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Nonprofit Hospital Community Benefit Requirements: An Exploration of National Health Policy Models

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NONPROFIT HOSPITAL COMMUNITY BENEFIT REQUIREMENTS:

AN EXPLORATION OF NATIONAL HEALTH POLICY MODELS

A DISSERTATION

by

JUSTIN P. SWEARINGEN

Concentration: Health Policy and Management

Presented to the Faculty at the Graduate School of Public Health and Health Policy in partial fulfillment
of the requirements for the degree of Doctor of Public Health

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ABSTRACT

Nonprofit Hospital Community Benefit Requirements:
An Exploration of National Health Policy Models

by
Justin P. Swearingen

Advisor: William Gallo

Introduction: Nonprofit hospital organizations are public charities with complete tax immunity. Such exemptions are worth $24.6 billion and impact the health of hundreds of millions of people, yet what these charities must do to meet the current “community benefit standard” to maintain their tax-exempt status remains a policy debate. To help inform policymaking, an evaluation of four national requirement models was performed: Tax Value Requirement (at least the value of the tax exemptions must be spent on community benefit), Grassley Requirement (at least 5% of revenue must be spent on community benefit), Expense Requirement (at least 3% of expenses must be spent on community benefit), and Facts and Circumstances Requirement (organization must pass a government review).

Objectives: This research aimed to evaluate whether nonprofit hospital organizations’ current community benefit spending would meet each of the four policy models and assess the impact of adding bad debt, Medicare shortfalls, and community building activities. Factors of interest, including organizational size, geography, accounting methods, and fiscal viability, were evaluated within the Grassley and Expense models. The research also aimed to gain insights into
the implications of the national policy models and make recommendations to policymakers regarding community benefit law.

Methods: Using a sample of 447 tax returns representing 997 hospitals in tax year 2012, descriptive statistics and evaluations of whether organizations could meet the various national policy models were explored. Additionally, chi-square tests of independence, independent sample t-tests, and logistic regressions were performed on each of the Grassley and Expense models to determine associations with census region, adherence to Healthcare Financial Management Association Statement 15, the number of hospitals filing together, the utilized accounting method, profit margin, the Federal Poverty Level (FPL) income threshold to receive free and discounted care, and the number of employees. To explore whether hospitals are meeting the Facts and Circumstances Requirement and implications of the policy models, key informant interviews with 14 hospital administrators were performed.

Results: Although there was variation in reporting and the analysis assumed no behavioral response to any future policy changes, nonprofit hospital organizations, in aggregate, could satisfy a Tax Value, Grassley, or Expense Requirement. For the Tax Value Requirement, national community benefit spending is 212% of the value of tax exemptions. Approximately 75% and 90% of organizations could meet the Grassley and Expense requirements, respectively. Adding bad debt, Medicare shortfalls, and community building activities increased the ability to meet such standards. For the Grassley Requirement, a policy that adds bad debt may not help hospital organizations to become more forgiving of medical debt while a policy that adds Medicare Shortfalls may help organizations in the Northeast more easily pass the requirement. For the Expense Requirement, a narrow policy (without bad debt, Medicare shortfalls, or community building activities) may help hospital organizations to become more forgiving of
medical debt while a policy that is either narrowly defined or one that adds only Medicare shortfalls may help hospital organizations to become more generous with providing discounts on medical debt. Variation exists in whether hospitals could meet a Facts and Circumstance Requirement, although institutional isomorphism is helping to improve community benefit policies and practices.

