Hospital Community Benefit Program

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The Hilltop Institute

analysis to advance the health of vulnerable populations

Hospital Community Benefits after the ACA:

Schedule H and Hospital Community Benefit—Opportunities and Challenges for the States

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Introduction

The Hospital Community Benefit Program, established in 2010 by The Hilltop Institute at the University of Maryland, Baltimore County (UMBC), is the central resource for state and local decision makers who seek to ensure that tax-exempt hospital community benefit activities are responsive to pressing community health needs. One of the program's functions is to publish a series of issue briefs on promising practices, new laws and regulations, and study findings on community benefit activities and reporting. This is the fourth issue brief in a series funded by the Robert Wood Johnson Foundation and the Kresge Foundation to be published over three years.

The program's first and second issue briefs (Folkemer et al., January 2011; April 2011) outline the new requirements for nonprofit hospitals established by §9007 of the Affordable Care Act (ACA);[1] pose policy questions these requirements suggest; and explore federal and state approaches to community needs assessment, regulation of hospital financial assistance and billing and collection policies, and community benefit reporting and oversight strategies. The third issue brief (Somerville, Nelson, Mueller, Boddie-Willis, & Folkemer, 2012) focuses on community-engaged collaborations or partnerships centered on community needs assessment, priority setting, strategic planning, and the implementation of health improvement initiatives.

This fourth issue brief discusses key federal community benefit reporting requirements developed by the Internal Revenue Service (IRS) as **Form 990, Schedule H**[2] and explores the opportunities and challenges these present to state officials and policymakers. It presents an analysis of the federal community benefit reporting framework and its implications, as well as options for the states that these implications suggest.

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Overview

New federal community benefit reporting requirements found in 26 U.S.C. §501(r) and Schedule H provide the general public with more detailed information about the charitable practices of tax-exempt hospitals. This issue brief examines many of these requirements, along with the potential uses and implications of this new information for state-level oversight. At least 24 states have existing hospital community benefit requirements, either in law or regulation that expressly address nonprofit hospitals' community benefit obligations or that are embedded in broader licensure laws, interpretive guidelines, or tax-exemption criteria (Folkemer et al., January 2011). What options do the new federal reporting requirements present to these and other states? If existing state reporting requirements duplicate their federal counterparts, should they be set aside? If they are not in alignment with federal requirements, should they be adjusted? If the new federal requirements do not effectively address state priorities, should states develop new requirements? What are the options for states in their use and dissemination of the data and information made available through Schedule H?

This brief offers some reflections on the potential tradeoffs that may factor into states' consideration of their options in oversight of community benefit practices. Most state governments currently operate in an environment of constrained resources (Oliff, Mai, & Palcios, 2012), and their consideration of policy options must accommodate these fiscal realities. New requirements that increase state oversight responsibilities will be accompanied by additional costs. Given the costs associated with hospitals' implementation of ACA-mandated reforms (Ellis & Razavi, 2012), new state legislative or regulatory initiatives may encounter substantial industry opposition. At the same time, public sector resource constraints create an imperative to ensure that the charitable resource allocations of tax-exempt hospitals are directed in a manner that optimally benefits local communities.

A state's consideration of options will also be affected by the level of progress it has made in laying the groundwork for implementation of the ACA. For example, the extent and pace of a state's election to expand its Medicaid program under the voluntary expansion option[3] may have an impact on hospital community benefit policy. In geographic areas with higher concentrations of uninsured residents, expanded Medicaid eligibility could ease the demand for nonprofit free and discounted care, enabling nonprofit hospitals to redirect charitable resources toward care coordination and investments in preventive services and activities that address the root causes of poor health.

Finally, the consideration of options should acknowledge and accommodate the substantial diversity in structures, functions, and ownership of hospitals and the communities they serve. New state requirements for an increased level of detail in hospital community benefit reporting beyond what is now available through Schedule H may or may not provide enough useful information to justify hospitals' commensurately increased reporting costs. In addition, efforts to prescribe the form or content of hospitals' community benefit investments at the state level may undermine the ability of hospitals to work with local stakeholders to develop innovative strategies that take optimal ad-

vantage of their unique circumstances and opportunities.

IRS Form 990, Schedule H: Impetus and Implications

The recent decision by the Supreme Court to uphold the ACA was welcomed by many hospital leaders as an essential—if partial—step toward the needed transformation in health care financing and delivery (Spoerl, 2012; Carlson, 2012). There is growing recognition that the continuing escalation of America's health care costs is unsustainable, putting insurance coverage out of reach for an increasing number of Americans with low and middle incomes (Centers for Disease Control and Prevention [CDC], 2011). The ACA offers the potential to bring coverage into reach for the majority of those who are currently uninsured and underinsured, at the same time providing new revenue sources for hospitals and other providers.

In addition, the ACA's emphasis on evidence-based, quality health services (e.g., by encouraging the establishment of accountable care organizations and other innovative care delivery models) anticipates rewarding practices that produce better outcomes, including the potential reduction of hospital readmissions and preventable emergency room and inpatient utilization. There is growing recognition of a need to broaden the base of health care coverage and shift incentives in a manner that reduces the demand for treatment of preventable illnesses and rewards organizations that provide more efficient, higher-quality care at lower cost (The Commonwealth Fund, 2012; Ginsburg, 2009).

