Hospital Community Benefit Program

The Hilltop Institute

analysis to advance the health of vulnerable populations

Community Benefit Briefing

March 2012

Through news updates, state research and policy analysis, and policy questions, this newsletter is meant to assist state and local policymakers to understand and monitor hospital community benefit activities. The Community Benefit Briefing will report, discuss, and analyze various aspects of hospital community benefits, including the effects of the Affordable Care Act (ACA).

News

New Schedule H Instructions for 2011: IRS Policy Shift on Community Building Reporting?

Each year, tax-exempt hospitals are required to file Form 990 (*Return of Organization Exempt from Income Tax*) and the accompanying Schedule H, in which they report their costs associated with providing community benefits. From its inception, Schedule H has defined "community building" to include hospital activities fostering health improvement by supporting physical improvement and housing, economic development, community support, environmental improvements, leadership development and training for community members, coalition building, community health improvement advocacy, and workforce development (IRS, 2008-2012; Catholic Health Association, 2011).

Since its adoption in 2007, Schedule H has required hospitals to report community building activity costs separately in Part II of the schedule, rather than in Part I as community benefit expenses. This reporting dichotomy has led to confusion as to whether community building activities "count" as community benefits. The IRS indicated in 2007 that hospitals' community building activities "might constitute community benefit or other exempt purpose activities, [but] more data and study is [sic] required" (IRS, 2007). In 2008, the then-current senior technical advisor to the commissioner of the IRS's Tax Exempt and Government Entities Division (Division) reiterated this position, indicating that the separate reporting requirement was a strategy for collecting data the Division could use to determine what kinds of community building activities should qualify as community benefits, based on how directly they connect to health promotion (Catholic Health Association, 2008).

On January 21, 2012, the Internal Revenue Service (IRS) released an updated Form 990 and Schedule H for hospitals' 2011 tax year, along with accompanying instructions. The 2011 Schedule H instructions include a new statement that "[s]ome community building activities may also meet the definition of community benefit," and may be reported in Part I of Schedule H (line 7e) as costs of a community health improvement service (IRS, 2012a, p. 4). Although Schedule H instructions for prior tax years have never stated that community building activities promoting community health could not be reported in Part I as community benefits, the new language quoted above appears to mark the first instance in which the IRS

has expressly acknowledged the legitimacy of reporting qualifying community building activities as community benefits. Although the new language in the 2011 Schedule H instructions may have no real legal effect, it may nevertheless signal that the IRS's initial reservation about community building activities' connection to health promotion and community health is easing. It may also reassure hospitals that the IRS will recognize community building activities as community benefits, thereby encouraging hospital support of initiatives to improve the social, economic, and physical environments of the communities they serve.

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IRS Exempt Organizations Division Annual Report and Work Plan

On February 8, 2012, the Division released its 2011 Annual Report and 2012 Work Plan, reporting its major activities in FY 2011 and identifying priority Division activities for FY 2012.

The Affordable Care Act requires the IRS to review community benefit activities of hospital organizations at least once every three years. Reviews began in March 2011. The Work Plan states that the reviews are "not examinations," and indicates that it will use information gathered in the reviews for purposes of research, reporting, compliance, and to identify areas in which additional guidance, education, or changes to Form 990 are needed (IRS, 2012b). Regarding the ACA's community health needs assessment requirements, the Work Plan notes the July 2011 issuance of IRS Notice 2011-52 (*Community Benefit Briefing*, August and October 2011) and indicates that the Division "continue[s] to work with Treasury and Counsel to develop guidance on the new Section 501(r) requirements" (IRS, 2012b, p. 7).

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Update on Minnesota: Efforts to Align Community Benefits with State Health Improvement Program

As reported in Hilltop's most recent issue brief (Somerville, et al 2012), Minnesota's biennial budget was amended before enactment last July to require the state health commissioner (Commissioner), in consultation with nonprofit hospitals and health maintenance organizations (HMOs), to develop an implementation plan to incorporate "evidence-based strategies from the statewide health improvement program" into hospitals' and HMOs' community benefit investments, and to convene an advisory board to "determine priority needs for health improvement in reducing obesity and tobacco use… and to review and approve" hospital and HMO community benefit activities (2011 Minn. Laws, 1st Sp. Sess., Ch. 9, H.F. 25, Art. 10, Sec. 4, Subd. 2, Statewide Health Improvement Program (b)). The Minnesota Hospital Association (MHA) opposes the new requirement, and has launched an advocacy campaign to reverse it (MHA, 2012a).

In a letter to the Department of Health, MHA argued that the state review process would duplicate federal needs assessment and reporting requirements under the Affordable Care Act, emphasizing that "further state action or involvement is not necessary" (MHA, 2012b). Proposed legislation in both the House (H.F. 2237) and Senate (S.F. 1809) seeks to repeal the new requirements (H.F. 2237, 2012; S.F. 1809, 2012). In the meantime, the Department of Health convened town hall collaboration meetings with stakeholders (including hospitals, health plans, and community-based organizations) soliciting feedback on a draft version of its implementation plan. Following these meetings, the plan was revised and finalized, released, and submitted to the legislature on February 15, 2012 (Office of Statewide Health Improvement Initiatives, 2012). It proposes a "Building Community Capacity and Prevention (BCCP) Advisory Board" (Board) composed of representatives from hospitals, health plans, local public health agencies, and communities affected by health disparities. The Board would review hospital community benefit activities and HMO collaboration plans. Rather than establishing an approval process, the implementation plan provides for the Board to make "comments and suggestions" to hospitals and HMOs based on criteria to be established by the Board (Office of Statewide Health Improvement Initiatives, 2012).

