



# Comparing the Community Benefit Spending of Critical Access, Other Rural, and Urban Hospitals

John Gale, MS; Zach Croll; Andrew Coburn, PhD; Jamar Croom, MS  
University of Southern Maine

## KEY FINDINGS

- Spending for direct patient care (including charity care, subsidized care, and unreimbursed costs of government-sponsored programs) represents a larger portion of CAH community benefit expenses than for other rural and urban hospitals.
- CAHs report a higher rate of community benefit spending on subsidized health services (1.6 percent) compared to other rural (1.1 percent) and urban (0.9 percent) hospitals.
- Despite interest in counting community building activities as a community benefit, these activities represent less than one percent of all nonprofit hospitals' total expenditures.
- CAHs in areas with high unemployment and/or lower competition have higher rates of community benefit spending for direct patient care services compared to CAHs in areas with lower unemployment and greater competition.

## INTRODUCTION

There is increasing focus on the safety net role of tax-exempt hospitals, including Critical Access Hospitals (CAHs), and specifically on their charity care and other community benefit policies and activities. This attention was reflected in the Patient Protection and Affordable Care Act's (ACA) amendments to the Internal Revenue Service (IRS) tax code which clarified and expanded hospital charity care obligations and community benefit reporting requirements.<sup>1,2</sup> In a previous paper, we reported on the charity care, uncompensated care, and bad debt activities of CAHs.<sup>3</sup> This policy brief expands on that work by examining variations in the types and levels of hospital charity care, other community benefit spending, and community-building activities across Critical Access (CAH), other rural, and urban hospitals.

## BACKGROUND

Community benefit activities demonstrate the charitable missions, commitments to community, and obligations under

federal tax regulations of tax-exempt (501(c)(3)) hospitals as determined by the Internal Revenue Service (IRS).<sup>4,5</sup> Using IRS Form 990 Return of Organization Exempt from Income Tax, Schedule H (Hospitals), hospitals report information on the cost and volume of a range of community benefit activities including the cost of financial assistance provided to patients (e.g., charity and discounted care), unreimbursed costs of participation in Medicaid and other means-tested government programs, community health improvement services, community benefit operations, health professions education, subsidized health services, research, and cash and in-kind contributions for community benefit.<sup>5</sup>

Hospitals are also asked to report data on community building activities and the unreimbursed cost of Medicare.<sup>6</sup> The IRS will use the data collected through Schedule H to evaluate whether these two categories of activity should be included in its community benefit framework in the future. Community building activities seek to improve population health by proactively investing in preventive services and programs to address the "upstream" causes of poor health and may include activities such as housing,



economic development, community support, environmental improvement, leadership development and training for community members, coalition building, community health improvement advocacy, and local healthcare workforce development.<sup>7-9</sup>

## METHODS

**Data:** This study examined data from the tax year 2009 IRS Form 990: Return of Organizations Exempt from Income Tax, Schedule H compiled by the National Center for Charitable Statistics. All tax-exempt (501(c)(3)) hospitals are required to file Form 990 annually. Specifically, this study used data for hospitals that filed an individual IRS Form 990 (not part of a consolidated filing for multiple hospitals in a system) for Tax Year 2009, with a fiscal year ending date of 2010. The data set included hospitals whose Tax Year 2009 IRS Form 990s had been reviewed and cleared by the IRS for posting to the GuideStar website through August 2012. This data file was linked with the 2010 American Hospital Association's Annual Survey Database, the United States Department of Health and Human Services' 2012-2013 Area Health Resource File, and the United States Department of Agriculture's 2013 Rural Urban Continuum Codes (RUCCs) to compare community benefit activity across CAH, other rural, and urban hospitals. Urban hospitals are those facilities located in RUCC metro county codes 1, 2, and 3. Other rural hospitals are those facilities located in RUCC nonmetro county codes 4, 5, 6, 7, 8, and 9 and not designated as a CAH.

