Understanding the Community Benefit Activities of Critical Access Hospitals

John A. Gale, MS

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Flex Monitoring Team
University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine

Overview of Presentation

- Review the community benefit (CB) activities of Critical Access Hospitals (CAHs) using data from:
  - CAH site visits
  - 2007 CAH Survey
  - Pilot Test of CB Indicators
  - 2007 IRS Compliance Study
  - 2007 AHA Annual Survey
- Reporting issues and challenges
- Policy issues
  - Provisions in Patient Protection and Care Act

Context

- Catholic Health Association reporting initiative
- Interest in hospital charity care and billing activities and ventures with for-profit hospitals and companies
  - Grassley, R-Iowa and Bingaman, D-NM committed to setting standards (5% minimum is a common figure)
- IRS Form 990 to collect CB information from non-profits
- CB provisions in Patient Protection and Affordable Care Act

Community Benefit Categories

- Charity care (does not include bad debt)
- Government-Sponsored Health Care
- Community Health Improvement Services
- Health Professions Education
- Subsidized Health Services
- Research
- Financial and In-Kind Contributions
- Community-Building Activities
- Community Benefit Operations

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Findings from CAH Site Visits

- Identifying unmet community needs
  - Broad based collaboration is critical
  - Strong leadership and resources are key
  - Informal knowledge is not a substitute for formal, systematic process
- Addressing unmet community needs
  - Service growth/expansion
  - Community focused, subsidized activities
- Prevention and health improvement (more than marketing)
- Building continuums of care and enhancing community health system capacity

Results from 2007 CAH Survey

- Charity and uncompensated care
  - 99% offer financial assistance to patients.
  - 87% offer charity care and discounted charges
  - 33% base eligibility at 100-200% of Federal Poverty Levels. 25% use higher income eligibility levels
- Identifying and addressing unmet community needs
  - 48% conducted formal community needs assessments in the last 3 years
  - 66% have formal planning processes to address hospital and community

Results from 2007 CAH Survey (cont'd)

- Prevention and health improvement
  - Nearly all offer combination of subsidized community health education, preventive screenings, clinical preventive services, and support services
- Enhancing community health system capacity
  - Financial/other support to primary care providers (46%), FQHCs (29%), LTC (40%), Mental Health (31%), EMS (34%)
  - Health system development activities: recruitment of providers, job creation and training programs, workforce education

Results from Pilot Test

- Field test of CB tracking tool and indicators
  - Conducted prior to implementation of IRS 990, Schedule H
- Participants were not tracking:
  - All CB activities they are engaged in
  - Strategies to notify patients about charity care availability
  - Charity care and bad debt separately (some participants)
- Software tool:
  - Mixed ratings for usefulness of tool to report, particularly charity care and other regularly occurring activities
- Problem – preceded reporting IRS requirements and many CAHs (public) are exempt from reporting

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Results from 2006 IRS Hospital Compliance Project

Composition of CB spending (as a % of overall community benefit spending)

	High Population	CAH	Rural Non-CAH	Urban & Suburban	All Hospitals
Uncompensated care	42%	77%	76%	69%	56%
Medical training & education	26%	4%	17%	21%	23%
Medical research	25%	0%	1%	5%	15%
Community programs	7%	19%	6%	5%	6%

Results from 2006 IRS Hospital Compliance Project

Average Levels of CB spending (as a % of total revenues)					
	High Population	CAH	Rural Non-CAH	Urban & Suburban	All Hospitals
Uncompensated care	7.9%	5.6%	7.6%	7.3%	7.2%
Medical training & education	2.7%	0.2%	0.6%	1.3%	1.3%
Medical research	3.2%	0%	0.5%	0.7%	1.6%
Community programs	1.7%	1.0%	0.6%	0.8%	0.9%
Total	12.7%	6.3%	8.4%	8.9%	9.2%

Results from IRS Project: Range of CB Expenditures

- % with CB expenditures < 2% of revenues
  - 39% of CAHs
  - 31% of rural hospitals
  - 21% of all hospitals
- % with CB expenditures < 5% of revenues
  - 61% of CAHs
  - 57% of rural hospitals
  - 43% of all hospitals

2007 AHA Annual Survey

Core indicators of CB	CAH	Rural	Metro
Long term-plan for improving the health of the community	77%	85%	84%
Specific budget for community benefits activities	55%	68%	72%
Works with other providers, public agencies, or community representatives to conduct a health status assessment of the community	75%	80%	77%
Works with other providers, public agencies, or community representatives to develop a written assessment of the appropriate capacity for health services in the community	63%	67%	70%

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2007 AHA Annual Survey

Supplemental indicators of CB	CAH	Rural	Metro
Mission statements includes a focus on community benefit	93%	94%	93%
Dedicated community benefit staff	42%	57%	63%
Provides support for community building activities	41%	46%	46%
Provides financial/in-kind support for community programs	70%	77%	76%
Partners with schools to offer health or wellness programs	66%	68%	65%
Uses health status indicators to design or modify services	68%	79%	84%
Uses results of health status assessments to identify unmet needs, excess capacity, or duplicative services	66%	72%	75%
Works with other providers to collect, track, and community clinical and health information across cooperating organizations	74%	81%	84%
Disseminates reports to the community on the quality and cost of health care services	60%	70%	72%

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2007 AHA Annual Survey

- CAHs more likely than other hospitals to offer adult day care, ambulance, and long term care services
- For long term care services, CAHs are more likely to offer skilled nursing and intermediate care services and less likely to offer acute long term care
- CAHS are less likely to offer substance abuse, dental, hemodialysis, OB, psychiatric, and palliative services

What does PPACA have to do with community benefit?

- Reductions in uncompensated care costs through expansion of insurance coverage
- Changes to IRS tax code for not-for-profits
  - Community health needs assessments every 3 years
  - Financial assistance policies
  - Charges
  - Billing and collection
  - Organizations with multiple hospitals must meet the four requirements separately for each hospital

Expansion of Coverage

- Expected to reduce uncompensated care costs
  - Insurance reforms and expansion of coverage will reduce but not eliminate uncompensated care
- Estimates from health policy experts
  - # of uninsured will fall from 49.1M to 15.1M (69.3% drop)
  - Uncompensated care cost will drop from $61.1B to $25.2B (58.7% drop although significantly financed by federal, state, and local governments Medicare/Medicaid/DSH)
- Uncompensated care cost are the largest component of CAH and small rural hospital spending

Additional Reporting Requirements and Penalties

- Secretary of the Treasury shall:
  - Review CB activities of individual hospitals at least once every 3 yrs
  - Report to Congress on:
    - Levels of charity care; bad debt; and unreimbursed costs for services provided under means-tested and as non-means-test (Medicare) government programs for tax-exempt, taxable, and government-owned hospitals and CB activities of tax-exempt hospitals
    - Trends in the above not later than 5 years after enactment
- $50,000 excise tax for any taxable year that hospital fails to comply with needs assessment requirements
- Potential challenges to tax exempt status

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Contact Information

- John A. Gale, M.S.

  Maine Rural Health Research Center

  University of Southern Maine

  207-228-8246

  jgale@usm.maine.edu