HOSPITAL COMMUNITY BENEFITS IN OREGON: OUR HOSPITAL, OUR BENEFIT?

By definition, nonprofit hospitals are charitable organizations. Federal tax law requires nonprofit hospitals to provide "community benefits" in exchange for the tax exemptions they receive. However, while hospital community benefits are generally obligated, they are poorly defined and regulated.

This paper seeks to clarify how community benefits are defined in our country and state and how Oregon hospitals currently invest these funds. We also offer suggestions for next steps that Oregonians and hospitals can take to maximize the impact of community benefits funds on our most pressing health needs.

TIMELINE OF COMMUNITY BENEFITS: A TALE OF LOOSENING DEFINITIONS WITH BROAD TAX IMPLICATIONS

1956 IRS ruling: hospital must be operated to the extent of its financial ability for those not able to pay for the services rendered (charity care).

1965 Medicare and Medicaid programs established, radically impacting the level of charity care provided at most hospitals.

1969 IRS ruling introduces "community benefit" term. Rather than strictly requiring charity care, hospitals permitted to promote the health of any broad class of persons to qualify as a nonprofit (e.g. offering emergency room services to all, even if they don't otherwise serve people unable to pay.)

1983 IRS ruling: hospital can be tax exempt, even if it does not operate an emergency room.

2008 IRS introduces "Schedule H" requiring nonprofit hospitals to report on community benefit activities.

2014 Millions of uninsured Americans receive healthcare through Medicaid expansion and enrollment requirements under the ACA. Hospital charity care in Oregon drops by nearly half compared to 2013.

> *"The federal criteria for provided tax exemptions to nonprofit hospitals have changed over time and have been gradually loosened"*
>
> – CONGRESSIONAL BUDGET OFFICE – [1]

THE EVOLUTION OF HOSPITAL TAX EXEMPTIONS

The concept of hospital charity and community benefits has evolved in relation to hospitals' role in our communities and their rationale for tax-exempt status.

From the first enactment of the Income Tax Code in 1913, organizations dedicated to "charitable purposes" have been allowed tax exemptions. Although the Internal Revenue Code does not specifically recognize the promotion of health as a qualifying "charitable purpose," hospitals have traditionally been seen as part of the safety net for vulnerable populations.[2] Indeed, for the first half of the 20th century, upper- and middle-class Americans generally received care in their own homes from private physicians, leaving hospitals to primarily serve poor and homeless populations with no other options. Not only did hospitals offer last-resort healthcare, they were also a primary source of shelter for the poor. By providing such services, hospitals fulfilled an indisputably charitable purpose.[3]

There were no specific tax rules relating to nonprofit hospitals until 1956. As hospitals expanded their services beyond those to the poor, the IRS revised its rules to require nonprofit hospitals to operate, to the extent of their financial ability, for those not able to pay for the services rendered (i.e., charity care).

The second hospital-related amendment to revenue rules followed on the heels of the creation of Medicare and Medicaid. These programs created dramatic new classes of paying patients and revenue streams for all involved in healthcare. In 1969 the IRS introduced the concept of "community benefits," and rather than strictly requiring charity care, hospitals were allowed to promote the health of any broad class of persons in order to qualify as a nonprofit (e.g., offering emergency room services to all, even if a hospital didn't otherwise serve people unable to pay). In 1983, the IRS went a step further, allowing a hospital to be tax-exempt even if they did not operate an emergency room.[4]

HOW ARE COMMUNITY BENEFITS CHANGING NOW?

