Community Impact and Benefit Activities of Critical Access, Other Rural, and Urban Hospitals, 2019

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KEY FINDINGS

- CAHs were less likely than other rural and urban hospitals to provide certain community benefit and essential healthcare services (i.e., community outreach, enrollment assistance, health fairs, community health education, health screenings, health research, indigent care, substance use treatment, psychiatric services, home health services, hospice care, palliative care, dental services, hemodialysis, obstetrics, and designation as a certified trauma center).
- CAHs were more likely than other rural and urban hospitals to offer adult day care, ambulance services, and long-term care services.
- CAHs reported higher rates of non-Medicare and non-reimbursable Medicare bad debt and higher unreimbursed costs of Medicaid, CHIP, and state/local indigent care programs than other rural and urban hospitals.

INTRODUCTION

Non-profit and publicly-owned hospitals, including Critical Access Hospitals (CAHs), have obligations to address the health needs of their communities. Non-profit hospitals are required to report their community benefit activities to the Internal Revenue Service using Form 990, Schedule H. Community benefit activities include programs and services that provide treatment and/or promote health in response to identified community needs. Publicly-owned hospitals are also held accountable to the needs of their communities through the oversight of their governing boards and local governments. To monitor the community impact and benefit activities of CAHs and to understand whether and how their community impact and benefit profiles differ from those of other hospitals, we compared CAHs to other rural and urban hospitals using a set of indicators developed by the Flex Monitoring Team (FMT). This report enables State Flex Programs and CAH administrators to compare the community impact and benefit profiles of CAHs nationally (Tables 1 and 2) to the performance of CAHs in their state (see links to state-specific tables here). Table 1 provides data for select measures of community impact and benefit, including the provision of essential health care services that are typically difficult to access in rural communities. Table 2 provides data on hospital charity care, bad debt, and uncompensated care activities.

APPROACH

This report uses data from the American Hospital Association (AHA) Annual Survey Database and Worksheet S-10 cost report data from the Center for Medicare and Medicaid Services (Form CMS-2552-10) for fiscal year 2019 to compare the community benefit profiles of CAHs with those of other hospitals. We used these data as the data collected through Form 990, Schedule H are not available in an electronic, machine-readable format. Additionally, only tax-exempt (501(c)(3)) hospitals are required to complete Form 990. As publicly-owned (i.e., government-owned) and for-profit hospitals are exempt from filing Form 990, this would exclude significant numbers of hospitals from our comparative analysis. The AHA and cost report data allow us to assess comparable data to that available through Form 990 for all hospitals.

We used the FMT's list of CAHs to identify hospitals in the AHA Survey data that were certified as a CAH prior to or during calendar year 2019. We linked the AHA data with the 2013 Rural Urban Continuum Codes (RUCCs) to classify the remaining hospitals as either rural (RUCCs 4 through 9) or urban (RUCCs 1 through 3), and then linked the resulting data set to Worksheet S-10 cost report data retrieved from the Center for Medicare and Medicaid Services website. The 2019 AHA database contains self-reported data on 1,347 CAHs, 763 other rural general medical and surgical hospitals, and 2,241 urban general medical and surgical hospitals located in the 45 states that have hospitals designated as CAHs. Comparison data for other rural and urban hospitals from these 45 states were included in this analysis. Data for hospitals located in American territories and the five states that do not have CAHs (Connecticut, Delaware, Maryland, New Jersey, and Rhode Island) were excluded from the analysis.

The FMT developed "core" and "financial" indicators of community benefit activity for use in this analysis. The 28 core indicators show the provision of community benefit and essential health services directly by hospitals and through participation in a health system or joint venture. The four financial indicators compare the levels of charity care, bad debt, total uncompensated care, and unreimbursed costs of serving patients covered by Medicaid, the Children's Health Insurance Program (CHIP), and other state and local indigent care programs, across all hospital types (i.e. CAH, other rural, and urban). Calculating charity care and bad debt performance as a percentage of adjusted revenue allows comparison across hospitals regardless of differences in volume, service mix, and charge rates.

Some hospitals included in the AHA database did not respond to the 2019 AHA survey. For non-responding hospitals, the service fields used in this analysis are left blank and, as a result, are treated as missing for these hospitals. Also, cost report data were not available for all hospitals in the AHA database and, conversely, some hospitals with valid cost report data did not respond to the 2019 AHA survey. As a result, hospital sample sizes differ for AHA (core) and cost report (financial) indicators. Please see table footnotes for sample size information.

