

BEYOND MEDICAL CARE FACT SHEET

Leveraging hospital community benefit for upstream prevention



What is hospital community benefit?

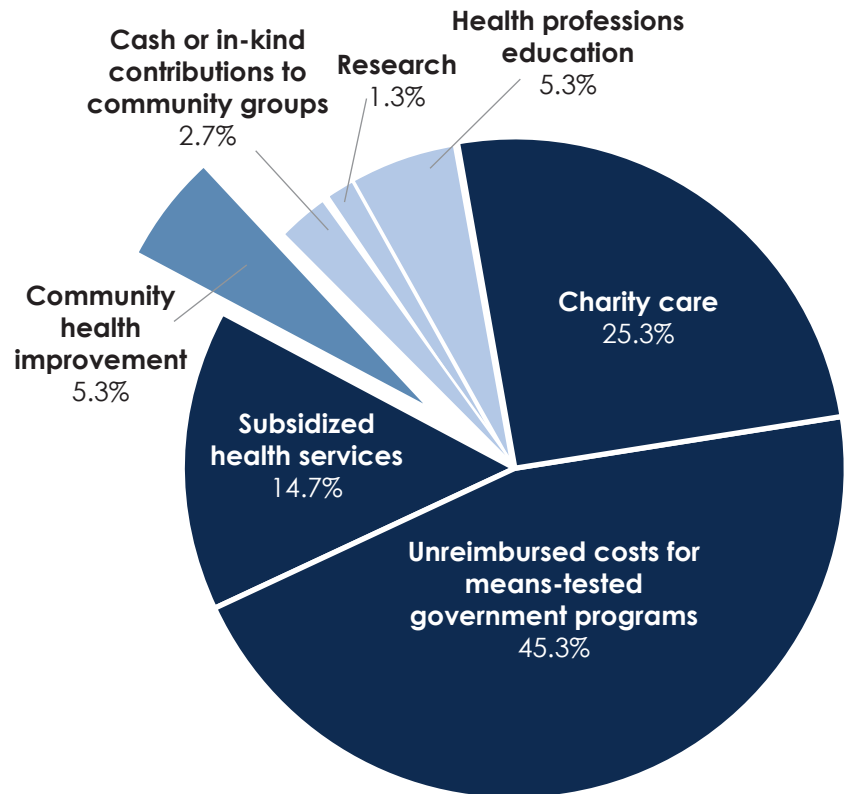
The IRS requires nonprofit hospitals to justify their tax exempt status by allocating a portion of their operating expenses towards the provision of community benefit – defined as initiatives or activities undertaken by hospitals to improve the health of the communities in which they serve. Tax-exempt hospitals report their community benefit expenditures on Schedule H of their annual 990 tax forms.

Historically, charity care and other forms of uncompensated direct patient care, such as unreimbursed Medicaid costs, have made up the bulk of hospital community benefit activities and expenditures. A national study of 2009 nonprofit hospital tax filings found that 85.3% of community benefit expenditures were for direct patient care and only 5.3% were allocated to community health improvement activities (see Figure 1).¹

Over the past few years, several policy changes have resulted in an unprecedented opportunity to shift some hospital community benefit expenditures away from charity care and other forms of direct patient care toward community-based prevention. First, changes in IRS reporting requirements have broadened the types of activities that are reported to the IRS as community benefit to include certain activities that address social, economic, and physical environments that impact health (see Instructions for Schedule H). Second, expanded availability of health insurance through the Affordable Care Act (ACA) is reducing the number of people who are uninsured. This means that hospitals may have lower charity care costs in coming years, potentially allowing hospitals the opportunity to invest more in community health improvement activities.

Finally, the ACA requires nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) every three years and adopt an Implementation Strategy to address prioritized health needs. This requirement prompts hospitals to deepen their engagement with their surrounding communities in order to improve population health. Recent IRS guidelines around CHNAs also clarify that health needs identified and addressed by hospitals may include social, behavioral and environmental factors that influence health in the community.

Figure 1. National distribution of community benefit expenditures, 2009



Source: Young, Gary J., et. al. "Provision of Community Benefits by Tax-Exempt U.S. Hospitals." *New England Journal of Medicine*, Oct. 2014.

Note: See HPIO publication "Making the most of community health planning in Ohio: The role of hospitals and local health departments" for a description of these categories.

What's the landscape in Ohio?

Ohio is in a good position to maximize the impact of hospital community benefit on population health for the following reasons:

- **Broad reach.** As of 2013, 85.2% of hospitals in Ohio were classified as either nonprofit or government-owned, compared to 78.7% of hospitals nationally.³ Although 12 of Ohio's 88 counties do not have a nonprofit hospital located within their borders, all but four counties were included in the areas covered by nonprofit hospital Community Health Needs Assessments (CHNAs).⁴
- **Significant resources.** Ohio nonprofit and government hospitals spent a total of \$3.86 billion towards net community benefit activities in 2012, an average of 6.46% of total hospital expenditures for each hospital.⁵
- **Declining uninsured rate.** Ohio's decision to extend Medicaid to adults up to 138% of the Federal Poverty Line, along with other provisions of the ACA, is reducing the number of people who are uninsured in the state. From 2012 to 2015, Ohio's adult uninsured rate dropped from 14% to 7%.⁶ The Ohio Department of Medicaid has estimated significant reductions in uncompensated care costs for Ohio's hospitals as a result of Medicaid expansion.⁷ However, it is difficult to determine the extent to which these reductions will impact the amount of hospital community benefit expenditures available for upstream prevention.

