How Do CAHs Benefit Their Communities?: A View from the National Level

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Purpose

- Describe state and national issues driving interest in the community benefits of hospitals
- Provide an update on the IRS 990, Schedule H community benefit reporting requirements
- Describe findings from our 2006/2007 survey of CAHs
- Present a framework for measuring CAH community impact

Flex Monitoring Team

- Funded by the Federal Office of Rural Health Policy
- Rural Health Research Centers at the Universities of Minnesota, North Carolina, and Southern Maine.
- Charged with assessing the impact of Flex on CAHs and communities and the role of states in achieving the following objectives:
  - Improving access to and quality of CAH health care services;
  - Improving the financial performance of CAHs; and
  - Engaging CAHs and their communities in health care system development.

National Context

- Community benefit reporting standards developed by Catholic Health Association, VHA, Public Health Institute
- Sen. Grassley's and Senate Finance Committee interest in hospital charitable activities, billing activities, and ventures with for-profit hospitals and companies
- Interim Report on the IRS 2006 Compliance Check Questionnaire mailed to 600 tax-exempt hospitals
- IRS’s December 2007 revisions to Form 990 to collect community benefit information (Schedule H)

State Context

- Community benefit reporting initiatives
  - 19 with mandatory reporting regulations
  - 1 with voluntary reporting standards developed by Attorney General's Office
  - 6 with voluntary reporting process developed by state hospital association
- Intent is to quantify community benefits provided by hospitals to justify non-profit tax benefits

Flex Context

- ORHP has established explicit expectations and financial incentives for CAHs to:
  - Engage with their communities;
  - Develop collaborative delivery systems in their communities with CAHs as the hub of those systems of care; and
  - Undertake collaborative efforts to address unmet community health and health system needs.

CAH Context

- Concerns about cost-based reimbursement for CAHs by MedPac and other policymakers
- Pressures on CAHs to respond to a broad range of community needs including care for the uninsured and indigent
- Need for CAHs to become more strategic about their community benefit activities given limited resources
- Recognition that many CAHs needed assistance in telling their community impact stories

IRS Form 990, Schedule H

- Final Form released on 12/20/07. Instructions for the form are not yet available.
- Based on CHA standards.
- Mandatory for tax-exempt hospitals. Not a bad idea for those not required to complete Form 990.
- Reporting requirements will be phased in as follows:
  - For tax year 2008 (returns filed in 2009), hospitals must complete Part V of Schedule H, providing basic facility information.
  - For tax year 2009 (returns filed in 2010), hospitals must complete the full form with data on the value and scope of community benefit activities and charity care.

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The Six Parts of Schedule H

- I: Charity care and certain other community benefits
- II: Community building activities
- III: Bad debt, Medicare, and collection practices
- IV: Management companies and joint ventures
- V: Facility Information
- VI: Supplemental information

Major Revisions Made by the IRS

- Based on extensive comments, IRS adopted the final changes to accommodate concerns about Medicare shortfalls, bad debt, and community building activities.
- Hospitals must report Medicare shortfalls and bad debt
  - Neither will automatically be counted as community benefits
  - Hospitals must justify why some portion of its Medicare shortfalls (if any) and bad debt should be considered a community benefit
- Hospitals must report community building activities as the IRS wants to collect further data to determine if they are community benefits.

Preparing for Schedule H

- Form a committee to strategically address the reporting demands of Schedule H
- Study the CHA community benefit accounting framework
- Review current programs and activities to ensure that they meet IRS standards as community benefits
- Collect data throughout the year, rather than at year end
- Think strategically about community benefit activities
- Consider the use of IT to facilitate data collection
- Sharpen your charity care policies
- Use tax year 2008 as a dry run

Community Impact

- Includes activities and programs that positively impact the health and well-being of communities, including:
  - Have positive results for the community (service expansion or the economic benefits of the CAH as an employer);
  - Are unsubsidized, have a source for reimbursement to the CAH, and/or are expected to be self-sustaining; or
  - Fall into the more tightly defined category of community benefit activities as defined by CHA and adopted by the IRS and state community benefit reporting initiatives.

Community Benefit

- Programs or activities that provide treatment and/or promote health in response to an identified community need. Key criteria:
  - Generates a low or negative margin;
  - Responds to needs of special populations (e.g., uninsured);
  - Supplies a service/program that would likely be discontinued if based on financial criteria;
  - Responds to public health needs; or
  - Involves education or research that improves overall community health.

Community Benefit Questions

- Key questions to determine whether a program or activity is a community benefit:
  - Does the activity address an identified community need?
  - Does the activity support the organization's community-based mission?
  - Is the activity designed to improve health?
  - Does the activity produce a measurable community benefit?
  - Does the activity survive the "laugh" test?
  - Does the activity require subsidization?
  - Given a choice and in the face of limited resources, would this be an activity residents would choose to improve the health of their community?

