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analysis to advance the health of vulnerable populations

Hospital Community Benefits after the ACA: *The Emerging Federal Framework*

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Introduction

The Hospital Community Benefit Program, established by The Hilltop Institute at the University of Maryland, Baltimore County (UMBC), is the central resource created specifically for state and local decision makers who seek to ensure that tax-exempt hospital community benefit activities are more responsive to pressing community health needs. One of the program's initial activities is to publish a series of issue briefs on best practices, new laws and regulations, and study findings on community benefit activities and reporting.

This is the first issue brief in a series, funded by the Robert Wood Johnson Foundation, to be published over three years. It presents the emerging federal framework for hospital community benefits set forth by the Affordable Care Act (ACA).¹ This brief provides historical background on federal hospital community benefit policy; outlines the new requirements described in the ACA; and identifies new challenges and opportunities for state and federal decision makers as they begin to develop responses to the new federal requirements.

Hospital Community Benefits Policy: Background

Federal Policy. The first federal peacetime income tax expressly exempted “corporations, companies, or associations organized and conducted solely for charitable, religious, or educational purposes” (Wilson-Gorham

Tariff Act of 1894). Tax exemption for institutions dedicated to the pursuit of “charitable purposes” has been part of the United States’ income tax structure ever since (Arnsberger, Ludlum, Riley, & Stanton, 2009). The ratio-

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nale supporting this policy was that the government (or the public) is compensated for the potential but unclaimed tax revenues in two ways. First, nonprofits relieve the government of financial burdens that otherwise would be a public responsibility to be discharged at public cost. Second, in the case of hospitals, the public benefits from the “promotion of the general welfare” undertaken by these institutions (Gustafsson, 1996, p. 4). Public policy supporting the exchange of tax revenue for a nonprofit’s good works implies a public trust established for the purpose of generating public benefit.²

Charity care was first regulated at the federal level under the Hill-Burton Act in 1946.³ In exchange for grants funding construction and modernization of public and nonprofit hospitals, grantee facilities became obligated to provide free or discounted care to those who could not pay their hospital bills (Sullivan & Moore, 1990). However, in the absence of clear qualitative standards or effective enforcement, hospital noncompliance was widespread (Dowell, 1987). When Hill-Burton was amended in 1975, regulatory enforcement mechanisms were established. When it was amended in 1979, required levels of charity care were defined.

While Hill-Burton required charity care as a condition for grant funding, the provision of charity care was first introduced as a requirement for nonprofit hospitals’ federal tax exemption in 1956. That year, the Internal Revenue Service (IRS) issued a revenue ruling requiring nonprofit hospitals, as a condition of qualifying for and maintaining federal tax exemption, to provide as much charity care as they could afford.⁴ Thus, the initial federal standard governing tax-exemption was based on a hospital’s volume of charity care. In response to the enactment of Medi-

care and Medicaid in 1965, the IRS issued Revenue Ruling 69-545, which shifted the analysis of activity that would qualify a nonprofit hospital for federal tax exemption from charity care to “community benefits.” Because Medicare and Medicaid increased insurance coverage, hospitals were caring for fewer uninsured individuals and therefore rendering less uncompensated care. The new IRS ruling required nonprofit hospitals to provide “community benefits” to retain their federal tax-exemption, which broadened the scope beyond charity care to include activities that benefit the community as a whole. The ruling also indicated that tax-exempt nonprofit hospitals should be operated under a community board of trustees, and defined activities such as public health initiatives and health promotion as community benefits (Colombo, 2005).⁵

In the past decade, the adequacy of nonprofit hospitals’ community benefit activities has increasingly been the subject of congressional scrutiny. The Senate Finance Committee held two hearings covering federal tax exemptions on nonprofit hospitals: one on June 22, 2004 (Senate Finance Committee, 2004), and a second on September 13, 2006 (Senate Finance Committee, 2006). In addition, the Senate Finance Committee minority staff published two reports that resulted in an examination of community benefit requirements (Minority Staff, 2004 & 2007). The 110th Congress proposed that each hospital maintain and publicize its charity care program and report the percentage of total expenditures attributable to charity care (Lunder & Liu, 2009). In 2008, at the request of the Senate Finance Committee, the Government Accountability Office (GAO) conducted a study on the variation in state activity in the definition and application of community benefit requirements (GAO, 2008). This collec-

tive activity led to the redesign of federal tax Form 990, a long-established reporting form that tax-exempt organizations have been required to file to the IRS since 1950 (ACT, 2006).