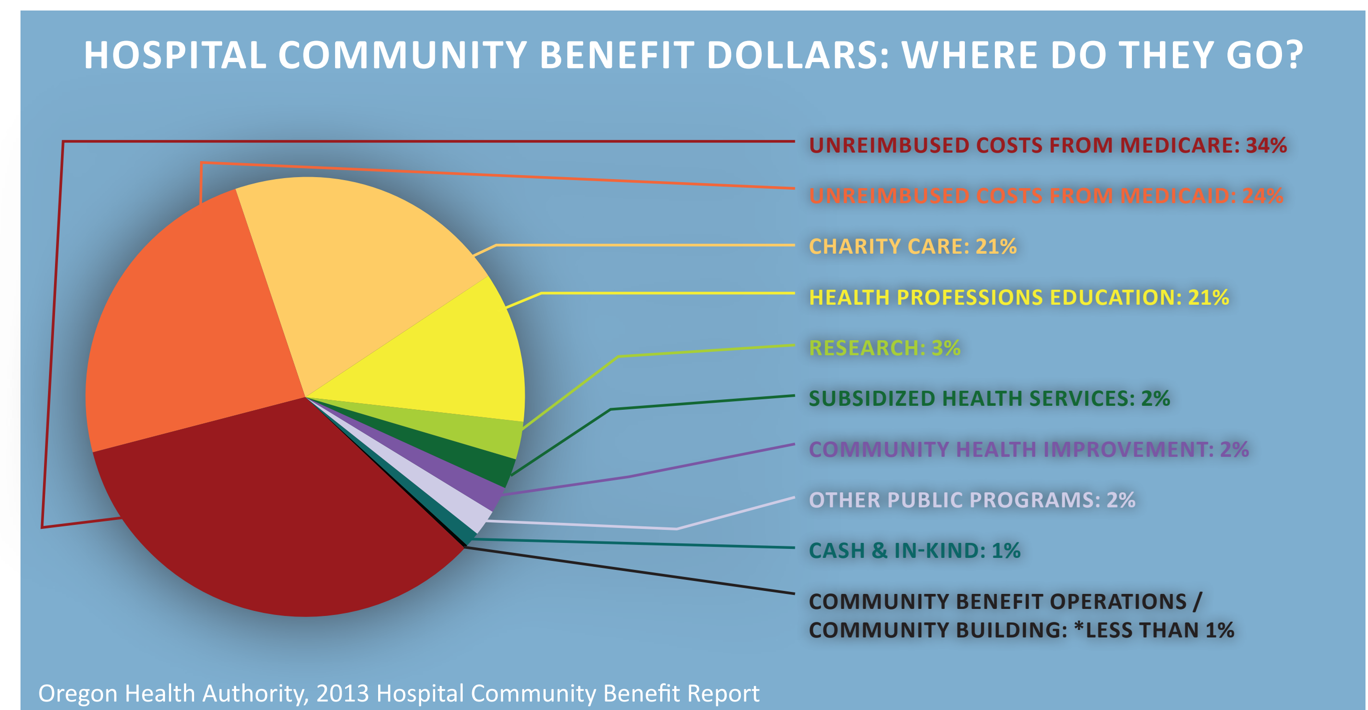
Hospital community benefits are in another period of change due to dramatic impacts of the Affordable Care Act. At the root of these changes is the shift of millions of Americans from being uninsured to being covered by Medicaid or private insurance plans. In Oregon, the percentage of Oregonians without health insurance dropped from 14 percent of the population in 2013 to just 5 percent in 2014, largely driven by the expansion of Medicaid.

With Medicaid providing expanded coverage, hospitals reduced their spending on free and reduced price services (charity care). Comparing the first six months of 2013 to 2014 shows a decline of over 47 percent in hospital charity spending. Nearly all Oregon hospitals reduced their charity care, with the majority cutting such spending by half or more.
There has also been a corresponding increase in hospital profits as patients who were previously served out of hospitals' charity funds at a cost to the facility, are now generating revenue for the hospital through insurance payments. In the same six-month period examined above, profits at Oregon hospitals increased by more than 74 percent.[5]

In recognition of this shift (and the potential impact on hospitals' charitable status), the Oregon Association of Hospital and Health Systems (OAHHS) announced a new community benefit policy package in March of 2015. The voluntary package includes hospitals committing to keep "overall community benefit spending at or above levels from prior years." Theoretically, this will dedicate dollars previously used to fund charity care towards other community benefit activities, placing greater importance on where and how hospitals invest community benefit funds.

HOW ARE COMMUNITY BENEFITS DEFINED AND TRACKED IN OREGON?

Oregon took steps to define and track hospital community benefits in 2007, when it passed House Bill 3290. The bill directed the Oregon Health Authority to adopt an annual reporting system for hospital community benefits, which were defined as "a program or activity that provides treatment or promotes health and healing in response to an identified community need." The statute included six broad classes of community benefit. The Oregon Health Authority's annual hospital community benefit report now includes eleven categories for hospitals to report their community benefits. (Current categories and



Oregon Health Authority, 2013 Hospital Community Benefit Report

their definition are listed in Table A at the end of the document.) Each hospital in the state groups its spending in the provided categories and reports the associated dollar value.