Community Impact Framework

- Provision of charity and uncompensated care:
  - To patients unable to pay for all/part of their care or covered by public programs that do not cover the full cost of care. Information on charity care policies is widely disseminated to reduce barriers to seeking care
- Identifying unmet community needs:
  - Through a process of information gathering and action planning around community or population health needs
- Addressing unmet community needs:
  - By developing services needed by the community and critical to the viability of the hospital

Community Impact Framework

- Prevention and disease management:
  - By strengthening primary prevention and chronic care programs
- Building a continuum of care:
  - By developing service and organizational linkages with local clinical and community health organizations
- Building community health system capacity:
  - Through community partnerships to address local health needs and developing a local service mix to maximize the use of community resources and address community needs

Community Benefit: Arising from Patient Care Services

- Charity care:
  - Includes free or discounted services provided to persons who cannot afford to pay and meet criteria for financial assistance; does not include bad debt.
- Bad debt:
  - Includes uncollectible charges from persons that have failed to pay, where appropriate, and excludes contractual adjustments.
- Government-Sponsored Health Care
  - Includes unpaid costs/shortfalls for care provided to beneficiaries covered by Medicaid, SCHIP, local or state public or indigent care programs, and Medicare, where appropriate. Excludes contractual adjustments.

Community Benefit: Programs and Activities

- Community Benefit Services include:
  - Community Health Improvement Services
  - Health Professions Education
  - Subsidized Health Services
  - Research
  - Financial and In-Kind Contributions
  - Community-Building Activities
  - Community Benefit Operations

Community Health Improvement Services

- Community health services include:
  - Community health education;
  - Community-based clinical services;
  - Support groups and self-help programs;
  - Health care support services; and
  - Social services programs for vulnerable populations in the community.
- Examples include:
  - Health fairs, smoking cessation programs, free clinics, transportation programs to enhance access to care

Health Professions Education

- Health professions education includes:
  - Physicians / medical students;
  - Nurses / nursing students;
  - Other health professional education; and
  - Scholarships / funding for professional education.
- Examples include:
  - Internships and residencies, job shadowing and mentoring projects, continuing medical education and in-service programs for professionals in the community

Subsidized Health Services

- Subsidized health services are services provided to the community that are not expected to be self sustaining and may include:
  - Emergency and trauma care services;
  - Hospital outpatient services;
  - Women's and children's services;
  - Renal dialysis services;
  - Continuing care;
  - Behavioral health services; and
  - Palliative care.

Research

- Research includes:
  - Clinical research; and
  - Community health research.
- Examples include:
  - Studies on health issues for vulnerable populations, research studies on innovative health care delivery models, unreimbursed/unfunded costs of studies on therapeutic protocols

Financial and In-Kind Contributions

- Financial and in-kind contributions include:
  - Cash donations;
  - Grants;
  - In-kind donations; and
  - Cost of fund-raising for community programs.
- Examples include:
  - Contributions and/or matching funds to not-for-profit organizations, event sponsorship, meeting space for not-for-profit organizations and groups, cost of fundraising for community programs

Community-Building Activities

- Community-building activities include:
  - Physical and environmental improvements;
  - Economic development;
  - Support system and workforce enhancement;
  - Leadership development / training for community members;
  - Coalition building; and
  - Community health improvement advocacy.
- Examples include:
  - Community vegetable gardens, chamber of commerce membership, disaster readiness, lead and radon programs, recruitment of providers for federal medically underserved areas

Community Benefit Operations

- Community benefit operations include the costs associated with community benefit strategy and operations, including:
  - Dedicated staff;
  - Community health needs / health assets assessment; and
  - Other resources.
- Examples include:
  - Staff costs to coordinate community benefit volunteer programs; community health needs assessment; costs of developing a community benefit plan, conducting community forums, and reporting community benefit

Capturing Community Benefit

- Community benefits are typically reported in terms of the dollar value of the costs of developing and offering these services and programs.
- This cost focus tells only part of the story - data is needed on the outputs and outcomes of community benefit activities to tell the full story.