In 2008, the IRS significantly revised Form 990 for the first time since 1979. The new Form 990 included a core form to be completed by all tax-exempt organizations, as well as schedules, depending on the organization's type and activities. The new Schedule H format for hospitals was derived from the Catholic Health Association's (CHA's) community benefit reporting standards, which require each CHA-affiliated hospital to report the number of persons receiving charity care and the proportion of the institution's operating expenses attributable to such care (Lunder & Liu, 2009). The American Hospital Association also developed guidelines, which included bad debt and Medicare payment shortfalls in addition to activities that are included in CHA's community benefit definition.

Schedule H was intended to "combat the lack of transparency surrounding the activities of tax-exempt organizations that provide hospital or medical care" (IRS, 2007, p. 1). Schedule H contains six parts (IRS, 2009):

- I. Charity Care and Certain Other Community Benefits at Cost
- II. Community Building Activities
- III. Bad Debt, Medicare, and Collection Practices
- IV. Management Companies and Joint Ventures
- V. Facility Information
- VI. Supplemental Information

These new reporting requirements were phased in: in tax year 2008, nonprofit hospi-

als were required to submit the revised Form 990 and Section V of Schedule H (describing facilities operated by the reporting institution); in tax year 2009, they were required to complete the entire Schedule H. Failure to comply could result in revocation of a hospital's federal tax-exempt status (GAO, 2008).

State Interpretation of Community

Benefits. Despite intense federal interest, neither Schedule H nor any IRS guidance has detailed the specific overall level or the specific composition of various forms of community benefits that a nonprofit hospital must provide in order to qualify for or maintain its tax-exempt status (CBO, 2006). In the absence of federal specificity, state and local governments, which separately confer significant tax exemptions (e.g., property tax, state and local income tax, and state and local sales tax), have taken various courses of action to clarify community benefit standards and their application to nonprofit hospitals for purposes of evaluating whether hospitals are entitled to exemption from various state and local taxes. States are not required to defer to federal tax-exemption standards: they may, in fact, develop their own. State approaches vary as to community benefit definition, populations to be served, and quantitative requirements.

Through their own legislative processes, 15 states have hospital community benefit requirements in law or regulation, and another 9 have established community benefit requirements through broader hospital licensure laws, interpretive attorney general guidelines, and property tax exemption standards (GAO, 2008).⁶ Since 1990, 16 laws requiring nonprofit hospitals to report their level of community benefits to the appropriate state agency in order to maintain their

state tax exemption have been enacted (Helinger, 2009). Overall, 14 states have mandatory community benefit reporting,⁷ 20 states (including the District of Columbia) have voluntary reporting requirements,⁸ and 10 states have both mandatory and voluntary reporting requirements⁹ (Catholic Health Association, 2010). Seven states have neither mandatory nor voluntary community benefit reporting requirements (Catholic Health Association, 2010).¹⁰

A 2010 decision of the Illinois Supreme Court, *Provena Covenant Medical Center v. Department of Revenue (Provena)*, spurred considerable discussion about community benefit policy. Rather than addressing the hospital system's community benefit responsibilities, the court's decision was based on a

state law concerning whether land owned by the hospital system qualified for an Illinois property tax exemption. The qualification turns on whether the property is owned by a charitable institution and whether the property is used "exclusively for charitable purposes," a standard markedly different than that of federal community benefit doctrine. *Provena* is nevertheless of interest. The plurality opinion included an insightful analysis of the extent to which a hospital's activities benefit its community and, conversely, of the benefits a hospital enjoys as the result of tax-exempt status. The opinion also discussed the nature of charitable activity and served as an example of a state approach to charitable tax exemption that developed independently of federal tax rules.

New Community Benefit Requirements of the ACA

Policy Framework. With nearly 50 million uninsured persons in the United States (Kaiser Commission on Medicaid and the Uninsured, 2010), the provision of charity care to hospital patients historically comprised a large portion of hospital community benefit activities. The ACA, signed into law on March 23, 2010, includes numerous coverage, subsidy, and penalty provisions that will effectively extend insurance coverage to almost all Americans when fully implemented in 2014. These provisions include the expansion of Medicaid to cover all individuals with incomes below 133 percent of the federal poverty level (FPL); an individual mandate for health insurance; the creation of state American Health Benefit Exchanges; new private insurance regulations; and penalties to certain large employers that do not offer insurance (Kaiser Family Foundation, 2010). As these provisions are implemented and additional insurance payments become avail-

able, hospitals will have fewer patients relying on charity care. To ensure that nonprofit hospitals continue to provide "community benefit," Section 9007 of the ACA sets forth a new set of requirements for hospitals seeking to maintain tax-exempt status.

