

Critical Access Hospitals' Community Benefit Activities: An Updated Review

**Flex Monitoring Team
Briefing Paper #40
December 2018**

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HIGHLIGHTS

- Over 94 percent of community benefit expenditures for the study Critical Access Hospitals (CAHs) was for direct patient care activities, compared to less than 6 percent for community-focused (e.g., community education or health improvement) activities.
- Total community benefit spending among the study CAHs represented 8.4 percent of total hospital expenses; this was slightly higher than in previous studies.
- Although nearly two-thirds of the study CAHs reported spending for community building activities, the level of spending was less than 1 percent of total hospital expenses.¹
- Despite written financial, billing, and collection policies and efforts to publicize the availability of financial assistance to low income and uninsured patients, CAHs indicated high levels of bad debt suggesting they are not reaching patients eligible for financial assistance under their Financial Assistance Policies.
- Although the hospitals' financial assistance, billing, and collection policies align with IRS requirements, CAHs appear to need technical assistance in areas related to how they set the maximum amounts charged to patients eligible for financial assistance and how they identify and qualify these individuals for financial support.
- State Flex programs can be a valuable source of technical assistance to improve CAH community benefit performance and better align their policies with the Affordable Care Act-mandated changes to the IRS tax code for financial assistance, billing, and collection practices.

INTRODUCTION

The Medicare Rural Hospital Flexibility (Flex) Program supports the development of local systems of care with Critical Access Hospitals (CAHs) as the hubs, and the development of initiatives to address local population health priorities.¹ This view of CAHs as central resources in rural health systems is consistent with the Internal Revenue Services' (IRS) ongoing efforts to hold tax-exempt (501(c)3) hospitals, including tax-exempt CAHs, accountable for addressing the unmet needs of their communities through implementation of the IRS' community benefit reporting framework in 2007 and the Affordable Care Act (ACA)-mandated community

¹Community building activities are a category of hospital expenditures captured on *Form 990*, Schedule H, Part II which focus on upstream factors (social determinants) that influence health as opposed to IRS-defined community benefit activities that focus on the medical determinants of health. Although the IRS does not currently treat community building expenditures as a community benefit, it is monitoring this area of hospital spending to determine if they should be classified as such in the future. Community building expenditures, as discussed in this briefing paper, are not included in the category of expenditures that we have classified as community-focused community benefits.

health needs assessment (CHNA) and financial assistance requirements.^{2,3} Many community benefit and hospital experts view these regulatory requirements as an opportunity to encourage tax-exempt hospitals to leverage their spending in these areas to improve the health of their communities.³⁻⁹

This brief examines community benefit data from the *IRS Form 990, Return of Organization Exempt from Income Tax* filings for a sample of 50 tax-exempt CAHs to understand how these hospitals are fulfilling their community benefit obligations and to describe the composition of their community benefit spending patterns. This brief updates the Flex Monitoring Team's (FMT) prior study of the community benefit activities of CAHs and identifies opportunities for CAHs to strengthen their portfolio and reporting of community benefit activities. It also discusses how state Flex programs can support CAHs in meeting their community benefit obligations and address potential gaps in their compliance with the ACA-mandated CHNA financial assistance and billing requirements.

BACKGROUND

The IRS' 2007 revisions to *Form 990* and the 2010 ACA-mandated changes to the tax code requiring tax-exempt hospitals to conduct triennial CHNAs and implement written financial assistance and billing policies are the latest iterations in federal policy focused on the extent to which tax-exempt hospitals are returning benefits to the community in exchange for the tax benefits they receive.³⁻⁵ The IRS' 2007 revisions to *Form 990* (which became effective for tax year 2009) added Schedule H (Hospitals) to *Form 990* to capture data on a defined set of hospital community benefit programs and services that provide treatment and/or promote health and healing in response to identified community needs.¹⁰ The IRS retained its historical focus on the provision of charity care in its community benefit framework and added sections to capture data on the uncompensated cost of Medicaid and other means tested government programs; health professions education; research; community health improvement services;ⁱⁱ community benefits operations;ⁱⁱⁱ subsidized health services; and cash and in-kind services donated to community organizations or to the community at large for community benefit purposes.¹¹ The goal is to enable the public and policymakers to compare the dollar value of the costs (not charges) of the benefits (as defined by the IRS community benefit framework) returned by hospitals to their communities to the tax benefits the hospitals receive.