Schedule H is intended to foster transparency and facilitate government monitoring of tax-exempt hospitals' compliance with their charitable obligations (IRS, 2007). To date, the most significant form of charitable contribution by tax-exempt hospitals has been costs associated with the provision of unplanned charity care and public pay shortfalls. Although this is the traditional and, as some might argue, most clear-cut form of charitable commitment by tax-exempt hospitals, it could also be viewed as a passive, reactive approach to charitable contribution—one that often involves high-cost treatment of preventable conditions in emergency room and inpatient settings. If the goal of charitable organizations (and tax exemption) is to produce optimal benefits with limited resources, then one might ask whether this form of charity represents good stewardship of the public subsidies accruing to these organizations. Tax-exempt hospitals in many circumstances can provide benefits for more people at lower cost through strategic investments that reduce the demand for medical care. A more explicit recognition of hospitals' role in community-based prevention may encourage an approach to charitable investment that builds population health capacity for hospitals and contributes to the achievement of targeted health outcomes in the community.

A growing number of hospitals across the country are taking steps to reduce the demand for treatment of preventable illnesses. The new federal community benefit reporting requirements reinforce this shift in emphasis to quantitative evidence, strategic investment, and engagement of diverse community stakeholders to leverage hospital resources. In this context, community benefit can serve as an engine to build population health capacity through internal alignment of hospital and health system governance, management, and operations with their charitable mission, as well as through expanding partnerships

with diverse stakeholders in local communities.

Before the ACA's enactment, the revision of Form 990 and development of Schedule H followed a period of burgeoning public scrutiny of charitable hospitals' tax exemption sparked by reports of certain nonprofit hospitals' distinctly uncharitable billing and collections practices (Lagnado, 2003). Congress responded to calls for action. Both the House Ways and Means and Senate Finance Committees initiated a series of public hearings to explore current practices in the tax-exempt sector and consider federal policy relating to the charitable tax exemption (U.S. House of Representatives Committee on Ways and Means, 2005; United States Congress Joint Committee on Taxation, 2006).

Under the leadership of United States Senators Charles Grassley (Iowa) and Max Baucus (Montana), the Senate Finance Committee was highly visible in its investigation of tax-exempt hospital practices. A central question posed by the Senate Finance Committee was how the benefits that tax-exempt hospitals provided to communities compared with the financial value of their tax exemption. The hearings involved testimony from a variety of stakeholders and experts, including staff and leadership from the IRS and Treasury. Witnesses at these hearings noted the relative lack of clarity and consistency of standards to guide the charitable practices of tax-exempt hospitals. This Congressional activity informed the drafters of ACA §9007 and ultimately led to the development of the new, detailed reporting requirements of Schedule H.

Key Elements of Schedule H: State Options for Oversight and Facilitation

The development of Schedule H by IRS and Treasury staff is an important contribution that increases the transparency of nonprofit hospital charitable activities and processes. By providing a framework for detailed documentation of community health needs assessments and implementation strategies, Schedule H's implementation lays the groundwork for the advancement of community health improvement practices by nonprofit hospitals and their engagement of diverse stakeholders. A key question addressed in this brief is the degree to and manner in which these federal reporting requirements may inform state and local policy development, oversight, and/or the dissemination of data and information to the general public.

Schedule H consists of six parts; five of these are discussed below:

- Part I: Financial Assistance and Certain Other Community Benefits at Cost
- Part II: Community Building Activities
- Part III: Bad Debt, Medicare, and Collection Practices
- Part V: Facility Information
- Part VI: Supplemental Information

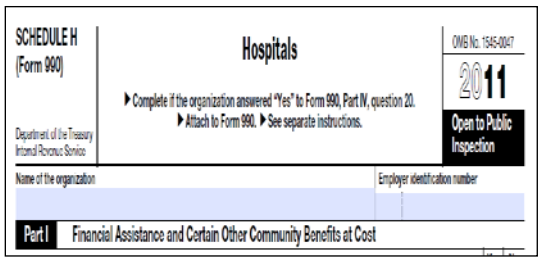
Parts I through IV[4] of Schedule H collect information at the organization level; this allows systems that operate multiple hospital facilities to describe the organization's policies and how these are applied to its individual hospital facilities, as well as to quantify the organization's Schedule H–reportable costs on a systemwide basis. Part V, Section B requires a breakout of organizational costs

and processes for each of the organization's hospital facilities listed in Part V, Section A (see **Schedule H Instructions**). Part VI provides a structure for narrative descriptions of community benefit initiatives, criteria, methodologies, and processes identified in other parts of the form.

This brief's discussion of key elements of Schedule H and their implications for states is divided into three sections: Accounting Criteria and Methods, Community Health Needs Assessments and Implementation Strategies, and Community Building.

Accounting Criteria and Methods

Section 9007 of the ACA, 26 U.S.C. §501(r)(4) sets forth the requirement that tax-exempt hospitals adopt written financial assistance policies, what these policies must address, and how they must be disseminated to patients and to the community. The IRS has proposed regulations to clarify these requirements (IRS, 2012).


SCHEDULE H (Form 990)

Hospitals

OMB No. 1545-0047

2011

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
▶ Attach to Form 990. ▶ See separate instructions.

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization

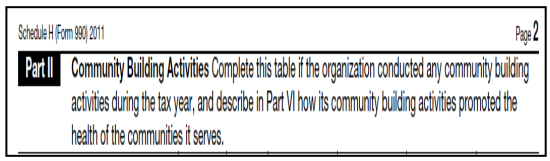
Employer identification number

Part I Financial Assistance and Certain Other Community Benefits at Cost

In Part I of Schedule H, lines 1-5 require descriptions of organization-level financial assistance policies, along with an indication of the degree to which the policies apply to the organization's individual hospital facilities or, conversely, whether financial assistance policies are "generally tailored to individual hospital facilities" (line 2). (Facility-level financial assistance policies are reported in Part V, Section B.) Hospital organizations also report in Part I the criteria used to determine eligibility for free or discounted care (e.g., income at specified percentages of federal poverty guidelines), whether they budget for financial assistance, whether financial assistance provided during the reporting period exceeded the budgeted amount, and whether budget considerations have resulted in the organization's inability to provide free or discounted care to individuals eligible under the financial assistance policy.

