



Community Benefit Contributions and Reporting: *Emerging Standards Present an Opportunity for the U.S. Nonprofit Hospital Sector to Articulate Benefits Clearly and with a Unified Voice*

Introduction

As the economic downturn deepens and state and national budget deficits reach unprecedented levels, government, media and community leaders increasingly are asking whether U.S. nonprofit hospitals and health systems provide benefits sufficient to justify their tax-exempt status. Senate Finance Committee hearings on the subject chaired by Senator Charles Grassley (R-Iowa), state legislative proposals and new Internal Revenue Service (IRS) community benefit reporting requirements all have increased scrutiny of this area. Media coverage also has heightened public and policymaker interest in this issue, though these articles all too often provide a skewed and incomplete view of the topic. At the same time, exposés of financial and accounting irregularities are calling into question the veracity of financial reporting at all levels. Thus community benefits, once the sole purview of marketers and tax departments, are now subject to scrutiny as never before.

This paper explores the topic of community benefits provided by the nation's nonprofit healthcare organizations. It examines related questions such as:

- What level of community benefit is being provided currently by nonprofit hospitals and health systems?
- What is the emerging standard for community benefit contribution that U.S. nonprofit hospitals and health systems must be prepared to meet?
- How should community benefit contributions be quantified and reported?
- What controls and procedures are warranted to ensure that the reporting is disciplined, credible and capable of standing up to scrutiny in the future?

Leaders of healthcare provider organizations across the nation struggle to articulate the substantial benefits their

organizations provide to the communities they serve in a compelling, understandable manner.^{1,2,3} Differences in how organizations account for and report community benefits have contributed to the skepticism of industry onlookers. Many of the more sophisticated nonprofit healthcare provider organizations have evolved from systems of hospitals into hybrid organizations that may include academic/educational and research components, insurance products and/or other business ventures. While these business extensions are intended to solidify health system revenue streams in response to declining reimbursement, they often complicate the community contribution picture and raise additional questions as follows:

- How should one account for the substantial teaching and research investments made by major teaching hospitals and academic medical centers (AMCs)? Such institutions support their nonprofit medical schools and contribute to their regional economies in ways that extend beyond direct patient care.
- How should the community benefits provided by organizations that serve as both healthcare providers and health insurers be quantified? Such organizations have broader missions and offer a wider portfolio of services and benefits to the communities they serve. Their community contributions also should be measured and reported in a consistent manner.

Background and Political Climate

The origins of healthcare community benefit contributions lie in the early twentieth century when the nation's first hospitals were founded as charitable organizations providing healthcare to the poor at no cost or for a nominal charge. As hospitals grew and began to offer a sophisticated array of diagnostic and treatment services, they became

the location of choice for patients of all socioeconomic levels. Most hospitals evolved into tax-exempt organizations under which they collected payments for services like traditional businesses while continuing to serve as a social safety net. Such nonprofit hospitals qualify under the IRS code as charitable organizations and are exempt from federal and, typically, state and local taxes.

Over time, the IRS definition for how hospitals qualify for tax-exempt status has changed. Originally, providing charity care at a level equal to approximately 5% of net patient service revenue qualified a hospital for tax-exempt status. In 1969, the IRS implemented an evaluative standard after the creation of the Medicare and Medicaid programs. Current tests for tax exemption include requirements such as whether an organization reinvests in facility improvements or has a community-based Board of Directors. No current federal guidelines prescribe a specific threshold of benefit, with the IRS instead “considering the relevant facts and circumstances” in any audit of tax-exempt status.⁴

How Much Community Benefit Should Nonprofit Hospitals Provide?

In the absence of specific federal standards, some states have legislated levels of community benefit necessary to maintain state tax-exempt status. State statutes often require levels of benefit similar to the economic value of the organization’s tax exemption. For example, Texas law and Rhode Island and Illinois proposals stipulate that hospitals must provide benefits equal to 3-5% of the greater of net operating revenues or total expenses; they also require hospitals to have written charity care policies and plans for serving the community and the uninsured. Other states, such as California, Massachusetts and Pennsylvania, have mandated community benefit reporting guidelines.