Schedule H also captures data on community building activities, which focus on upstream factors (social determinants) that influence health as opposed to more traditional community benefit activities that focus on the medical determinants of health (e.g., charity and subsidized care, health fairs, or screening programs). Community building activities may include physical improvements and housing, economic development, community support, environmental improvements, leadership development and training for community members, coalition building, community health improvement advocacy, workforce development, and other activities.^{10,11} The

ⁱⁱCommunity health improvement services include health education; community-based clinical services for uninsured persons; support groups; support services; self-help programs; chaplaincy, spiritual care, and pastoral outreach programs; and community health initiatives addressing specific health targets and goals.

ⁱⁱⁱCommunity benefit operations include the costs of staff assigned to community benefit activities, conducting CHNAs, and other costs (including overhead) associated with community benefit strategies and operations.

IRS will evaluate the community building data over time to determine if these activities should be formally counted as a community benefit.

Subsequent to the implementation of the IRS' community benefit reporting requirements, the ACA added the following new accountability requirements for tax-exempt hospitals:

1. Conduct a CHNA every three years and adopt an implementation plan to address identified needs (effective for tax years beginning after March 23, 2012)
2. Establish written financial assistance and emergency care policies (effective March 23, 2010)
3. Limit amounts charged for emergency and other medically necessary care to patients eligible for financial assistance based on the hospital's written policies (effective March 23, 2010)
4. Make good faith efforts to determine eligibility under the hospital's financial assistance policies prior to pursuing aggressive collection action against the patient (effective March 23, 2010)¹²

These new requirements responded to two ongoing concerns regarding the community benefit activities of tax-exempt hospitals. The first involved the lack of transparency in how hospitals make decisions regarding their community benefit activities.¹³ The second involved the inconsistency in the application of hospital charity care policies, the lack of transparency on hospital billing and collection practices, and concerns about the treatment of low income patients. The IRS updated *Form 990*, Schedule H to capture information on the extent to which hospital are complying with these requirements.

METHODS

The goals of this project were to examine the alignment between the IRS *Form 990*, Schedule H filings, CHNA reports, and implementation plans for a random sample of 50 tax-exempt CAHs; better understand their community spending and activities; and explore the extent to which CAHs are using their community benefit reports, CHNAs, and implementation plans to inform their population health strategies and activities. This is the second of two briefs summarizing the results of this project. The first brief, [*Critical Access Hospitals' Community Health Needs Assessments and Implementation Plans: How Do They Align?*](#)¹⁴ examines how CAHs are using the CHNA process and information to address community needs. This brief addresses the following questions:

- What is the composition of community benefit spending and activities of our study CAHs?
- To what extent are these hospitals participating in community building activities?
- How are these hospitals addressing the ACA-mandated financial assistance, billing and collection, and emergency care requirements?

Using the universe of 707 nonprofit CAHs, we generated a random sample of 50 tax-exempt CAHs that filed *Form 990s* alone rather than as part of a system. We specifically identified and excluded hospitals that filed their *Form 990s* as part of a system.^{iv} IRS filing due dates are based on each hospital's fiscal year and must be filed by the 15th day of the fifth month following the close of the hospital's fiscal year.¹⁵ Once submitted, the *Form 990* filing is reviewed and approved by the IRS and it may take 12 to 18 months before it becomes available to the public through the IRS or through websites such as Guidestar, the Foundation Center, the Economic Research Institute, or Pro Publica.¹⁶ We downloaded the *Form 990* filings for the 50 CAHs from Guidestar. Our database contained *Form 990* filings for tax years 2012 (4 CAHs), 2013 (41 CAHs), and 2014 (5 CAHs) based on the close of their fiscal years. We transcribed the relevant financial data from the *Form 990s* into a Microsoft Excel database for analysis. We analyzed *Form 990*, Schedule H data for the 50 sample hospitals, generating means and counts for the indicators discussed and shown in the tables below.

Analysis of the IRS Form 990, Schedule H Data

Financial Assistance, Means-Tested Government Programs, and Other Community Benefits

CAHs in our study reported total community benefit activity costs of 8.4 percent of hospital expenses (Table 1). The subtotal of community benefit expenses for direct patient care activities account for slightly over 94 percent of the overall community benefit expenditures by our study CAHs (7.9 percent of total hospital expenses). In comparison, the subtotal of community benefit expenses for community-focused activities account for approximately 6 percent of the study CAHs' community benefit expenditures (0.51 percent of total hospital expenses). As discussed earlier, community-focused activities represent our categorization of allowable activities under the IRS community benefit framework to distinguish activities that benefit individual patients (e.g. charity care, unreimbursed costs of Medicaid, or subsidized care) from those that benefit the broader community (e.g., community health improvement, research, or health professions education). They differ from the category of hospital expenditures for community-building activities that address the social determinants of health (as discussed in the next section).