Total community benefit expenses attributable to providing financial assistance or to a hospital's participation in Medicaid and other means-tested government programs are reported in line 7(a)-(d) of Schedule H. Total costs of "other benefits," including community health improvement services, health professions education, subsidized health services, research, contributions for community benefit, and "other benefits," are reported in lines (e)-(k). An optional worksheet for line 7 (Worksheet 4) is included (see Schedule H Instructions, pp. 4 and 14).

Hospitals are instructed to use their "most accurate costing methodology" (e.g., cost accounting system or cost-to-charge ratio) and to list the total expense, direct offsetting revenue, net expense, and percentage of total expense these costs represent for the organization (see Schedule H Instructions, p. 3).


Schedule H (Form 990) 2011 Page 2

Part II Community Building Activities Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

In Part II, hospital organizations report community building activities that are not reported in Part I (see Schedule H Instructions, p. 4).

Part III Bad Debt, Medicare, & Collection Practices

Part III, Section A asks hospitals to report bad debt totals and estimate how much is attributable to patients eligible under the financial assistance policy adopted by the organization. Medicare shortfalls are reported in Section B, along with estimates of the portion that should be documented as community benefit. For both sections, hospitals are expected to specify the criteria and methods used to derive these estimates and present a rationale for including any portion of these costs as community benefit (see Schedule H & Instructions). In Section C, hospitals provide information on their debt collection policies and practices, including whether they had a written policy in place during the tax year and whether it includes provisions to collect funds due from those who qualify for financial assistance.

State Options. Neither §9007 of the ACA, the Schedule H Instructions, nor the IRS Notice of Proposed Rulemaking (NPRM)[5] establishes prescriptive parameters for financial assistance eligibility criteria or thresholds. The request for structured reporting of detailed information, however, will provide invaluable insight into the accounting practices of different hospitals and health systems.

In the establishment of categories for reporting, existing state statutes and reporting requirements are highly variable and may lack the specificity and clarity of Schedule H standards and terminology. Some states require reporting in specific categories, whereas others call for aggregate totals (Rosenbaum, Byrnes, & Rieke, 2012). California's statute, for example, lays out a detailed set of categories that are closely aligned with Schedule H. Nevada, on the other hand, defines community benefits broadly as "goods, services and resources provided by a hospital to a community to address the specific needs and concerns of that community, services provided by a hospital to the uninsured and underserved persons in that community, training programs for employees in a community and health care services provided in areas of a community that have a critical shortage of such services…." (Nev. Rev. Stat. §449.490).

Only four states have adopted mandatory minimum financial contribution levels for tax-exempt hospitals' charity care and community benefit: Pennsylvania, Texas, Utah, and, most recently, Illinois (10 Pa. Cons. Stat. Ann. §§371-85; Tex. Health & Safety Code Ann. §§ 311.031-.048; Utah State Tax Comm'n, 2011; 35 ILCS 105/3-8).[6] Other states interested in minimum thresholds for tax-exempt hospital charitable contributions should take the following issues into consideration:

- Both anecdotal and empirical evidence suggests that nonprofit hospitals' financial officers may view government-specified minimum thresholds as the upper limit of their community benefit investment, rather than as guidelines to encourage quality improvement and the general advancement of community benefit practices. For example, when it was enacted in 1995, Texas' minimum charity care threshold (at least 4 percent of net patient revenue) was effective in that it prompted hospitals previously providing a lower amount of charity care to increase charity care spending to compliant levels. However, some hospitals that previously had provided more than the threshold level of charity care reduced charity care expenditures, thus effectively eliminating charity care costs in excess of the minimum requirement. Overall,

charity care provided by affected Texas hospitals decreased, on average, after the institution of the minimum threshold requirement (Kennedy, Burney, Troyer, & Sroup, 2010).

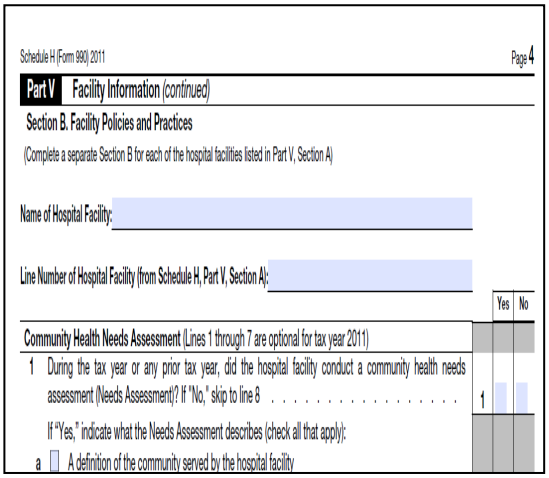
- Expanding insurance coverage, the move toward evidence-based medicine, and a shift toward financing mechanisms that incentivize keeping populations healthy can combine to reduce the demand for unplanned charity medical services and increase the emphasis on community-based prevention activities that produce measurable outcomes.

Given these practical realities, states may consider a number of other approaches. States with existing community benefit reporting standards may choose to adjust their financial criteria and methods to align with Schedule H. This could reduce nonprofit hospitals' overall reporting costs as well as state costs associated with monitoring state-specific community benefit requirements. Nonregulatory actions could include the publication and dissemination of hospital-reported financial criteria, budgeting for financial assistance, and debt collection and charity care policies. For example, a state could list the totals budgeted by different hospitals for financial assistance compared with their annual revenues. Findings could be aggregated at the state level or disaggregated by type and size of hospital, by service areas' demographic profiles (e.g., rural or urban), or by jurisdiction (e.g., by county, metropolitan statistical area [MSA], or legislative district). These data could inform hospitals' community benefit budgeting and planning and, by improving the public's ability to effectively access these data, increase their transparency.

