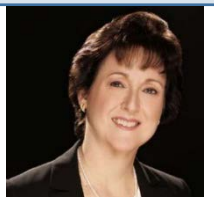
Hospital Community Benefit Spending: How to Increase Investments in Population Health

NASHP
NATIONAL ACADEMY FOR STATE HEALTH POLICY

Tuesday, January 10, 2017
12:30pm-2:00pm Eastern

Supported by the Robert Wood Johnson Foundation

Webinar Agenda

12:30 pm	**Welcome and Introductions** **Trish Riley**, Executive Director, NASHP	
12:40 pm	**Overview of Community Benefits Spending** **Maureen Byrnes**, MPA, Lead Research Scientist, Department of Health Policy and Management, Milken Institute School of Public Health, George Washington University	
1:00 pm	**Overview of Study** **Sara Rosenbaum**, J.D., Harold and Jane Hirsh Professor, Department of Health Policy and Management, Milken Institute School of Public Health, George Washington University	
1:20 pm	**Opportunities for States** **Cynthia Woodcock**, MBA, Executive Director, The Hilltop Institute	
1:40 pm	**Questions and Discussion**	

Aligning Federal Community Benefit Tax Policy with Community-Wide Health Improvement

Supported by Kresge Foundation and Robert Wood Johnson Foundation

January 10, 2017

Milken Institute School of Public Health
THE GEORGE WASHINGTON UNIVERSITY

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

Role of Hospitals in Improving Community Health

Drivers of change:

- A growing focus on social determinants of health.
- Health care reform.
- Expanding and refining the community obligations of tax-exempt hospitals.

Rosenbaum, S. 2016. Hospitals as community hubs: Integrating community benefit spending, community health needs assessment, and community health improvement. Retrieved at https://www.brookings.edu/research/hospitals-as-community-hubs-integrating-community-benefit-spending-community-health-needs-assessment-and-community-health-improvement/

Community Benefit

- **1956**: IRS rules that hospitals can meet the community benefit test if they furnish charity care.
- **1969**: IRS broadens community benefit definition to encompass hospital activities that benefit communities as a whole.
- **2009**: IRS introduces the Form 990 Schedule H Worksheet

SCHEDULE H (Form 990)

Hospitals

OMB No. 1545-0047

2015

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
▶ Attach to Form 990.
▶ Information about Schedule H (Form 990) and its instructions is at *www.irs.gov/form990*.

Name of the organization

Employer identification number

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a		
b	If "Yes," was it a written policy?	1b		
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year.			
	☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☐ 200% ☐ Other _____%	3a		
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☐ 400% ☐ Other _____%	3b		
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4		
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a		
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		
6a	Did the organization prepare a community benefit report during the tax year?	6a		
b	If "Yes," did the organization make it available to the public?	6b		

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)						
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs						
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)						
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j **Total.** Other Benefits						
k **Total.** Add lines 7d and 7j						

For Paperwork Reduction Act Notice, see the Instructions for Form 990. Cat. No. 50192T Schedule H (Form 990) 2015

Part II Community Building Activities

Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing						
2	Economic development						
3	Community support						
4	Environmental improvements						
5	Leadership development and training for community members						
6	Coalition building						
7	Community health improvement advocacy						
8	Workforce development						
9	Other						
10	Total						

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	
6	Enter Medicare allowable costs of care relating to payments on line 5	6	
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☐ Cost to charge ratio ☐ Other		

Section C. Collection Practices

			Yes	No
9a	Did the organization have a written debt collection policy during the tax year?	9a		
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b		

Part IV Management Companies and Joint Ventures

(owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Schedule H (Form 990) 2015

The Numbers

- > 50% of all U.S. hospitals (> 2900) operate as nonprofit corporations.
- Between 2002 and 2011, national value of tax exemption estimated to nearly double, from $12.6 billion to 24.6 billion (federal and state income taxes, state and local property and sales taxes)
- IRS reported > $62 billion in community benefit spending in 2011

ACA Reforms to Tax-Exempt Policy

- EMTALA compliance
- Financial assistance policy
- Limits on charges
- Bar against unreasonable collection efforts
- Community Health Needs Assessment (CHNA) requirements including transparent, public-involved planning, transparency, and implementation strategy
- No change to pre-existing community benefit definition

What's Missing?

