

Hospital Community Benefit Program



The Hilltop Institute

analysis to advance the health of vulnerable populations

Hospital Community Benefits after the ACA: *Building on State Experience*

SUMMARY

PROGRAM BACKGROUND

The Hospital Community Benefit Program, established by The Hilltop Institute at the University of Maryland, Baltimore County (UMBC), is the central resource for state and local decision makers seeking to ensure that tax-exempt hospitals are responsive to community health needs. This encompasses identifying state and federal experiences and developing policy background and analysis useful to state community benefit policymakers.

The program's first issue brief explored the expanded regulatory framework for hospital community benefits established by the Affordable Care Act (ACA), outlined its new community benefit requirements, and explored the challenges and opportunities these requirements present to state policymakers as they reexamine state community benefit policies in order to evaluate nonprofit hospitals' existing exemptions from state and local taxation (Folkemer et al., 2010).

The program's second issue brief explores existing state community benefit requirements and practices, analyzing similarities and differences between these and the new federal framework, with focus on the following areas:

- Community Health Needs Assessment
- Financial Assistance, and Billing and Collection Practices
- Community Benefit Reporting and Oversight Strategies

This review of policies, laws, and regulations from selected states explores their varied approaches to aligning hospital community benefit activities with state and local public health goals. There is no requirement for states to adopt and implement the new federal community benefit standards. However, examples from the states illustrate a range of state policy decisions that may be useful in the interpretation of ACA §9007, as well as in state policymakers' consideration of their states' and local governments' options for enhancing the value that hospitals' community benefit activities afford to the communities they serve.

COMMUNITY HEALTH NEEDS ASSESSMENT

Defining the Community. The initial step in conducting a community health needs assessment (CHNA) is to identify the community to which it will be directed. The ACA requires that hospitals conduct CHNAs with the input of “persons who represent the broad interests *of the community served by the hospital facility*” (emphasis added), suggesting that a hospital’s CHNA should target its service area. The Catholic Health Association (CHA) views the hospital’s geographic service area as the starting point for community definition but recognizes that the scope of community assessment may extend more broadly to include areas of the greatest need. CHA identifies the following factors as relevant to a hospital’s identification of the community on which it focuses its CHNA:

- The hospital’s primary and secondary service areas
- Patient categories served by the hospital (e.g., the hospital’s general patient population or subsets of that population (e.g., children or individuals with disabilities))
- Geographic areas that are beyond the hospital’s traditional service boundaries (e.g., an area with concentrations of at-risk populations (e.g., those who are medically underserved or chronically ill))

A community benefit planning guide issued by California’s Office of Statewide Health Planning and Development recommends that hospitals define a community as a group of people with common features (place, identity, or experiences). Then, after needs assessment is completed and health priorities are identified, define more specifically the population to be targeted for community benefit interventions. Connecticut requires that hospitals opting to develop community benefit programs base them on an assessment of the needs and resources of targeted populations, “particularly low and middle-income, medically underserved populations” and those who experience barriers to health care access. Texas requires a “community-wide” assessment of the hospital’s primary geographic service area and patient categories for which the hospital provides health care services. In Massachusetts, hospitals must submit community benefit plans as a condition of original licensure, but established hospitals may choose to comply with the Attorney General’s voluntary community benefit guidelines. The guidelines suggest three approaches to defining a hospital’s community for purposes of CHNA: geographic (e.g., political boundaries), demographic (e.g., older adults or uninsured persons with low incomes), or health status (defining the community in terms of disease prevalence). As the foregoing discussion illustrates, the understanding of the “community” appropriately targeted for needs assessment varies greatly from state to state and hospital to hospital. In states without concrete legislative guidance, the absence of clear national standards in this area can frustrate hospitals’ attempts to appropriately focus their CHNA activities.