The most recent report available discloses hospital community benefit expenditures for 2013. That year, similar to the previous five years, shows just three categories accounting for the vast majority (79%) of hospital community benefit spending. Those categories are: unreimbursed Medicare costs, unreimbursed Medicaid (Oregon health Plan) costs, and the cost of providing charity care.[6]

The single largest category of community benefit spending for Oregon hospitals in 2013 was unreimbursed costs associated with serving Medicare patients. Interestingly, such costs are not universally considered a community benefit. **While Oregon includes Medicare-related losses in its community benefit report, the federal government does not include it in its community benefit tally.**

ARE "COSTS" RELATED TO MEDICARE TRULY A COMMUNITY BENEFIT? FEDS SAY NO.

For nonprofit hospitals, rising revenue has been linked to rising costs since there are few incentives for them encourage efficiency. Counting "unreimbursed costs" exacerbates perverse incentives for nonprofit hospitals.

Reports made to Congress by the Medicare Payment Advisory Commission (MedPAC)* help explain why the federal government does not consider unreimbursed Medicare costs a community benefit. In its March 2015 report to Congress on Medicare Payment Policy, MedPAC demonstrated that the Medicare payment rate is set to cover the costs of an efficient hospital. As hospitals are able to demand higher rates from private insurers and employers, they can be less motivated to constrain costs. Often as hospital prices and profits increase, the relative "losses" associated with servicing Medicare patients tend to grow. Given that hospitals set and drive their own costs, using "unreimbursed costs" associated with Medicare services can become a subjective and skewed measurement. Of note, in 2013 hospitals' total profit margins across all payers were at the highest level in over 20 years.

MedPAC demonstrated the adequacy of Medicare payments by several means, including looking at cohorts of hospitals. MedPAC compared a cohort of relatively efficient hospitals to other hospitals. They noted that not only did the efficient hospitals have a positive overall Medicare margin in 2013, but they also had lower mortality and readmissions rates, and lower costs per discharge than the national median. Not only were the hospitals more efficient, but they were arguably more effective.[6]

* MedPAC is a nonpartisan legislative branch agency that provides the U.S. Congress with analysis and policy advice on the Medicare program.

ANALYSIS OF COMMUNITY BENEFITS IN OREGON HOSPITALS

While hospitals report dollar figures dedicated to different categories of community benefits, it is difficult to figure out exactly how the dollars were spent and what results they produced. Some details of the most admirable giving are published by hospitals themselves. Other details make their way to media reports, such as the Eugene Register Guard's 2010 article covering the MRI performed on a sea otter and paid for by the Samaritan Pacific Communities Hospital's community benefit fund.[7]

Federal tax filings require hospitals to list organizations to whom they provided grants or other assistance of $5,000 or greater. While bringing transparency to only a slice of total hospital money dedicated toward community benefits, such disclosures offer some insight and highlight shortcomings with current reporting practices.

For this analysis, we reviewed federally-reported grant recipient lists for Oregon hospitals (usually for fiscal years beginning in 2012, the most recent available). We looked at the list of recipients and reported purposes through the lens of a hospital's obligation to pursue a charitable mission, one that presumably includes addressing the health needs of its population. We observed some unfortunate patterns:

Level of disclosure is inconsistent

While some recipient organizations need no explanation (such as funding a clinic primarily serving migrant farmworkers) others play an unclear role in the community, making the disclosed purpose of the grant important to understanding its intent and value. While some hospitals took time to record detailed purposes for their largest grants, others show far less specificity and raise questions about the use of the funds:

- PeaceHealth reported donations to 28 organizations in 2012 and offered one of three generic purposes each time: "Education Support", "Mission Support", and "Community Health Needs".[8]
- Tuality Healthcare listed the same purpose for every single grant disclosed, "various community and health enrichment".[9]
- In contrast, St Charles offered a unique purpose description for nearly each of its grant recipients and Providence linked many of their grants with specific community needs and services such as, "healthcare fair at TET festival," "Rx assistance- diet related diseases," and "black asthma intervention program."[10]

Some hospitals may be tipping the scale more towards public relations than community benefit

Combing through tax filings of Oregon nonprofit hospitals reveals both laudable and questionable claims of community benefit. The following examples illustrate the blurred line between what is clearly charitable in nature and what appears to be leaning away from health and more towards advertising and public relations work.

