hospitals reported uncompensated care in this survey makes comparisons difficult. Specifically, the definition of uncompensated care shortfalls (e.g., the difference between hospital charges and the amounts paid or allowed by different third-party payers) is a problem as it is not possible to compare activity across hospitals without information on the variation in charge structures.

Table 2: Levels of Community Benefit Spending (as a Percentage of Total Revenues) by Type of Hospital

Category of Community Benefit Expenditure	High Population		Rural CAH		Rural Non-CAH		Other Urban and Suburban		Aggregate	
	Average (%)	Median (%)	Average (%)	Median (%)	Average (%)	Median (%)	Average (%)	Median (%)	Average (%)	Median (%)
Uncompensated Care	7.9	4.8	5.6	2.1	7.6	2.7	7.3	4.3	7.2	3.9
Medical Training and Education	2.7	1.6	0.2	0.1	0.6	0.2	1.3	0.4	1.3	0.3
Medical Research	3.2	0.4	0.0	0.0	0.5	0.3	0.7	0.1	1.6	0.2
Community Programs	1.7	0.2	1.0	0.3	0.6	0.2	0.8	0.2	0.9	0.2
Total	12.7	9.8	6.3	2.8	8.4	3.2	8.9	5.8	9.2	5.5

Source: IRS Exempt Organizations (TE/GE) Hospital Compliance Project Final Report, 2009

It should also be noted that the definition of shortfalls used in the questionnaire to collect data from the hospitals (e.g., the difference between payments received and original charges) does not conform to the IRS/CHA community benefit framework either in the types of shortfalls included or how the shortfalls are calculated (e.g., the actual cost of providing care to individuals receiving charity care or covered by Medicaid and other means-tested government programs less any payments received).

Notwithstanding the potential problems with these findings, they suggest the importance of understanding more about the safety net role of CAHs and their community benefit activities. As rural communities are plagued by higher rates of uninsurance⁴, underinsurance⁵, and poverty⁶, it would be reasonable to expect that they would report similar, if not higher, percentages of patients receiving uncompensated care. In fact, CAHs reported the lowest average and median percentages of patients receiving uncompensated care than any of the other hospitals at 7% and 2% respectively (compared to 10% and 3% respectively for all hospitals). There are a number of possible explanations for the differences. One is that the demand for uncompensated care may exceed the capacity of low-volume, financially vulnerable CAHs to provide it. A second is that the payer mixes of CAHs have become Medicare-focused and CAHs may not be reaching uninsured patients. A third is that CAHs may be less sophisticated than larger hospitals when it comes to tracking the provision of uncompensated care and are therefore underreporting their activity. Finally, the small-town location of these hospitals may discourage local residents from

⁴ The most rural areas have an uninsurance rate of 23%, compared to 19% for urban areas (Lenardson, Ziller, Coburn, & Anderson, 2009).

⁵ 10-12% underinsurance in rural areas compared to 6% in urban areas (Ziller, Coburn, & Yousefian, 2006).

⁶ 15% in rural areas compared to 12% in urban areas (DeNavas-Walt, Proctor, & Smith, 2008).

seeking charity care from CAHs within their communities due to concerns about confidentiality and privacy.

Conclusions from the IRS study: Conclusions regarding the community benefit activities of CAHs from the IRS Final Report must be drawn cautiously, as the framework used for the questionnaire, particularly the sections related to uncompensated care expenditures, is inconsistent with the framework adopted by the IRS subsequent to the study. Further, the questions are worded in a way that allows for considerable inconsistency in the responses (Ernst & Young LLP, 2006), (Internal Revenue Service, 2009), (Hatton, 2006).

Nevertheless, the IRS study suggests that CAHs are likely to have difficulty meeting a 5% threshold for community benefits such as that proposed by Senators Grassley (R-Iowa) and Bingaman (D-New Mexico). This is due in part to the low patient volumes that make CAHs less likely to participate in education and/or research activities. Another contributing factor is the financial constraints related to operating size (e.g., low patient volumes) and rural environments of these facilities located in communities burdened by higher rates of poverty, lower average incomes, and higher levels of uninsurance and underinsurance. CAHs report lower levels of excess revenues (expressed as a percentage of total revenues) than other hospitals and are more likely than other hospitals to report deficits or zero excess revenues. A final contributing factor may be that CAHs are less sophisticated than larger facilities in identifying, costing, and reporting community benefits.

Findings from the report suggest that CAHs, along with other types of hospitals, may have difficulty complying with the reporting requirements established by the IRS for Form 990, given the variation in the types of activities reported across the community benefit categories by responding hospitals. Although Form 990, Schedule H for Hospitals should promote uniformity among hospitals in terms of what is reported within community benefit categories, it does not address the administrative difficulties that CAHs and other hospitals may have in changing their accounting and reporting systems to collect and report the required data. This is a significant task that requires sophisticated cost accounting and extensive data collection.