For this analysis, we focused primarily on the data reported by tax-exempt hospitals in Parts I and II of IRS Form 990, Schedule H. Part I collects expenditure data on the provision of hospital charity care and related policies, the unreimbursed costs of means-tested government programs, community health improvement services and community benefit operations, health professions education, subsidized health services, research, and cash and in-kind contributions to community groups. Part II collects expenditure data on community building activities undertaken to protect or improve the community's health or safety that are not reportable in Parts I or III of the schedule.<sup>7</sup>

**Sample:** Our analytic file contained data for the universe of 2,074 tax-exempt (501(c)(3)) hospitals that filed a Form

990 containing data only for their hospital (excluding those hospitals that are included as part of a consolidated, multi-hospital report). The study population included 529 CAHs, 361 other rural hospitals, and 1,184 urban hospitals.

**Measures:** To allow comparison across hospitals of different sizes and revenue and expense profiles, we calculated the ratio of community benefit expenses to total hospital expenses for each hospital category. To support multivariate analyses to identify the correlates of community benefit spending across hospital types, we adopted an approach taken by Young and colleagues<sup>10</sup> and grouped the eight community benefit measures found on line 7f (percent of total expense for each category of community benefit activity), Part I of Schedule H into two discrete summary variables for hospital community benefit expenses pertaining to: (1) direct patient care services, and (2) community-focused activities. To create the direct patient care services summary variable, we combined the measures for charity care expenses, unreimbursed costs for Medicaid and other means-tested government programs, and subsidized health services. To create the community-focused activities variable, we combined the measures for community health improvement services and community benefit operations, research, health-professions education, and cash and in-kind contributions to community groups.

In multivariate analyses to examine the relationship between hospital and market area characteristics and variations in community benefit spending among CAHs, market area was defined as the county where each hospital is located. The level of market competition was determined by the Herfindahl-Hirschman index, which is the sum of squares for the ratio of admission for each hospital in the market area (i.e. county) to the total admissions for general, acute care hospitals within the market area. We examined hospital characteristics, including bed size, system affiliation, religious affiliation, and profit margin, and county-level characteristics, including per capita income, percent of population below the federal poverty level, unemployment rate, and percent of population under 65 without health insurance as factors potentially associated with community benefit spending and activities.

**Analysis:** Descriptive analyses examined the direct patient care services, community-focused activities, and community building activities of tax-exempt CAH, other rural, and urban hospitals. We employed descriptive statistics to



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examine community benefit spending and the institutional and market area characteristics of sample hospitals. As noted earlier, we also conducted multivariate analyses to examine the relationship between hospital and market area characteristics and variations in community benefit spending among CAHs.

### FINDINGS

#### *Patterns of Community Benefit Spending*

In comparison to other rural and urban hospitals, CAHs reported lower total community benefit spending (as a percent of total hospital expenses) as well as lower rates of charity care and unreimbursed costs of Medicaid. Spending rates among CAHs were lower for community-focused activities, health professions education, and research than they were among other rural and urban hospitals, but higher for subsidized health services (Table 1, next page).

#### *Spending on Direct Patient Care Services vs. Community-Focused Activities*

Direct patient care services consumed the highest relative percentage of total overall community benefit spending for CAHs compared to other rural and urban hospitals (Figure 1). The financial vulnerability of CAHs and, to a lesser extent, other rural hospitals may limit the availability of financial resources to support community-focused activities.<sup>11</sup> CAHs and small rural hospitals are also less likely to have dedicated staff for community benefit and community/population health improvement activities than are urban hospitals.<sup>12</sup>

The results of our multivariate analyses of factors related to variations in these two categories of community benefit spending indicate that location in areas with high unemployment and less competition was associated with higher rates of CAH spending on direct patient care services and overall levels of community benefit. In comparison, membership in a hospital or health system and/or having a higher profit margin was associated with higher CAH spending on community-focused activities (data not shown).