Conclusions: Even with variation in reporting, nonprofit hospital organizations are claiming sufficient community benefit. While mandating minimum spending may seem a viable policy option, not all activities have a tangible dollar allocation and not all expenditures fit into the current community benefit categories. Given their size, scope, and significance, nonprofit hospitals require flexibility in justifying their tax-exempt status. Policy recommendations to help ensure nonprofit hospitals provide sufficient community benefit are to: assess community benefit with the Facts and Circumstances Requirement, audit more hospitals, mandate competency training, maintain Section 501(r) of the Affordable Care Act and not implement the American Health Care Act of 2017, exclude bad debt and include community building activities and Medicare shortfalls as community benefit, grant nonprofit hospitals access to income data, encourage regional Community Health Needs Assessment (CHNA) partnerships, and modify the CHNA cycle from three to five years.
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The author has no conflicts of interest and nothing to disclose.
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CHAPTER 1: Introduction

Within the hospital and health system industry, organizations are divided into private, for-profit (investor-owned), private, not-for-profit (nonprofit or tax-exempt), and governmental (public) hospital organizations. The largest group are the private, not-for-profit hospitals which, due to their status as Internal Revenue Service (IRS) section 501(c)(3) public charities, receive complete tax exemption from federal, state, and local governments, including property tax, business income tax, and sales tax. Despite the fact that such exemptions were worth billions in the year 2012 and helped to impact the health of hundreds of millions of individuals through numerous public health improvement programs, there has been remarkably little consensus regarding what these charities must do to meet the current IRS “community benefit standard” or how this sum should be best spent in order to improve the public’s health.2,3

Few matters are more critical to the financial strength and mission of nonprofit hospitals than their federally-granted tax-exempt status. However, determining what these nonprofits must do to “deserve” their exemption or even how to uniformly measure these community benefits is an ongoing topic of policy debate.2,4 Numerous studies have found that continued ambiguity has made it increasingly difficult to differentiate nonprofit from for-profit healthcare providers and there is growing concern that hospitals with tax-exempt status are not adequately fulfilling their charitable missions.2,5,6 Previous sessions of Congress, various policy makers, and government officials have even adopted a skeptical perspective of whether federal tax exemption for nonprofit hospitals is justified.5,7,8

In an effort to initiate coordinated tracking of the nature and extent of community benefits provided by nonprofit hospitals and move toward a national policy, the federal government has begun the process of making the first significant changes to federal community
benefit language in over 40 years. Starting in 2009, a redesigned Internal Revenue Service (IRS) tax form for nonprofit hospitals and health systems called Form 990, Schedule H was issued to enhance transparency and capture data on policies and practices related to hospital community benefits. Part I of the form, “Charity Care and Certain Other Community Benefits at Cost,” consists of eight basic categories of community benefit activities (see the Addressing Policy Considerations section on page 26 for more detail), Part II or “Community Building Activities” includes potentially charitable actions not reported elsewhere that protect or improve community support and/or safety, and Part III called “Bad Debt, Medicare, & Collection Practices” includes the debated categories of bad debt expense and unreimbursed Medicare costs (Medicare shortfalls).\(^9\)

Such standardized reporting will provide a more accessible portrait of the philanthropic activities of charitable hospitals and enable unprecedented comparisons and evaluations which may ultimately help lawmakers make informed policy decisions that can be incorporated into a law. Before such law can be developed, however, important questions remain unexplored. Over the past decade, four models of a possible national policy have emerged regarding how to legally define the minimum necessary contributions to society, but disagreements exist as to which categories of spending should count as charity and how much needs to be spent to justify tax exemption.\(^{10-12}\) Research to evaluate the feasibility of each model will thus contribute greatly to the national discourse.