CAHs reported a larger proportion of community benefit activities focused on community programs; these activities could enhance their community benefit profiles. Here, too, it is possible that CAHs have been less successful in tracking their activities than larger hospitals. More information is needed about the types of community benefit activities in which CAHs are engaged and how they are tracking and reporting this information. Our study sought to assess the utility and feasibility of tracking and reporting community benefit information.

Community Benefit Activities of CAHs from the 2007 FMT Survey of CAHs

In 2007, the Flex Monitoring Team conducted a telephone survey of 450 CAH administrators in 45 states that inquired about CAHs' community-focused activities. Three hundred and eighty-one (381) CAHs responded to the survey (85% response rate). The survey yielded important information about the financial assistance provided to patients by CAHs, the involvement of CAHs in conducting community needs assessments, the extent to which they engage in formal planning processes to address community needs, the types community health and other services offered, their level of networking with community providers, the support they offer to community providers, their community building activities, and the impact of CAH conversion on

communities. The results from the survey are consistent with the findings of the IRS 2006 Hospital Compliance Study in that CAHs reported being engaged in a wide range of community-focused activities.

Survey results indicated that almost all CAHs offer charity and discounted care to their patients, although it was not possible to quantify how much charity and discounted care they offer. Eligibility for charity and discounted care is generally set below 200% of the federal poverty level (FPL), although some CAHs set eligibility at between 200% and 400% FPL. Less than half of the CAHs surveyed had performed a community needs assessment within the preceding three years. Almost 80% reported having a formal planning process for developing and enhancing services, caring for vulnerable populations, or other activities.

When asked about the community services they offered, CAHs most commonly reported offering community health education services, free or reduced-cost care, health screenings, and enrollment assistance. In addition, more than half of the CAHs surveyed offered disease management or chronic care services. The report noted that in order to compare the performance of CAHs, it would be necessary to quantify the value of many community benefit activities and gather information about trends over time (Loux, Coburn, Gale, & Lenardson, 2008).

THE PILOT TEST OF COMMUNITY BENEFIT INDICATORS AND DATA COLLECTION TOOL

With the implementation of the IRS's reporting requirements, all nonprofit CAHs will be required to collect and report on their community benefit activities beginning in tax year 2009. To assess the interest and willingness of CAHs to include community benefit indicators in their performance monitoring systems and to test the feasibility of collecting the data necessary for using these indicators, the FMT piloted the use of a set of community benefit indicators and measures with a small sample of CAHs. The purpose of the test was to identify the issues and challenges related to the collection of community benefit data by CAHs for the purposes of: a) reporting to the IRS, b) reporting to ORHP, and c) informing hospital leadership and boards on a range of community benefits.

We worked with staff from the Performance Management Institute of Stroudwater Associates to develop a community benefit module for their RPM system. RPM is a web-based performance management tool based on Kaplan and Norton's balanced scorecard, designed to support the performance improvement activities of small rural hospitals. The community benefit module collects data on community benefit activities including the costs involved with each activity and the number of individuals being served by these programs. Using this module, which was based on the IRS's instructions for completing Schedule H of Form 990, CAHs can collect and summarize the data needed to complete the schedule. In early 2008, following completion of the module, we worked with PMI to recruit four CAHs in each of six states (Indiana, Louisiana, Maine, Pennsylvania, Tennessee, and Texas) that had a significant concentration of CAHs that were using or planning to use RPM to participate in a pilot test of the indicators and RPM community benefit module.

Training for pilot test participants began with an initial one-hour webinar on community benefit, including definitions and methodology. This training was offered at multiple dates and times to accommodate hospital representatives' schedules. We suggested that participants from each

hospital include the administrator, the individual responsible for administering the RPM module, and a member of the hospital's finance staff. Nineteen recruited CAHs completed this initial training. A second webinar to explain the data entry and reporting functions of the RPM module was offered by PMI. Fourteen recruited CAHs completed the second training. Most CAHs—including all of the recruited CAHs in Tennessee—dropped out of the study prior to the start of data collection in May/June 2008; only seven of the originally recruited CAHs remained in the study.

We asked CAH representatives why their hospitals dropped out of the study. Some indicated concern about pricing for the RPM module. Many of the publicly-owned CAHs withdrew from the study when they realized they are not required to file Form 990. Still other representatives told us that they did not have time to track community benefit information in tax year 2008 before it was required by the IRS, and that they would start tracking community benefit activities in tax year 2009, when reporting became required.

After completing the training, CAHs collected community benefit data for approximately eight months, after which the remaining participating hospitals were asked to participate in an evaluation of the usefulness and feasibility of collecting community benefit data using the RPM module. Subsequent to the start of the study, one CAH in the group began using Lyon Software's Community Benefit Inventory for Social Accountability (CBISA) software instead of RPM to collect its community benefit data. This change occurred when the hospital system to which the CAH belonged adopted the CBISA tool for all its hospitals. Given that our primary interest is in the indicators rather than the software platform, we included this hospital in our evaluation, and added another CAH from the same system to our evaluation group. Most evaluations were completed over the phone, but several were completed independently by CAH representatives and returned via fax or email.

