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Community Benefit Activities of Critical Access, Other Rural, and Urban Hospitals: National and North Carolina Data

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Introduction

Nonprofit hospitals, including Critical Access Hospitals (CAHs), are required to report their community benefit activities to the Internal Revenue Service using Form 990, Schedule H. Community benefit activities are programs and services that provide treatment and/or promote health in response to identified community needs. In order to monitor the community benefit activities of CAHs and understand whether and how their community benefit profiles differ from those of other hospitals, we compared CAHs to other rural and urban hospitals using a set of community benefit indicators developed by the Flex Monitoring Team (FMT). The following report provides a summary of CAH community benefit activities at the national level, with indicators for CAHs in North Carolina attached in table format to allow State Flex Program and CAH administrators to compare the community benefit profiles of CAHs in their state to national averages.

Methods

This report uses data from the American Hospital Association (AHA) Annual Survey Database and Worksheet S-10 cost report data from the Center for Medicare and Medicaid Services (Form CMS-2552-10) for fiscal year 2012 to examine the community benefit profiles of CAHs. We linked the AHA Survey data with the Flex Monitoring Team's list of CAHs (as of June 30, 2013) to identify CAHs in the dataset and with the 2013 Rural Urban Continuum Codes (RUCCs) to classify the remaining hospitals as either rural (RUCCs 4 through 9) or urban (RUCCs 1 through 3). This resulting dataset was then linked to Worksheet S-10 cost report data retrieved from the Center for Medicare and Medicaid Services website. The 2012 AHA database contains self-reported data on 1,328 CAHs, 1,011 other rural hospitals, and 3,902 urban hospitals. Hospitals located in Puerto Rico, the Marshall Islands, Guam, American Samoa, the Virgin Islands, and the Northern Mariana Islands were excluded from the analysis.

We constructed community benefit profiles using a set of core and supplemental indicators developed by the FMT. Some of the core and supplemental indicators used in previous years are no longer available in the AHA data. As a result, we collapsed the remaining available indicators into a revised core set which shows the provision of important health services by hospitals either directly or through participation in a system, network, or joint venture. Additionally, we developed a set of four financial indicators to compare the levels of charity care, bad debt, total uncompensated care, and unreimbursed costs of serving patients covered by means-tested government programs (i.e., Medicaid, State Children's Health Insurance Programs (SCHIP), and other state and local indigent care programs) across all hospital types (i.e. CAH, other rural, and urban). The calculation of charity care and bad debt performance as a percentage of adjusted revenue allows for comparison across hospitals regardless of differences in volume, service mix, and charge rates.

Core Indicators for All U.S. Hospitals

Services offered by hospitals. We compared CAH involvement in the provision of important health care services to the performance of other hospitals. CAHs were more likely than other rural and urban hospitals to offer health screenings (81%, 78%, and 71% respectively) and immunization programs (41%, 34%, and 40% respectively). CAHs and other rural hospitals were more likely than urban hospitals to offer community health education services (75%, 75%, and 71% respectively). CAHs were slightly less likely than other rural but more likely than urban hospitals to conduct health fairs (78%, 79%, and 68% respectively). A lower percentage of CAHs compared to other rural and urban hospitals engage in community outreach (62%, 69%, and 69% respectively), provide enrollment assistance (40%, 49% and 58% respectively), participate in health research (2%, 8% and 36% respectively), and operate indigent care clinics (9%, 9% and 21% respectively). As shown, the widest differential was in health research. This finding was not unexpected given that CAHs and other small hospitals typically lack the patient volume required to participate in medical research activities.