The overall community benefit spending level for the study hospitals (8.4 percent) was somewhat higher than in our earlier study of 2009 CAH community benefit spending (7.0 percent of total hospital expenses), although the distribution of community benefit spending among study hospitals was relatively consistent with our earlier study.¹¹ In 2009, direct patient care accounted for 93 percent of total community benefit compared to 94 percent in this study. Community focused activities accounted for 7.0 percent of total community benefit spending in 2009 compared to 6.0 percent in this study.¹¹

Prior studies of hospital community benefit performance provide a context for understanding the current community benefit spending of the study hospitals. Analysis of Schedule H data

^{iv}To obtain a list of study hospitals, we generated a randomly ordered list of the 707 tax-exempt CAHs. We downloaded each *Form 990* starting at the beginning of the list using an iterative process. As we reviewed each *Form 990*, we added each single filing hospital to the study population and excluded each system filing hospital as we encountered them. We followed this process until we reached a study population of 50 CAHs. As *Form 990* data are not available as an electronic public use file, we are unable to determine how many of the 707 tax-exempt CAHs were part of a system filing.

Table 1. Composition of CAH Community Benefit Expenses

	N	Mean Net Expense	Mean Percent of Total Hospital Expenses	Range
Direct Patient Care Expenses				
Charity and discounted care	47	\$385,927	1.5%	\$0 - \$2,019,569
Unreimbursed cost of Medicaid	44	\$633,178	3.1%	\$-2,354,552 - \$2,538,423 *
Unreimbursed costs of other means tested government programs	11	\$106,323	0.4%	\$-90,582 - \$2,141,782
Subsidized health services	27	\$776,663	2.9%	\$0 - \$6,539,611
Subtotal	49	\$1,902,091	7.9%	\$-2,270,592 - \$4,130,784 *
Community-Focused Expenses				
Community health improvement services and benefit operations	37	\$69,344	0.2%	\$0 - \$365,302
Health professions education	24	\$45,870	0.1%	\$0 - \$366,464
Research	2	\$743	< 0.01%	\$0 - \$36,170
Cash and in-kind contributions for community benefit	30	\$42,813	0.2%	\$0 - \$434,676
Subtotal	45	\$158,770	0.51%	\$0 - \$6,824,682
Total Community Benefit Expenses				
Total	50	\$2,060,861	8.4%	\$-53,317-10,049,635*

*The instructions for *Form 990* direct hospitals to report their estimated costs for participation in Medicaid and other means tested government programs and the total reimbursement received from these payers. In cases where their reimbursement exceeds their costs, hospitals are instructed to report a negative value on *Form 990*. This negative value does not reduce the total dollar value of overall community benefit spending.

following the implementation of community benefit reporting (for tax year 2009) found that community benefit spending by all tax-exempt hospitals averaged 7.5 percent of total hospital expenses with the majority of that spending (over 6.4 percent) allocated to providing care for individual patients (e.g., charity care; the unreimbursed costs of Medicaid and other means-tested government programs; and subsidized care).^{13,17} Comparatively little spending (1.1 percent of total expenses) was dedicated to community health improvement projects, cash and in-kind contributions, research, and health professions education. An FMT study on the 2009 community benefit patterns of CAHs, other rural and urban hospitals found that CAHs had lower community benefit spending (7.0 percent of total hospital expenses) compared to other rural (8.1 percent) and urban (8.6 percent) hospitals. Spending on patient care activities accounted for 93 percent of CAHs' total community benefit spending compared to 89 percent for other rural hospitals and 79 percent for urban hospitals.¹¹ These findings raise questions regarding the extent to which the IRS' community benefit framework adequately balances the emphasis on community health improvement and population health activities (as presented in Table 1 under Community-Focused Expenses) versus charity, discounted, or subsidized care provided to individual patients.¹³ The framework encourages hospitals to focus on community benefit activities targeted to individual patients and should be revised to align with and encourage the growing interest in hospital efforts to address population health concerns.

Community Building Activities

As discussed earlier, Schedule H collects data on the community building activities of tax-exempt hospitals to allow the IRS to determine whether or not these activities should be counted as community benefits. Although they are not currently counted as a community benefit, the IRS intends to use the information collected to formulate recommendations on whether or not they should be counted in future revisions to the framework. Consistent with previously discussed studies, the community building expenses reported by the study CAHs represented an extremely small percentage (0.12 percent) of total hospital expenses, with a mean net expense of \$36,274. The largest portion of these expenses comprised workforce development (0.05 percent) and community support^v (0.03 percent). As a comparison, our study of hospital community benefit spending using 2009 *Form 990* data found CAHs reported spending on community building activity of just under 0.1 percent of total hospital expenses, while other rural and urban hospitals reported community building spending at 0.3 percent and 0.1 percent of total hospital spending.¹¹ Similarly, the largest proportion of CAH community building expenses were in the areas of workforce development (0.03 percent), community support (0.02 percent), and community health improvement advocacy (0.02 percent).