The governor's proposed 2016-17 budget called for the formation of a "Population Health Planning and Hospital Community Benefit Advisory Workgroup" to develop recommendations regarding designation of "a portion of each nonprofit hospital's community benefit to fund regional population health priorities in order to be eligible for tax benefits."⁸ The workgroup would have also explored the possibility of establishing regional wellness trusts as a mechanism for distributing a portion of community benefit.⁹ Although the proposed population health planning language was removed from the final version of the budget bill, the Office of Health Transformation has indicated interest in convening a population health workgroup regardless of legislative action.

What are the potential policy mechanisms?

In addition to drawing upon community benefit as a funding source for **wellness trusts**, there are several other mechanisms states can use to encourage hospitals to invest their community benefit in upstream prevention activities:

- Provide training and technical assistance to nonprofit hospitals on evidence-based prevention strategies, community engagement, health equity and other population health topics, or to develop a common template or checklist for CHNA and Implementation Strategy documents that prompts inclusion of these strategies.
- Require hospitals to include specific components in their Implementation Strategies that address prevention and population health, such as measurement of a common set of outcomes, or to choose from an approved menu of evidence-based interventions when developing their Implementation Strategies.
- Promote greater transparency for community benefit spending by requiring hospitals to report more detailed information about community benefit activities than is documented on the IRS Form 990, or to file implementation plans with a state entity.

Community building activities

Only activities under Part I of Schedule H are designated as legitimate community benefit expenditures for hospital tax exemption purposes. However, hospitals are also required to report on "community building activities," in Part II of Schedule H which include:

- Physical improvements, including housing, parks and playgrounds
- Economic development, such as small business development and new employment opportunities in areas with high rates of joblessness
- Community support, such as child care, mentoring and violence prevention programs
- Environmental improvements, including alleviation of water and air pollution or other environmental hazards
- Leadership development and training for community members, such as training in conflict resolution or medical interpreter skills
- Coalition building, including participation in community health collaboratives
- Community health improvement advocacy, such as support for policies that promote access to care, housing or transportation
- Workforce development, including collaboration with educational institutions to train and recruit healthcare professionals for medical shortage areas
- Other community building activities that protect or improve the community's health and safety

The IRS indicated in 2012 that some hospital community building activities may meet the definition of community benefit and should be reported in Part I of Schedule H rather than in Part II.

For expenditures to be reported in Part I, there must be an established community need for the activity or program. The IRS Schedule H instructions state that community need may be demonstrated through a CHNA conducted or accessed by the organization or other documentation that demonstrates community need.²

The inclusion of some community building activities as part of community benefit indicates a significant shift in policy away from charity care and toward upstream approaches that address the social determinants of health. However, lack of clarity on which community building activities can be counted as community benefit has diffused incentives for nonprofit hospitals to invest community benefit dollars upstream. There continues to be dialogue at the federal level to broaden Part I reporting to include all hospital community building activities currently reported in Part II of Schedule H.

The **Catholic Health Association** provides several useful resources for hospitals in identifying the types of activities that count towards hospital community benefit, including **guidance** for determining whether to report an activity as community health improvement or community building.

Ohio nonprofit hospitals go upstream

Many nonprofit hospitals in Ohio are investing their community benefit dollars in innovative strategies to address the social, economic and physical environments that impact health:

- **Good Samaritan Hospital's Phoenix Project** partners with the City of Dayton to invest in a revitalization project in two neighborhoods adjacent to the hospital that led to the creation of a park, a playground, community gardens and a new school.
- **Cincinnati Children's Hospital** partners with the Legal Aid Society of Greater Cincinnati to address housing code violations that lead to asthma triggers like mold.
- **Nationwide Children's Hospital's Healthy Neighborhoods, Healthy Families initiative** aims to improve housing quality, early childhood education and workforce development within a three-zip code area near the hospital in Columbus. Their SPARK home visiting program, for example, helps to improve kindergarten readiness for preschool-age children, and their FastPath workforce development project connects unemployed adults with training and job placement through a partnership with Columbus State Community College.
- **Cleveland Clinic, University Hospitals** and other partners launched the Evergreen Cooperative Initiative to create living-wage jobs in six low-income neighborhoods. The initiative has developed a network of worker-owned businesses, such as a laundry facility and vegetable greenhouse, linked to health system supply chains.

