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The Community Benefit and Impact of Critical Access Hospitals:The Results of the 2007 CAH Survey

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Introduction

The Medicare Rural Hospital Flexibility Program (Flex Program) contains explicit expectations and financial incentives to encourage Critical Access Hospitals (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. Given these expectations and incentives, there is growing interest in understanding the community impact and benefits of CAHs. The engagement and impact of the Flex Program and CAHs in supporting and building the local infrastructure of rural health services is one of three major components of the Flex Monitoring Team's assessment of the Flex Program.[1] In 2007, the Flex Monitoring Team conducted a national telephone survey of 381 CAH administrators covering a wide variety of questions concerning hospitals' community benefit and impact activities. This Briefing Paper reports on the community benefit and impact findings of this survey.

The results of the 2007 survey indicate that CAHs are active in monitoring the health and health system needs of their communities, are engaged with other community organizations and stakeholders to address those needs, and provide services (often free) for patients and other provider organizations in the community that enhance access to care and help build the local rural health system.

Key Findings

- Most CAHs offer financial assistance to patients.
- CAHs are engaged in activities that demonstrate their commitment to community and rural health system needs.
- Many CAHs have relationships with community organizations including hospitals, primary care providers, emergency medical services, and schools.

- **Nearly all CAHs offer financial assistance to patients in the form of both charity care and discounted charges.**

Eligibility for charity care and discounted charges is typically set below 200% of the Federal Poverty Level. Nearly 90% of CAHs have formal processes to inform patients of their eligibility for charity care, discounted charges, and/or free care, although hospitals vary in how aggressive and transparent they are in communicating these policies to patients and in their training of staff on the policies.

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• **In addition to free and discounted care provided to patients, CAHs are engaged in community needs assessments, gap-filling service development and other activities that demonstrate their attention and responsiveness to community and rural health system needs.**

Nearly half of the CAHs surveyed had conducted a formal community needs assessment in the past three years and two-thirds have a formal planning process for addressing new service or other hospital and community needs. Moreover, a large majority of these hospitals actively involve the community in planning committees, meetings, and other components of the planning process, including local government, health care providers, consumers, local businesses and other community organizations. Nearly all of the CAHs surveyed offer services to address gaps in the community, including community health education, preventive screenings, free or reduced cost clinic services, clinical preventive service, and support services (e.g. Medicaid enrollment assistance). Moreover, these services are typically subsidized or offered at a final loss.

• **Over three-quarters of CAHs have relationships with other CAHs and non-CAH hospitals, EMS, schools, and public health agencies. CAHs are also supporting many of these community organizations, especially schools, primary care, and EMS.**

The development of networks among CAHs and other health care providers in the community and or region is a core strategy in the Flex Program for helping to expand or develop local services. The support CAHs provide to other community health organizations varies by organization but is most often in the form of financial support and help with recruitment and retention of personnel. Other health system development and community building activities include active recruitment of providers, job creation and training programs, and workforce education. Relatively few CAHs are involved in the development of Rural Health Clinics or Federally Qualified Health Centers.

It is currently impossible to assess the comparative performance of CAHs without more precise quantification of the value of many of these community benefits activities and in the absence of an understanding of trends over time and whether CAHs differ from other hospitals with regard to these activities. The Flex Monitoring Team's Community Benefit and Impact Performance Reporting module which will be piloted and finalized in 2008 will allow for quantification of the dollar value of some of the community benefit and impact activities of CAHs. If implemented nationally, it would also allow for comparisons of trends over time. In addition, the projected implementation in 2009 of the Internal Revenue Service's revised rules regarding the reporting of community benefit through Form 990 and Schedule H[2] would provide national data for assessing the performance of all CAHs over time and in relation to other hospitals.

Additional Information

This policy brief is based on Flex Monitoring Team Briefing Paper No. 19, available at www.flexmonitoring.org. For more information, please contact Stephenie Loux (207) 780-5774 or sloux@usm.maine.edu

[1]The others are: state performance and institutional performance, including financial and quality performance.
[2]American Hospital Association *IRS Releases Final --- and Mostly Improved --- Schedule H.* (Legal Advisory). Washington, DC: American Hospital Association; 2008.