Alignment with ACA Guidelines on Financial Assistance and Emergency Care Activity

Schedule H collects information to determine alignment with the ACA-mandated changes to the tax code related to financial assistance, billing and collection, and emergency care. All of our study hospitals reported having written Financial Assistance Policies (FAP) (data not shown). Although not required to do so, 94 percent extended free or discounted care to medically indigent patients (i.e., individuals whom the organization has determined are unable to pay some or all of their medical bills).¹⁵

With regard to the determination of patient eligibility for charity and discounted care, 94 percent of these CAHs used the Federal Poverty Guidelines (FPGs) to determine eligibility for charity care and 78 percent used FPGs for discounted care (data not shown). Thirty percent of the study hospitals used a threshold of 100 percent or less of the federal poverty level to determine eligibility for charity care (Table 2). Sixty percent used an FPG threshold between 101 and 200 percent and 11 percent used a threshold of 201 percent or higher for charity care eligibility. To determine eligibility for discounted care, 41 percent used a threshold between 101 and 200 percent, 39 percent between 201 and 300 percent and 16 percent between 301 and 400 percent. Two hospitals were outliers with one using a more restrictive standard (100 percent or less) and one using a more generous standard (401 percent or greater) to determine discounted care eligibility.

^vAccording to IRS instructions for Schedule H, “community support can include, but is not limited to, child care and mentoring programs for vulnerable populations or neighborhoods, neighborhood support groups, violence prevention programs, and disaster readiness and public health emergency activities, such as community disease surveillance or readiness training beyond what is required by accrediting bodies or government entities.”¹⁵

Table 2. Federal Poverty Guidelines Used to Determine Charity and Discounted Care Eligibility

FPG Eligibility Threshold	Percent used for Charity Care	Percent used for Discounted Care
100% or less	30%	2%
101% - 200%	60%	41%
201% - 300%	9%	39%
301% - 400%	2%	16%
401% or over	0%	2%

Transparency of the FAP Application Process

In recognition of the vulnerability of individuals who may seek financial assistance to deal with medical issues, the IRS included a series of questions in Schedule H to determine how transparent hospital FAPs are in terms of detailing the criteria used to determine the amount charged to patients and the documentation necessary to support a patient’s FAP application. Almost 90 percent of the study hospitals’ FAPs provided information on the factors used to calculate the amounts charged to patients (Table 3). Income and asset levels, insurance status, uninsured discounts, and Medicare/Medicaid eligibility were all used by more than half of the study hospitals for calculating the amounts charged to patients with only medical indigency, state regulations, and “other” reported by less than 50 percent of the hospitals.

Table 3. Factors Used to Explain the Calculation of Amounts Charged to Patients

Factors	Percent Yes
Income level	84%
Asset level	80%
Insurance status	72%
Uninsured discount	68%
Medicare/Medicaid	56%
Medical indigency	44%
State regulation	38%
Other	16%
Residency*	100%

*This was a new response option offered in 2014 but not in 2012 and 2013. Five study hospitals in our study group completed the 2014 *Form 990* and selected this as a factor to explain the calculations of amounts charged to patients. The remaining factors were response options across all three years.

In 2014, the IRS added new questions to determine the types of information and documentation necessary to support a FAP application and sources of support to assist patients (data not shown). All of the five study hospitals that completed the 2014 *Form 990* identified the information and documentation that patients are required to provide to support their applications. Sixty percent provided the contact information of hospital staff who can respond to questions on the FAP and 40 percent provided information on external non-profit and/or government agencies that provide assistance with FAP applications.

Determination of Maximum Amounts Charged to Individuals Eligible for Financial Assistance

The ACA’s requirement that hospitals describe the approach used to determine the maximum charges reflects longstanding concerns that low income and self-pay patients are among the few

that are charged gross prices (also referred to as chargemaster prices) rather than discounted and/or negotiated rates.^{18,19} The ACA mandates that non-profit hospitals must charge FAP-eligible patients a lower rate than gross prices for any care received at the hospital and, as an outer limit, prohibits hospitals from charging FAP patients more than the “amounts generally billed” to an insured patient for medically necessary and emergency care.²⁰

The study hospitals varied in how they determine the maximum amounts charged to FAP-eligible individuals (Table 4) with the majority tying their maximum amounts to Medicare payment rates, their lowest negotiated commercial insurance rates, or an average of these reimbursement rates. Eight hospitals (17 percent) based the amounts billed to FAP-eligible patients on the rates for different combinations of payers such as the average rate paid by all managed care contracts, the average payment for the three largest payers, the average rate paid by all commercial payers including Medicare, the discount provided to the largest insurance payer, the average commercial charge, and a maximum charge less than the average of all negotiated commercial rates. Five hospitals (10 percent) did not discuss how charges were determined for FAP-eligible patients but explained that they applied automatic discounts to uninsured and self-pay patients and discounted the charges if the patients qualified for financial assistance. The initial discounts ranged 15 to 30 percent with one hospital applying a graduated discount that increased with the size of the bill to a maximum of 40 percent for self-pay charges exceeding \$50,000. Two of these hospitals provided an additional discount for prompt payment of balances.