Three key factors inform the conversation and collaboration:

- A clear link between health planning and community benefit investment
- Transparency in community benefit investment choices
- Incentives to spend on community-wide health improvement

Community Benefit Web Resource

- Prototype developed by GW for Robert Wood Johnson Foundation.
- Full web resource scheduled to be available in 2017.

Charity Care and Certain Other Community Benefits at Cost for Tax Year 2011: Number and Selected Financial Data by Type of Community Benefit*

Type of Community Benefit	Number of activities or programs	Number of persons served	Total community benefit expense	Direct offsetting revenue	Net community benefit expense	Percent of total expense[x]
Total Community Benefits[†]	(1)	(2)	(3)	(4)	(5)	(6)
	553,999	**82,710,801**	**$149,281,744**	**$86,927,818**	**$62,463,371**	**9.67**
Total charity care and means-tested government programs[±]	**399,099**	**15 ,747,656**	**104,046,778**	**69,186,996**	**35,054,051**	**5.42**
Charity care at cost	25,575	3,159,408	17,415,426	2,500,841	15,011,379	2.32
Unreimbursed Medicaid	372,742	11,758,070	82,406,170	63,769,821	18,736,792	2.90
Unreimbursed costs— other means-tested government programs	782	830,178	4,225,182	2,916,334	1,305,880	0.20
Total other benefits[v]	**154,900**	**66,963,145**	**45,234,966**	**7,740,822**	**27,409,320**	**4.24**
Community health improvement services and community benefit operations	131,187	53,208,425	3,029,646	369,626	2,659,025	0.41
Health professions education	9,804	1,465,110	13,621,372	4,389,163	9,232,250	1.43
Subsidized health services	2,497	5,577,800	17,113,507	11,916,218	5,113,403	0.79
Research	1,405	130,351	9,435,570	1,022,817	8,412,686	1.30
Cash and in-kind contributions to community groups	10,007	6,581,459	2,034,871	42,998	1,991,957	0.31

Note: Money amounts are in thousands of dollars. Detail may not add to totals due to rounding.

New Research

CHNAs emphasis on importance of upstream spending on social risk factors:

- 72 percent of hospitals identified obesity;
- 68 percent identified mental health; and
- 62 percent identified diabetes

… as the top health challenges of their communities.

Current IRS Policy

- IRS separates community building (community-wide efforts) from community benefit spending while requiring separate justification for community-wide health improvement efforts

- IRS does not require hospitals to report CHNA-linked CB spending or describe how CB spending responds to CHNA priorities

IRS Policy Opportunities

- Broaden the definition of community benefit to clearly include community health improvement activities that encompass community-wide efforts, now classified as separate community building activities
- Revise Schedule H reporting to include hospital reporting on the Relationship between CHNAs, implementation strategies, and CB spending
- Advance best practices in community-wide health improvement through government-wide advisory committee that identifies evidence-based upstream spending initiatives that hold promise to improve community health

Suggested Reforms

1. Eliminate regulatory obstacles to “upstream” spending
2. Clearer link between CHNAs and community benefit spending
3. Transparency

The Hilltop Institute

analysis to advance the health of vulnerable populations

Hospital Community Benefit Policy: Opportunities for States

January 10, 2017

Cynthia Woodcock

National Academy for State Health Policy

UMBC

AN HONORS UNIVERSITY IN MARYLAND

Presentation Overview

- Promoting community involvement in the Community Health Needs Assessment (CHNA) process
- Using regulatory tools to incentivize a focus on social and economic determinants of health
- Encouraging hospital transparency and accountability
- Repeal and Replace: Implications for states