- Asante stated in their filing that they gave clothes to 170 indigent patients and free rides to medical appointments to 1,500 seniors, clearly providing community benefit. However, they also highlighted giving money to Jacksonville Britt Festival and the Oregon Shakespearean Festival.[11]

- Tuality Healthcare admirably staffs the first aid booth the Oregon International Airshow. However, they also use their funds to sponsor the large event, donating $6,500 in a cash grant in 2012.[12]

WHO PUTS THE COMMUNITY IN COMMUNITY BENEFITS?

Congress and the President, through the Affordable Care Act (ACA), took dramatic steps to insert a stronger community voice into hospital community benefit spending. The ACA requires all private, nonprofit hospitals to individually conduct a Community Health Needs Assessment (CHNA) at least once every three years. IRS dictates that such assessments "must take into account input from persons who represent the broad interests of the community served by the hospital facility." The method of input can vary wildly. A review of nonprofit tax filings and CHNA reports for Oregon hospitals showed hospitals doing one-on-one interviews with heads of different organizations, holding focus groups, hosting open forums for the public or even online surveys.

While there is at least a nod toward community input included in each assessment, true accountability comes in monitoring how funds were spent, who was served and what change was actually created. State community benefit reports offer little help in this arena. Oregon requires hospitals to report dollar values attributed to services in certain community benefit categories, but little other information is collected. Across the country eleven states require hospitals to submit state-specific community health needs assessments and ten require public implementation plans.[13] New federal requirements now require hospitals in every state to evaluate the impact of their actions in relation to specific needs identified within assessments; this requirement provides a hopeful step in the right direction.

With proper input, the most important health needs of a community can be identified and highlighted. Once the correct issues are highlighted, the work begins to define the most appropriate use of available funds to mitigate or solve the problems. Many organizations are already working to address some of the root causes of poor health. The collaboration between community, public health, and local hospitals on a select list of needs has the potential to focus energy and funds to create more effective change.

> *"The current legal and regulatory structures...provide hospitals substantial flexibility while requiring little accountability or evidence of effect on population health."*
>
> JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION [14]

GUIDE TO INCREASING THE COMMUNITY BENEFIT IN HOSPITAL COMMUNITY BENEFITS

Many great organizations offer resources for communities and hospitals to further understand and collaborate to maximize the impact of community benefit funds. Here are some initial tips offered by one such group, Community Catalyst*:

Q: How can community members and leaders get involved in a hospital's community health needs assessment process?

A: The law says hospitals must involve public health officials and other community representatives in the assessment. Community members and organizations frequently have valuable relationships, information, and insight into the community that can help hospitals better understand the needs, strengths and priorities of the neighborhoods that hospitals serve. Incorporating community feedback and perspectives early in the assessment process can help hospitals create programs that communities truly want, need, and support. Here are some suggestions:

- Find out who oversees your hospital's community benefit program and request a meeting. Chances are high that this person is responsible for the community health needs assessment and planning now required by federal law.

- Ask where the hospital is in its assessment process. How are they planning to get community input and feedback along the way (e.g., public forums, community meetings, surveys)? Are they working with other community organizations or public agencies? How does the hospital decide what its community benefit priorities for the year will be?

- Offer to be actively involved in the assessment and planning process, and share what you have learned about the strengths and needs of your community.

- Work with other groups in the community to make sure all community voices are heard. Consider approaching groups that also have relationships or knowledge of the community's strengths and needs that impact health.

Want more? Check out Community Catalyst's Hospital Accountability Project at www.communitycatalyst.org

* Used with permission from Community Catalyst.

COMMUNITY BENEFITS: AN OBLIGATION AND AN OPPORTUNITY

How we define, track, and utilize community benefit funds not only impacts the tax status of many of our local hospitals, but has the potential to positively impact our communities and reduce health disparities. On the one hand, tax-exempt hospitals have an obligation to give back to communities who subsidize their tax-free status. On the other hand, there are substantial health problems in our communities and barriers to care, including the outright cost of care. If brought together, community benefit funds could start to address the symptoms and underlying causes of such problems.