For hospitals, the implementation plan provides for Board review and comment only with respect to two of the federal Schedule H community benefit categories: *community health services* and *community building activities*, pointing out that hospital costs reported under these two categories collectively comprised just 6 percent of the total 2009 community benefit expenditures of Minnesota hospitals. Hospitals are to identify expenditures in these two categories that align with state health improvement goals. The Department of Health states this requirement is "the only additional reporting requirement beyond existing state and federal reporting requirements" (Office of Statewide Health Improvement Initiatives, 2012, at p. 13).

The implementation plan is now under review by the relevant legislative committees. The Department of Health will solicit feedback from stakeholders and refine the implementation plan before its submission to the commissioner by May 31, 2012. The law requires that the Plan be implemented by July 1, 2012 (Office of Statewide Health Improvement Initiatives, 2012).

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American Hospital Association: Results of the 2009 Schedule H Project

The American Hospital Association commissioned Ernst & Young to provide a national analysis of hospitals' community benefit activities reported on Schedule H. The January 2012 report determined that the 571 hospitals and hospital systems surveyed contributed an average of 11.3 percent of total annual expenses to community benefits. Medicare shortfall (2.4 percent), bad debt expense attributable to charity care (0.4 percent), and community building (0.1 percent) collectively comprised 2.9 percent of total annual expenses. Charity care, means-tested government programs, and other benefits comprised 8.4 percent of total annual expenses (Ernst & Young, 2012).

Whether bad debt expenses and Medicare shortfall should qualify as community benefits for reporting purposes remains an ongoing discussion. Community Catalyst, citing a March 2011 report (Medicare Payment Advisory Commission, 2011), argues that Medicare payments are adequate for efficient providers: a hospital reporting Medicare shortfall likely operates either inefficiently or in a less competitive market that permits it to charge relatively high private rates, which can subsidize costs associated with Medicare patients (Community Catalyst, 2012). Community Catalyst proposes greater efforts by hospitals to assess whether patients qualify for a hospital's financial assistance policy. Reductions in charges to patients who qualify for financial assistance under hospital policies would then qualify as community benefits.

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New Publications

Hilltop Releases Issue Brief on Partnerships for Community Health Improvement

Hilltop's Hospital Community Benefit Program released its third issue brief, entitled ***Hospital Community Benefits after the ACA: Partnerships for Community Health Improvement***. The brief discusses a variety of options for collaboration in assessment, planning, priority setting, and implementation of health improvement initiatives; provides examples of diverse models already in place; and examines their impact on the communities in which they occur. It is the third in a series, funded by the Robert Wood Johnson Foundation and the Kresge Foundation, to be published over three years. For the brief, go to http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-HCBPIssueBrief3-February2012.pdf

Report of the Proceedings of CDC's Community Health Needs Assessment and Implementation Strategy Forum

The Public Health Institute (PHI) released its report, ***Best Practices for Community Health Needs Assessment and Implementation Strategy Development: A Review of Scientific Methods, Current Practices, and Future Potential***. The proceedings summarized in this report draw from expert panel meetings held in Atlanta, Georgia on July 11-13, as well as a series of key informant interviews conducted prior to the expert panel meeting. For the complete report, go to http://www.phi.org/pdf-library/2012-3-12CDCReportOfProceedings.pdf

Upcoming Webinars

Setting Priorities: Linking Assessment to Planning. April 3, 2012, Noon - 1:30 pm EST

This program, led by public health professor Dr. Leslie Beitsch, MD, JD, will describe established methods and tools for setting priorities for community health improvement. Sponsored by the Catholic Health Association (CHA), attendance cost is $60 (free to CHA members). For more information, go to https://www.chausa.org/Intro_CB_Overview.aspx

On the Road to Better Health: County Health Rankings and Roadmaps. April 10, 2012, 2 -3:00 pm EST

The Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute will release the third annual County Health Rankings on April 3, 2012. The *County Health Rankings* provide an annual check-up of a community's health by focusing at the county level on factors that influence health status and health outcomes. This webinar will be the second webinar outlining the rankings model and 2012 measures, the County Health Rankings website and its features, and how they can be useful to policymakers. To register for this free webinar, go to https://www1.gotomeeting.com/register/385224153?utm_source=Upcoming+Webinars+Reminder+2%2F24%2F12&utm_campaign=February+Webinars+Reminder&utm_medium=email.

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a nationally recognized policy and 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.

Hilltop's Hospital Community Benefit Program *is the central resource created specifically for state and local policymakers who seek to assure that tax-exempt hospital community benefit activities are more responsive to pressing community health needs. The program provides tools to state and local health departments, hospital regulators, legislators, revenue collection and budgeting agencies, and hospitals, as these stakeholders develop approaches that will best suit their communities and work toward a more accessible, coordinated, and effective community health system. The program is funded for three years through the generous sponsorship of the Robert Wood Johnson Foundation (www.rwjf.org) and the Kresge Foundation (www.kresge.org).*

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