Community Health Needs Assessment and Implementation Strategies

As indicated in ACA §9007, 26 U.S.C. §501(r)(2)(B)(ii) and by the IRS in Notice 2011-52, tax-exempt hospital organizations must satisfy the community health needs assessment and implementation strategy development requirements for each hospital facility they operate. These policies and processes are reported in Part V, Section B of Schedule H. (The related Instructions clarify that references to a hospital facility's actions "mean that the organization took action through or on behalf of the hospital facility.")

Reporting in Part V, Section B, lines 1-7 (relating to community health needs assessment) is optional for tax year 2011, consistent with the ACA §9007(f)(2) proviso that the needs assessment and implementation strategy requirements of §9007(a), 26 U.S.C. §501(r)(3) apply to hospital organizations' tax years "beginning after the date which is 2 years after" the ACA's date of enactment (i.e., two years after March 23, 2010).


Schedule H (Form 990) 2011 Page 4

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities listed in Part V, Section A)

Name of Hospital Facility:

Line Number of Hospital Facility (from Schedule H, Part V, Section A):

	Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for tax year 2011)		
1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8 1		
If "Yes," indicate what the Needs Assessment describes (check all that apply):		
a ☐ A definition of the community served by the hospital facility		

This has allowed hospitals three or more years after the ACA established the needs assessment requirements in which to conduct the assessment and report that, with respect

to its first tax year beginning after March 23, 2012 (ACA §9007(a), 26 U.S.C. §501(r)(3)(A)), it:

(i) has conducted a community health needs assessment…in such taxable year or in either of the 2 taxable years immediately preceding such taxable year, and

(ii) has adopted an implementation strategy to meet the community health needs identified through such assessment.

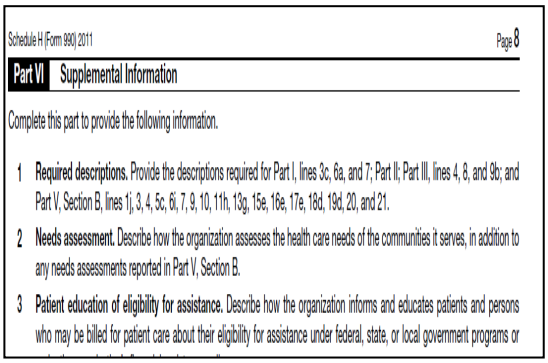
Part V, Section B, lines 1-7 of Schedule H focus on specific elements in the needs assessment process. Line 1 includes 10 yes/no checkboxes (a-j) for indicating whether a hospital's community needs assessment includes certain required descriptions, such as (Schedule H, Part V, line 1):

- A definition of the community served (line 1a)
- The community's demographics (line 1b)
- Existing community resources available to meet the community's health needs (line 1c)
- How data were obtained (line 1d)
- The process used to identify and prioritize community health needs and services to meet these needs (line 1g)
- Other (line 1j)

For each hospital facility, tax-exempt hospital organizations must also include in Part VI of Schedule H a description of information described in a hospital's needs assessment that does not have a corresponding checkbox in Part V, lines 1a-i, as signified by a "yes" entered in line 1j ("other"), along with additional narrative information relating to community health needs assessment to supplement yes/no entries in Part V, lines 3-7 with descriptions indicating:

- How the hospital facility took into account input from community representatives (Part V, line 3)
- Whether the needs assessment was conducted with one or more other hospital facilities (Part V, line 4)
- How the needs assessment was made widely available to the public (Part V, line 5)
- How the organization assesses community health needs (Part V, line 6)
- Whether all of the community's needs identified by the assessment were addressed and the reasons any identified needs were not addressed (Part V, line 7)

Community Definition. Part VI, line 4 of Schedule H requires a description of the community served by the organization, "taking into account the geographic area and demographic constituents it serves."


Schedule H (Form 990) 2011 Page 3

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or

IRS Notice 2011-52 provides additional guidance, indicating that in defining the community it serves, a hospital organization may take into account all relevant facts and circumstances. Although the notice indicates IRS's general expectation that community definition will focus on a hospital's geographic location "such as a city, county, or metropolitan region," it acknowledges that "in some cases, the definition … may also take into account target populations served… and/or the hospital facility's principal functions …." (IRS, 2011, p. 14). Hospital organ-

izations are cautioned, however, that "a community may not be defined in a manner that circumvents the requirement to assess the health needs of (or consult with persons who represent the broad interests of) the community served by a hospital facility by excluding, for example, medically underserved populations, low-income persons, minority groups, or those with chronic disease needs" (IRS Notice 2011-52, p. 14).

In defining community, it is of central importance to acknowledge that there is significant variation in the demographic profile of populations and communities proximal to different tax-exempt hospitals. Many are located in areas with high concentrations of low-income, uninsured residents and provide a high volume of free and discounted services. In contrast, other hospitals within the same region may be located in more affluent areas, with limited exposure to low-income populations. Although state-level pooling arrangements and federal subsidies for disproportionate share hospitals have balanced this disproportionate burden somewhat, this effect will diminish as ACA provisions phasing out these subsidies begin to take effect in 2014. Legitimate questions arise about the degree to which there is an equitable sharing of charitable burden among tax-exempt hospitals in different geographic locations with populations that have vastly different levels of need. Although examples of regional needs assessment have been reported, for example, in Oregon (The Hilltop Institute, 2012c), California (Ainsworth, Diaz, & Schmidtlein, 2010), Virginia/Tennessee (Mountain States Health Alliance, 2012), and elsewhere, additional consideration to the development of community definitions that support a more equitable sharing of the charitable burden among hospitals at the regional level, in both urban and rural areas, is needed.