After holding hearings in September 2006, the Senate Finance Committee issued a Staff Discussion Document in July 2007, proposing, among other things, that 5% of annual operating expense or net revenue be spent on charity care to maintain tax-exempt status.⁵ Despite the intense interest in this subject, definitions and reporting methodologies are yet to be clearly defined and the application of charity care guidelines remains uneven and confusing at best. Most nonprofit healthcare organizations report community benefit as a percentage of net patient revenue in an effort to objectively quantify their contribution.⁶ This is the

same measure used by the new IRS guidelines presented in IRS Form 990 Schedule H. The Chartis Group recently conducted an analysis of the community benefit reporting of the *U.S. News & World Report’s* Top 20 Hospitals for 2007 and found that over 80% of them report at least 5% in total community benefit when the new IRS guidelines are applied. Separately, the Congressional Budget Office concluded that in aggregate, nonprofit hospitals’ uncompensated care costs total to 4.7% of operating expenses; this suggests that with other types of community benefit included, nonprofit hospitals generally meet or exceed the 5% test.^{7,8}

Defining and Quantifying Community Benefit in a Consistent Manner Is Important

Culture, local needs, quality of reporting, and success with financial assistance programs all lead to variability in community benefit reporting. Most nonprofit hospitals do provide substantial community benefits at levels equal to or greater than their tax exempt status; however, the hospital industry is inconsistent in its quantification and reporting, leading to a lack of credibility and a reduced ability to clearly demonstrate the substantial benefit provided.⁹ For example, some hospitals measure charity care based on charges as opposed to calculated costs, and shortfalls in payments by various government programs are handled in different ways, with the result that the boundary between bad debt and charity care is often unclear. Many patients who might qualify for charity care fail to provide the necessary documentation and are therefore classified as “bad debt” along with other services for which the hospital expected but was unable to secure payment. For this reason, charity care too often provides a limited view of community benefit; hospitals need to engage patients prospectively using consumer-friendly forms and processes to ensure that all patients who can qualify for coverage are, in fact, signed up.

Over the past several years, the Catholic Health Association (CHA) in cooperation with the Voluntary Hospitals of America (VHA, Inc.), have established the industry’s first widely distributed and standardized approach to recognizing and reporting community benefit.¹⁰ Increasingly, CHA’s recommended methodologies for reporting community benefit are being adopted and utilized by other organizations. In addition, the Healthcare Financial Management Association (HFMA) has developed specific accounting guidelines for differentiating charity care from bad debt.¹¹

The new IRS reporting requirements announced in December 2007 for Form 990 Section H are based on the CHA and HFMA guidelines; these emerging standards are fast becoming a key driver of increased adoption of the CHA and HFMA standards. The new reporting was optional in 2008 but is required for 2009. Ultimately, moving toward a standardized and defensible methodology for the quantification and articulation of community benefit will serve the industry well because the methodology will make it easier for broader constituencies to understand and appreciate all that nonprofit hospitals do to support their missions and communities.

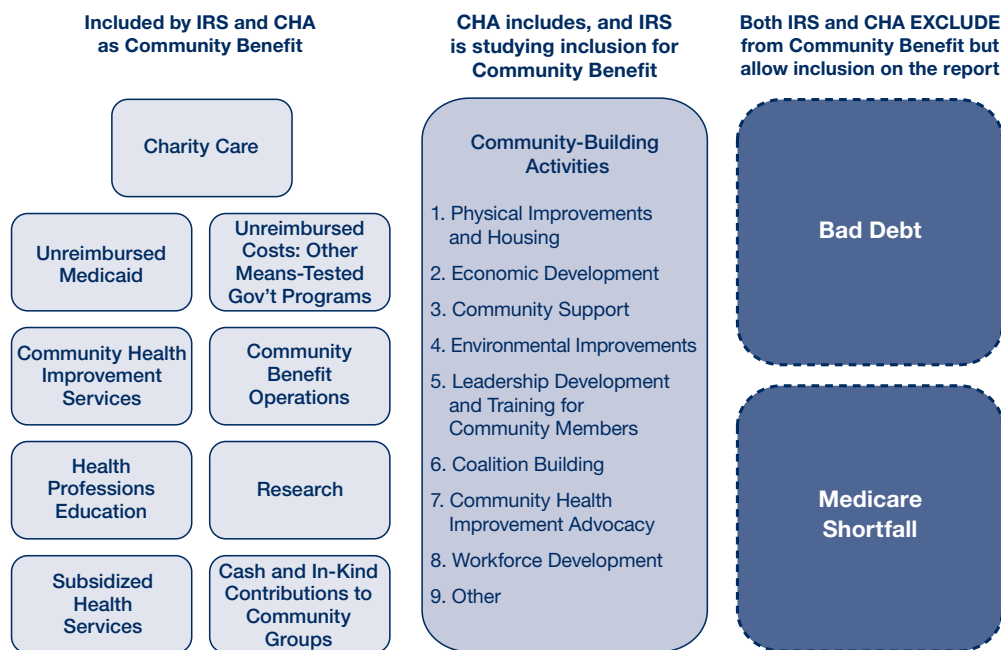
Below is a diagram showing, at left, the categories of community benefit expenditure that are included in the IRS reporting guidelines and the CHA definition of community benefit. The middle category lists additional categories of benefit that CHA includes and that the IRS is still studying for potential future inclusion under the category of community benefit. Both categories listed at right, Bad Debt and Medicare Shortfall, are excluded from the IRS and CHA definitions of community benefit that may be included or mentioned in an institution's community benefit report.