The first model, which is currently employed by the IRS, is a “facts and circumstances” test to assess whether a hospital’s community benefit expenditures are sufficient to support its 501(c)(3) charitable status.\(^{13}\) Investigating this model becomes important because this standard (heretofore called the “Facts and Circumstances Requirement”) is inexact and allows flexibility
for hospital organizations to determine how much community benefit is sufficient. According to the Department of Treasury regulations, the Facts and Circumstances Requirement includes reviewing “the size, scope, nature, and significance of the organization’s failure, as well as the reason for the failure and whether the same type of failure has previously occurred.” The IRS also considers whether the discrepancy was corrected promptly. Hospitals that fail such a Facts and Circumstances Requirement subsequently experience a facility-level tax on all income derived during the tax year. The application of the facility-level tax to a noncompliant hospital will not, in and of itself, affect the tax-exempt status of bonds issued to finance the noncompliant hospital facility, although this benefit may also be placed at risk.13

While laws prior to 2010 were less rigorous, the Patient Protection and Affordable Care Act, otherwise known as the Affordable Care Act (ACA), enacted on March 23, 2010, more clearly codified the community benefit requirements of nonprofit hospital organizations by putting into law four new conditions that 501(c)(3) hospital organizations must meet in order to pass the Facts and Circumstances test.14 Although most of the standards technically went into effect upon enactment of the ACA, final regulations of this new 501(r) section were not issued until 2014 and hospitals were given until 2016 to become fully compliant with all of the policies and procedures. These nonprofit facilities must now 1) establish written financial assistance and emergency medical care policies, 2) make efforts to ensure eligibility for financial assistance under such policies before engaging in collection activities, 3) limit amounts charged for emergency and medically necessary care for those who qualify for financial assistance to the average amount allowed by insurance payers such as Medicare, and 4) conduct a community health needs assessment (CHNA) every three years to identify the most demanding public health needs and develop an implementation strategy to meet those identified needs.13-15
Both the financial assistance policies and the community health needs assessments are to be made public and will greatly enhance the transparency and accountability of the hospital’s effort to improve community health. Such reports should provide another new tool for public health researchers to better understand the role of the hospital in improving the health of individuals and communities. Nevertheless, how developing policies and evaluating community needs actually translate into setting organizational priorities and proactively budgeting scarce resources in times of uncertainty remains to be seen. Whether nonprofit healthcare organizations have become more effective at meeting community needs or whether they have simply become more effective at accounting for activities previously being performed is similarly untested.

Charging charity care patients the same as insured patients may assuage discriminatory practices against the poor and uninsured. However, beyond emergency care (which is more clearly defined in other legislation such as the Emergency Medicine and Active Labor Act), the final 501(r) regulations allow leeway in determining what care is medically necessary. The hospitals must publish a list of providers (other than the hospital itself) that deliver emergency and medically necessary care, but they may also continue to self-govern income threshold qualifications for their charity care programs. 501(r) does not prohibit hospitals from making their charity policies more restrictive so that fewer patients qualify. As such, the new rule stipulating that these hospitals must provide charity care to those who qualify is similarly vague.\textsuperscript{13,16}

The regulations do prohibit a hospital facility from engaging in extraordinary collection actions before making reasonable efforts to determine whether someone is eligible for financial assistance.\textsuperscript{14} Extraordinary actions include reporting people to credit agencies or starting legal processes such as filing liens, foreclosures, or garnishments, while reasonable efforts include
waiting at least 120 days post-discharge to start collection activities, providing a written notice at least 30 days before the initiation of collections, and notifying the patient orally (usually through a phone call) about the financial assistance policy and how to apply. These practices are in addition to the wide publication (through website pages and distributing plain language summaries before discharge) of the hospital’s financial assistance policy. Yet, similar, to the other requirements of 501(r), adherence to these nascent polices remains unexplored.13

As time progresses past the implementation for the Affordable Care Act, what is known is that the nation is achieving unprecedented levels of insured citizens.17 Concomitant to greater insurance coverage, the public need for uncompensated care may continue to diminish which could refocus hospitals toward other public health improvement programs as they strive to validate their tax exemption. Perhaps more worrisome for policymakers, though, under the Facts and Circumstances Requirement, some hospitals contribute less than one percent of every dollar they make to the community while other contributions are greater than 20%. Hospitals may also spend very little on charity or other community benefit activities as a total percent of their overall expenses and they may also continue to provide community benefit at a lower value than the worth of their tax breaks.