CAHs were less likely than other rural and urban hospitals to provide substance abuse (5%, 12%, and 25% respectively), dental (7%, 21%, and 27% respectively), hemodialysis (4%, 21%, and 43% respectively), obstetrical (37%, 73%, and 55% respectively), psychiatric (23%, 47%, and 56% respectively), palliative care (15%, 25%, and 44% respectively), or inpatient palliative care (4%, 8%, and 13% respectively) services. CAHs were more likely than other rural and urban hospitals to be certified as trauma centers (39%, 37%, and 33% respectively), and to offer adult day care (5%, 4%, and 4% respectively), ambulance services (23%, 18%, and 12% respectively), and long-term care services (49%, 32%, and 28% respectively). For specific long-term care services, CAHs were more likely than both other rural and urban hospitals to provide skilled nursing (43%, 26%, and 16% respectively), intermediate (16%, 7%, and 6% respectively), and other long-term care services (9%, 5%, and 4% respectively). However, CAHs were less likely than other rural and urban hospitals to offer acute long-term care services (3.5%, 4.3%, and 10.8% respectively).

Services offered by hospital systems, networks, and joint ventures. Hospital involvement in systems, networks, or joint ventures can greatly expand the availability of services within communities. Generally speaking, the involvement of hospitals in systems, networks, and joint ventures expanded the overall level of services available in urban communities more than in rural communities. For example, the availability of any long-term care services rose by 18% for urban hospitals, compared to 7% for other rural hospitals, and just 4% for CAHs. Availability of certified trauma centers and ambulance services followed a similar pattern (certified trauma centers increased by 11% for urban hospitals, 3% for other rural hospitals, and 2% for CAHs; ambulance services increased by 35% for urban hospitals, 20% for other rural hospitals, and 25% for CAHs). While participation in systems, networks, and joint ventures generally had a greater impact on the availability of services in urban hospitals, CAHs were more likely than other rural and urban hospitals to offer ambulance services (48%, 38%, and 47% respectively), hospice programs (59%, 55%, and 58% respectively), and any long-term care services (53%, 39%, and 46% respectively) in their communities through involvement in systems, networks, and joint ventures. Overall, hospital participation in systems, networks, and joint ventures improved the availability of services. In general, availability improved more in urban communities (between 5% and 35%) than in rural communities (between 2% and 25% for CAHs and between 2% and 20% for other rural hospitals).

Charity Care and Bad Debt Spending Patterns for All U.S. Hospitals

The four financial indicators developed using the S-10 cost report data were expressed as a percentage of adjusted revenue and used to estimate the relative differences in uncompensated care (i.e., charity care and bad debt) spending patterns between CAHs and other hospitals. When viewed as a percentage of adjusted revenues, urban hospitals provided greater rates of charity care (3.5%) than other rural hospitals (1.9%) and CAHs (1.8%). In contrast, CAHs absorbed greater rates of non-Medicare and non-reimbursable Medicare bad debt (4.7%) compared to other rural (4.3%) and urban hospitals (2.1%) respectively. Overall, CAHs provided greater rates of uncompensated care (e.g., charity care and non-Medicare and non-reimbursable Medicare bad debt) at 6.6% compared to other rural (6.3%) and urban (5.6%) hospitals. Finally, the total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (the difference between the cost of providing these services and the amount hospitals are reimbursed by the programs) was relatively similar for all hospital types, with other rural hospitals at 3.8%, CAHs at 3.6%, and urban hospitals at 3.4%.

Conclusions

In general, CAHs were less likely than other rural and urban hospitals to provide certain community benefit and essential services (e.g., community outreach, enrollment assistance, mental health, substance abuse, obstetrical care, dental, palliative care, and hospice services) reflected in the core and supplemental community benefit indicators we examined. This may be attributable to their limited size and relatively vulnerable financial status. However, CAHs were more likely than other rural and urban hospitals to offer long term care and ambulance services, as well as community benefit services such as health screenings and immunization clinics. Indicators on which CAHs outperform other hospitals may indicate areas where CAHs fill critical gaps in the local safety net. Participation in systems, networks, or joint ventures may provide opportunities to develop and offer services that hospitals could not otherwise offer on their own. With regard to the financial indicators, CAHs reported lower rates of charity care and greater rates of non-Medicare and non-reimbursable Medicare bad debt and uncompensated care than other rural and urban hospitals. Further research is needed to understand the factors driving variations in community benefit activity by CAHs and the resources and incentives needed to help CAHs refine and target their community benefit activity.

