Understanding Hospital Community Benefit Obligations: A Guide for Health Centers

Developing Community Partnerships to Expand Access to Care

Prepared by Capital Link

CAPITAL LINK

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About Capital Link

Capital Link is a non-profit organization that has worked with hundreds of health centers and Primary Care Associations over the past 15 years to plan capital projects, finance growth and identify ways to improve performance. We provide innovative advisory services and extensive technical assistance with the goal of supporting and expanding community-based health care.

Established in the late 1990s as a joint effort of the National Association of Community Health Centers (NACHC), several state-based Primary Care Associations (PCAs), and the Bureau of Primary Health Care, Capital Link grew out of the community health center family and continues to support it through our activities. For more information, visit www.caplink.org.

Introduction

The Affordable Care Act includes a variety of provisions designed to improve access to care and enhance coordination among health care providers. For Federally Qualified Health Center grantees (health centers), the law established a primary care trust fund to expand and strengthen the health center network. The law also specifically spelled out how hospitals could better report on local community needs and their plans to help meet these needs. Taken together, these provisions offer an opportunity for unprecedented collaboration between local providers seeking to meet community health needs. This publication describes hospital community benefit requirements and how they can spur community efforts to expand access to care and improve local health outcomes.

Community Benefit Obligations: Background and Origins

Community benefit obligations stem from a requirement that hospitals must offer certain benefits to the communities they serve in exchange for receiving tax-exempt status from the Internal Revenue Service. Although the concept itself is relatively simple, the functional implementation of these requirements has been a source of contention since their inception.

In its first ruling on this subject, the IRS laid out a "financial ability" standard requiring that a charitable hospital be "operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay."[i] In other words, the hospital was expected, within reason, to offer some relief to those who couldn't afford care. In 1969, the IRS revisited the issue, officially establishing the "community benefit" terminology in use today. Seeking to provide additional clarity about the extent to which hospitals were obligated to provide care to all community members, the 1969 ruling established broad guidelines that required charitable hospitals to provide open access to emergency room care as a means of providing service to the entire community. Hospitals were not necessarily obligated to offer inpatient care beyond initial emergency treatment.[ii] The ruling also spelled out several other qualifying factors for hospitals, including:

- Management by an independent board of trustees composed of representatives of the community (as opposed to financially interested individuals).
- Maintenance of an open medical staff policy, with privileges available to all qualified physicians.
- Providing care to all community members who are able to pay.
- Utilizing surplus funds to improve the quality of patient care, expand its facilities, and advance medical training, education, and research.

Although this ruling did not necessarily result in additional charitable investments in the community, it did give hospitals a more specific understanding of what the IRS expected of them. These guidelines have remained largely unchanged until Congress began reviewing non-profit hospitals and their tax-exempt status in the last ten years.

Since the initial IRS rulings, the health care industry has dramatically expanded in size and scope. Hospitals and their balance sheets have also grown considerably. Critics have contended that some non-profit hospitals now gain far more from their tax-exempt status than is justifiable by the benefits they provide to their communities. In 2002, the Congressional Budget Office estimated that the value of the exemption was $12.6 billion. Moreover, congressional studies into the provision of uncompensated care have reported mixed results. Although non-profit hospitals on average reported higher levels of uncompensated care than similar for-profit hospitals, individual hospital results varied widely. In some cases, tax-exempt hospitals could claim vast tax savings, even though the community benefits they provided were far less.[iii] Often, it was difficult for policy makers and local communities to know exactly how much care was being provided relative to community need. Exactly what hospitals considered community benefit and the value of those benefits was often a mystery. Additionally, there were no clear guidelines concerning integration with broader community health planning processes.

New Reporting Rules Emerge: Schedule H

Faced with increased Congressional scrutiny, in 2009 the IRS offered its first significant ruling on the tax-exempt hospital issue since the 1969 "community benefit" decision. Designed to shed light on community benefit activities, the IRS required all hospitals to complete a new form, Schedule H, as part of their annual Form 990 filings. The new form defined categories of "community benefit" and required hospitals to explicitly spell out and quantify what community benefits they provide each year. Equally important, the form is publicly available alongside each hospital's Form 990 filings. This added level of reporting and public accessibility offers the possibility of comparing community benefits across hospitals and neighborhoods and creates new opportunities for community engagement. To learn more about how local hospitals report their community benefits, health centers should consider reviewing 990 filings—especially Schedule H.

Schedule H is broken down into several key subcategories including:

1. Financial Assistance and Community Benefits At Cost

   Financial assistance includes:

   a. Financial Assistance at cost
   b. Participation in Medicaid
   c. Costs of other means-tested programs

   Community Benefits Include:

   a. Community health improvement services
   b. Health professions education
   c. Subsidized health services
   d. Research
   e. Cash and in-kind donations for community benefit

2. Community Building Activities:

   - Physical improvements and housing
   - Economic development
   - Community support
   - Environmental improvements
   - Leadership development and training for community members
   - Coalition building
   - Community health improvement advocacy
   - Workforce development

3. Bad debt, Medicare, and collection practices
4. Management companies and joint ventures
5. Facility information

Needless to say, these activities offer a wide variety of opportunities for hospitals and health centers to work together to identify community health needs and develop partnerships to respond accordingly.