The definitions of each category of expenditure are shaped primarily by the CHA guidelines. The categories

included in the IRS definition encompass many aspects of direct community benefit, from providing subsidized and free charity care, to un-reimbursed Medicaid expenses, to spending on community health improvement. The middle category of benefits, including activities or forms of funding not yet allowable by the IRS, can be considered to be of less direct benefit to specific individuals but still beneficial to the community at large.

Among the excluded items at right, bad debt is the more controversial item because many organizations still include this in their reporting of community benefit. Such organizations maintain that a high proportion of bad debt derives from patients who are not able to pay for services and that the provision of such services at a loss constitutes a form of community benefit. While this position may be defensible in concept, the IRS, HFMA and CHA all argue that accounting for charity care vs. bad debt should be rigorous and tied back to a clearly defined charity care policy at each organization. They maintain that bad debt should consist solely of write-offs on care for which the organization expected to be paid. Most organizations are challenged in their efforts to cleanly differentiate between these two categories because a major portion of bad debt is considered to be free or discounted care that was provided at a direct cost to the institution.

Categories of Community Benefit Using New IRS Reporting Framework



Shortfalls on services provided to patients reimbursed by Medicare are not considered "community benefit" since the government takes the perspective that Medicare is an attractive payer in many markets and that prospective payment was designed to make facilities more efficient. This is a challenging argument since many providers—especially those with longer lengths of stay—lose money on care provided to Medicare patients. Some specific program losses can be included under the category of "subsidized health services" to the extent that providers are able to demonstrate that they provide these programs at a loss after separately accounting for charity care and bad debt.

What's Been Missing from the Debate: Unique Benefits Provided by Nonprofit AMCs and Integrated Healthcare Organizations

The community benefit debate has been framed largely from the perspective of community hospitals or health systems. Consequently, available definitions and reporting requirements have focused mostly on health-related programs and patient care services and less so on other types of community benefit that more diverse healthcare organizations provide. The two types of organizations not generally addressed as completely on these topics as they might be included the following:

1. **Academic Medical Centers (AMCs)** that are primary teaching affiliates of a medical school with a major component of their mission oriented to teaching and research. This category of institutions includes major teaching hospitals though the level of activity and investment in their academic missions is generally considerably less than it is for hospitals serving as primary teaching affiliates.
2. **Integrated delivery systems** or organizations that include employed physicians and/or a health plan as part of their organization.

Academic Medical Centers

The AMC category includes more than 125 institutions that are frequently the largest and most clinically sophisticated providers in their communities. Many AMCs provide substantial charity care and subsidized services to the extent that they function as safety net institutions in economically disadvantaged inner-city and urban areas. AMCs also offer programs and services that are essential to their educational and academic missions but very costly to provide, such as major trauma programs.¹² AMCs also differ from traditional community hospitals in that many provide unique forms of community benefit through their university relationships. To further complicate the picture, some AMCs are owned by a university, and others conduct their own research—as opposed to providing direct investment support to their academic affiliates.

The Chartis Group recently completed an independent review and evaluation of community benefit programs and activities with the University of Pittsburgh Medical Center (UPMC). UPMC is a highly integrated, nonprofit health system that, in addition to operating an expansive provider network with 20 academic, community and regional hos-

pitals, also operates an insurance services division, has international and commercial services capabilities, and is closely affiliated with the University of Pittsburgh. The Chartis Group assessment was commissioned as part of a broader effort by UPMC to audit existing community benefit contributions and processes, to ensure that a disciplined and consistent model for collection is in place, and to implement best-practice approaches to reporting on community benefit activities.

As part of this engagement, The Chartis Group analyzed the community benefit contributions of the *U.S. News & World Report's* Top 20 Hospitals for 2007, all of which are AMCs. The Chartis Group found that there is significant variability both in how community benefits are reported among the top 20 institutions (particularly around the academic mission) and in the magnitude of those contributions relative to patient revenue. To standardize the available information, The Chartis Group analysis applied the CHA guidelines and included any research and education benefits that were reported. Total community benefit as a percent of patient revenue for the top 20 institutions ranged from 2.5% to 12.8%; however, only half of the institutions reported any benefit from education and/or research. Among those that did, there was little consistency in what was included in the quantification. Four of the organizations studied attempted to report in a significant manner on their educational and research investments as part of their community benefit reporting. For those AMCs (Mayo Clinic, Cleveland Clinic, University of Michigan Medical Center, and Partners Healthcare), education and research made up nearly half of their reported community benefit, but each institution quantified and reported benefits differently.