Fifteen percent of the study hospitals noted that they billed all patients, including FAP-eligible patients, for the gross or chargemaster rates and discounted the charges after determining FAP eligibility. Another 17 percent did not identify a process for determining rates charged to FAP-eligible patients and focused instead on their charity care policies and/or sliding fee scales. Three hospitals did not complete this section or provide any explanation. These responses suggest that hospitals may not understand this provision of IRS tax-code for tax-exempt hospitals as the responses do not allow the IRS to determine their compliance with this requirement.

Table 4. Determination of Maximum Amounts Charged to FAP-Eligible Individuals*

Approach	Percent Yes
Lowest negotiated commercial insurance rates	13%
The average of hospital's three lowest negotiated commercial insurance rates	19%
Medicare rates	17%
The average for different combinations of insurance rates	17%
Automatic discounts for self-pay/uninsured patients	10%
Gross or chargemaster rates	15%
No explanation of process for rates billed to FAP eligible patients	17%

*Some states provided multiple answers to these questions for FAP eligible, uninsured, and self-pay patients.

Schedule H contains additional, related questions to determine how consistently the hospitals applied their policies regarding the amounts charged to FAP-eligible individuals. A small number of CAHs reported charging FAP-eligible individuals that had received emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care (6 percent), or an amount equal to the gross charge amount for any services provided to them (10 percent) (data not shown).

Publicizing FAPs within the Community

As part of the ACA's emphasis on hospital financial assistance and billing and collection policies, tax-exempt hospitals are required to make good faith efforts to publicize the availability of charity and discounted care. Schedule H collects data to monitor the different approaches used to notify patients in need of their FAPs (Table 5). Sixty-eight percent of the study CAHs publicize the availability of their FAPs by posting them on the hospital website, in emergency rooms or waiting rooms, and in hospital admissions offices; 70 percent provide them to patients during admission or the registration process; 84 percent post notices and signs widely throughout the hospital; and 90 percent make them available by request. A smaller percentage attach them to billing invoices (42 percent). Twenty percent indicated an "other" method of publicizing FAPs with examples of those other methods described in Table 5.

Table 5. Approaches Used to Publicize Financial Assistance Policies

Approach	Percent Yes
Posted on hospital website	68%
Attached to billing invoices	42%
Posted widely in hospital emergency rooms, waiting areas, admissions, etc.	84%
Provided to patients on admission	70%
Policy available on request	90%
Other (e.g., financial counselors/health resource navigators, attempting to contact uninsured or under-insured patients, providing information to collection agencies and law firms dealing with low income individuals, and using contracted vendors to reach out to potentially eligible patients).	20%

In general, the study hospitals leaned towards relatively passive efforts to publicize their FAPs such as making the information available on request; posting the information on websites or in hospital emergency departments; or providing information to patients upon admission or registration. It is not clear how proactive hospitals are in their attempts to identify patients potentially eligible for financial assistance. Do they just share information on the financial assistance policies as part of their admissions process or do they prescreen patients upon admission to determine eligibility before care is provided? Do they reach out to patients that may be eligible for financial assistance due to lack of health insurance or under-insurance? Do they reach out directly to patients who are carrying large balances to determine eligibility or do they wait for patients to contact the hospital business office? Twenty percent of the hospitals described more proactive outreach efforts using patient navigators, financial counselors, or business office staff to prescreen and reach out to potentially vulnerable patients.

Implementation of Collection and Billing Policies

Under the ACA-mandated changes to the IRS tax code, hospitals are required to make good faith efforts to determine eligibility under their FAPs prior to pursuing aggressive collection action against patients. Nearly all (96 percent) of the study hospitals had either separate billing and collections policies in place or included collection and billing policies in their written FAPs that explained all of the actions a hospital might take upon non-payment. The hospitals identified limited options they might employ before making reasonable efforts to determine a patient's eligibility under its FAP with 18 percent reporting that they may refer a patient to a

credit agency and 10 percent reporting that they may take legal action such as seeking a lien on property. During the fiscal year of their *Form 990* filing, 12 percent of hospitals reported patients to credit agencies and 16 percent undertook actions requiring a legal or judicial process before making reasonable efforts to determine patients' eligibility under their FAPs (data not shown).