#### *Community-Building Activities*

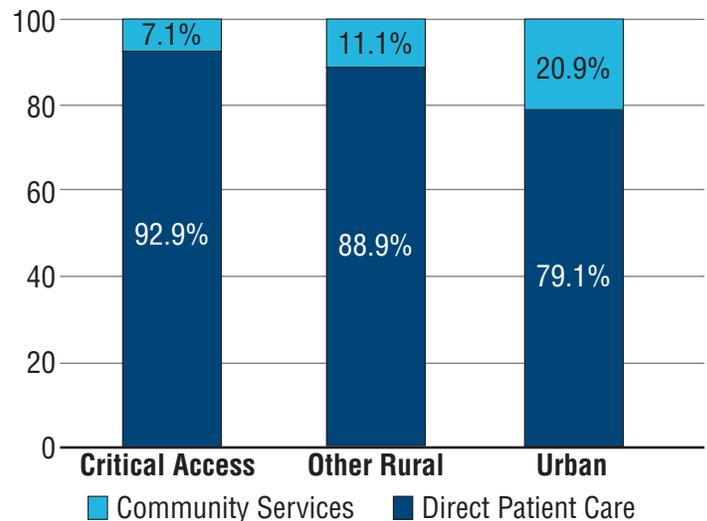
Despite hospital support for the inclusion of community building activities in the IRS community benefit framework, our analyses indicate that these activities represented a very

small fraction of total expenditures among not-for-profit hospitals (Table 2, next page). Community building activities totaled less than one percent of operating expenses for each type of hospital in 2009-2010 with spending ranging from a low of 0.09 percent for CAHs to 0.3 percent for other rural hospitals. Hospitals did not seem to favor any specific category of community building activity.

### LIMITATIONS

There are important limitations to this study. The findings are applicable only to tax-exempt 501(c)(3) hospitals that filed an individual IRS Form 990 for Tax Year 2009 (with a fiscal year ending date of 2010). The results, therefore, are not generalizable to tax-exempt hospitals that are included as part of a multiple hospital system. They are also not generalizable to publicly-owned or proprietary hospitals. Another limitation involves the use of counties as a proxy for market areas in our multivariate analyses as county boundaries typically do not perfectly coincide with actual market areas for rural hospitals. Although not ideal, the use of counties as a proxy for hospital area is consistent with past studies of this topic.<sup>10</sup> Finally, potential inconsistent reporting practices and accounting errors by those who filed the IRS Form 990 may have affected our results. Such errors may be mitigated in the future by ACA requirements directing the IRS to audit Form 990 filings.

**Figure 1. Community Benefit Spending on Patient Care vs. Community Services**



**Table 1. Community Benefit Spending as a Percentage of Total Expenses by Hospital Type**

Indicator	CAH (n=529)	Other Rural (n=361)	Urban (n=1184)
Direct Patient Care Services	6.5%	7.2%	6.8%
Charity Care	1.8%	2.3%	2.3%
Unreimbursed Medicaid	2.9%	3.6%	3.2%
Unreimbursed other means-tested gov't programs	0.2%	0.2%	0.4%
Subsidized health services	1.6%	1.1%	0.9%
Community-Focused Activities	0.51%	0.91%	1.8%
Community health improvement services and community benefit services & operations	0.3%	0.3%	0.4%
Health professions education	0.1%	0.2%	0.8%
Research	0.01%	0.01%	0.3%
Cash and in-kind contributions	0.1%	0.4%	0.3%
<b>Total Community Benefit</b>	<b>7.0%</b>	<b>8.1%</b>	<b>8.6%</b>

Source: IRS Form 990, Schedule H, Fiscal Years 2009-2010

**Table 2. Community Benefit Spending on Community Building Activities**

Indicator	CAH (n=529)	Other Rural (n=361)	Urban (n=1184)
Physical improvements and housing	0.01%	0.01%	0.03%
Economic development	0.00%	0.02%	0.00%
Community support	0.02%	0.03%	0.03%
Environmental improvements	0.00%	0.00%	0.01%
Leadership development/training for community members	0.00%	0.00%	0.00%
Coalition building	0.01%	0.00%	0.01%
Community health improvement advocacy	0.02%	0.02%	0.01%
Workforce development	0.03%	0.20%	0.03%
Other	0.01%	0.03%	0.01%
<b>Total Community Building Activities</b>	<b>0.09%</b>	<b>0.30%</b>	<b>0.10%</b>