Overall, the evaluations indicated satisfaction with both the usefulness and feasibility of collecting community benefit data using either the RPM or CBISA software tools. Many of our respondents' answers regarding the tracking of community benefit activities echoed the findings of the IRS Hospital 2006 Compliance Project's findings regarding community benefit expenditures. Our findings suggest that CAHs may not be tracking and reporting all community benefit activities in which they are engaged. Most respondents reported not using the RPM or CBISA software tools to track the following community benefit indicators:

- Charity and/or discounted care provided to low-income and uninsured patients vs. charity and/or discounted care provided to medically indigent patients;
- Use of federal poverty levels to determine eligibility for charity and/or discounted care;
- Strategies used to notify patients and the public about availability of charity and/or discounted care;
- Community needs assessment and planning activities;
- Physician/medical student education;
- Subsidized health services; and
- Research.

Respondents characterized some indicators, such as research and some subsidized health services, as “not applicable” which is also consistent with the findings of the 2006 Compliance Project. This finding suggests that some community benefit activities and the related indicators are not well-suited to CAHs, given their small size and limited patient volume. Other activities and indicators, such as community needs assessment and planning activities and eligibility criteria for charity and/or discounted care, may be tracked easily outside of the RPM or CBISA systems, as these indicators are not likely to change regularly. This finding suggests that a software tracking tool may not be necessary for community benefit indicators that remain relatively static and do not change over time. Although tracking all indicators using a single tool is likely to simplify reporting by centralizing community benefit data in one location, our findings suggest that respondents did not find this to be a significant benefit. As indicated in Table 3, respondents’ ratings of the usefulness and feasibility of using the RPM or CBISA software tools to track community benefit indicators fell into four categories.

Respondents reported that tracking the provision of charity and/or discounted care to low-income and uninsured patients was both useful and feasible, while separating and tracking charity care and bad debt costs was useful but less uniformly feasible. This may reflect inconsistencies in how the costs are calculated or how the data is captured and classified upon rendering patient services. It may also indicate separation between community benefit tracking, patient billing, and financial accounting systems. While respondents judged the tracking of many indicators using the RPM or CBISA tools to be useful and feasible, they rated a significant number as having mixed feasibility, mixed usefulness, or both. Some of these mixed ratings may result from the low volume of activities occurring in CAHs, while others may result from misunderstandings about what constitutes community benefit, why it is important to track it, and how best to do so. The mixed ratings may also reflect the timing of the pilot test, which required participants to track information before community benefit reporting on Form 990 was required by the IRS; respondents’ ratings could change once the revised Form 990 is fully implemented.

Table 3: Usefulness and Feasibility of Community Benefit Indicator Tracking Using RPM/CBISA

Useful and Feasible	Useful with Mixed Feasibility
<ul style="list-style-type: none"> - Provision of charity/discount care to low-income and uninsured patients - Inclusion of community benefit in mission statement - Resources for community benefit activities - Community health education activities - Community-based clinical services - Support group activities - Self-help programs 	<ul style="list-style-type: none"> - Charity care and bad debt costs - Health care support services
Feasible with Mixed Usefulness	Mixed Usefulness and Feasibility
<ul style="list-style-type: none"> - Nursing/nursing student education, other health professional education, or scholarships/funding for professional education - Staff dedicated to community benefit operations 	<ul style="list-style-type: none"> - Government-sponsored program shortfalls - Pastoral outreach programs - Social service programs - In-kind donations, cash donations, and grants - Community-building activities

DISCUSSION

There are at least three uses for community benefit data. The first is to complete the IRS Form 990 or fulfill state community benefit reporting requirements, an annual reporting function. The second is as a strategic management tool; this could be a periodic or ongoing reporting function for both hospital staff and board. The third purpose of community benefit data is to support the Flex Program by providing ORHP with information about the types of community benefits CAHs are providing, how much community benefit they are providing, and how CAHs are tracking and reporting community benefits as part of assessing their overall community impact.

The community benefit data required to complete Form 990 and/or state reporting requirements are comprised of data that might be reported on a monthly basis—such as the number of community health improvement activities, number of persons served, and the expenditures for these activities—as well as data that would be recorded once, such as the % FPL used to determine eligibility for charity and/or discounted care. Our pilot test asked hospitals to rate the usefulness and feasibility of tracking data required for Form 990. We found that participants tended not to use the community benefit tools to track data that is recorded on a single occasion, but did find the tools useful for tracking recurrent or ongoing activities and services. The reluctance of participants to enter single-occurrence data into the tools suggests that these tools may not be ideal “one stop” sources for Form 990 data. On the other hand, since we conducted our pilot test prior to the full implementation of the revised Form 990, it is possible that once CAHs will see the benefit of using a single tool to track all community benefit data when they are required to fully complete Form 990.