Notably, some states have requirements for hospitals that are more prescriptive than IRS guidelines, including mandatory minimum threshold amounts for community benefit expenditures, mandated levels of community engagement, use of evidence-based practices, or inclusion of measurable objectives as part of CHNAs and Implementation Strategies.¹⁰ Ohio law does not currently have any of these additional requirements.

Examples from other states

The New York State Department of Health issued policy guidance to nonprofit hospitals and local health departments requesting that they work together on their community health plans. The Department also requires that hospitals and local health departments select at least two priorities from the State Health Improvement Plan, the *Prevention Agenda*. The Department provides technical assistance to hospitals and health departments on these priorities. New York hospitals and health departments are also expected to address health disparities in their plans.¹¹

By statute, Maryland requires hospitals to include efforts to track and reduce health disparities in their implementation strategies.¹²

California, Maryland and New Hampshire define community benefit to explicitly include activities that address the social determinants of health.



Hospital community benefit recommendations

Nonprofit hospitals can:

1. Exchange information and ideas with other nonprofit hospitals about upstream prevention activities that can be reported as community benefit.
2. Partner with local health departments and other community-based organizations to identify, implement and evaluate prevention activities.
3. Devote community benefit dollars to the implementation of evidence-based primary prevention activities.

State, local and regional associations and prevention organizations can:

4. Provide education about the broad range of activities that are allowable as community benefit expenditures by showcasing upstream work already being done by many Ohio nonprofit hospitals.
5. Offer training and technical assistance to nonprofit hospitals on evidence-based prevention strategies, program evaluation, community engagement, health equity, policy and environmental change, and other population health topics.

State agency leaders can:

6. Develop guidance for nonprofit hospitals designed to increase transparency and encourage collaboration that results in greater investments in community-based prevention.
7. Bring hospital and public health stakeholders together to identify strategies for increasing alignment, coordination and effectiveness of local health improvement planning, including effective allocation of community benefit spending.

Recommended resources

- **Making the most of community health planning in Ohio: The role of hospitals and local health departments**, HPIO policy brief, 2015
- **The Hilltop Institute Community Benefit Program**
- **Catholic Health Association Community Benefit resource page**
- **Additional requirements for charitable hospitals, final rule**, Internal Revenue Service, 2014

Sources

1. Young, Gary J., et al. "Provision of Community Benefits by Tax-Exempt U.S. Hospitals." *New England Journal of Medicine*, Oct. 2014.
2. Internal Revenue Service. "Instructions for Schedule H (Form 990)." Accessed April 22, 2015. <http://www.irs.gov/pub/irs-pdf/i990sh.pdf>.
3. 2013 data. Henry J. Kaiser Family Foundation. "Hospitals by Ownership Type." Accessed April 24, 2015. <http://kff.org/other/state-indicator/hospitals-by-ownership/>.
4. Based on HPIO's review of CHNAs completed in Ohio from 2012 to 2014. Clinton, Fayette, Pickaway and Vinton counties were not included in a CHNA-defined service area. Counties without a tax-exempt hospital are Brown, Carroll, Clinton, Lawrence, Meigs, Monroe, Morgan, Noble, Perry, Preble, Putnam, and Vinton. (See: HPIO. "Making the most of community health planning in Ohio: The role of hospitals and local health departments," 2015.)
5. HPIO. "Making the most of community health planning in Ohio: The role of hospitals and local health departments." 2015. <http://www.healthpolicyohio.org/making-the-most-of-community-health-planning/>.
6. Adults age 19 years and older. Ohio Medicaid Assessment Survey. OMAS Adult Dashboard. Accessed September 11, 2015. http://grcapps.osu.edu:3838/OMAS_Adult/
7. Ohio Department of Medicaid: FY16-17 budget priorities. Testimony from John McCarthy, Medicaid Director to House Finance Subcommittee on Health and Human Services, February 26, 2015. Slide 52. Accessed March 5, 2015. <http://medicaid.ohio.gov/Portals/0/Resources/Testimony/House-Finance-HHS-Testimony-2015-02-26.pdf>.
8. HB 64, Section 289.60 as introduced
9. Office of Health Transformation. "Improve Population Health Planning." Accessed March 5, 2015. <http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=VKSljKWUH48%3d&tabid=252>.
10. Somerville, M., Nelson, D., and Mueller, C. "Hospital Community Benefits after the ACA: The State Law Landscape." Hilltop Institute. March 2013. <http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-StateLawLandscapeIssueBrief6-March2013.pdf>.
11. New York State Department of Health. "Local health department community health assessment and improvement plan and hospital community service plan guidance, 2013". October 2012. Accessed March 6, 2015. https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/docs/planning_guidance.pdf.
12. Hilltop Institute. "Hospital community benefits after the ACA: Addressing social and economic factors that shape health." May 2014.

To learn more

To view the complete publication "Beyond medical care: Emerging policy opportunities to advance prevention and improve health value in Ohio," as well as more fact sheets about the specific policy opportunities discussed in the report, visit:

www.hprio.net/beyond-medical-care



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