These new provisions require nonprofit hospitals to 1) give increased attention to working with others to determine community health needs and take action to meet those needs and 2) implement financial assistance and billing and collection policies that protect consumers. The new requirements strengthen hospitals' obligation to collaborate with public health agencies, align patient payment requirements with patient financial capacity, advance community participation, and promote public knowledge about hospital practices. Each of the new requirements for tax exemption specified in the ACA are described below.

Community Health Needs Assessments.

As outlined above, the ACA requires non-profit tax-exempt hospitals to perform community health needs assessments at least every three years. These assessments must take into account input from persons who represent the broad interest of the community served by the hospital facility (ACA §9007). The results of the assessment must be made available to the public, and hospitals are further required to adopt implementation strategies to meet the needs identified (ACA §9007). The ACA does not, however, define community health needs assessment or specify the contents of or process for conducting one (Verité, 2010). The degree to which forthcoming regulations will add specificity to the community health needs assessment requirement will have significant implications for hospitals and policymakers. Extensive requirements may strain hospital resources, especially for small and critical access facilities (Verité, 2010). On the other hand, vague requirements will make it difficult to determine whether a hospital is in compliance (Verité, 2010). Further, the ACA offers no guidance on how to prioritize the needs identified by the assessment, other than requiring the consideration of input from the community that the hospital serves (Verité, 2010). Public health organizations have suggested that future regulations require the inclusion of local public health agencies in the hospitals' community health needs assessment process, due to their expertise in gathering community level data, working with partners, and developing health improvement plans (NAACHO, 2010; ASTHO, 2010).

Financial Assistance and Emergency Care Policies. According to Section 9007 of the ACA, nonprofit hospitals must establish a written financial assistance policy that includes:

- Eligibility criteria
- An indication of whether the policy includes free or discounted care
- The basis for calculating charges
- The method for applying for financial assistance
- With respect to hospitals that do not have separate billing and collections policies, a specification of the actions the organization may take in the event of nonpayment, including collection actions and credit agency reporting
- Measures to widely publicize the policy within the community served by the hospital

The ACA also mandates hospitals to have a written emergency medical care policy that requires the hospital to provide, on a nondiscriminatory basis, care for EMTALA¹¹-defined emergency medical conditions, regardless of a patient's eligibility for the financial assistance policy (ACA §9007). However, the ACA provides no guidance for implementing these requirements. For example, the ACA does not define key terms used in the standards, such as the "community served by the hospital" or "widely publicized" (Verité, 2010).

Limits on Charges, Billing, and Collection Activities. The ACA limits billing, collection actions, and charges directed to uninsured individuals. Hospitals may not engage in extraordinary collection actions before making reasonable efforts to determine eligibility for financial assistance. Further, hospitals may not charge individuals eligible for financial assistance more than they would charge individuals with insurance for the same care. Gross charges are also prohibited (ACA §9007). "Extraordinary collection actions," however, is another key term that the ACA neglects to define (Verité, 2010).

The ACA includes new reporting provisions for enforcement of these requirements. Hospitals are required to report the following to the IRS: the results of the community health needs assessment, an implementation plan to meet the needs identified by the assessment, a description of how the hospital is meeting those needs, and an explanation of why any identified needs are not being addressed (ACA §9007). Hospitals must also submit audited financial statements. These new reporting requirements are in addition to the pre-existing requirements of Form 990 and Schedule H. Hospitals that fail to comply with the new reporting requirements are subject to an excise tax penalty of \$50,000 and the loss of their federal tax exemption. The U.S. Department of the Treasury is charged with reviewing a hospital's community benefit activities every three years and, in consultation with the Department of Health and Human Services (HHS), is also required to

provide an annual report and trend study on charity care, bad debt collections, and reimbursement shortfalls associated with Medicare and Medicaid payment rates (ACA §9007).

In addition to the interpretive uncertainties outlined above, many other important concepts within the law will require additional definition, and hospitals will need guidance to implement ACA requirements in a manner consistent with the law's nuances. For example, the law does not specify "whether [its] requirements apply to 'hospital organizations' as a whole ... or only to activities of 'hospital facilities'" (Verité, 2010, p. 1). In May 2010, the IRS requested that public comments inform its promulgation of regulations implementing Section 9007 of the ACA. Other federal agencies, such as the Centers for Disease Control and Prevention, may provide additional input on the regulatory framework.

The ACA Community Benefit Framework: New State Opportunities and Challenges

The ACA requirements now provide a federal template for hospital community benefit accountability. The national framework requires collaborative community health planning; mandates more transparent financial assistance and collections policies; and refines existing rules for consistent reporting of community benefit activities. For state and local governments, the issue will become whether (and to what extent) these governments will incorporate this federal framework into state and local laws and policy in order to evaluate ongoing exemptions from state and local taxation.

