Nonprofit Hospitals' Community Benefit

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Hospital Community Benefit

- The link between mission and operations
- Programs and activities providing treatment and/or promoting health that are responsive to identified community needs, not provided for marketing purposes

True community benefit involves at least one of following

- Generates low or negative margin
- Responds to needs of vulnerable and/or medically underserved populations
- Provides service that would likely be discontinued by hospital if operations were made based purely on finances
- Involves education or research that improves community health
- Responds to public health needs

CB Categories: developed by Catholic Health Association

- Unreimbursed costs of charity care, Medicaid, Medicare (in Oregon), other government programs
- Services and programs
  - Community health services
    - Community health education, screenings, free clinics, support services (transportation, etc.)
  - Health Professions Education
    - School, internships, rotations, scholarships
  - Financial contributions
    - Cash, grants, in-kind donations

Community Benefit Categories

- Subsidized health services (when operate at a loss)
  - Emergency, trauma, neonatal intensive care, behavioral health
- Research
  - Clinical, community health research
- Community Building (social determinants)
  - Housing, economic development, workforce development, built and physical environment
- Community Benefit operations
  - Dedicated staff, community needs assessment

CB Reporting Requirements

- Oregon
  - Hospitals submit CB dollars by category to state following close of fiscal year
  - State publishes by hospital data statewide
- Federal/IRS
  - Schedule 990H: questions related to community benefit—dollars (costs), financial assistance policies, executive compensation and community needs assessments
- Accepted metric: Community benefit = % (costs) of net patient service revenue

Community Benefit Dollars

- State-wide DRG reimbursed hospitals (includes all tri-county hospitals) total CB 2011: 19.8% of net patient service revenue

- Tri-County (Clackamas, Multnomah, Washington)
  - 12 hospital 2010 total CB: $756.8 million
  - Unreimbursed costs: $488.7 million
  - Discounting disproportionate OHSU dollars for education and research ($185.3 million), unreimbursed costs constitute 86% of CB
  - Charity care by hospital ranged from 3.5% to nearly 9% of net patient service revenue

National and Local Attention to CB

- Federal and state level attention focused on unreimbursed costs, particularly charity care—as percent of net patient service revenue
  - With Affordable Care Act implementation, theory is that charity care costs will decrease
  - How will hospitals continue to meet financial 'obligations' to remain nonprofit?
- Hospital discussions
  - Coverage does not mean access (continued use of emergency depts.)
  - Low income individuals (particularly those 139-200% of FPL) eligible for tax subsidies on the Exchange will not be able to afford the premiums, copays, deductibles, i.e., will not enroll
  - The timeline that charity care will decrease and by how much is unknown
  - Will increase in Medicaid unreimbursed costs offset decreases in charity care?

Community Health Needs Assessments

- Community Benefit definition
  - Programs and activities providing treatment and/or promoting health and healing that are responsive to **identified community needs**, not provided for marketing purposes

- Historically, hospitals have varied widely in how and when they conducted community needs assessments

CHNAs: Hospitals—Federal/IRS

- Affordable Care Act: as of March 23, 2012 hospitals must conduct a community needs assessment every three years, meeting specific requirements within the assessment
  - IRS Schedule 990H: questions related to community benefit--…community needs assessments
- CHNA Requirements (among many others)
  - Take into account input from local health departments and vulnerable communities
  - Develop a community health improvement plan (prioritized issues, strategies and tactics)

CHNAs: Public Health Departments

- Public Health Accreditation Board gives local health departments the opportunity to achieve accreditation by meeting a set of standards that document capacity to deliver core functions

- Conducting a community health assessment and a community health improvement plan are prerequisites in applying for accreditation

A Regional Approach to CHNAs

- Over two year period—2010-2012, Clackamas, Clark, Multnomah, Washington counties' 14 hospitals and 4 public health departments formed Healthy Columbia Willamette to meet portion of hospital and health departments' CHNA needs
  - 2013: Tri-County Coordinated Care Organizations (CCOs) joined as are required by Oregon Health Authority to conduct community needs assessments

Healthy Columbia Willamette: Purpose

- Conduct a comprehensive study of the community health needs for Clackamas, Clark, Multnomah and Washington Counties
  - Align efforts/build relationships between hospitals, public health and coordinated care organizations
- Prioritize community health needs
- Develop strategies that will begin to address prioritized community health needs
- Identify indicators used to monitor health outcomes

Process Year One: June 2012-May 2013

- Identify community health needs
  - Reviewed prior community needs assessments
  - Analyzed health status assessments (reports, data)
  - Obtained input from public health departments and vulnerable communities at risk of disparities
  - Inventoried hospital and public health department capacity to address needs
  - Conducted epidemiology review of indicators

Process Year Two: June 2013-May 2014

- Designated priority community health need issues
  - Access to health care
  - Behavioral health: suicide prevention and opiate use reduction
  - Chronic disease: increase in breast feeding and reduction in tobacco use
- Develop one strategy and tactic per issue as collaboration
- Hospitals, CCOs and health departments will develop individual CHNAs to meet their specific requirements
  - Regional CHNA will be incorporated into individual CHNAs

Process Year Three: June 2014-May 2015

- Community health improvement plan implementation and sustainment
- Indicator evaluation and review
- Planning for regional CHNA: 2015-2016

What questions do you have?

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