Community Involvement and Collaboration. A number of states, as well as the ACA, identify community input as an essential feature of meaningful needs assessment. The National Association of County and City Health Officers (NACCHO), the Association of State and Territorial Health Officers (ASTHO), and the National Public Health Performance Standards Program (NPHSP) recognize community needs assessment as an essential public health function and a responsibility of state and local health departments. Collaborative assessment among hospitals and public health agencies may fulfill the ACA requirement that hospital CHNAs take into account input from “individuals who represent the broad interests of the community ... including those with special knowledge of or expertise in public health.” Such partnerships can increase the efficiency and effectiveness of hospitals’ community benefit initiatives and leverage scarce public

resources for health departments' CHNAs with the private resources of nonprofit hospitals that must be allocated to CHNAs in order to comply with the ACA's requirements.

FINANCIAL ASSISTANCE, AND BILLING AND COLLECTION PRACTICES

The ACA requires tax-exempt hospitals to establish written financial assistance policies that are widely publicized and include a description of:

- The hospital's financial assistance eligibility criteria, including whether free or discounted care is available
- The basis for calculating patient charges
- How an individual may apply for financial assistance
- The hospital's potential actions in the event of nonpayment

Although the ACA does not mandate a minimum level of financial assistance, the Internal Revenue Service's (IRS's) revised Schedule H (Form 990) requires tax-exempt hospitals to report financial assistance policies and practices in effect in 2010 and subsequent tax years. In terms of billing and collection practices, the ACA prohibits tax-exempt hospitals from charging patients eligible for discounted care more than the generally billed rate. It also prohibits the use of gross charges and extraordinary collection practices.

Thirteen states and the District of Columbia mandate free care for patients unable to pay. Eighteen states and the District of Columbia have uniform standards for financial assistance eligibility, while seven states require hospital charges for uninsured patients to be based on sliding scales that reflect patient ability to pay. Only seven states impose limits on charges. Twenty states and the District of Columbia require hospitals to notify patients and the public about their financial assistance policies.

COMMUNITY BENEFIT REPORTING AND OVERSIGHT STRATEGIES

States may adopt community benefit reporting requirements as a tool for determining a hospital's qualification for either state nonprofit status or other policy-related purposes. A state may have mandatory (14 states), voluntary (20 states), or both types (10 states) of community benefit reporting requirements. This national variation is a product of each state's unique business, regulatory, and political climate.

Besides classifying state approaches to community benefit reporting as voluntary or mandatory, the following distinction may be helpful:

- *A process approach* (as adopted, e.g., in California) emphasizes periodic CHNAs and flexibility in the development of community health improvement initiatives. States that adopt a process approach typically do not impose a minimum community benefit threshold.
- *A prescriptive approach* (as adopted, e.g., in Texas, Maryland, and Indiana) requires more detailed information and may include minimum community benefit thresholds. More specific community benefit reporting categories can improve accountability.

States have established a variety of accountability mechanisms to ensure hospital compliance with community benefit requirements. Some states impose monetary penalties on hospitals that

fail to submit required reports in a timely manner (e.g., Texas, Indiana, and Maryland). States also may also require or encourage hospitals to evaluate the effectiveness and outcomes of their community benefit activities (e.g., California, Indiana, Maryland, Massachusetts, and Rhode Island).

CONCLUSION

States are paying significant attention to community health needs assessment, financial assistance and collection policies, and reporting requirements. Their work can inform the efforts of others to improve hospital accountability and better connect hospital community benefits with state health goals.

About The Hilltop Institute

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a nationally recognized policy and research center dedicated to improving the health and wellbeing of vulnerable populations. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations, and nonprofit organizations at the national, state, and local levels. 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 assure that tax-exempt hospital community benefit activities are more responsive to pressing community health needs. The program provides tools to state and local health departments, hospital regulators, legislators, revenue collection and budgeting agencies, and hospitals, as these stakeholders develop approaches that will best suit their communities and work toward a more accessible, coordinated, and effective community health system. The program is funded for three years through the generous sponsorship of the Robert Wood Johnson Foundation (www.rwjf.org) and the Kresge Foundation (www.kresge.org).



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