Community Engagement. The ACA requires that hospitals "[take] into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health" (ACA §9007(a), 26 U.S.C. §501(r)(3)(B)(i)). Schedule H Part V, lines 1h and 3 require that a hospital describe in Part VI its process for consulting with persons representing the community's interests, as well as how it takes the resulting input into account; and directs the hospital to identify those consulted in the process. Individual members of groups consulted through community forums, focus groups, survey groups, and the like need not be identified (Schedule H Instructions, p. 7), but if a hospital takes into account input from an organization, it must "provide the name and title of at least one person from that organization" (IRS, 2011).

Hospitals' responses to Parts V and VI of Schedule H will provide important insights into alternative approaches to community needs assessment and their relative effectiveness. At present, however, it is not clear what constitutes either "input" or "taking into account." Is "input" a strong statement of support by a recognized community leader or organization regarding a health issue of personal concern? Is it support for addressing a need identified as a priority in a community survey? Is it support for addressing a need selected from a short list of options developed by the hospital? How are externally identified priorities weighed against options viewed as more in line with a hospital's internal strategic priorities? In what way do the design and framing of questions influence responses?

It would be unreasonable to expect hospitals to take action on every recommendation made by individuals in the course of a focus

group session or town hall meeting, but how may such input inform a priority-setting process? What are the factors, criteria, and processes that can promote a selection of priorities that represent the most cost-effective target for action using limited resources? An examination of these issues raises a larger issue addressed neither by ACA §9007, Schedule H, nor IRS Notice 2011-52: the potential role of community stakeholders in a hospital's development of an implementation strategy. In an environment of constrained resources, and in the interest of shared ownership of community health initiatives, tax-exempt hospitals and their communities may benefit from hospital engagement of diverse stakeholders as full partners, not only in conducting community needs assessments, but also in the planning, implementation, and evaluation of evidence-based health improvement strategies. This may or may not require additional federal or state mandates, guidance, or incentives concerning the manner and form of community engagement. The intention here is to highlight the opportunity presented by implementation strategy development to encourage innovations that contribute to the advancement of community benefit practices in the field.

State Options. Given that responses to the community health needs assessment questions (Schedule H Part V, Section B, lines 1-7) are optional for 2011, it seems likely that hospital responses and documentation provided voluntarily will include more descriptions of exemplary practices than might be expected of mandatory submissions. Careful review of information that responding hospitals provide in their 2011 Schedule H and associated documentation will provide valuable insight for the refinement of future reporting requirements at the federal level, as well as for the consideration of options at the state and local levels.

In general, the federal approach to reporting community needs assessment and implementation strategy processes outlines general expectations in a manner that accommodate the diversity of institutions and the communities they serve. This is arguably a sufficient reason to conclude that it would be premature for states without existing requirements to develop new reporting standards in these areas at this time.

On the other hand, states with existing community needs assessment requirements may want to adjust these standards to increase their alignment with federal reporting standards. For example, North Carolina has adjusted local health department accreditation standards to provide health departments the option of conducting periodic community needs assessment (previously required every four years) every three or four years. This encourages hospital and health department collaboration by aligning local health department assessment time frames with the timing of Schedule H requirements of tax-exempt hospitals (Somerville et al., 2012). The North Carolina experience demonstrates that prudent action by states can take advantage of new federal requirements to improve opportunities to expand and deepen collaboration, thereby encouraging more strategic investment of resources and more comprehensive approaches to community health improvement.

For states that currently require hospitals to report information on community needs assessments and implementation strategies, access to the detailed information that federally tax-exempt hospitals will be required to report on Schedule H offers the option to set aside state-level reporting and redirect state resources to the analysis and use of federal data to support the advancement of best practices. For example, a state might employ ge-

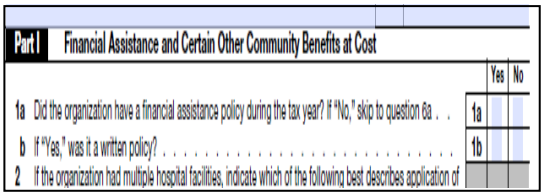
ographic information system (GIS) technology to generate maps of localities and regions displaying demographic data and targeting metrics to serve as proxies for health disparities, overlaid with hospital facilities and jurisdictional boundaries of ZIP code, municipality, county, and MSAs. These maps could be disseminated to regions in conjunction with assessment parameters as defined by hospitals in Schedule H reporting, offering the potential for states to encourage focusing substantial hospital investment in areas where disparities are concentrated. Such an approach would provide an opportunity to encourage collaboration and equitable sharing of the charitable burden by hospitals in the region. One such tool is currently under development by Community Commons, with the support of Kaiser Permanente and the CDC. This web-based platform employs GIS technology to develop community needs assessment parameters based on population income (as a percentage of the federal poverty level), high school non-completion rates, and other evidence-based indicators as proxies for health disparities (Community Commons, 2012).

Where data are available, states could also conduct analyses of hospital utilization data (perhaps focused on areas such as ambulatory care-sensitive conditions)[7] by ZIP code, municipality, county, and payer source (commercially insured, Medicare, Medicaid, or uninsured). These could be overlaid with hospital-defined assessment parameters, providing insight into both potential gaps and opportunities for collaboration. If resources can be identified, states, academic institutions, and research institutions could provide technical assistance to advance practices and facilitate alignment with state priorities.