RESULTS

Services Offered by Hospitals

We compared CAH involvement in the provision of community benefit services, including essential healthcare services, to that of other rural and urban hospitals. As indicated in Table 1, CAHs were less likely than other rural and urban hospitals to offer traditional community benefit programs such as community outreach, enrollment assistance, health fairs, community health education, health screenings, health research, and indigent care. They were also less likely to offer essential services including substance use treatment, psychiatric services, home health services, hospice care, palliative care, dental services, hemodialysis, obstetrics, or to be designated as a certified trauma center. However, the percent of CAHs offering some of these essential services did increase

from 2018 to 2019, including substance use outpatient (2.9% to 4.1%, a 30.7% increase), psychiatric outpatient (27.0% to 29.4%, an 8.1% increase), and palliative care services (16.8% to 18.0%, a 6.6% increase). The percent of CAHs designated as a certified trauma center increased as well (45.0% to 47.0%, a 4.4% increase). CAHs were more likely than other rural and urban hospitals to offer services such as adult day care, ambulance services, and long-term care services including skilled nursing, intermediate, and other long-term care (e.g., residential or elderly care) services. CAHs were more likely than other rural hospitals but less likely than urban hospitals to operate immunization programs. CAHs and urban hospitals were less likely than other rural hospitals to offer home health services.

Services Offered by Hospital Systems and Joint Ventures

Because hospital involvement in health systems or joint ventures can expand the availability of services within communities, we also examined the extent to which services offered by hospital health systems and joint ventures contributed to improvement in the level of community benefit and/or essential services offered by hospitals. For 10 of the 28 core indicators, inclusion of services offered via health systems and joint ventures increased service availability most among CAHs followed by urban and then other rural hospitals (community outreach, community health education, any substance use services including inpatient and outpatient care, any psychiatric services and psychiatric inpatient care, hospice programs, inpatient palliative care programs, and obstetrics care). For five core indicators (health research, psychiatric outpatient care, palliative care programs, dental services, and hemodialysis) inclusion of services offered by health systems and joint ventures boosted availability most among CAHs and least among urban hospitals.

For eight core indicators, inclusion of health systems and/or joint ventures expanded service availability most among urban hospitals and least among CAHs (immunization programs, adult day care, ambulance services, designation as a certified trauma center, and any long-term care including skilled nursing, intermediate nursing, and other long-term care). Heath fairs, health screenings, and home health services also increased most among urban hospitals because of involvement in health systems or joint ventures, followed by CAHs and other rural hospitals. Health systems and/or joint ventures increased enrollment assistance services availability most among other rural hospitals followed by CAHs and urban hospitals, and operation of indigent care clinics increased most among other rural hospitals followed by urban hospitals and CAHs.

Charity Care and Bad Debt Spending Patterns

The four financial indicators derived from S-10 cost report data are expressed as a percentage of adjusted revenue and can be used to estimate the relative differences in uncompensated care (i.e., charity care and bad debt) spending patterns among CAHs and other hospitals. Overall, CAHs provided the highest rates of uncompensated care followed by other rural and urban hospitals, respectively. While urban hospitals provided higher rates of charity care on average than other rural hospitals and CAHs, CAHs had the highest average rates of non-Medicare and non-reimbursable Medicare bad debt, followed by other rural and then urban hospitals. The total unreimbursed cost of Medicaid, CHIP, and state and local indigent care programs (the difference between the cost of providing services and the amount reimbursed by the programs) was highest among CAHs, followed by urban and then other rural hospitals.

CONCLUSIONS

In general, CAHs were less likely than other rural and urban hospitals to provide certain community benefit and essential healthcare services reflected in the core indicators we examined (i.e., community outreach, enrollment assistance, health fairs, community health education, health screenings, health research, indigent care, substance use treatment, psychiatric

services, home health services, hospice care, palliative care, dental services, hemodialysis, obstetrics, and designation as a certified trauma center). This may be partly attributable to CAHs' smaller size and more insecure financial status. It may also be due to the fact that the service areas for CAHs may not have sufficient population density to support the development of viable specialty services. However, a greater proportion of CAHs than other rural and urban hospitals report offering adult day care, ambulance services, and long-term care services including skilled nursing, intermediate, and other long-term care (e.g., residential or elderly care services). Indicators on which CAHs out-perform other hospitals may indicate areas where CAHs fill critical gaps in the local safety net. This report also shows that participation in health systems and joint ventures can enable hospitals to develop and offer services they cannot offer on their own. For the financial community benefit indicators we examined, urban hospitals reported higher rates of charity care than CAHs and other rural hospitals. However, CAHs reported higher rates of bad debt and unreimbursed costs of Medicaid, CHIP, and state and local indigent care programs than both other rural and urban hospitals.