Pilot test participants gave mixed ratings for the usefulness and feasibility of tracking charity and bad debt costs using RPM/CBISA. This might indicate that some CAHs are tracking this information in their financial management systems and are disinclined to re-enter the data into the community benefit tool. Alternatively, this could reflect an inability of existing hospital systems to distinguish charity care from bad debt. We know from the IRS study that CAHs report lower percentages of patients receiving uncompensated care and include bad debt as uncompensated care less often than hospitals overall. A clearer understanding of how, where, and when to report bad debt and charity care might encourage CAHs to use community benefit tools to track and report this information.

Using community benefit data as a management tool requires that data be entered in a timely and consistent manner into a single tracking system or tool, or into a set of integrated tools. A community benefit management tool should be useful not only for understanding past performance, but also for strategically managing community benefit activities. Our pilot test results, with a number of indicators excluded from the tracking tools and mixed ratings on the usefulness and feasibility of tracking a number of other indicators, suggest that some CAHs have not yet determined whether and how to use the available community benefit tools to manage their community benefit activities.

The 2007 survey indicated that CAHs are participating in a variety of community benefit activities, including many subsidized services. Software tools such as RPM and CBISA can help CAHs track all of these activities on an ongoing basis using a single tool. Our pilot test revealed that CAHs were successfully tracking some programs and services using these tools. In general,

the tools seemed best suited to tracking community-based programs and services rather than hospital-based activities.

Although they are not specifically related to the use of the tracking tool, 2007 survey findings together with the findings from this pilot test suggest that CAHs may be falling short of conducting a formal community needs assessment on a periodic and regular basis as recommended by the Catholic Health Association and IRS guidelines. These findings also suggest that at least some of the community benefit activities of CAHs may be “legacy” activities and not necessarily tied to the current needs of their communities.⁷ The use of a community benefit management tool that ties community benefit activities and their effects (e.g. numbers or people served, reductions in barriers to access, and improvements in community health) to a current assessment of community needs could help CAHs strategically develop and manage their community benefit activities, thereby improving their effect on the health of their communities.

Accurate tracking and reporting of CAHs’ community benefit activities is important for assisting the Flex Program and ORHP in understanding how CAHs are benefiting their communities. We know from the IRS study that the community benefit profiles of CAHs are different than those of other hospitals. Not only do CAHs appear to be providing lower levels of community benefits when measured as a percentage of total revenues, but the types of community benefits are different as well. Understanding how and why the community benefit profiles of CAHs are different could be helpful in advocating for community benefit standards that do not disadvantage CAHs, perhaps by considering their broader community impact as well as their size and location. In addition, such an understanding may inform Flex Program funding priorities as ORHP seeks to ensure that CAHs are providing the most appropriate benefits to the rural communities they serve.

CONCLUSIONS AND POLICY IMPLICATIONS

CAHs may not yet have fully grasped the significance and value of tracking and strategically managing their community benefit activities. Being able to accurately report a hospital’s benefit to its community can help the hospital defend its nonprofit status by providing information about how the hospital identified community needs, developed programs and services to meet those needs, and the effect of those programs and services on the health of the community and its residents. More work may yet be needed to perfect existing community benefit tools and to convince CAHs to use them. In addition, our findings suggest several areas in which policy changes may encourage CAHs to more fully and accurately track and report their community benefit activities.

Use of community benefit tracking software to collect and report community benefit activity: As with any software tool or management information system, a critical part of the implementation of community benefit tracking software involves a review of the hospital’s systems and processes necessary to accurately identify, capture, and report data on its community benefit activities. Although the IRS, through the adoption of the Catholic Health Association community benefit guidelines, has established consistent definitions and methods for reporting community

⁷ Schedule H asks hospitals to describe how they assess the needs of the communities they serve. It also asks hospitals to describe the geographic areas and demographic constituents they serve.

benefit activity, the findings from the 2006 Hospital Compliance Study and our pilot test suggest that CAHs have substantial need for support and technical assistance in the use of the CHA/IRS framework and in developing the underlying administrative, clinical, and financial systems necessary to capture and report this data. The CAHs participating in the pilot test may find that their impressions of the tools and their value change as they gain experience with their use as well as with the process of capturing and reporting community benefits.

Tracking and reporting of uncompensated care: Inconsistencies in tracking and reporting uncompensated care suggest that CAHs may benefit from technical assistance in managing their charity care and bad debt activities. While uncompensated care includes charity care, government program shortfalls, and bad debt, only charity care and means-tested government program shortfalls are considered community benefits under the CHA and IRS guidelines.⁸ CAHs that report bad debt as uncompensated care less often than other hospitals may compare unfavorably to other hospitals when uncompensated care is measured, although the portion of uncompensated care that constitutes community benefit may vary. Consistency is needed across all hospital types in how uncompensated care is tracked and reported before standards are set for the level of community benefits nonprofit hospitals must provide.