As part of its work with UPMC, The Chartis Group developed for their consideration guidelines for quantifying education and research community benefits. In late 2008, after the engagement was completed, the IRS released more detailed Schedule H (Form 990) reporting guidelines that have incorporated rules on the quantification of education and research missions for hospitals. These guidelines have been reviewed and compared to guidelines developed by The Chartis Group. They are generally consistent and provide a starting point for the broader AMC community to more consistently quantify and articulate the academic benefits provided.

The latest IRS guidelines for community benefit reporting were applied to quantify the community benefit provided by UPMC. For 2007, UPMC was found to provide nearly \$500

million in qualified community contributions, including \$139 million in uncompensated care, \$71 million in community programs and donations, and \$237 million in support for research and education of health professionals.

Integrated Delivery Systems

Integrated delivery organizations with health plans and/or employed physicians also have difficulty measuring community benefit using the same guidelines as a community hospital. For example, the definitions of charity care and financial assistance are blurred since these organizations can offer discounted or free access to health plan services that are separate from charity care services provided through the hospital. Organizations that employ physicians may also provide free and discounted medical services through their physicians. Examples of diverse providers with large health plans include Kaiser Permanente (the largest of the U.S. integrated delivery providers), Geisinger, UPMC, and Health Partners in Minnesota.

The methodology employed by each healthcare provider organization to quantify and report their community benefit contributions should reflect the organization's unique characteristics. Integrated organizations like Kaiser are wise to report subsidized health plan memberships and services, whether free or discounted, based on the enrollee's ability to pay in a manner similar to how hospitals account for charity care. Community benefit programs that are directly funded or sponsored and are oriented to improvement of health (including the provision of a specific service for free or at a discount) should be incorporated. This should include health education or health promotion activities as well as cash and in-kind contributions to community groups. Activities that can be construed as promotional or marketing related should be excluded in our view.

The standard approach to reporting community benefits as a percent of net patient revenue is complicated for integrated delivery organizations because of the diversity of their revenue sources. Community benefit for these organizations should, in our view, be quantified in a manner that adjusts for revenues tied to various component parts of the organization. For example, organizations could separately report benefits for their direct care vs. health plan components as a percent of the associated revenue.

For some highly integrated organizations like Kaiser Permanente, this is not a straightforward analysis because a major portion of the healthcare services provided are paid through member fees while some facilities also provide services to non-members. One possible approach to address this issue is to measure the integrated revenues from services and membership fees; however, such an approach can be challenging to appropriately account for and is likely to create comparability issues with other institutions. An alternative approach would be to measure community benefit as a percentage of net income. This requires further study and consideration.

Summary Discussion

The move by the IRS to standardize the reporting of community benefit will ultimately benefit the industry to the extent that the substantial community benefits provided by the nonprofit hospital sector are better understood and more widely recognized. In fact, in early 2009, the IRS released a compliance project report which indicates that hospitals surveyed on average spend 9% of net revenues on community benefit.¹³ This new reporting process will be helpful for the industry and needs to be incorporated into the broader community benefit reporting of organizations.

The discussion of what "qualifies" as community benefit reporting is not complete. Many tangible and intangible benefits can be identified that have not yet been fully considered. For example, UPMC spends more than \$2 million annually to assist patients in obtaining coverage for which they are eligible, but this cost is not recognized or reported as a community benefit. Further, many organizations have historically under-reported community benefit, and the focus on charity care is limited and misses important aspects of many hospitals' charitable mission. Our research indicates that organizations that mobilize their leadership teams around defined community benefit strategies can enhance the impact of the benefits they provide while ensuring that their contributions are appropriately recognized.

It is important to keep in mind that the capital generated by nonprofit organizations is not passed on to shareholders or investors. Rather, as these organizations invest in themselves, they are investing in the diverse communities they serve.

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About The Chartis Group

The Chartis Group is an advisory services firm that provides management consulting and applied research to leading healthcare organizations. The firm is comprised of uniquely experienced senior healthcare professionals and consultants who apply a distinctive knowledge of healthcare economics, markets, and organizational dynamics to help clients achieve unequaled results.

Boston

60 State Street
Suite 700
Boston, MA 02109

Chicago

203 North LaSalle Street
Suite 2100
Chicago, IL 60601

New York

140 Broadway
46th Floor
New York, NY 10005

San Francisco

One Market Street
36th Floor
San Francisco, CA 94105

1.877.667.4700

www.chartis.com