As part of this series of questions, hospitals were asked to identify the actions they take before initiating collection activity. Eighty-two percent determine eligibility for financial assistance prior to initiating collection action and 80 percent notified patients of the availability of the FAP in communications regarding their bills. A smaller number notified patients of the FAP on admission (64 percent) or discharge (48 percent).

Despite these written policies and communications regarding financial assistance, billing and collections, the study hospitals reported mean bad debt expenses of \$1,448,667 (6.2 percent of total expenses) during the fiscal year of their *Form 990* filings. Although we do not have comparative data for other rural and urban hospitals that align with the data from our study hospitals, our 2015 study of the charity care and bad debt of CAHs, other rural, and urban hospitals provides a context for understanding this figure.²¹ Based on 2009 IRS *Form 990* data, CAHs reported mean bad debt expenses of \$1,330,097 (5.6 percent of total expenses), other rural hospitals reported \$3,078,550 (3.6 percent of total expenses), and urban hospitals reported \$6,294,845 (2.8 percent of total expenses).

Additionally, nearly half of the study hospitals reported that, on average, \$376,827 of their bad debt (slightly more than 28 percent of total bad debt) was attributable to patients eligible under their FAPs. Our 2015 study of charity care and bad debt spending of CAHs (based on 2009 *Form 990* data) found that CAHs reported mean total bad debt expenses of \$1,330,097 with an estimated 10.5 percent (\$139,662) of this total attributable to patients that would otherwise be eligible for charity care.²¹ As 2009 was the first year of mandatory community benefit reporting using the revised *Form 990*, it is not clear how sophisticated the reporting hospitals were in estimating the portion of their bad debt that would be attributable to FAP eligible patients. Without further study, it is not possible to determine whether the portion of bad debt attributable to FAP eligible patients is actually rising or the increase is due to better reporting and analysis by the study hospitals.

Policies Relating to Emergency Medical Care

Finally, hospitals are required to implement written emergency care policies regarding the provision of care, without discrimination, for patients with emergency medical conditions regardless of the patient's eligibility under their FAPs. Nearly all (98 percent) of the study hospitals had implemented such policies (data not shown). One hospital had not implemented such policies stating that it had not provided emergency care in the past year.

DISCUSSION

Our review of the IRS *Form 990* Schedule H filings suggests that the community benefit activities of the 50 study CAHs are focused primarily on health care (e.g., charity and discounted care, subsidized services, health fairs, and screening programs) with almost 94 percent of their

community benefit spending allocated to this area of activity. Their remaining spending supports a variety of community-focused activities including community health improvement services, health professions education, and cash/in-kind contributions for community benefit. Although the overall level of community benefit spending for the study hospitals is slightly higher than in previous studies, the distribution of spending between health care and community-focused activities is consistent with the distribution of community benefit spending patterns in those studies.^{11,17}

The data from this study show that more than half of the study hospitals are moving to address broader health-related community needs through community building initiatives such as community support (14), coalition building (11), workforce development (12), economic development (9), community health improvement advocacy (9), and other activities (10). Although many hospitals reported spending on community building in one or more of the activity categories, the overall level of spending was very low at 0.12 percent of total hospital expenses.

In terms of their alignment with the ACA-mandated financial, billing and collection, and emergency care requirements, all study hospitals reported having implemented written FAPs and 94 percent extend free or discounted care to medically indigent patients. Most (94 percent) use the FPGs to determine eligibility for charity or discounted care. Nearly a third provide charity care to those earning 100 percent or less of the FPGs and 60 percent use a threshold of 101 to 200 percent. For discounted care, the most commonly used thresholds were 101 to 200 percent of the FPGs (41 percent) and 201 to 300 percent (39 percent). Hospitals that use more restrictive eligibility criteria for charity or discounted care risk excluding FAP eligible patients with legitimate financial difficulties that impact their ability to pay for their care. As a result, these hospitals may have higher rates of bad debt related to care provided to these patients (and a corresponding reduction in the level of community benefits they report).

The study hospitals used a variety of methods to publicize their FAPs with the most common approaches involving making the policy available on request and posting notices to the hospital website or in emergency rooms, patient waiting areas, or admissions offices. A smaller number of the study hospitals employ a more proactive approach by providing written policies to patients on admission and/or attaching the policies to patient bills.