A Performance Monitoring Resource for Critical Access Hospitals, States, and Communities
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COMMUNITY BENEFIT PERFORMANCE: ALL STATES

Core Indicators

	Hospital provides service (%)[1]			Service provided by hospital and/or system, network, or joint venture (%)		
Indicator	**CAH**	**Other Rural**	**Urban**	**CAH**	**Other Rural**	**Urban**
Community outreach	61.8	68.7	69.2	65.9	71.8	74.7
Enrollment assistance services	39.9	49.4	58.1	44.4	57.4	67.6
Health fair	78.4	78.9	67.8	83.2	81.4	75.2
Community health education	75.0	75.2	71.1	78.8	77.9	77.2
Health screenings	80.7	78.3	70.8	83.4	80.8	76.3
Health research	1.7	8.0	35.6	6.6	13.0	48.8
Immunization program	41.2	33.9	39.9	48.0	38.1	51.5
Indigent care clinic	8.5	8.5	20.7	15.4	18.6	38.3
Adult day care	5.2	3.5	4.4	8.2	8.1	14.3
Any substance abuse services	5.0	12.3	24.5	13.2	19.0	42.4
Alcohol/drug abuse or dependency inpatient care	2.7	7.2	13.5	6.6	11.5	27.8
Alcohol/drug abuse or dependency outpatient services	2.9	9.2	20.4	10.2	15.6	38.5
Ambulance services	23.2	17.6	11.5	47.8	38.2	46.6
Certified trauma center[2]	39.0	37.2	33.0	41.2	40.2	43.7
Dental services	6.6	20.9	26.8	26.3	30.1	42.4
Hemodialysis	4.0	20.7	43.2	14.2	43.9	75.8
Home health services	27.6	39.4	22.2	51.2	58.3	54.6
Hospice program	17.7	22.6	20.4	58.7	55.0	58.2
Obstetrics care	36.6	72.7	55.2	42.9	75.9	65.1
Any psychiatric services	22.5	47.3	56.2	39.7	57.0	71.3
Psychiatric inpatient care	6.9	34.9	44.6	12.9	40.1	60.9
Psychiatric outpatient services	18.6	37.0	50.1	36.2	47.5	65.9
Palliative care program	14.6	25.4	44.2	25.9	34.0	58.3
Inpatient palliative care unit	4.0	7.7	13.1	8.6	10.8	23.5
Any long-term care	48.8	31.7	27.9	52.6	39.1	46.2
Skilled nursing care	42.9	25.8	16.2	46.3	32.5	31.4
Intermediate nursing care	16.0	7.3	5.6	18.5	11.8	18.0
Acute long-term care	3.5	4.3	10.8	6.6	8.5	24.5
Other long-term care	9.0	5.2	4.4	12.1	9.6	15.1

Source: 2012 American Hospital Association Annual Survey

[1] The United States Department of Agriculture's 2013 Rural Urban Continuum Codes (RUCCs) were used to classify non-Critical Access Hospitals as either "other rural" (RUCCs 4 through 9) or "urban" (RUCCs 1 through 3).
[2] Because of the nature and wording of the AHA survey, hospital responses may not align with state and/or American College of Surgeons (ACS) lists of certified trauma centers.

