The Hilltop Institute

analysis to advance the health of vulnerable populations

Hospital Community Benefits After the ACA: Building on State Experience

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Academy Health Research Meeting

Community Benefit Pre-Conference

UMBC

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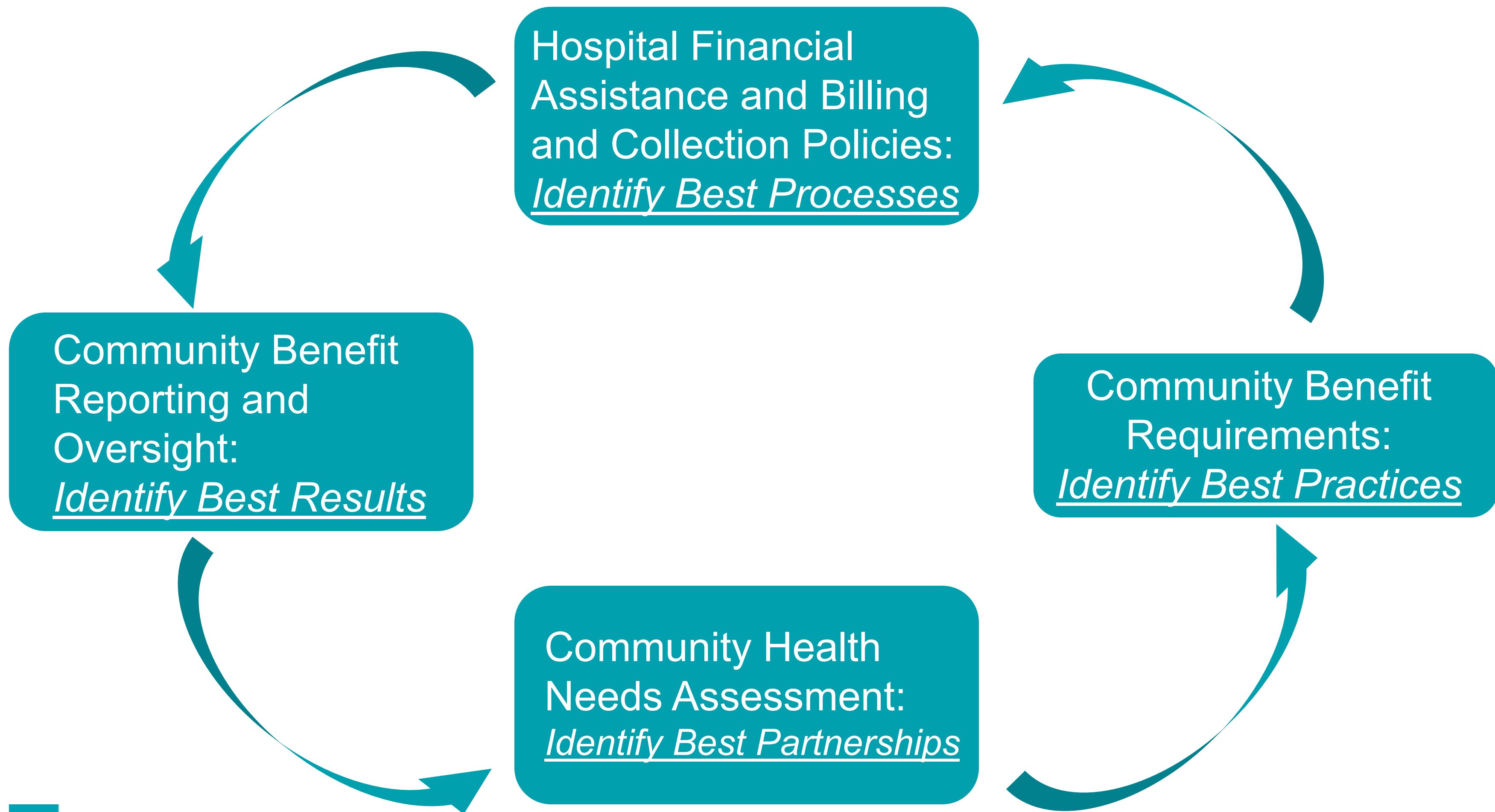
Hospital Community Benefit Program

- Located within The Hilltop Institute at the University of Maryland, Baltimore County (UMBC).
- Funded by the Robert Wood Johnson and Kresge Foundations.
- Committed to being a comprehensive resource engine for state and local policymakers.

Principle of
Hospital Community Benefit Program



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Three Aspects of §9007 of the ACA Discussed in Issue Brief #2

- Community Health Needs Assessment
- Hospital financial assistance policies
- Community benefit reporting and oversight strategies

Community Health Needs Assessment – Defining Community

- CA – recommends hospitals define community as a group of people with common features (*place, identity, or experiences*)
- CT – requires hospitals who choose to develop CB program to establish guidelines that "*particularly target low and middle-income, medically underserved, and other populations with barriers to access*"
- TX – defines community as the primary geographic area (*at least an entire county*) and patient categories for which the hospital provides health care services
- MA - nonprofits may choose to define community by (1) geography, (2) demographics, or (3) health status

Community Health Needs Assessment – Defining Community (Lack of National Standard)

- Hospitals
  - In states that do not provide clear legislative guidance, makes it difficult to confidently focus their CHNA activities