Recent experience in Minnesota[8] (The Hilltop Institute, 2011; 2012a; 2012b) suggests that states should be cautious about establishing prescriptive standards for alignment of hospital community benefit investment with state-defined priorities. Aside from the fact that such a step is likely to encounter opposition from stakeholders with considerable political power, prescriptive community benefit standards can raise concerns about a state's commitment to encouraging local innovation and decision making (Massa, 2012).

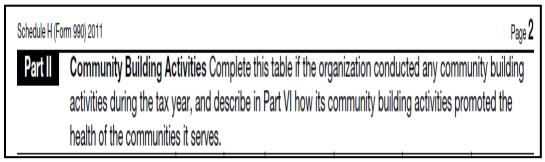
Community Building

The term "community building" is generally understood to mean activities that benefit community health but do not involve the provision of medical care (Congressional Research Service [CRS], 2008). These activities address the root causes of poor health in areas such as education, employment, income, housing, community design, family and social support, community safety, and the environment (CDC, 2012; U.S. Department of Health and Human Services [HHS], 2011; Institute of Medicine, 2011). Community building activities are proactive strategic investments in prevention that represent an approach to community health that reduces the need for costly medical intervention by addressing the "upstream" causes of poor health status and premature death. As such, community building activities are fully aligned with the prevention-based cost-containment goals of national health reform.


Part I Financial Assistance and Certain Other Community Benefits at Cost

		Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a . . .	1a	
b	If "Yes," was it a written policy?	1b	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of		

The categories of hospital community benefit activities reportable under Part I of Schedule H are consistent with the reporting framework developed by the Catholic Health Association of the United States (CHA) (CHA, 2006), with one exception: unlike CHA's *Guidelines*, Part I of Schedule H does not specifically include a "community building" category. Instead, Schedule H features a separate Part (II) for reporting community building activities.

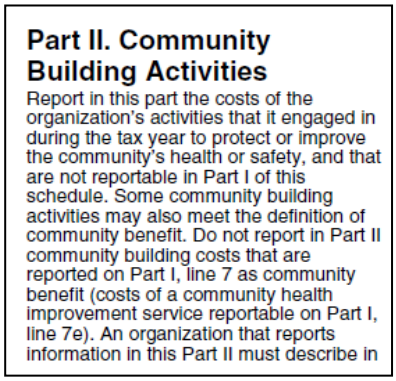

Schedule H (Form 990) 2011 Page 2

Part II **Community Building Activities** Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

Activities that may be reported under Part II of Schedule H as "community building" include the following:

- Physical improvements and housing
- Economic development
- Community support (e.g., child care, mentoring, and violence prevention)
- Environmental improvements
- Leadership development for community members
- Coalition building
- Community health improvement advocacy
- Workforce development
- Other

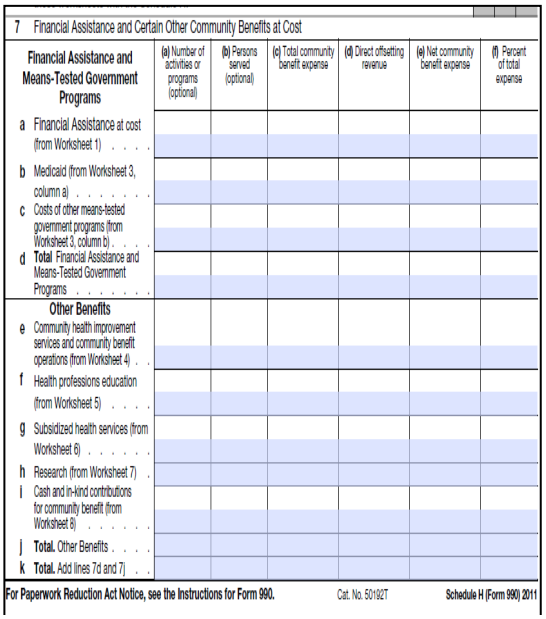
The IRS decision in 2007 to require separate reporting of community building costs appears to have centered on IRS's admittedly poor understanding of the relationship between community building and community health improvement (CHA, 2008; Lunder & Liu, 2009).[9] Until recently, separate reporting of community building activities led to a not uncommon inference among hospitals that the IRS would not consider community building costs when assessing the "facts and circumstances" of a hospital's charitable activities and whether they adequately support the organization's federal tax exemption. However, in the 2011 Schedule H Instructions (p. 4), IRS included a statement that "[s]ome community building activities may also meet the definition of community benefit" and a direction not to report in Part II "community building costs reported on Part I, line 7 as community benefit (costs of a community health improvement service reportable on Part I, line 7e)."


Part II. Community Building Activities

Report in this part the costs of the organization's activities that it engaged in during the tax year to protect or improve the community's health or safety, and that are not reportable in Part I of this schedule. Some community building activities may also meet the definition of community benefit. Do not report in Part II community building costs that are reported on Part I, line 7 as community benefit (costs of a community health improvement service reportable on Part I, line 7e). An organization that reports information in this Part II must describe in

(Schedule H Instructions, p. 4)

In other words, "some" community building activities may be reported on line 7e of Part I as a "community health improvement service."