Multiple systems: CAHs may be reluctant to enter information into multiple tracking and reporting systems (e.g., community benefit and financial systems). Financial data, such as charity care and bad debt costs, government shortfalls, and the level of subsidization of critical departments, may be required in separate systems. To the extent possible, community benefit tools should not duplicate existing management tools. Where duplication is unavoidable, systems should be integrated or designed to reduce the need for double entries by drawing information from other systems.

Community benefit standards: As pressure mounts for a set of community benefit standards for nonprofit hospitals, it will be important for CAH advocates to understand how and why the community benefit profiles of CAHs are different from those of other hospitals. Uniform standards for all nonprofit hospitals may disadvantage CAHs, which, due mostly to their small size, are often unable to participate in programs requiring a high volume of patients, such as research and medical education. Policymakers should consider whether modified standards, or standards that encompass CAHs' community impact beyond specific community benefits, would be appropriate for measuring CAHs' contributions to their communities.

⁸ Schedule H asks hospitals to provide information on their bad debt expenses including an estimate of the amount of their bad debt expenses attributable to patients eligible under hospital charity care policies (IRS 2008). It also asks hospitals to report on their Medicare activities and to describe the extent to which their shortfalls, if any, should be treated as community benefits. .

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APPENDIX A: COMMUNITY BENEFIT INDICATORS

Community Benefit Indicators by Category
<i>Charity (Free) and Discounted Care</i>
% of CAHs providing charity/discounted care to low income and uninsured patients
Mean ratio of uncompensated care costs to total hospital costs
Mean ration of uncompensated care costs to total (and/or net) hospital margin
% of CAHs separately identifying charity care and bad debt within their accounting systems
% of CAHs using federal poverty guidelines to determine eligibility for charity and discounted care
% of FPL used by CAHs to qualify individuals for charity care? Discounted care?
% of CAHs using other methods to qualify individuals from charity/discounted care?
% of CAHs using any of the following strategies to notify the general public and patients of the availability of charity/discounted care: <ul style="list-style-type: none"> • upon request • written materials provided to all patients upon registration • notices posted in public areas of the hospital and hospital facilities • admissions staff informs patients of availability of charity/discounted care at intake • billing/collection staff informs patients of availability of charity/discounted care • billing statements contain notice of availability of charity/discounted care • notifies social service agencies and/or local health care providers • public service announcements and/or advertisements in local media • brochures distributed in community
<i>Government Sponsored Health Care</i>
Ratio of Medicaid shortfall costs to total hospital costs
Ratio of SCHIP shortfall costs to total hospital costs
Ratio of local/state shortfall cost to total hospital costs
<i>Hospital Commitment</i>
% of CAHs with a mission statement that includes a focus on community benefit
% of CAHs that have resources for community benefit activities
<i>Identifying and Meeting Community Needs</i>
% of CAHs with a formal planning process for one or more of the following community-focused activities: <ul style="list-style-type: none"> • service development and enhancement • caring from vulnerable populations • public/population health • other
% of CAHs involving any of the following in these planning process: <ul style="list-style-type: none"> • Health care providers • local government representatives • human service agencies • consumers (not employed by or a board member of the hospital) • local employers/businesses (not a board member of the hospital) • local/regional economic development organizations • other organizations
% of CAHs that conducted a formal or systematic community needs assessment in the past three years
% of CAHs identifying community needs using one or more of the following sources of information:

<ul style="list-style-type: none"> • focus groups/community meetings • tracking health statistics • meetings with community providers • community surveys • provider surveys • other methods
Community Health Services
<p>% of CAHs offering:</p> <ul style="list-style-type: none"> • community health education services • community based clinical services • free clinics • free/reduced cost medications • health care support services • other community health services
Services That Fill Vital Community Needs
<p>% of CAHs offering one or more of the following services:</p> <ul style="list-style-type: none"> • mental health services • substance abuse services • public health services • EMS or ambulance services • Primary care services for low income and/or uninsured patients
Community Engagement
<p>% of CAHs providing support to stabilize another provider</p>
<p>% of CAHs providing support to stabilize one or more of the following types of providers (CAH Survey):</p> <ul style="list-style-type: none"> • primary care providers • Federally Qualified Health Centers • EMS and/or ambulance services • nursing home/long-term care providers • mental health providers • other type of providers
<p>% of CAHs hospital engaged in one or more of the following community building activities</p> <ul style="list-style-type: none"> • coalition building • advocacy to improve public health, transportation, access to care for the uninsured, etc. • development of RHCs or FQHCs • in-kind donations to non-health care organizations or programs • job creation and training programs for health and non-health careers • workforce education programs for health and non-health employees • recruitment of physicians and other providers (to support community providers, serve underserved populations/areas) • other community building activities
<p>% of CAHs engaged in networking with other providers to enhance local services</p>
<p>% of CAHs networking with one or more of the following providers to enhance local services:</p> <ul style="list-style-type: none"> • RHCs or FQHCs • other CAHs • other hospitals • public health • EMS • dentists • mental health providers • other providers

APPENDIX B: THE EVOLUTION OF COMMUNITY BENEFIT STANDARDS

Introduction

Although the development of community benefit standards for nonprofit hospitals is currently the subject of a heated policy debate, the origins of community benefit can be traced back to English common law; specifically, an 1891 legal decision that defined four types of charitable organizations or trusts for the relief of poverty, advancement of education, advancement of religion, and other purposes beneficial to the community (IOM, 2004; Crimm, 1998). This charitable trust framework has been reflected in United States tax code governing the provision of tax exemption to nonprofit organizations serving religious, charitable, scientific, literary, or educational purposes since the first federal taxation act in 1894 (ibid).

