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Changes in Health Care Financing & Organization (HCFO)

findings brief

The Provision and Reporting of Community Benefits by Hospitals: Lessons from Maryland

key findings

- Most Maryland hospitals experienced a difficult learning curve in 2004 when they were required to begin filing annual reports on community benefit expenditures, but hospital leaders now generally see the reporting requirements to have been beneficial for hospitals.
- Charity care and health professional education each account for about one-third of community benefit expenditures in Maryland hospitals, and mission-related services around 20 percent.
- Community benefit accounts for more that 7.2 percent of hospitals' expenditures on average, with the range from less than two percent to more than 14 percent. Charity care averages 2.1 percent of expenditures, with the range from less than 1 percent to more than 6 percent of expenses.

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Introduction

Federal tax exemption for nonprofit hospitals turns on their providing community benefit, but they have never been required to report what community benefits they provide. That will change in 2010 when organizations that operate nonprofit hospitals will have to complete a new Internal Revenue Service form, called Schedule H, that requests expenditure information for charity care, uncompensated costs in government programs, community health services, subsidized health services, health professional education, research, charitable donations, community building, and bad debt. A similar reporting requirement has been in place in Maryland since 2004. Using categories and definitions specified by the Health Services Cost Review Commission (HSCRC), the regulatory agency to which reports must be submitted, nonprofit hospitals in Maryland report annually on community benefit expenditures for activities "intended to address community needs and priorities primarily through disease prevention and improvement of health status."[1]

Bradford Gray, Ph.D., of the Urban Institute and Mark Schlesinger, Ph.D., of Yale University studied Maryland's experience with this reporting requirement to understand how it worked, to learn what the reports revealed about hospitals' community benefit expenditures, and to anticipate what will happen with Schedule H. To understand Maryland's experience, the researchers analyzed data in the community benefit reports filed by Maryland hospitals during the first four years of the program and they interviewed those in key leadership positions at the hospitals. The results of their research have been published in a pair of articles in *Health Affairs* and *Inquiry*.[2]

Methodology

Gray and Schlesinger analyzed the community benefit expenditures reports submitted to the HSCRC from 2004–2007. They also interviewed senior executives (chief executive officer, chief financial officer, or chief operating officer) and persons responsible for community benefit activities at 20 of the 45 nonprofit hospitals. The hospitals were chosen to reflect the state's diversity

and included a mix of hospitals based on size, region, type of community served, mission, system membership, and level of community benefit activity. The interviews with executives were composed of mainly open-ended questions covering many different aspects of the community benefit report. The interview responses were then analyzed and compared.

Findings

Community Benefit Expenditures in Maryland

Over a three year period in Maryland, community benefit expenditures for hospitals accounted for 7.2 percent of hospitals' total operating expenses. Charity care and health professional education each account for about one-third of community benefit expenditures, and mission-driven services accounted for 20 percent. However, many services considered mission driven could be counted as charity care (e.g., payments to physicians for services to hospitals' charity patients), which further complicates the understanding of how to categorize certain services. The balance of community benefit expenditures includes community health services, community-building activities, and the cost of operating the community benefit program.

Across the state of Maryland, hospitals differed greatly in the levels of community benefit expenditures reported, ranging from 1.2 percent of operating expenses to 14.1 percent. The higher percentage spending areas tended to be located in low-income areas where the need for charitable activities is greater.

The changes in community benefit expenditures and the variation across Maryland hospitals are the result of a number of complex factors. These include:

- Hospitals' ability to capture and report pertinent information;
- Hospitals' ability to finance or secure support for community benefit activities; and
- Hospitals' conceptions of their missions.

The complexity of the many factors influencing the type and level of community benefits provided by a hospital makes it difficult to assess the adequacy of hospitals' community benefit expenditures in response to community needs.

The Challenges of Defining Community Benefits

The reporting requirements set forth by the HSCRC presented many challenges as hospitals were asked to identify and capture activities and expenditures that previously had not be tracked. Catholic hospitals had the advantage of prior experience in responding to the Catholic Health Association's guidelines for community benefit accountability, while other hospitals faced significant difficulty in properly complying with the reporting requirements. Challenges reported by hospitals officials included the following:

- Relevant information resides among multiple sources, in varying formats, and is not defined uniformly or consistently within a hospital or across hospitals.
- What constitutes a reportable event may depend on context and often is subjective and variable depending on hospital type, as well as familiarity of staff with relevant activities.
- Charity care and bad debt may not be consistently categorized.
- Numerous activities fall along a scale of what should be reported and what could be reported.

The overarching theme from those interviewed was a concern that not all reportable activities were being captured; that some hospitals might be including some expenditures inappropriately, and that developing systems to capture all community benefit expenses was a difficult challenge. Even so, most hospital executives believed that the reporting requirement was beneficial on balance, increasing both hospitals' awareness of the topic and the public's understanding of hospitals' activities.

