Could Hospital Community Benefit Enhance Community Health Improvement?

Erik Bakken; David Kindig, MD, PhD

The Internal Revenue Service recently revised and standardized the reporting requirements of nonprofit hospitals as a condition of their tax-exempt status, officially known as Schedule H of IRS form 990 for nonprofit organizations. In a recent issue of this journal, we reported results from 2009, the first year that data were available.[1] In that year, Wisconsin hospitals reported $1.064 billion in community benefits, or 7.52% of total hospital expenditures. Of this amount, 9.1% was for charity care, 50% for Medicaid subsidies, 11.4% for other subsidized services, and 4.4% for Community Health Improvement Services. We noted that there was considerable variation across hospitals in both the total amount reported as well as the allocation across allowable categories, but we did not spell out the extent of this variation.[1] We believe such wide variation calls for the possibility of guidelines or standards to increase the allocations to true community health improvement investment, and we propose one such potential model for consideration.

We calculated the frequency distribution of the community benefit data reported by Wisconsin hospitals in 2009. Figure 1 displays the variation in the more than $1 billion by hospital, ranging from 0 to more than 20% of total hospital expenditures, averaging about 7.5%. Figure 2 shows the similar variation in the $47 million category of community health improvement, ranging from 0 to 1.6%. Similar variation can be seen in the other categories (additional figures available online www.wisconsinmedicalsociety.org/_WMS/publications/wmj/pdf/113/1/bakken_figs.pdf). This variation reflects the current policy reality that no standards or guidelines govern either the total amount of community benefit or its allocation across categories justifying tax-exempt status. It is our opinion that community benefit policy is too important and the needs for community health improvement resources too great to leave this decision exclusively to the individual institutions. Current efforts for joint community health needs assessment are to be commended, but only if they lead to resource allocation aligned with local population health improvement priorities.

There are 2 general potential solutions to standardize this variation. The first is to mandate the overall level of benefit required. We think one place to start is the approach first implemented in Utah[2] of having community benefit bear some relationship to the tax benefit received. In Utah, hospitals are required to have community benefit totals equal to their total state and local tax relief. The only time this was estimated for the nation was in 2006 for the 2002 year at $12.6 billion.[3] This amount needs to be updated for the nation and individual states.

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Similarly, we believe that some guidance should be considered for allowable allocation across the 8 categories. Unreimbursed Medicaid was found to account for half of the total reported in Wisconsin; the amounts claimed ($536 million of the more than $1 billion total just in Wisconsin) and their range (from less than 10% to more than 80% of total community benefit reported in Wisconsin) call for deeper scrutiny.

A second category that has received little policy discussion is that of subsidized health services, defined as clinical inpatient and outpatient services provided by the hospital despite a financial loss, which would be otherwise undersupplied to the community. Examples given by IRS are substance abuse,

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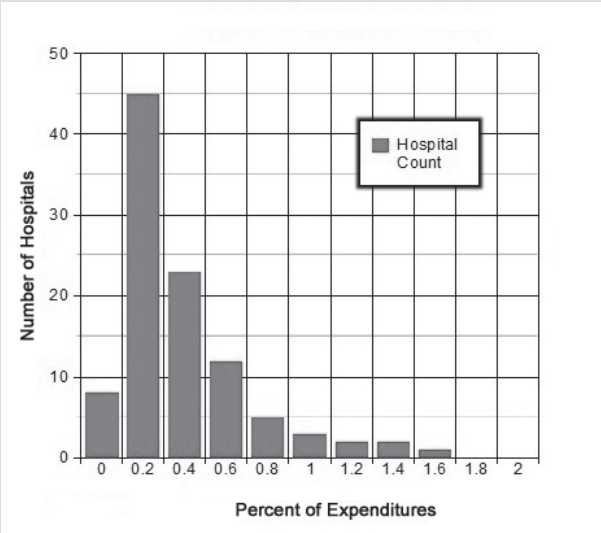
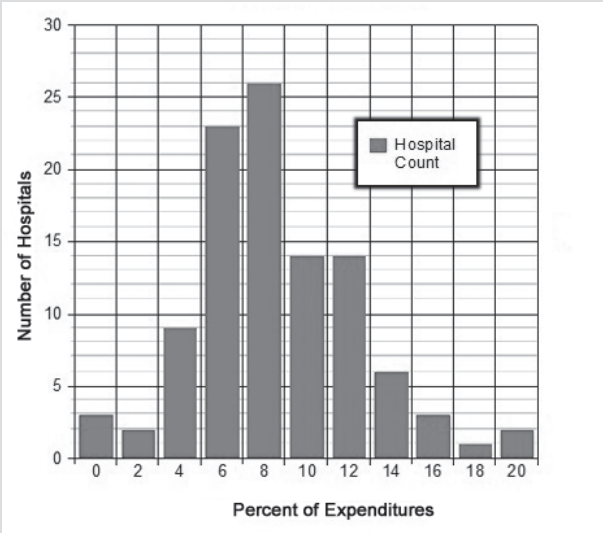
Figure 1. Total Community Health Improvement



