A Performance Monitoring Resource for
Critical Access Hospitals, States, and Communities

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

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Introduction

This brief examines the community benefit activities of Critical Access Hospitals (CAHs) using data from the Flex Monitoring Team's (FMT) pilot test of a set of community benefit data collection tools and performance indicators, the Internal Review Service's (IRS) 2006 Hospital Compliance Study, and the 2007 FMT CAH survey. This work reflects the growing national interest in the benefits provided by nonprofit hospitals to their communities. The primary purposes of this pilot test were to assess the value of a set of community benefit performance indicators for CAHs and to determine whether it would be possible for CAHs to collect community benefit data for purposes of reporting to the IRS using Form 990, Schedule H for Hospitals, reporting to the federal Office of Rural Health Policy (ORHP), and informing hospital leaders and boards on hospital community benefits. In this brief, we review the background of this project, examine evidence of differences in the community benefits provided by CAHs compared to larger hospitals, and discuss the issues for CAHs in complying with IRS community benefit reporting requirements.

Background

The FMT has developed a three-tiered framework to identify and categorize the activities and programs that improve the health and well-being of rural communities:

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

These activities provide a framework to describe how CAHs address local health care needs and impact their communities.

Key Findings

- CAHs may benefit from technical assistance and other support in collecting and reporting community benefit data using the CAH/IRS framework and managing their charity and uncompensated care activities.
- CAHs may be unlikely to use community benefit tools that duplicate existing management tools or are not integrated with existing management information systems.
- CAHs are less likely to participate in medical research and education; two significant areas of community benefit activity in larger hospitals, due to their sizes and limited patient volumes.
- Development of arbitrary hospital community benefit standards may disadvantage CAHs as they typically provide lower levels of community benefits when measured as a percentage of total revenues.

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Our pilot test focused on the Tier 2 community benefits activities of CAHs. As defined by CHA and the IRS, Tier 2 community benefits encompass two categories of activities. The first includes community benefits that arise from the delivery of patient care services, including the provision of charity care and shortfalls in revenues over expenses of government-sponsored health care programs. The second category includes community programs or services developed and provided by the hospital in response to community needs.

IRS Hospital Compliance Study and the 2007 FMT CAH Survey

The results of these studies indicate that CAHs are providing a wide range of community benefit programs and services but that they may be falling short of conducting the formal, periodic needs assessments necessary to support and strategically target their community benefit activities. The 2006 IRS study also suggests that CAHs provide a lower level of community benefits compared to larger hospitals (when measured as a percentage of revenues). This is due in part to the lower patient volumes that make CAHs less likely to participate in medical education and/or research activities than larger hospitals as well as the financial constraints related to the size and operating environments of CAHs. CAHs may also be less sophisticated than larger facilities in identifying and reporting community benefits.

These studies further suggest that CAHs may have difficulty complying with the reporting requirements established by the IRS for Form 990, Schedule H as well as difficulty meeting a 5% community benefits standard as proposed by some policymakers. While the IRS's adoption of the CHA framework as the basis for its community benefit reporting requirements should promote uniformity in terms of how hospitals report their community benefit activities, CAHs may have difficulty changing their accounting and data collection systems to collect and report the required data. This task requires sophisticated cost accounting and extensive data collection. More information is needed about the types of community benefit activities undertaken by CAHs and how they are tracking and reporting this information.

Our study sought to assess the utility and feasibility for CAHs of tracking and reporting community benefit information.

Methods

Nonprofit CAHs are required to report their community benefit activities to the IRS beginning in tax year 2009 (for returns filed in 2010). To test the feasibility of collecting the data necessary to comply with the IRS's reporting requirements and for reporting the community benefit performance of CAHs to ORHP, the FMT tested a set of community benefit indicators with a small sample of CAHs along with an on-line data collection tool.

In collaboration with Performance Management Institute (PMI), which works with hospitals and systems to develop platforms for monitoring performance, we developed a community benefit module for PMI's Rural Performance Management (RPM) system, a web-based performance management tool to support the performance improvement activities of small rural hospitals. The community benefit module collects data on community benefit activities, including the costs for each activity and the number of individuals served by the programs. The module is based on the IRS's instructions for completing Schedule H of Form 990 to assist CAHs in completing the schedule. In early 2008, we recruited four CAHs in each of six states to participate in a pilot test of the community benefit indicators and RPM module. After attending two training webinars, participants collected data for approximately eight months using the RPM tool. During the pilot, the hospital system with which one CAH is affiliated adopted the Community Benefit Inventory for Social Accountability (CBISA) reporting tool developed by Lyon Software. As our interest was in testing the feasibility of collecting community benefit data and not on the use of a specific tool, we retained the hospital in the pilot test and added a second CAH from the same system to the study. Following the data collection period, participants assessed the utility and feasibility of using available software tools to collect and manage community benefit data.

Discussion

Participants' evaluations indicated moderate satisfaction with both the utility and feasibility of collecting community benefit data using either the RPM or CBISA software tools. It remains unclear, however, whether CAHs are tracking and reporting all of the community benefit activities in which they are engaged. Participants reported that they did not use the software tools to report all of their community benefits, particularly activities, such as charity care, that are routinely tracked in a hospital's financial or billing system, or community benefit activities that do not occur on a frequent basis, such as community needs assessments. These findings suggest that community benefit reporting tools may need to be better integrated with hospital financial, accounting, and billing systems before they can serve as a "one stop" repository for Form 990 data.

Our pilot test results, with hospitals excluding a number of indicators from the tracking tools and with mixed ratings on the utility 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. Finally, accurate tracking and reporting of CAHs' community benefit activities is important for CAHs' reporting to the IRS, as well as to assist the Flex Program and ORHP in understanding how communities benefit from CAHs , as ORHP seeks to ensure that CAHs are maximizing their impact on the health of the rural communities they serve.

More work may be needed to assist CAHs in managing and reporting their community benefit activities. Our findings suggest policy changes in several areas to encourage CAHs to do so.

This policy brief is based on Flex Monitoring Team Briefing Paper No.24 available at http://flexmonitoring.org/documents/BriefingPaper24/Community-Benefits-CAHs.pdf

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