Regional and community partnerships can increase the effectiveness of the CHNA process

- Multi-facility collaborations and collaborations between hospitals and public health agencies are not only permitted but *encouraged* by the 2014 IRS final rules
- Collaborations help align hospital community benefits with public health planning and avoid duplication of effort
- Potential partners: hospitals, physician groups, state and local public health and social services agencies, community stakeholders, health plans, private funders

States can encourage or require community involvement in the CHNA process

- **Massachusetts**: Attorney General's guidelines encourage hospitals to seek input from community groups representative of the populations served
- **Maryland**: Requires hospitals to consider CHNAs developed by state/local health departments and encourages consultation with community groups
- **Texas**: Requires hospitals to consider input from local health departments, public health districts, and community stakeholders
- **Utah**: Mandates annual consultation with county health officials by hospitals and nursing homes as part of the CHNA process

Some successful regional and community collaborations

- Integrating Community Health Improvement and Population Health: Children's National Health System, Washington, DC
- Mayor's Healthy City Initiative: Baton Rouge, LA
- From Volume to Value: Carroll Hospital, MD
- Soccer for Success: Trinity Health

Some successful regional and community collaborations continued

- Enos Park Access to Care Collaborative: Springfield, IL
- Communities that Care Coalition: Franklin County, MA
- Allies for Substance Abuse Prevention of Anderson County: Anderson County, TN

Some states use regulatory tools to encourage investment in social and economic determinants of health

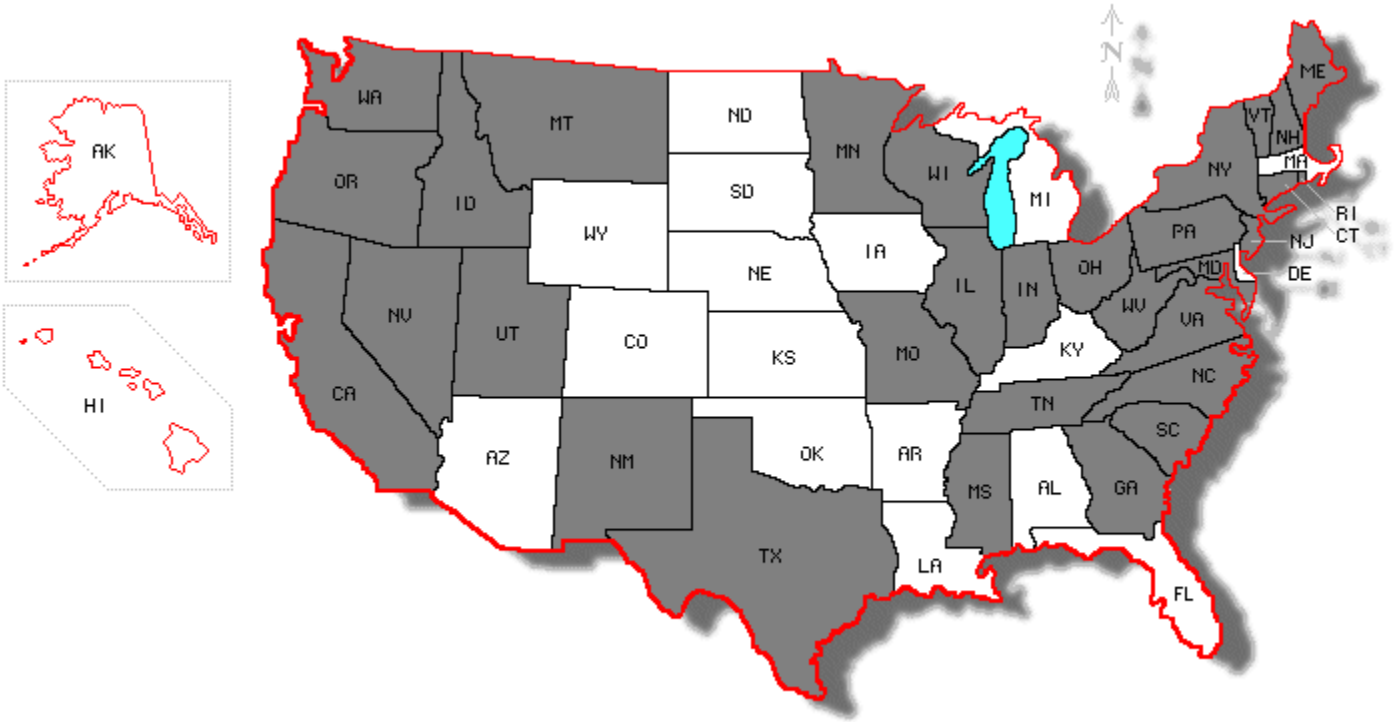
- **New York**: Implementation strategies must focus on at least two of five state Prevention Agenda priorities
- **California**: Statute gives examples of community benefit activities that address social and economic factors that shape health
- **Maryland**: Statute requires hospital implementation strategies to describe efforts to track and reduce health disparities