In terms of their financial reporting obligations, the study hospitals' financial assistance, billing and collection policies generally aligned well with the IRS requirement. However, some hospitals appeared to confuse their financial assistance policies with the requirement that hospitals clearly describe how they determine the maximum amounts charged to individuals eligible for financial assistance. The IRS guidelines provide clear examples of acceptable explanations for determining the maximum amount charged (i.e., the hospital's lowest negotiated commercial insurance rate, the average of the hospital's three lowest negotiated commercial insurance rates, or the hospital's Medicare rates). Over one-third of the study hospitals either did not answer the question or simply referenced the hospital's FAPs and/or sliding fee scales to explain how these patients would be charged. It is clear that some hospitals would benefit from additional education on these policies.

It also appears that, despite written financial, billing, and collection policies and efforts to publicize the availability of financial assistance to low income and uninsured patients, some hospitals are not reaching patients eligible for financial assistance under their FAPs. In an effort to determine the financial impact of bad debt on hospitals, *Form 990*, Schedule H asks hospitals to report their total bad debt for the financial year and to estimate the portion of their bad debt attributable to patients eligible under their FAPs. Twenty four of the study hospitals estimated that, on average, just over 28 percent of their bad debt was attributable to FAP eligible patients (the other 26 did not provide an estimate of their bad debt attributable to FAP eligible patients). The mean bad debt for these CAHs was \$1,317,373 (compared to a mean of \$1,448,667 for all 50 study hospitals); the average estimated amount attributable to FAP eligible patients was \$376,827. This level of bad debt activity is higher than in our earlier study of CAH charity care and bad debt performance.²¹ These data suggest that CAHs could benefit from technical assistance and support to assist them in identifying and qualifying eligible individuals under their FAPs. This would reduce bad debt levels, increase the dollar value of the community benefit CAHs provide, and better serve those patients unable to afford the cost of their care.

The Role of State Flex Programs in Supporting CAH Efforts to Identify and Address Community Needs

The results of this study highlight areas in which CAHs could benefit from technical assistance and support to improve their community benefit planning and reporting, better manage their charity care and financial assistance programs, reduce bad debt, and strengthen their alignment with the ACA-mandated financial requirements under IRS tax code. State Flex programs can play an important role in providing technical assistance and support to CAHs in these areas. Support for CAHs to enhance the impact of their community benefit portfolios can be accomplished under Program Area 3b: Enhancing the Health of Rural Communities through Community/Population Health Improvement. State Flex programs can support CAHs by reviewing their *Form 990* filings and providing updates on changes to the IRS tax code.

At the same time, a review of CAH *Form 990* data would inform state Flex program assessment activities under Program Area 2: Financial and Operational Performance Improvement. This is particularly true for hospitals reporting bad debt attributable to individuals that would otherwise qualify for support under their FAPs. An analysis of *Form 990* data could identify CAHs that would benefit from technical assistance to improve their alignment with the IRS financial assistance and billing and collection requirements, and their revenue cycles, by identifying FAP-eligible patients. Technical assistance could help these hospitals streamline the FAP application process, improve access to services for low-income individuals, better manage their bad debt and charity care, and minimize potential risks from failure to comply with IRS financial requirements. The assessment of CAH performance in this area of community benefit activity would inform the assessment process under Program Area 2 and help identify specific interventions to best meet their hospitals' needs.

CAHs would also benefit from technical assistance to develop programs to more efficiently address the health care needs of low-income residents of their communities. Specifically, these hospitals could better manage their charity care spending by developing alternative programs to manage chronic conditions, reduce high-risk behaviors (e.g., smoking, excess drinking, poor

eating habits, and inactivity), encourage patients to seek care when their illness is less acute and more easily treated, and hopefully reduce costly emergency department use.

CONCLUSION

CAHs, along with all hospitals, face public scrutiny regarding their community benefit performance and the negative impact of their financial assistance, billing, and collection policies on low-income and other vulnerable populations within their communities. The ways in which hospitals handle billing and collection activities are receiving greater attention from national, state, and local policymakers as well as the media, and can be a significant source of negative publicity for CAHs and other hospitals.¹⁹⁻²² State Flex programs can provide technical assistance and support to CAHs to improve their performance in this important area of community benefit activity and better align their policies with the ACA-mandated changes to the IRS tax code for financial assistance, billing, and collection practices.

The inclusion of population health as a core program area (along with quality, financial, and operational performance improvement) presents an opportunity to demonstrate the Flex Program's leadership in supporting CAHs in this important area of hospital activity, much as it has done with quality improvement. As with quality improvement, Flex Programs are ideally positioned to provide technical assistance and other resources to improve CAH performance in designing and carrying out their community benefit activities and financial assistance and reporting systems.