Survey of CAHs

- Conducted during the winter of 2006/Spring 2007
- Random sample of 450 CAHs
- Response rate 85% (381 respondents)
- Questions focused on community impact activities, quality and performance improvement, and access to capital

Charity Care

- CAHs assist low income patients 97%
  - Charity care only (100% write off of charges) 11%
  - Discounted care only (partial write offs) 3%
  - Both charity and discounted care 87%
- Use Federal Poverty Guidelines for charity care 79%
- Use Federal Poverty Guidelines for discounted care 78%
- Determine charity care eligibility in advance of care 51%
- Policies apply to all services 91%

Charity Care Policies

- CAHs train staff on charity/discounted care policies 80%
  - Admissions/patient registration 71%
  - Financial staff 75%
  - Patient support 57%
  - Direct care staff 35%
  - Administrative staff 58%
  - Reception staff 50%

Charity Care Promotion

- CAH has process for promoting charity care availability 88%
  - Upon request 62%
  - Written materials at registration 50%
  - Notice posted in public area 69%
  - Notifies patient at admissions 57%
  - Patients notified by billing staff 69%
  - Notices are placed in statements 25%
  - Notifies local providers 46%
  - Public service announcements 22%
  - Brochures distributed in community 29%

Community Need Assessments

- Conducted a systematic CNA in the last 3 years 49%
- Sources of information for CNA
  - Focus groups/community meetings 78%
  - Tracking health statistics 89%
  - Meetings with community providers 94%
  - Community surveys (residents and/or businesses) 69%
  - Provider surveys 55%

Hospital Planning Process

- Formal planning process for any of the following?
  - Service development and enhancement 66%
  - Caring for vulnerable populations 49%
  - Public health/Population health 43%
- Organizations involved in the planning process:
  - Health care providers 77%
  - Local government representatives 55%
  - Human service agencies 36%
  - Consumers 58%
  - Local employers/businesses 40%
  - Economic development organizations 36%

Community Services

Service	%
Health information/education classes/publications	96%
Self-help groups	65%
Community or worksite wellness programs	68%
Health promotion services or facilities	77%
Free or reduced cost clinics?	48%
Free or reduced cost medications?	32%
Health care support services (e.g., insurance enrollment assistance, interpretation)	84%

Services to Meet Community Needs

- Mental health services 37%
  - Inpatient MH services 20%
  - Outpatient MH services 76%
- Substance abuse services 11%
  - Inpatient SA services 24%
  - Outpatient SA services 68%
- Public health services 24%
- EMS or ambulance services 32%
- Primary care services for low income patients 57%

Networking to Develop Community Services

- Networked with other providers or organizations to expand/develop local services in last three years 87%
  - RHCs/FQHCs 56%
  - Other Critical Access Hospitals 80%
  - Other hospitals 92%
  - Public health 75%
  - EMS 87%
  - Mental health providers 71%
  - Schools/school clinics 83%

Support to Community Providers

- Involved in providing financial, material, in-kind, or other support to community providers in last 3 years
  - Primary care providers 59%
  - FQHCs 14%
  - EMS/ambulance 57%
  - Nursing home/long-term care 41%
  - Mental health providers 27%
  - Schools/school clinics 71%

Community Building Activities

- Involved in the following community-building activities within last three years
  - Advocacy to improve public health, transportation, access to health care by uninsured persons, etc. 61%
  - Development of RHCs or FQHCs 40%
  - In-kind donations to non-health organizations/programs 60%
  - Job creation/training for health and non-health careers 84%
  - Workforce education for health/non-health employees 75%
  - Recruitment of physicians/other providers (to support local organizations, serve underserved populations/areas) 89%

Goal of the Community Impact Indicators Project

- Develop a data collection and reporting system to:
  - Document the CI work underway in CAHs;
  - Monitor the progress of CAHs in addressing community needs;
  - Provide the Federal Office of Rural Health Policy with community performance indicators to document Flex Program performance (GPRA/PART); and
  - Provide tools to CAHs to strategically manage, monitor, and report their community impact activities.

Indicator Development

- Draft Indicators: CHA, VHA, PHI, AHA Annual Survey, Wisconsin Hospital Association, and others
- Expert Committee Input: Committee members prioritized indicators based on: validity, significance, reliability, and feasibility
- Revised indicators: Committee's rankings were used to select a revised set of core indicators.
- CAH Survey: Revised indicators formed the basis of our survey questions.
- Pilot Test: Survey validated indicators for use in the pilot test.
- Feedback from Pilot Test: Will drive revisions to the final set of indicators to be submitted to ORHP.

Policy Lessons

- CAHs are engaged in a wide range of activities that benefit their communities.
- The Flex Program supports community initiatives and can encourage community impact monitoring activities.
- Data on these activities are not collected or reported in a consistent fashion.
- It is not clear how CAHs plan for, implement, and manage their community strategies.
- Collecting information on these activities is challenging given the diversity of CAHs and rural communities.

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Final Thoughts

- The community benefit train is getting ready to depart the station. It is time to climb on board.
- CAHs need to think strategically about their community benefit activities
- We need data on CAH community impact activities. CAHs need data to tell their community impact stories
- Tools, indicators, and TA are needed to support CAHs in managing and reporting community activities
- Flex community impact indicators can support CAHs in their efforts to comply with IRS and state level reporting requirements