State reporting forms can include a focus on social and economic determinants of health

- **New Hampshire**: The state's community benefit reporting form requires hospitals to indicate socioeconomic "needs" being addressed, such as poverty, unemployment, educational attainment, high school completion, vandalism/crime, homelessness, air quality, and water quality

State reporting requirements can encourage transparency and accountability

31 states require hospitals to report on community benefits



Examples of state reporting requirements that encourage transparency and accountability

- **California** hospitals must complete a narrative section on community benefit activities
- **Vermont** requires community benefit reports to be posted on both the hospital's website and the state's website
- **New York** and **Washington** require hospitals to post implementation strategies on their websites
- **Indiana** and **Maryland** hospitals must report on the effectiveness of community benefit initiatives
- **New Hampshire** and **Rhode Island** require hospitals to report activities that they anticipate undertaking in the near future
- **Maryland**, **Indiana**, and **Texas** can impose civil penalties on hospitals for overdue community benefit reports

How can states be more proactive in promoting targeted and collaborative hospital community benefits?

- Now that the CHNA process mandated by the Affordable Care Act (ACA) is established, states should focus on:
  - More regional, multi-stakeholder collaboration
  - Greater transparency
  - Implementation processes and challenges
  - Evaluation to assess whether desired outcomes are being achieved
  - More comprehensive reporting by hospitals that goes beyond Schedule H and can be used to monitor progress with state health reform initiatives

Repeal and Replace: Where does this leave states?

- Repeal of §9007 of the ACA would:
  - Eliminate the requirement for hospitals to conduct CHNAs every 3 years (as well as to adopt CHNA implementation strategies and conduct evaluations)
  - Do away with reforms related to financial assistance policies, limitations on charges to patients who are eligible for financial assistance, and billing and collections practices
- States need to act now to develop their own legislative and regulatory "replace" strategies in the event Congress does not see this as a priority

About The Hilltop Institute

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a nationally recognized research center dedicated to improving the health and wellbeing of vulnerable populations. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations, and nonprofit organizations at the national, state, and local levels.

www.hilltopinstitute.org

Contact Information

Cynthia Woodcock

Executive Director

410.455.6274

cwoodcock@hilltop.umbc.edu

Blair Inniss

Policy Analyst

410.455.1441

binniss@hilltop.umbc.edu

The Hilltop Institute
University of Maryland, Baltimore County (UMBC)
www.hilltopinstitute.org

Questions & Discussion

Please type your questions into the chat box.

Thank you!

Your opinion is important to us. After the webinar ends, you will be redirected to a web page containing a **short survey**. Your answers to the survey will help us as we plan future NASHP webinars.