7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)						
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs						
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)						
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j **Total.** Other Benefits						
k **Total.** Add lines 7d and 7j						

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(Schedule H)

The 2011 Instructions change may signal a shift in IRS policy relating to community building or may represent no more than a clarification of the less definite language found in previous versions of the Schedule H Instructions.[10] Nevertheless, the 2011 Schedule H Instructions' statement that "some community building activities may also meet the definition of community benefit" begs the question, "which ones?" In this regard, it is important to note that for *any* activity to qualify as a "community health improvement service" reportable in Part I, the activity must (Schedule H Instructions, pp. 13-15):

- Be carried out or supported for the purpose of improving community health or safety
- Be subsidized by the organization
- Not generate an inpatient or outpatient bill
- Not be provided primarily for marketing purposes
- Not be more beneficial to the organization than to the community (e.g., not designed primarily to increase referrals of patients with third-party coverage)
- Not be required for licensure or accreditation
- Not be restricted to individuals affiliated with the organization (employees and physicians)
- Meet at least one community benefit objective, including improving access to health services, enhancing public health, advancing generalizable knowledge, and relief of government burden
- Respond to a demonstrated community need

Schedule H Instructions have always specified three means of demonstrating community need in the context of community health improvement services and community benefit operations reported in Part I, line 7e (2008-2011 Schedule H Instructions, Worksheet 4, pp. 13-15):

- *A community health needs assessment developed or accessed by the organization;*
- *Documentation that demonstrated community need or a request from a public agency or community group was the basis for initiating or continuing the activity or program; and*
- *The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the activity or program.*

Regardless of whether the addition to the IRS's 2011 Schedule H Instructions signals an IRS policy shift or only a clarification, logic suggests that community building activities reported in accordance with the Instructions for Worksheet 4 would be assessed by the IRS on the same basis as other community health improvement activities. This and other reporting issues concerning community building activities are explored more fully in Hilltop's companion brief, ***Hospital Community Benefits after the ACA: Community Building and the Root Causes of Poor Health***.

State Options. In considering options for states relating to community building activities, a good starting point is the examination of existing state reporting standards. Some states—such as Oregon (Or. Admin. R. §409-023-0100 (2)) and Minnesota (Minn. Stat. §144.699.5)—include a specific community benefit category for reporting community building activities, whereas others—like New Hampshire (N.H. Rev. Stat. Ann. §7:32-d (III))—define "community benefits" in a way that can be interpreted to include community building activities. Other states define com-

munity benefits more narrowly; for example, in Rhode Island, "community benefit" means "the provision of hospital services that meet the ongoing needs of the community for primary and emergency care in a manner that enables families and members of the community to maintain relationships with persons who are hospitalized or are receiving hospital services, and shall also include, but not be limited to charity care and uncompensated care" (R.I. Gen. Laws §23-17.14-4(5)).

A lack of clarity at the federal level regarding what community building activities "count" as community benefit, and under what circumstances, may have discouraged tax-exempt hospitals' allocation of charitable resources to support community building activities. On the other hand, this ongoing conversation concerning federal recognition of community building activities as community benefit has perhaps contributed to a greater understanding—not only by the IRS, but also among hospital leadership—of how community building contributes to population health improvement. As such, one would expect increased attention to ways in which hospitals can include community building elements into their community health improvement initiatives, either through direct investment or by partnering with other stakeholders and the community to assess the need for such activities and support them.

States wishing to encourage hospital adoption of prevention-focused community benefit policies and initiatives may consider different approaches that respond to each state's unique circumstances. If current reporting structures do not expressly recognize hospitals' community building activities as community benefit, legislative action or regulatory interpretation might provide greater clarity and ease hospital uncertainty about the state-level reporting consequences of these investments. Alternatively, states could directly request hospital initiation of community building activities or solicit hospital participation in or support of health department-led initiatives. This approach might allay hospital concerns about the activities' federal reporting status, as it would—according to the Schedule H Instructions, Worksheet 4—establish the community's need for the activity, a key requirement of federal community benefit reporting (pp. 14-15).

State and local public health agencies, which can contribute their expertise regarding what kinds of activities are effective, may act as conveners of community partnerships in which nonprofit hospitals collaborate with the business community, community-based organizations, and other government agencies (e.g., transportation, housing, and parks and recreation) to plan and support activities and investment that address the root causes of poor health (Trust for America's Health, 2012).

Reflections and Conclusions

By examining selected elements of Schedule H, this brief is intended to explore its implications for states and localities that seek to advance the charitable practices of tax-exempt hospitals. The federal community benefit reporting requirements offer a rich potential for analysis and dissemination of useful information that is of interest to state and local government agencies, as well as to the academic community, advocacy organizations, and the public at large.

Schedule H dramatically increases the transparency of nonprofit hospital charitable activities and processes. By providing a framework for detailed documentation of community health needs assessments and implementation strategies, it also lays the groundwork for nonprofit hospitals' engagement of diverse stakeholders, as well as for the advancement of community health improvement practices. At the state level, there is significant variation both in terms of the degree of specificity in community benefit reporting categories and in their associated definitions.

A key question is the degree and manner in which state governments will incorporate the reporting requirements of ACA §9007 and Schedule H into state and local law and policy.

Options include:

- Adjusting existing state laws and reporting requirements to align with their federal counterparts, advancing any additional state-specific reporting or analytical requirements by building on the federal law framework
- Preserving existing state requirements or developing new ones designed to advance state-specific community benefit policy
- Eliminating or deferring the establishment of state requirements in order to streamline hospital reporting and reduce the need for community benefit monitoring at the state level
- Exploring nonregulatory actions that foster optimal compliance and the advancement of community benefit practices

Some states may decide to build on the federal reporting requirements by establishing compatible state-level criteria and methods based, for example, on a review of hospital reporting patterns in the state. In general, states with existing reporting standards may choose to preserve those standards, perhaps adjusting their terminology and guidelines to be more reflective of federal reporting standards. This approach could reduce confusion and the burden of reconciling inconsistencies in the state and federal reporting processes. Other states may conclude that it is easier to eliminate existing state standards as a gesture of commitment to consistency and clarity in community benefit reporting. Finally, state options include nonregulatory approaches, such as the publication and dissemination of hospital-reported financial data in ways that enhance the transparency of hospital community benefit planning and budgeting processes and increase the usefulness of these data to community stakeholders.