TABLE 1. National Comparison of Service Indicators

Indicator	Hospital Provides Service (%)[1]			Hospital, System, or Joint Venture Provides Service (%)		
	% CAH[2]	Other Rural[2]	Urban[2]	% CAH[2]	Other Rural[2]	Urban[2]
Community Benefit						
Community outreach	66.7	80.2	86.3	71.4	84.4	92.1
Enrollment assistance services	53.4	67.0	79.9	62.0	80.2	90.8
Health fair	74.4	87.4	82.5	81.2	91.6	91.7
Community health education	83.2	90.1	91.1	88.9	93.2	95.7
Health screenings	82.6	90.1	88.1	86.0	92.5	93.9
Health research	2.1	11.9	49.0	11.2	22.2	68.8
Immunization program	50.1	43.6	52.4	58.5	52.6	68.7
Indigent care clinic	10.0	10.4	25.1	19.1	26.2	53.6
Patient Care Services						
Behavioral Health Services						
Any substance use services	5.2	13.6	23.8	16.7	23.1	51.0
Substance use inpatient care	1.9	6.8	12.5	9.0	14.3	35.1
Substance use outpatient care	4.1	10.4	20.4	14.4	19.6	46.4
Any psychiatric services	31.3	51.7	63.5	55.6	67.4	84.3
Psychiatric inpatient care	5.9	33.5	42.7	16.5	43.4	67.5
Psychiatric outpatient care	29.4	43.8	59.4	54.0	59.9	80.7
Long Term Services and Supports						
Adult day care	4.5	2.2	3.4	8.0	5.7	17.0
Home health services	20.8	33.0	22.2	49.8	62.5	70.2
Hospice program	15.6	24.0	28.4	59.8	65.9	79.0
Palliative care program	18.0	30.6	65.5	35.8	47.1	81.4
Inpatient palliative care program	5.6	7.1	16.1	11.2	12.3	29.6
Any long-term care	42.8	25.5	17.6	49.5	34.8	45.0
Skilled nursing care	37.3	21.6	12.8	44.2	31.0	38.9
Intermediate nursing care	12.6	5.7	6.3	18.4	11.5	26.0
Other long-term care	7.0	3.7	2.1	10.1	7.9	13.9
Other Essential Services						
Ambulance services	21.8	18.7	14.7	52.4	50.9	64.3
Certified trauma center	47.0	48.5	50.3	52.5	54.8	68.6
Dental services	5.5	17.2	30.7	26.4	30.4	50.6
Hemodialysis	2.6	22.0	56.7	17.3	51.5	91.0
Obstetrics care	33.4	80.4	77.0	41.1	83.7	88.5

Source: 2019 American Hospital Association Annual Survey
Table 1 footnotes are listed on the following page

Table 1 Footnotes:
[1] The United States Department of Agriculture's 2013 Rural Urban Continuum Codes (RUCCs) were used to classify non-Critical Access Hospitals as either "other rural" (RUCCs 4 through 9) or "urban" (RUCCs 1 through 3).
[2] There were 1,347 CAHs, 763 other rural hospitals, and 2,241 urban hospitals in the U.S. in 2019. Of these, 966 CAHs, 546 other rural hospitals, and 1724 urban hospitals responded to the 2019 AHA survey.
[3] Because of the nature and wording of the AHA survey, hospital responses may not align with state and/or American College of Surgeons (ACS) lists of certified trauma centers.

TABLE 2. National Comparison of Uncompensated Care and Unreimbursed Cost of Means-Tested Government Programs

Indicator (expressed as a mean percentage of adjusted revenue)	% CAH[1]	% Other Rural[1]	% Urban[1]
Total uncompensated care costs (combined charity care and bad debt)	6.5	6.3	5.2
Charity care costs	2.8	3.0	3.4
Bad debt costs (non-Medicare and non-reimbursable Medicare)	3.8	3.2	1.8
Unreimbursed costs of means-tested government programs (Medicaid, CHIP, and state/local indigent care)	3.4	2.9	3.3

Source: 2019 Medicare Hospital Cost Reports, Form CMS-2552-10
[1] There were 1,347 CAHs, 763 other rural hospitals, and 2,241 urban hospitals in the U.S. in 2019. Of these, 1,308 CAHs, 695 other rural hospitals, and 1,967 urban hospitals reported valid cost report data.

Notes:
- Comparison hospitals include all general medical and surgical hospitals operating in the 45 states where CAHs operate. Due to refinements in the comparison group construction methodology and data cleaning process, data for other rural and urban hospitals in this report are not comparable to data for other rural and urban hospitals in reports released prior to August 2016. CAH data are comparable across years.
- Cost report data include Worksheet S-10 line 19 (total unreimbursed cost for Medicaid, CHIP, and state and local indigent care programs); line 23, column 3 (cost of charity care), line 29 (cost of non-Medicare and non-reimbursable Medicare bad debt expense); and line 30 (cost of uncompensated care). Hospital revenue data are from Worksheet G-3 line 3 (net patient revenues).
- Hospitals that did not report net patient revenues or any of the four cost report indicators we examined were removed from the cost report analyses. Eight hospitals (three CAHs and five urban hospitals) that reported one or more cost report indicator spending total that exceeded their net patient revenues were also removed from the cost report analyses to ensure the quality and integrity of the data.