Mean=0.4

Figure 2. Total Community Benefit



Mean=0.4

trauma centers, or mental health services.[4] While this is not as large a category as Medicaid, in Wisconsin it amounted to $121 million, or 17% of total benefit reported.

In our opinion, community benefit should be more aligned to directly improving community health metrics and closing disparities, with increased resources being added to community health improvement. As one example, we did projections that mandated that a minimum 10% of total community benefit in Wisconsin would have to be spent on the community health improvement category. We additionally increased this mandate by 2% for each 2.5% step of hospital profitability over 2.5% of revenue (ie, 2.5% profitability or below – 10% mandate; 2.6% to 5% profitability – 12% mandate; 5.1% to 7.5% profitability – 14% mandate; 7.6% to 10% profitability – 16% mandate; 10.1% to 12.5% profitability – 18% mandate; and above 12.5% profitability – 20% mandate.

This regulatory scenario would more than triple the amount of available public health dollars through community benefit provision, from $46 million to $139 million. Community health improvement would then be 13% of total community benefit, if 2009 total levels remained constant. We present this model as just an example of the type of guidance that could be imposed to achieve such a goal; certainly alternative models deserve development and critique.

This model does not project where such reallocation would come from, although we suggest that serious consideration be given initially to the Unreimbursed Medicaid and Subsidized Service categories. We do not specify how these increased revenues might be allocated. The local Community Health Improvement Plan process should be 1 guide; other priorities have been suggested by McCulloch et al in their recent Health Dividend proposal.[5]

We understand that hospitals face demanding challenges, having to produce a positive bottom line while ever improving quality and outcomes of treatment. On the other hand, we know that similar health outcomes can be obtained with lower medical care and greater nonmedical determinant investment. Community benefit dollars represent a real opportunity to improve statewide health outcomes, but under the current voluntary process are failing to meet their possible positive impact. We believe it is appropriate to have a more robust and transparent policy discussion regarding the enhanced role that standards or guidelines in community benefit obligations might bring. Several states have gone beyond federal regulation on the community benefit issue, so why not Wisconsin?

Acknowledgments: This study was supported by the Robert Wood Johnson Health and Society Scholars program at the University of Wisconsin-Madison. This program had no involvement in the design and conduct of the study; collection, management, analysis, and interpretation of the data; and preparation, review, or approval of the manuscript. Additional funding was provided by the La Follette School of Public Affairs through the Ina Jo Rosenberg and Shiri Eve Leah Gumbiner Fellowship. The authors have no financial or other potential conflicts of interest. E. Bakken had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

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3. Internal Revenue Service. 2012 Instructions for Schedule H (form 990). http://www.irs.gov/pub/irs-pdf/i990sh.pdf. 2012. Accessed December 4, 2012.

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Figure 3. Total Subsidized Services.