The development of community benefit standards for nonprofit hospitals is based predominantly on the view of community benefit as a social contract between nonprofit hospitals and society in which these hospitals have an obligation of public service to the community in exchange for the tax exemptions they receive (Craig, 2008). The nature of this obligation has varied over time based on Internal Revenue Service (IRS) rulings and legislative activity. Its early focus on the provision of care to the poor gave way to a focus on promoting the health of the community in the mid 1960s. More recently, the nature of the public service “owed” by nonprofit hospitals has returned to a central focus on the provision of services to the poor and uninsured.

The Origins of Community Benefit

Community benefit is a legal term originating in English Common law that describes charitable activities that benefit the community as a whole. In *Commissioners for Special Purposes of Income Tax v Pemsel* (1891), the English court identified four categories of charity organizations or trusts:

- Trusts for the relief of poverty;
- Trusts for the advancement of education;
- Trusts for the advancement of religion; and
- Trusts for other purposes beneficial to the community (IOM, 2004; Charity Commission, 2008).

This framework found its way into United States tax law with the passage of the Tariff Act of 1894, in which Congress enacted the first federal income tax exemption for charitable organizations based on the outline of the framework established by Pemsel (Crimm, 1998; IOM, 2004). Although the Tariff Act was declared unconstitutional a year after its passage, its charitable trust framework was continued in the 1909 Payne Aldrich Tariff Act, which exempted corporations or associations organized and operated exclusively for religious, charitable, or educational purposes from excise taxes imposed by the Act, and the Revenue Act of 1913, which expanded the excise tax exemption to include any corporation or association organized and operated exclusively for religious, charitable, scientific, or educational purposes (Crimm, 1998). Subsequently, the Internal Revenue Code of 1939 exempted corporations and any community chest, fund, or foundation organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals, from

income taxation (ibid). Although modified and amended by subsequent legislation, court decisions, and IRS rulings, this framework remains central to the U.S. Tax Code governing the exemptions extended to nonprofit organizations.

Evolution of Community Benefit Standards for Nonprofit Hospitals

The development of specific community benefit standards for nonprofit hospitals dates back to a 1956 IRS ruling (56-185) that required nonprofit hospital be established for educational, scientific, or public charitable purposes to qualify for tax exemption (Craig, 2008). IRS 56-185 established specific criteria for each of these three purposes that nonprofit hospitals had to meet to qualify for tax exemption. Under the standards for public charitable purposes, a nonprofit hospital had to serve patients in need of hospital care who could not afford to pay for their services, within limits of the hospital's financial capacity. The 1956 IRS ruling embodied the notion of a social contract in which nonprofit organizations had an obligation to provide quantifiable benefits to society in exchange for the tax exemptions they received.

This standard remained in place through 1969, when an IRS ruling established a new community benefit standard for nonprofit hospitals (69-545) that eliminated the mandate that hospitals provide charity care. This change followed the implementation of Medicare and Medicaid, programs that changed the funding dynamic for hospitals by reimbursing hospitals for health care provided to the elderly and poor. As a result, it was believed that the need for the provision of charity care by hospitals would be substantially reduced. In place of charity care, the 1969 IRS ruling established the following requirements for hospitals seeking to qualify for nonprofit status: they must operate with a nonprofit structure; establish a community board; maintain an open medical staff; and promote the health of the community as a whole. A commonly used indicator of "community benefit" under the 1969 IRS ruling was that the hospital operated an emergency room upon to all persons regardless of ability to pay (AHA, 2007).

Although the 1969 IRS ruling eliminated the mandate that nonprofit hospitals provide care to all regardless of ability to pay, the Emergency Medical Treatment and Active Labor Act of 1985 (EMTALA) re-established this expectation by requiring all hospitals with emergency rooms, for-profit and nonprofit, to stabilize and treat all patients presenting through their emergency rooms regardless of ability to pay. This change began to blur the distinctions between for-profit and nonprofit hospitals (Craig, 2008). The distinctions were further blurred as both for-profit and nonprofit hospitals began to use educational, wellness, and outreach programs, long conducted by nonprofit hospitals as part of their community benefit activities, as marketing vehicles (ibid). Given these changes, it became more difficult to distinguish between the two types of hospitals based solely on the IRS's community benefit criteria.