REFERENCES

1. Federal Office of Rural Health Policy. *Funding Opportunity Announcement: Initial: New, Competing Continuation for the Medicare Rural Hospital Flexibility Grant Program*. Washington, DC: US Department of Health and Human Services, Health Resources and Services Administration, FORHP, Hospital State Division; February 3, 2015. HRSA-15-038.
2. Gale J, Coburn A, Pearson K, Croll Z, Shaler G. *Population Health Strategies of Critical Access Hospitals*. Portland, ME: Flex Monitoring Team, Maine Rural Health Research Center; August, 2016. Briefing Paper #36.
3. Rosenbaum S, Byrnes M, Rothenberg S, Gunsalus R. *Improving Community Health through Hospital Community Benefit Spending: Charting a Path to Reform*. Washington, DC: George Washington University; December 2016.
4. Woodcock C, Nelson GD. *Hospital Community Benefits after the ACA: Leveraging Hospital Community Benefit Policy to Improve Public Health*. Baltimore, MD: University of Maryland, Baltimore County; June 2015.
5. Rosenbaum S. *Hospitals as Community Hubs: Integrating Community Benefit Spending, Community Health Needs Assessment, and Community Health Improvement*. Washington, DC: Brookings Institution; March 2016.
6. Catholic Health Association of the United States. *Healing Communities and the Environment*. St. Louis, MO: Catholic Health Association of the United States; August 2013.
7. Eckstein E, Hattis P. *Hospital Investing in Health: Community Benefit in Massachusetts*. Boston, MA: Community Catalyst; October 2016.
8. Swider SM, Berkowitz B, Valentine-Maher S, Zenk SN, Bekemeier B. Engaging Communities in Creating Health: Leveraging Community Benefit. *Nurs Outlook*. Sep - Oct 2017;65(5):657-660.
9. Commonwealth of Massachusetts. *The Attorney General's Community Benefits Guidelines for Non-Profit Hospitals*. Boston, MA: Office of Attorney General; February 2018.
10. Gale J, Race M. *A Community Benefit Reporting Toolkit for Critical Access Hospitals*. Portland, ME: Flex Monitoring Team; 2009.
11. Gale J, Croll Z, Coburn A, Croom J. *Comparing the Community Benefit Spending of Critical Access, Other Rural, and Urban Hospitals*. Portland, ME: Flex Monitoring Team, Maine Rural Health Research Center; November, 2016. Policy Brief #45.
12. Internal Revenue Service. *New Requirements for 501(C)(3) Hospitals under the Affordable Care Act*. July 2, 2018. Available at: <https://www.irs.gov/charities-non-profits/charitable-organizations/new-requirements-for-501c3-hospitals-under-the-affordable-care-act>. Accessed June 27, 2018.
13. Crossley C. Health and Taxes: Hospitals, Community Health, and the Irs. *Yale Journal of Health Policy, Law, and Ethics*. 2016;16(1):51-110.
14. Gale JA, Croll Z, Zoll L, Coburn AF. *Critical Access Hospitals' Community Health Needs Assessments and Implementation Plans: How Do They Align?* Portland, ME: Flex Monitoring Team; October, 2018. Briefing Paper #39.
15. Internal Revenue Service. *2014 Instructions for Form 990 Return of Organization Exempt from Income Tax*. 2014. Available at: <https://www.irs.gov/pub/irs-prior/i990--2014.pdf>. Accessed July 5, 2018.
16. Grantspace. *Knowledge Base: Where Can I Find an Organization's Form 990 or 990-Pf?* Available at: <https://grantspace.org/resources/knowledge-base/finding-990-990-pfs/>. Accessed July 5, 2018.
17. Young GJ, Chou C-H, Alexander J, Lee S-YD, Raver E. Provision of Community Benefits by Tax-Exempt U.S. Hospitals. *N Engl J Med*. 2013;368(16):1519-1527.
18. Taylor P, Blewett L, Brasure M, et al. Small Town Health Care Safety Nets: Report on a Pilot Study. *J Rural Health*. Spring 2003;19(2):125-134.

19. Brill S. Bitter Pill: How Outrageous Prices and Egregious Profits Are Destroying Our Health Care. *Time Magazine*. March 13 2013;181(8):16-55.
20. Curtis J. *What Does the Affordable Care Act Say About Hospital Bills?* Boston, MA: Community Catalyst; June 15, 2018.
21. Gale JA, Croom J, Croll Z, Coburn AF. *Charity Care and Uncompensated Care Activities of Tax-Exempt Critical Access Hospitals*. Portland, ME: Flex Monitoring Team; June, 2015. Briefing Paper No. 35.
22. United States Senate, Committee on the Judiciary. *Letter from Charles E. Grassley to the Honorable John Koskinen, Commissioner, Internal Revenue Service*. June 9, 2016. Accessed August 27, 2018.