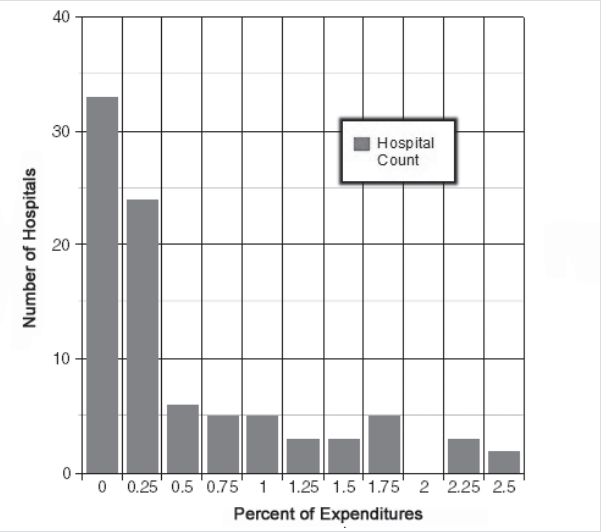

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Figure 4. Total Charity Care.

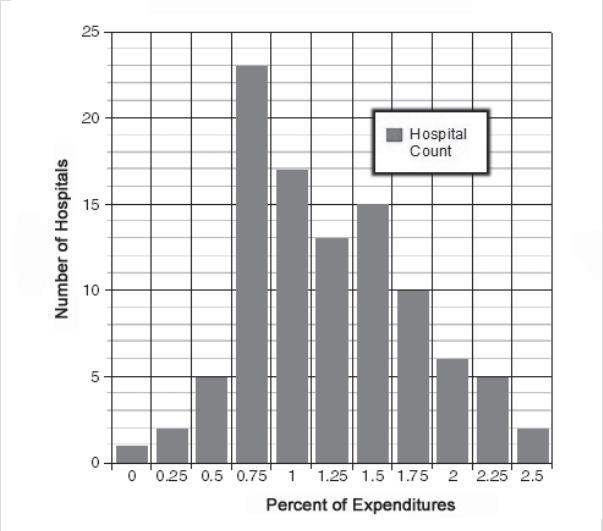

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Figure 5. Total Unreimbursed Medicaid.

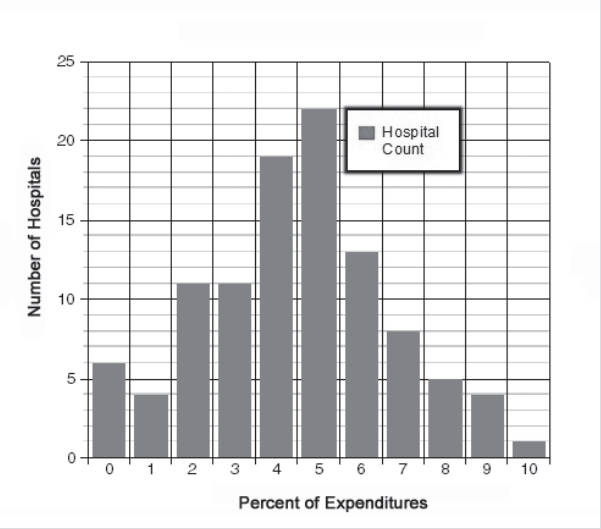

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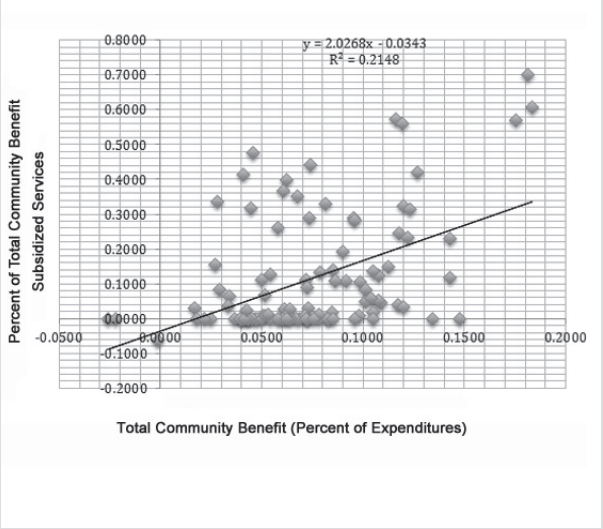
Figure 6. Total Community Benefit vs Subsidized Services.



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