As a recent article in the Journal of the American Medical Association suggested, "a modest reorientation of hospital community benefit programs could help accelerate the development of successful regional health improvement initiatives."[14]

We have an important window of opportunity for increasing the impact of community benefits in Oregon hospitals. Many hospitals are starting to undertake their next community health needs assessment now, to complete in 2016. All Oregon hospitals will be annually updating their implementation plans related to their health needs assessments. To that end, Oregon should pursue:

- **Increased transparency**: Current hospital community benefit reporting makes it nearly impossible to distinguish true investments in safety-net services and reductions in health disparities from public relations efforts. Transparency will build legitimacy.
- **Increased accountability**: Hospitals already report money being invested, but what do those funds produce? Accountability requires not only reporting of dollars spent, but also measurement of the return on investment (e.g., patients served, health outcomes increased, etc.)
- **Positive incentives**: We must ensure that Oregon is doing what it can to appropriately incentivize hospitals to invest their community benefit dollars wisely. This includes aligning with federal standards that do not allow hospitals to report Medicare shortfalls as community benefit.
- **Emphasize community**: Communities should engage with their hospitals on their health needs assessments. There are great tools and resources—including the Hospital Accountability Project created by Community Catalyst—available to guide community members and organizations in the CHNA process.
- **Promote collaboration**: Hospitals should be encouraged to pursue collaborative approaches, maximizing already-built structures and expertise within other organizations and agencies.

As hospital revenue increases and charity expenditures decline, we need to make sure that community benefit programs remain stable or grow. Equally important, we must demand a return on investment for hospital community benefit programs that is transparent, measurable, and effectively addresses critical health needs in our communities.

ENDNOTES

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11. Asante, Form 990. Internal Revenue Service, 2012.

12. Tuality Healthcare, Form 990. Internal Revenue Service, 2012.

13. Hilltop Institute "Community Benefit State Law Profiles Comparison" University of Maryland. Accessed April 21, 2015. http://www.hilltopinstitute.org/hcbp_cbl_state_table.cfm

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TABLE A. CATEGORIES OF COMMUNITY BENEFITS FOR OREGON HOSPITALS, PER OREGON HEALTH AUTHORITY

CATEGORY	OHA DESCRIPTION
CASH AND IN-KIND CONTRIBUTIONS	Funds and services donated to individuals or groups of the community. Typical contributions include grants, scholarships, staff hours, hospital space, food, and equipment.
CHARITY CARE COST	Charity care consists of health care services provided to people who are determined by the hospital to be unable to pay for the cost of health care services. Hospitals will typically determine a patient's inability to pay by examining a variety of factors, such as individual and family income, assets, employment status, family size, or availability of alternative sources of payment. A hospital may establish inability to pay at the time care is provided or through later efforts to gather adequate financial information to make an eligibility determination. Hospitals may use different methodologies to estimate the costs of charity care.
COMMUNITY BUILDING ACTIVITIES	Costs associated with non-health care programs provided by the hospital to minimize potential health problems. Some examples of these activities are neighborhood revitalization, tree planting, low-income housing projects, mentoring groups, air quality improvement, conflict resolution training, and workforce development programs.
COMMUNITY BENEFIT OPERATIONS	Costs associated developing and maintaining community benefit programs, such as staff hours, grant writing, needs assessments, and fundraising.
COMMUNITY HEALTH IMPROVEMENT	Costs associated with activities geared towards improving the health of the community including educational lectures/presentations, special community health screening events, clinics, telephone information services, poison control services, and hotlines.
HEALTH PROFESSIONS EDUCATION	Costs associated with training future health care professionals by providing a clinical setting for training, internships, vocational training, and residencies.
MEDICAID UNREIMBURSED COST	An estimate of the costs not reimbursed by Medicaid, the federal health insurance program that provides health and long-term care services to low-income populations.
MEDICARE UNREIMBURSED COST	An estimate of the costs not reimbursed by Medicare, the federal health insurance program for citizens over 65 and those determined disabled by the Social Security Administration.
OTHER PUBLIC PROGRAMS	An estimate of the costs not reimbursed by public health programs other than Medicaid and Medicare, such as Tricare, Champus, Indian Health Service, or other federal, state, or local programs.
RESEARCH	The cost of clinical and community health research, as well as studies on health care delivery. Requires that results of studies are shared with entities outside the hospital organization.
SUBSIDIZED HEALTH SERVICES	Clinical services that meet a particular community need that are provided despite a financial loss to the hospital. Emergency services may be included, such as an air ambulance or a trauma center.