In response to the blurring of the distinctions between for-profit and nonprofit hospitals, nonprofit hospital leaders in the late 1980s began to explore the development of community benefit standards. The goals of these standards were to better identify and document the community benefits provided by nonprofit hospitals and to clearly distinguish them from for-profit hospitals. The W.K. Kellogg Foundation was an early leader in this area through its funding of a three-year (1989-1992) national demonstration known as the Hospital Community Benefits Standards Program (HCBSP) (Himmelman, 2006). Coordinated through the Wagner Graduate School of Public Service at New York University, the HCBSP developed a set of four standards to help hospitals develop systematic programs to shape their community benefit

activities and identify what they are doing to fulfill their community commitments (Sigmond Paper, n.d). These standards were as follows:

1. There is evidence of the hospital's formal commitment to a community benefit program for a designated community.
2. The scope of the program includes hospital-sponsored projects for the designated community in each of the following areas: improving health status; addressing the health problems of minorities, the poor, and other medically under-served populations; and containing the growth of community health care costs.
3. The hospital's program includes activities designed to stimulate other organizations and individuals to join in carrying out a broad health agenda in the designated community.
4. The hospital fosters an internal environment that encourages hospital-wide involvement in the program.

Fueled by their community-oriented organizational missions and the desire to identify and document their community benefit activities, the Catholic Health Association of the United States (CHA) and VHA, Inc. (originally Voluntary Hospitals of America) built upon the work of the HCBSP to develop their own standards for community benefit reporting. CHA's early efforts included the development of a series of policies and practices for tracking needs, services, and results as outlined in the 1989 document, *The Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint* (Trocchio, 2006). In 2002, the CHA Board of Trustees approved a set of standards for community benefit and urged all members to implement them (ibid).

In 1990, VHA, Inc. convened a task force of member chief executives officers to develop recommendations for addressing issues related to nonprofit hospitals' community benefits and tax exempt status (Voluntary Hospitals of America, Inc., 1992). Based on the recommendations of this task force, VHA's Board approved a set of voluntary community benefit standards for its members. These standards called for VHA hospitals to: demonstrate leadership as charitable institutions; provide essential health care services; be accountable to the community; provide evidence of commitment to community benefit; and operate free from private profit.

In 2002, CHA and the Coalition for Not-for-Profit Health Care, with assistance from VHA, Premier, Inc, and the Alliance for Community Health Plans, published a document entitled *Community Benefit Planning: A Resource for Not-for-Profit Social Accountability* (CHA and the Coalition for Not-for-Profit Health Care, 2002). Throughout 2003, a group of CHA and VHA members worked together to revise existing community benefit definitions and categories in reporting guidelines (ibid). In 2005, CHA, VHA, and Lyon Software published the document: *Community Benefit Reporting: Guidelines and Standard Definitions for the Community Benefit Inventory for Social Accountability*, effectively bringing the two sets of standards into line (DeWolf and Trocchio, 2006). In 2006, CHA partnered with other hospital organizations and stakeholders to reach consensus on the CHA/VHA community benefit framework and related accounting principles. These were published in 2006 by CHA in cooperation with VHA in *A Guide for Planning and Reporting Community Benefit* and updated in 2008 (DeWolf and Trocchio, 2006). This document created a uniform and widely accepted set of standards for community benefit reporting that was adopted by the Internal Revenue Service as the basis for

community benefit reporting under its Revised Form 990, Schedule H and a number of state and hospital community benefit reporting systems.

Recent Interest in Community Benefits

More recently, there has been renewed interest at the national, state, and local levels in the community benefits provided by nonprofit hospitals. Nationally, this interest has been driven by the Senate Finance Committee under the leadership of Charles Grassley (R-Iowa) who started reviewing the charitable activities of tax-exempt hospitals in 2005 (Wilson, 2009). Under Grassley's leadership, the Senate Finance Committee called for a study of the quantity of community benefits provided by nonprofit hospitals as well as executive compensation levels and the hospitals' participation in joint ventures. In response, the IRS conducted a compliance study of 544 nonprofit hospitals and hospital systems in 2006 to examine these issues (Internal Revenue Service, 2009). Based on the preliminary results of this study, the IRS revised its Form 990, *Return of Organization Exempt from Income Tax*. The revisions include the development of a new schedule (Schedule H) to collect information on the charity care and other community benefit activities of nonprofit hospitals. The revised Form 990 was phased in during tax year 2008 (for returns filed in calendar year 2009) and collected basic background information from nonprofit hospitals. Form 990 was fully implemented in tax year 2009 (for returns to be filed in calendar year 2010). Hospitals required to complete Form 990 must provide a full range of community benefit information based on the CHA community benefit framework.