- State Regulators
  - Can frustrate ability to hold hospitals accountable for (1) needs assessment and (2) community health improvement

Community Health Needs Assessment – Community Involvement and Collaboration

- MA – **recommends** hospital community benefit planners seek input from community representatives who reflect the racial, cultural, and ethnic diversity of the population the hospital serves

- MD – requires that hospitals **shall** consider state or local health department developed CHNAs and **may** consult with community leaders, health care providers, and any appropriate individual that can assist in community needs identification

- TX – requires hospitals to **consider** the input of local health departments, public health districts, and other community stakeholders

- NH – requires hospital CHNAs to **include** the reports of public health agencies

Community Health Needs Assessment – Community Involvement and Collaboration

- Collaborative approaches may not be easy to achieve because:
  - Lack of common focus between hospitals and public health agencies – **differing philosophies and priorities**

- Possible Opportunity
  - Leverage scarce public health resources available for funding health department-led CHNAs with private resources that hospitals must devote to CHNAs for ACA compliance

Financial Assistance Policies

- MD – requires hospitals to provide free care to patients with family income below 200% of the FPL, and reduced cost to families between 200 and 300% of the FPL
- IL – requires rural hospitals to provide discounted care to uninsured patients up to 300% of the FPL, whereas urban hospitals must discount charges for families up to 600% of the FPL
- NJ – caps the payment responsibility of patients eligible for reduced-cost care to 30% of annual gross income

Financial Assistance Policies – Publication

- IL – requires policies to be posted on hospital websites and disseminated in non-English languages commonly spoke in community
- MD – requires hospitals to distribute policies to patients at the time of admission, before discharge, with hospital bill, and upon request by patients or their representative
- CA – requires hospitals to provide information in ER department, billing office, admissions office, and other outpatient settings
  - Also provides patient-friendly website

Billing and Collection Practices

- MD – requires written hospital policies that necessitate hospitals "active oversight" of third-party debt collection
- CA – hospitals cannot charge interest on outstanding bills, seek wage garnishment, or judicial garnishment order (*unless hospital proves patient has ability to pay*)
- NY – limits the interest rate hospitals may charge for medical debt; protects patient's primary residence from foreclosure
- MN – hospitals may not refer a patient's account to a collection agency or file suit before first confirming all potentially responsible insurers have been billed and a payment plan has been offered

Billing and Collection Practices

- MA – recommends that hospitals develop mechanisms for addressing patient complaints concerning collection agent actions and to require third-party collection agents to secure written consent from the hospital before initiating legal action or reporting a patient's medical debt to credit agency

Community Benefit Reporting and Oversight – Tax-Exemption

- 47 states have a state corporate income tax, of which 44 use the federal tax status as the deciding factor in granting state corporate tax-exemption (nonprofit status)
- 3 states (CA, NC, and MT) have a determination process **independent** of an entity's federal tax status

Community Benefit Reporting and Oversight – Mandatory vs. Voluntary

- 14 states with mandatory reporting requirements
  - Mandatory reporting is tied to one or more federal, state, or local tax exemption
- 20 states with voluntary reporting requirements
  - Voluntary reporting can bring about fuller disclosure of community benefit activities, and are used to align their reporting categories with those recommended by CHA and Schedule H
- 10 states with both forms of reporting requirements
- 7 states with no reporting requirements

Community Benefit Reporting and Oversight – Mandatory vs. Voluntary

- ND – determines whether a hospital is exempt by its federal tax status, but links **mandatory** community benefit reporting to state sales and use tax exemption
- NM – requires **mandatory** community benefit reporting for hospital seeking licensure
- NC – requires **mandatory** community benefit reporting for hospitals applying for tax-free bonds
- MA – requires **mandatory** community benefit reporting as a condition of original licensure (*for hospitals already licensed, reporting is voluntary*)

Community Benefit Reporting and Oversight – Process vs. Prescriptive

- Process
  - CA – defining community benefits as a "*hospital's activities intended to address community needs and priorities primarily through disease prevention and improvement of health status*"
    - Illustrates flexibility in the type of public health-directed initiatives nonprofits may choose to develop, implement, and report as long as they fall in the state-specified descriptive categories

- Prescriptive
  - IN, MD, and TX – provision of charity care, expenditure analysis of qualifying activities (community health services, health professions education, etc.)
    - Provides more detailed information of a hospital's progress in achieving community health improvement

Community Benefit Reporting and Oversight State Accountability Mechanisms (*Monetary Penalties*)

- IN & TX – impose civil penalties of $1,000 for each day a report is overdue
- MD – has the authority to impose $250 civil penalty for each day a report is overdue and may refuse to grant a rate increase

Community Benefit Reporting and Oversight State Accountability Mechanisms (*Evaluation*)

- CA, IN, MD, MA, and RI – require hospitals to **evaluate** their community benefit programs
- IN & MD – require hospitals to include a description of their efforts or mechanisms to evaluation the **effectiveness** of their community benefit initiatives in their annual community benefit reports
- CA – requires hospitals to provide additional explanation of their community benefit activities in a mandatory narrative section

Community Benefit Reporting and Oversight – Standardization

- Standardized Definitions of charity care and other community benefits
  - Facilitate a fair assessment of community benefit expenditures from hospital to hospital
  - Determine compliance with state community benefit threshold requirements

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.

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