Current public sector budgetary constraints may contribute to an inclination by state policymakers to consider legislative options targeting hospital community benefit investment to low-income communities as a way of countering the effects of the national economic downturn and reduced public sector safety net spending. In this regard, however, states should also consider the potentially negative impact of prescriptive community benefit requirements on hospital flexibility to address local needs and priorities. Moreover, as they consider their options, states should assess their capacity to commit state resources to community benefit monitoring.

In order to develop health improvement strategies that represent the optimal use of limited charitable resources, tax-exempt hospitals must take into consideration and accommodate a diverse array of local and regional factors, including but not limited to income and employment patterns, race and ethnicity, payer mix, configuration of community-based organizations and businesses, proximi-

ty and type of provider organizations, and even geographic characteristics and climate patterns. In addition, local governments and local stakeholders may be better able to assess the relative contributions of local hospitals and their alignment with local needs than regulators at the state or federal level.

For these and other reasons, and given the rich array of information now readily available through Schedule H, nonregulatory approaches that focus on the analysis and dissemination at the local and regional levels may represent the most promising role for states. At the state level, hospital-reported data can be disseminated in the form of periodic reports or briefs targeted to key leaders at the regional level. States might establish online resources to provide users with the tools to conduct their own comparative analyses of targeted factors. Analytic tools might also be developed at the national level to facilitate independent analysis by a broad spectrum of stakeholders.

All these approaches are designed to take optimal advantage of the substantially increased transparency of tax-exempt hospital practices made possible by the combination of Schedule H reporting and §9007 of the ACA. Because states will play an important role in the advancement of community benefit practices nationally, they should give serious consideration to a variety of available options and determine which approaches are most likely to help them achieve their goal of advancing the community benefit practices of tax-exempt hospitals.

The information in this brief is provided for informational purposes only and is not intended as legal advice. The Hilltop Institute does not enter into attorney-client relationships.

Endnotes

[1] The Patient Protection and Affordable Care Act, P.L. 111-148 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152. These consolidated Acts are referred to herein as the Affordable Care Act (ACA).

[2] Unless otherwise noted, references in this brief to Schedule H and Schedule H Instructions refer to those applicable to hospitals' 2011 tax year.

[3] In *National Federation of Independent Business v. Sebelius*, No. 11-393, 567 U.S. __ (2012), the Supreme Court generally rejected constitutional challenges to the ACA, but effectively made voluntary the law's requirement that state Medicaid programs expand eligibility to all citizens under age 65 with income at or below 138 percent of the federal poverty level (FPL). States will decide whether, to what extent, and when to expand Medicaid eligibility and can modify these decisions over time. See Cindy Mann's comments in this regard: National Council of State Legislatures. Medicaid State Options Under PPACA Clarified at NCSL Health Meeting. Retrieved from http://www.ncsl.org/issues-research/health/medicaid-state-options-clarified-at-ncsl-session.aspx

[4] In Part IV, hospital organizations report information relating to management companies and joint ventures.

[5] The NPRM, published June 26, 2012, clarifies many of the ambiguities surrounding the provisions of ACA §9007, 26 USC §501(r)(4)-(6) concerning tax-exempt hospitals' financial assistance policies, limitations on charges, and billing and collections. (77 Fed. Reg. 38148-69)

[6] Illinois enacted two new community benefit-related laws in 2012. P.L.97-0688 (35 ILCS 105/3-8) requires nonprofit hospitals, as a condition of retaining their property tax exemption, to provide community

benefits at a level at least equivalent to their estimated tax liability in the absence of the exemption. A second 2012 law, P.L.97-0690 (210 ILCS 89/10 §10(a)), established specific standards for hospital patients' eligibility for financial assistance.

[7] The term "care-sensitive conditions" is defined by Billings, Zeitel, Lukomnik, Carey, Blank, and Newman (1993) as "diagnoses for which timely and effective outpatient care can help to reduce the risks of hospitalization by either preventing the onset of an illness or condition, controlling an acute episodic illness or condition, or managing a chronic disease or condition" (p. 163).

[8] A 2011 Minnesota law required hospitals to direct their community benefit activities to addressing state health needs and priorities identified by the State Health Improvement Plan (SHIP) and to submit community benefit plans to the state health department for "review and approval." Following unprecedented industry push-back, in 2012, the legislature unanimously repealed the requirement.

[9] A 2009 CRS report, "501(c)(3) Hospitals and the Community Benefit Standard," notes that IRS comments in 2007 about the 2008 Schedule H final draft "reflected the view that the link between community building and health was still tenuous and that the reporting tools in Schedule H are intended to operate, in part, as data collection methods for the IRS to discern what links exist" (Lunder & Liu, 2009, p. 11). Regarding the historical underpinnings of the federal reporting distinction between community benefit and community building activities, see the companion to this issue brief: *Hospital Community Benefits after the ACA: Community Building and the Root Causes of Poor Health*.

[10] The Schedule H Instructions for tax years 2008-2010 included the sentence: "Report in this part the costs of the organization's activities that it engaged in during the tax year to protect or improve the community's health or safety, and that are not reportable in Parts I [or] III of this schedule" (p. 4).

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About The Hilltop Institute

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a non-partisan health research organization 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 is committed to addressing complex issues through informed, objective, and innovative research and analysis. To learn more about The Hilltop Institute, please visit **www.hilltopinstitute.org**.

Hilltop's Hospital Community Benefit Program is the central resource created specifically for state and local policymakers who seek to ensure that tax-exempt hospital community benefit activities are 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 and other 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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analysis to advance the health of vulnerable populations

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