Moreover, as the federal framework is refined through regulations and practices, state

experience in community benefit policy can provide guidance to the federal government and inform federal activity in oversight and regulation. Many state governments have given significant legislative and regulatory attention to this issue. While there is a great deal of variation in these laws (Hellinger, 2009), state approaches to community needs assessment, development and implementation of community health plans, and financial assistance policies can help inform federal policymaking.

A recent examination of state mandates related to community health needs assessment and implementation strategies found laws mandating community needs assessment

processes in 12 states (Catholic Health Association, 2010).¹² A few of these laws require a focus on vulnerable populations or give priority to public health needs. It may be useful for other states to review the implementation experience of states that already have addressed these issues in legislation. Other ACA requirements related to needs assessment and plan implementation are included in statutes in effect in one or more of the 12 states referenced above, including public disclosure of hospitals' community benefit plans and mechanisms to evaluate plan effectiveness.

As community benefit policy moves forward within the new federal framework, states and localities will need to consider reconciling existing state policies with the new federal requirements, as well as the possibility of independently instituting state tax exemption standards that go beyond those applicable to federal tax exemption. Vulnerable populations and their needs differ substantially from one community to another, and state and local leadership will be important in channeling community benefit efforts appropriately.

As states and localities weave together various strands of policy activity, they will be confronted by a range of issues, discussed below.

How can states and localities ensure that community needs assessments identify the right set of problems in communities? Federal law requires needs assessments to take into account “the broad interests of the community served by the hospital” (ACA §9007). Additional attention by states may be necessary to ensure accurate identification and prioritization of community-specific health needs.

How can states and localities ensure development of responsive community health implementation plans? Federal law requires hospitals to report how they are “addressing needs identified [by their] community health needs assessment” and to provide a “description of any such needs that are not being addressed together with the reasons ...” (ACA §9007). This may afford states an opportunity to provide additional guidance supportive of broad-based decision-making to prioritize identified community health needs.

What strategies can states and localities adopt to ensure that public health agencies, community stakeholders, and hospitals tackle problems in a collaborative and coordinated way? Public health agencies are integrally connected with hospital community benefit planning in some communities, but less so in others. How can states and localities ensure a tighter connection?

What policies can states adopt to ensure that community benefit implementation activities are effective at meeting community needs? What evaluative mechanisms can states adopt to measure success over time and to reshape activities that are less effective?

What strategies can better align hospital policies across a community or state? Will more consistent financial aid and collections policies among hospitals lead to improved access to care and better community health?

These and other questions will require attention as states and localities consider how to maintain their independent interests in community benefit accountability within the new federal framework.

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 herein referred to as the Affordable Care Act (ACA).

² Rev. Rul. 56-185, 1956-1 C.B. 202, relying in part on *Helvering v. Bliss*, 293 U.S. 144 (1934). For a discussion of historical development of the common law “public trust” doctrine, see Gustafsson, 1996, p. 593ff.

³ Hospital Survey and Construction Act, 60 Stat. 1040 (1946).

⁴ Rev. Ruling 56-185, 1956-1 C.B. 202.

⁵ Rev. Rul. 69-545, 1969-2 C.B. 117.

⁶ The 15 states identified by GAO as having community benefit laws or regulations are AL, CA, CO, ID, IL, IN, MD, MI, ND, NH, NY, PA, TX, WV, and WY. The nine states with provisions in other laws or guidance are CT, GA, MA, MN, NM, NV, OR, RI, and UT.

⁷ The 14 states with mandatory community benefit reporting are AL, CA, IL, MD, MS, ND, NH, NM, NV, PA, RI, TX, UT, and WV.

⁸ The 20 states that have voluntary community benefit reporting are AK, CO, DE, DC, FL, HI, IA, KS, KY, MA, MI, MO, MT, NE, NJ, OH, OK, SC, TN, and WA.

⁹ The 10 states that have mandatory and voluntary community benefit reporting are CT, GA, IN, ID, MN, NC, NY, OR, VA, and WI.

¹⁰ The 7 states with no hospital community benefit reporting requirements are AR, AZ, LA, ME, SD, VT, and WY.

¹¹ The Emergency Medical Treatment and Active Labor Act (EMTALA), §1867 of the Social Security Act (42 U.S.C. 1395dd).

¹² The 12 states with laws mandating community needs assessment processes are CA, CT, ID, IL, IN, MA, MD, NH, NY, RI, TX, and UT.

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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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