Source: IRS Form 990, Schedule H, Fiscal Years 2009-2010

## DISCUSSION AND POLICY IMPLICATIONS

In 2009-2010, CAHs reported lower overall rates of community benefit spending for both direct patient care services and community-focused activities (6.5 and 0.51 percent, respectively) compared to other rural (7.2 and 0.91 percent, respectively) and urban hospitals (6.8 and 1.8 percent, respectively). This should not be surprising given the smaller size and greater financial vulnerability of CAHs.

In terms of the relative distribution of community benefit spending within hospital types, CAH spending on direct patient care services represents a greater proportion of their overall community benefit portfolio (92.9 percent) than it does for other rural (88.9 percent) and urban hospitals (79.1 percent). These patterns of spending likely reflect differences in the size and role of these facilities within their local health care systems and communities. CAHs are often the primary healthcare provider for vulnerable residents of rural



communities. These individuals are more likely to be un- or underinsured, enrolled in Medicaid or CHIP, and have lower incomes.<sup>13</sup> Larger rural and urban hospitals, by virtue of their location, size, and greater ability to dedicate staff to community benefit programming, have greater capacity to develop community-focused activities and, with the exception of inner city safety net hospitals, are unlikely to be the sole source of safety net care in their communities. Moreover, greater patient volumes, more complex case mixes, and greater resources enable larger hospitals to develop health professions education and research initiatives.

We suggested in a previous study that, given their resource and income constraints, CAHs tend to control access to charity care and other forms of financial assistance through the development of more restrictive eligibility criteria, thereby affecting their hospital charity care and bad debt performance.<sup>3</sup> Despite this fact, CAHs are frequently the primary source of safety net services for low income, uninsured, and underinsured individuals in rural communities and, as such, spending on direct patient care represents a higher percentage of their total community benefit spending than other hospitals. The lower rate of unreimbursed Medicaid costs reported by CAHs may be attributed to the fact that at least 24 of the 45 states with CAHs provide enhanced reimbursement of CAHs for inpatient care, and 27 of the 45 provide enhanced reimbursement for outpatient services.<sup>14</sup>

Despite the support of the American Hospital Association, the Catholic Health Association, and other industry groups for inclusion of community building activities in the IRS community benefit framework, our analyses show that this category of activity represents a very small fraction of total community benefit spending (less than one percent), with

little variation across CAH and other nonprofit hospital types. Notably, hospitals may be unwilling to commit resources to community building activities in the absence of a commitment by the IRS to count spending in this area as a community benefit.

Regardless of the operating and financial challenges facing CAHs, they must meet ongoing IRS and local stakeholder expectations around financial transparency and community accountability. This expectation of accountability has been reinforced by ACA-mandated changes to the IRS tax code requiring tax exempt hospitals to conduct triennial community health needs assessments (CHNAs) and develop strategy plans to address local needs identified through the assessment process.<sup>15</sup> This provides an important opportunity for State Flex Programs to provide technical assistance and support to CAHs under Program Area 3: Population Health Management and Emergency Medical Services Integration. Potential areas of State Flex Program involvement include supporting CAHs in conducting their required CHNAs, developing strategies to address identified community and population health improvement needs, coordinating the assessment process with community benefit programming to maximize the use of scarce local resources, improving the impact of CAHs on the health of their communities, and enhancing the provision of safety net services to vulnerable rural populations. At the same time, support in these areas will help CAHs meet their regulatory obligations and demonstrate accountability to their communities.

For more information on this study,  
please contact John Gale at  
[john.gale@maine.edu](mailto:john.gale@maine.edu)



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**Flex  
Monitoring  
Team**

University of Minnesota  
University of North Carolina at Chapel Hill  
University of Southern Maine

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