In addition to advocating for the collection of data on the community benefit activities of nonprofit hospitals, Senator Grassley has joined with Senator Jeff Bingaman (D-New Mexico) in calling for the creation of standards for a minimum level of community benefits to be provided by all nonprofit hospitals. Senators Grassley and Bingaman have proposed a minimum threshold of 5% of operating expenses or revenues (Fierce Healthcare, 2008; Senate Finance Committee, 2007; Wall Street Journal, 2008). Although they have been unsuccessful in passing legislation to implement this standard, they remain committed to doing so (Wilson, 2009, Chicago Tribune, 2009).

There is also interest at the state and local levels in understanding the community benefit activities of nonprofit hospitals. Twenty-six states have implemented community benefit reporting requirements, either mandatory or, in the case of two states, voluntary reporting through the Attorney General's Office. (CHA, 2009, ACHI, 2008 July).⁹ The type and extent of data collected varies by state with 18 states requiring the reporting of community benefit expenses and/or process measures. Eight states only require hospitals to report charity care data. In addition, 29 state hospital associations have implemented statewide community benefit reporting systems (CHA, 2009, ACHI, 2008 December).¹⁰ These are not mutually exclusive

⁹ States with state government requirements and reports on community benefit expenses and/or process measures include: California; Connecticut; Idaho; Illinois; Indiana; Maryland; Minnesota; Nevada; New Hampshire; New York; North Carolina; Oregon; Pennsylvania; Rhode Island; Texas; and Utah. The following states required hospitals to report charity care activity only: Alabama; Georgia; Mississippi; New Mexico; Vermont; Virginia; West Virginia; and Wisconsin. Massachusetts and Montana have adopted voluntary reporting of community benefit data through their Attorney General's Offices.

¹⁰ States with state hospital association activity in this area are Alaska, Colorado, Connecticut; Delaware; the District of Columbia; Florida; Georgia; Hawaii; Idaho; Indiana; Iowa; Kansas; Kentucky; Michigan; Minnesota;

activities and some states have both state and hospital association activity in this area. The goals of these reporting activities are to understand and report the level of community benefits and/or charity care provided by hospitals as well as to develop support for hospitals and the hospital industry.

As state and local government budgets become more constrained, states are exploring minimum state-level community benefit standards and methods for valuing hospital charity care. In 2006, Illinois Attorney General Lisa Madigan backed unsuccessful legislation that would have set an 8% minimum standard (e.g., nonprofit hospitals would have been required to devote 8% of their annual income to charity care) (Jaeger, 2009). A work group of Texas legislators has proposed standard formulas for calculating the cost of charity care, as Texas hospitals use as many as six different formulas to calculate the amount of charity care they provide (Kaiser Daily Health Policy Report, 2009). In early 2008, Ohio Attorney General Marc Dann undertook an initiative to clarify what the state's nonprofit hospitals must do to maintain state property tax exemptions (Fierce Healthcare, 2008). His initiative was triggered by the efforts of several Ohio communities to contest the tax exempt status of their local nonprofit hospitals. At the municipal level, Boston, Massachusetts, home to a large number of nonprofit hospitals and academic organizations, has formed a task force to consider ways to increase voluntary payments from these entities to the City in lieu of instituting taxes (Slack, 2008).

Pennsylvania, Rhode Island, Texas, and Utah have successfully passed legislating standards of community benefit performance (CHA, 2008; CHA, 2009). In Pennsylvania, hospitals must meet one of seven standards related primarily to charity care and/or uncompensated care performance. In lieu of meeting these standards, hospitals may enter into voluntary agreements with local governments to provide payment in lieu of taxes and receive credit of 150% to 350% of their payment towards their uncompensated care expenditure liability. Texas nonprofit hospitals must provide a minimum community benefit, including charity care and government-sponsored indigent health care, in accordance with one of three standards including: a reasonableness standard calling for the provision of charity and government-sponsored indigent care at a level that is "reasonable" in related to community needs; a 100% of tax-exempt benefit standard calling for the provision of charity and government-sponsored indigent care equal to 100% of the hospital's tax exempt benefits (excluding Federal Income Tax); and charity care and community benefits mix standard calling for the provision of combined community benefits equal to 5% of net patient revenue of which charity and government-sponsored indigent care provided in an amount equal to 4% of the hospital's net patient revenue.

Rhode Island has taken a different approach by mandating that hospitals may not discourage medically indigent patients from seeking essential medical services and requiring hospitals to provide full charity care for individual with incomes of 200% of the Federal Poverty Level (FPL) or below. They must provide charity care for individuals with incomes between 200% and 300% of FPL. State law also mandates that hospitals must render eligibility decisions within 14 days, use a standardized application, publically disclose charity care policies, and report their performance annually. In order to qualify for property tax exemptions, a Utah nonprofit hospital

Missouri; Montana; Nebraska; New Jersey; New York; North Carolina; Ohio; Oklahoma; Oregon; South Carolina; Tennessee; Virginia; Washington; and Wisconsin.

must show that that its “community gift” exceeds its property tax obligation for that year and that it must return an amount equal to its tax exemption to the community every year.

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