Approaches and Effects

Accounting versus Managerial Approaches to Community Benefit

Some hospitals' responses to the community benefit were limited to trying to respond to the reporting requirement, while other hospitals have processes in place to actively manage their community benefit expenditures. Those that took the managerial approach, as distinct from focusing only on reporting based on accounting figures, did things like including community benefit in strategic plans, assessing community needs, budgeting community benefit expenses, assigning responsibility, and evaluating results. Most of the hospitals in Maryland fall somewhere in the middle on the spectrum of those two approaches. Gray and Schlesinger concluded that reporting requirements push hospitals toward the managerial approach to community benefit.

The Effects of Community Benefit Reporting

Community benefit reporting requirements have effects, even when, as in Maryland, no rewards or penalties are attached. Because the reports are public, they may stimulate change in hospitals, particularly among those whose community benefit expenditures appear inadequate in comparison with others. Reviewing the information compiled about their own hospital may stimulate leaders to think differently about their community benefit expenditures and how they relate to the hospital's role in meeting community needs. As a result of reporting requirements, some local public health officials initiated discussions with hospitals about priorities in addressing community needs.

Lessons from Maryland

The experience with Maryland's community benefit reporting requirement provides some lessons regarding what to expect as hospitals across the country work to comply with the Internal Revenue Service's Schedule H community benefit reporting requirements:

Learning Curve – Many hospitals will experience a steep learning curve and may initially struggle with how to capture

needed information. Reportable activities may occur in virtually every department. Variations in what gets reported are likely as hospitals figure out how to track and report data and how to assure that there is a clear understanding within the hospital about what is and is not reportable as a community benefit expenditure.

Potential for Misunderstanding – Even though provided with guidance regarding definitions of what does and does not count, some hospitals may still struggle with certain categories and distinctions. Some activities that should be counted may be overlooked; others may be inappropriately included. Officials in Maryland hospitals believe that under-reporting is a much more significant problem than over-reporting.

Feedback Loop – As in Maryland, the reporting process will create feedback loops within hospitals, as officials make comparisons with other hospitals. However, in Maryland, hospitals received little praise or criticism from external sources based on their community benefit reports.

Variation – Required reporting on Schedule H about the amount and types of community benefit expenditures will reveal large variations among hospitals, likely prompting questions about why these differences exist.

Appropriate Targets – Threshold requirements have been proposed regarding charity care or, in some cases, other charitable activities, but variations in amounts expended by Maryland hospitals raise questions about whether uniform thresholds are feasible. A 5 percent charity care threshold, as has been proposed by the minority staff of the Senate Finance Committee, seems unrealistic. The all-payer rate setting system in Maryland builds charity care expenses into the rates that hospitals are paid, giving hospitals no incentive to avoid charity care patients. Even so, charity care averaged only 2.1 percent of hospitals' expenses in 2006, with only two hospitals exceeding 5 percent.

Revised Expectations – As data becomes public on what nonprofit hospitals actually spend on community benefits, public debate may grow regarding what constitutes a community benefit and whether threshold requirements should exist.

Benefits of Managerial Approach – Complying with Schedule H may stimulate more hospitals to adopt a managerial approach to conducting and tracking community benefits, potentially leading to more effective community benefit programs in hospitals.

Limitations of Expenditures as a Measure of Community Benefit. – The expenditure data captured in Maryland and on Schedule H is valuable, but expenditures are an imperfect measure because they do not capture the impact of community benefit activities. For example, certain community benefit activities may improve health status, reducing use of hospitals and the amount of charity care needed or provided. Outcome-based measures would be preferable to expenditure information for some community benefit activities.

Conclusion

The experience in Maryland suggests that hospitals will face significant challenges with the new IRS reporting requirements, but that such requirements are quite feasible and may have beneficial secondary effects. The quality of reporting will likely improve in subsequent years. The information that is reported, and the variations among hospitals that will be revealed, may lead to valuable and better informed discussions about the charitable responsibilities of nonprofit hospitals and nonprofit health care organizations more generally.

About the Author

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Endnotes

1 Gray, B. and M. Schlesinger. "The Accountability of Nonprofit Hospitals: Lessons from Maryland's Community Benefit Reporting Requirements." *Inquiry*, Vol. 46 No. 2, Summer 2009, 122-139.

2 Findings are drawn from Gray, B. and M. Schlesinger. "The Accountability of Nonprofit Hospitals: Lessons from Maryland's Community Benefit Reporting Requirements." *Inquiry*, Vol. 46 No. 2, Summer 2009, 122-139. and Gray, B. and M. Schlesinger. "Charitable Expectations of Nonprofit Hospital: Lessons from the Maryland Community Benefit Reporting Requirement." *Health Affairs*, Web Exclusive Vol. 28 No. 5, 23 July 2009, w809-w821.