Affordable Care Act Requirements

Before the new Schedule H regulations could be fully implemented, Congress took additional steps to expand the new reporting requirements. As part of the Affordable Care Act, Congress added two new requirements for tax-exempt hospitals. First, hospitals must complete a regular Community Health Needs Assessment (CHNA). Once completed, hospitals are also required to develop and publish an implementation plan. The law encouraged community participation to complete both steps. Finally, hospitals are required to publish their assessment and implementation plan and include the status of each within their annual Schedule H filings. Each of these developments offers exciting opportunities for health centers and hospitals to find ways to collaborate to meet community needs.

A Community Health Needs Assessment Typically Includes:

- A definition of the community served by the hospital. Depending on the service area, the "community" can be defined by county, zip codes or census tracts, or in very urban areas, a few city blocks.
- Local demographic data, including age distribution, ethnicity, payor mix data, and any relevant demographic trends, historical as well as projected.
- Existing local health care facilities and resources.
- A review of community health needs.
- Health indicators with state and national benchmarks for comparison, including: primary and chronic disease needs and other health issues of uninsured, low income, and minority populations.
- Description of the process used to identify and prioritize community health needs, as well as how data for the report was obtained.
- Description of the community consultation process.

The Community Health Needs Assessment Process

The Affordable Care Act specified that hospitals must complete a CHNA at least once every three years and must show evidence of a CHNA beginning in March 2012. A CHNA must take into account input from persons who represent the broad interests of the community served by the hospital, including those with special knowledge of or expertise in public health, and must be made widely available to the public. Finally, the ACA required hospitals to develop and adopt an implementation strategy to meet the community health needs identified via the CHNA. Both the CHNA and implementation plan must be publicly available free of charge.

As key partners in the effort to address community health needs, health centers can play an important role in the development of both the CHNA and implementation plan. To begin, health centers should consider completing an assessment of their own market either alone or in partnership with local hospitals within the health center's service area. A market assessment will not only help inform the CHNA process, it is a critical step in planning for Affordable Care Act implementation.

A comprehensive market assessment will yield valuable information about who is in the health center service area and how the region is likely to change in the years to come. This information will help the health center determine critical expansion needs, decide which programs to add or eliminate, and plan for future workforce needs. Much like the CHNA, a health center market assessment should review critical demographic data and trends, review local health challenges, and identify existing resources in place to meet the community need. By carefully developing their own market assessments, health centers can be informed partners of hospitals seeking to update their own CHNA to best meet community needs.

Implementation Plan Requirements

To complement the CHNA process, hospitals are also required to adopt an implementation strategy to meet the community health needs identified via the assessment. Each hospital should have its own implementation strategy, which should include two key elements:

- A description of how the hospital facility plans to meet the prioritized health needs identified in the CHNA.
- A description of identified health needs that the hospital does not intend to meet and an explanation of why the hospital is not investing to meet those needs.

The implementation plan should also include a review of how the hospital plans to collaborate with other local organizations to meet specific community needs. The implementation plan must then be formally adopted by the hospital's governing body and attached to the annual Form 990 filing.

How Health Centers Can Help Hospitals Develop an Implementation Plan

Because of their strong roots within the community, health centers can be a strong ally and partner with hospitals in the development of an implementation plan. This is particularly true if a health center has already completed a market assessment and has developed a long-term strategic growth plan. A long-term strategic plan will likely include recommended community programs and a facilities and staffing plan to meet established programmatic goals. Health centers that have already identified their priorities for programming and facility growth can engage hospital partners to find ways to meet their goals in a mutually beneficial way.

By building complementary programs together, hospitals and health centers can meet community needs as well as fulfill federal requirements. As the insurance exchanges and Medicaid expansion included in the Affordable Care Act take effect in late 2013 and 2014, health centers are working hard to expand their outreach and enrollment activities. By helping patients establish health centers as their medical home, communities can dramatically reduce emergency room care—a goal on which both hospitals and health centers can agree.

At the same time, health centers pursuing growth strategies that will require new or expanded facilities can also work closely with hospitals to seek financial support either through direct or in-kind contributions or via low-interest financing opportunities. In many ways, the CHNA requirements for hospitals are similar to Community Reinvestment Act (CRA) lending requirements that have existed in the banking industry for decades. Similar to banks, hospitals must now show their immediate financial contributions to the communities they serve. As collaborative partners, health centers can work with local hospitals to offer opportunities for savvy local investments that will also improve overall health outcomes via enhanced access to primary care.

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[i] Rev. Rul. 56-185, 1956-1 C.B. 202, *modified* by Rev. Rul. 69-545, 1969-2 C.B. 117.
[ii] Rev. Rul. 69-545, 1969-2 C.B. 117.
[iii] Nonprofit Hospitals and their Community Benefits, Congressional Budget Office, 2006

Market Assessment Resources for Health Centers:

U.S. Census Bureau: *Key Demographic and Economic Data*	
American FactFinder	http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml
QuickFacts	http://quickfacts.census.gov/qfd/index.html
Business Patterns	http://www.census.gov/econ/cbp/
Visual Mapping Software of FQHC Service Areas With Data Downloads	
UDS Mapper/ HealthLandscape	http://www.udsmapper.org
Health Indicators	
County Health Rankings	http://www.countyhealthrankings.org/
Community Health Status Indicators	http://communityhealth.hhs.gov/HomePage.aspx
Behavioral Risk Factor Surveillance Survey	http://www.cdc.gov/BRFSS/
Payer Mix	
Centers for Medicare and Medicaid	www.cms.hhs.gov
Small Area Health Insurance Estimates	
U.S. Census Bureau	http://www.census.gov/did/www/sahie/index.html