Financial Indicators

Indicator (expressed as a percentage of adjusted revenue)	CAH %	Other Rural %	Urban %
Charity care costs	1.8	1.9	3.5
Non-Medicare and non-reimbursable Medicare bad debt costs	4.7	4.3	2.1
Uncompensated care (charity care and bad debt) costs	6.6	6.3	5.6
Unreimbursed cost of means-tested government programs (Medicaid, SCHIP, and state/local indigent care programs)	3.6	3.8	3.4

Source: 2012 Medicare Hospital Cost Reports

Critical Access Hospitals Responding to Survey: 1,328
Other Rural Hospitals Responding to Survey: 1,011
Urban Hospitals Responding to Survey: 3,902

COMMUNITY BENEFIT PERFORMANCE: NORTH CAROLINA

Core Indicators

	Hospital provides service (%)[1]			Service provided by hospital and/or system, network, or joint venture (%)		
Indicator	**CAH**	**Other Rural**	**Urban**	**CAH**	**Other Rural**	**Urban**
Community outreach	72.2	77.1	68.7	88.9	82.9	73.1
Enrollment assistance services	11.1	54.3	65.7	27.8	71.4	79.1
Health fair	72.2	82.9	77.6	88.9	85.7	82.1
Community health education	77.8	85.7	77.6	94.4	88.6	82.1
Health screenings	83.3	82.9	79.1	94.4	88.6	83.6
Health research	0.0	5.7	35.8	0.0	17.1	52.2
Immunization program	16.7	34.3	37.3	22.2	34.3	56.7
Indigent care clinic	0.0	14.3	19.4	11.1	42.9	55.2
Adult day care	5.6	2.9	3.0	11.1	2.9	9.0
Any substance abuse services	5.6	17.1	28.4	16.7	20.0	47.8
Alcohol/drug abuse or dependency inpatient care	0.0	8.6	17.9	5.6	8.6	29.9
Alcohol/drug abuse or dependency outpatient services	5.6	11.4	20.9	16.7	14.3	38.8
Ambulance services	0.0	17.1	25.4	11.1	31.4	50.8
Certified trauma center[2]	5.6	14.3	20.9	5.6	17.1	32.8
Dental services	5.6	42.9	29.9	22.2	48.6	49.3
Hemodialysis	0.0	20.0	44.8	5.6	45.7	71.6
Home health services	22.2	31.4	25.4	50.0	51.4	67.2
Hospice program	16.7	20.0	20.9	55.6	60.0	65.7
Obstetrics care	27.8	77.1	65.7	38.9	80.0	74.6
Any psychiatric services	11.1	54.3	61.2	33.3	71.4	79.1
Psychiatric inpatient care	11.1	37.1	53.7	22.2	45.7	67.2
Psychiatric outpatient services	5.6	45.7	53.7	27.8	60.0	71.6
Palliative care program	11.1	20.0	46.3	27.8	48.6	62.7
Inpatient palliative care unit	0.0	5.7	11.9	11.1	17.1	20.9
Any long-term care	38.9	42.9	32.8	44.4	54.3	59.7
Skilled nursing care	27.8	37.1	22.4	38.9	48.6	44.8
Intermediate nursing care	11.1	17.1	9.0	16.7	25.7	22.4
Acute long-term care	5.6	11.4	7.5	11.1	14.3	23.9
Other long-term care	0.0	2.9	1.5	5.6	8.6	9.0

Source: 2012 American Hospital Association Annual Survey

[1] The United States Department of Agriculture's 2013 Rural Urban Continuum Codes (RUCCs) were used to classify non-Critical Access Hospitals as either "other rural" (RUCCs 4 through 9) or "urban" (RUCCs 1 through 3).
[2] Because of the nature and wording of the AHA survey, hospital responses may not align with state and/or American College of Surgeons (ACS) lists of certified trauma centers.

Financial Indicators

Indicator (expressed as a percentage of adjusted revenue)	CAH %	Other Rural %	Urban %
Charity care costs	2.0	1.4	2.7
Non-Medicare and non-reimbursable Medicare bad debt costs	6.1	5.4	3.4
Uncompensated care (charity care and bad debt) costs	8.2	6.9	6.3
Unreimbursed cost of means-tested government programs (Medicaid, SCHIP, and state/local indigent care programs)	3.9	1.9	1.1

Source: 2012 Medicare Hospital Cost Reports

Critical Access Hospitals Responding to Survey: 18
Other Rural Hospitals Responding to Survey: 35
Urban Hospitals Responding to Survey: 67