Thus, to help ensure communities are sufficiently benefiting from the loss of tax revenue, three other community benefit requirement models have emerged on the national policy landscape. Besides the Facts and Circumstance Requirement, the second model mandates that nonprofit hospitals must spend at least 5% of revenues on charity care. As will be called the “Grassley Requirement” referring to Senator Charles Grassley (R-Iowa) who advocated for the rule, this national health policy model would stipulate that any hospital organization that spends less than five percent of every dollar received would not benefit the community enough to
maintain tax exemption. Numerous states, including Nevada and Texas, have employed a variation of such a requirement, although it is unknown whether all hospitals nationally could meet such a threshold.\textsuperscript{18,19}

The third model, which is an option in the state of Pennsylvania, will be called the “Expense Requirement.” This policy stipulates that all nonprofit hospitals must spend three percent of their expenses on community benefit or three cents of every dollar spent must go to the community.\textsuperscript{20} The fourth and final model, instituted in various forms in states like Illinois and Utah, is the “Tax Value Requirement” which requires that nonprofit hospitals must provide community benefit amounts equal to at least the worth of the hospital's tax-exempt benefits.\textsuperscript{21,22} As is the case for the Grassley Requirement, even though the Expense Requirement and the Tax Value Requirement models are currently employed to various degrees within individual states, research on the ability for a hospitals to meet such standards on a national level remains unexplored.\textsuperscript{20}

Lastly, as the United States considers a national ruling moving beyond the Facts and Circumstances Requirement to perhaps enacting a more prescriptive policy to ensure nonprofit hospitals are providing sufficient community benefit, two competing schools of thought have emerged within the industry. On one side, the Catholic Health Association (CHA), in connection with VHA, Inc. (a cooperative representing more than 1,400 nonprofit hospitals that was previously called Voluntary Hospitals of America), has published a guide consisting of eight items which they believe should count toward community benefit activities (the “Narrow Definition” of the Tax Value, Grassley, or Expense Requirement).\textsuperscript{12} Conversely, the American Hospital Association (AHA) believes that, in addition to these eight items, the categories of bad debt expense and unreimbursed Medicare costs should also be counted (which make up
“Expanded Definitions” of the Tax Value, Grassley, and Expense Requirement). In addition, both sides agree that categories related to “community building activities” should be considered, although the IRS definitions of these activities are evolving and remain questionable (see the Addressing Policy Considerations section on page 26 for more detail). Thus, the ability to assess how important the debated categories of bad debt, Medicare shortfalls, and community building activities are to nonprofit organizations as they attempt to provide enough community benefit to justify their tax-exempt status is an added complexity worthy of study.
CHAPTER 2: Specific Aims

In this exploration of nonprofit hospital community benefit requirement policy models, the following specific aims were used to guide the research:

AIM 1: To use data from IRS Tax Form 990, Schedule H for the tax year 2012 to help policymakers assess whether nonprofit hospital organizations’ current community benefit spending would meet various national health policy models:
- Tax Value Requirement in which community benefit spending is at least equal to the value of the tax exemptions
- Grassley Requirement in which at least 5% of revenue goes to community benefit
- Expense Requirement in which at least 3% of expenses go to community benefit

Sub-Aim 1: To help policymakers better understand the charitable activities of nonprofit hospital organizations by providing descriptive summaries of the size, scope, and nature of community benefit claims

AIM 2: To help policymakers better understand whether organizational size, geography, accounting methods, collection methods, and fiscal viability are related to current charitable spending using various plausible definitions of community benefit (including the debated categories of bad debt, Medicare shortfalls, and community building activities) should either the Grassley or Expense Requirement models be enacted

AIM 3: To collect data from key informant interviews with nonprofit hospital administrators to help policymakers assess whether nonprofit hospital organizations could meet a Facts and Circumstances Requirement.
- Sub-Aim 1: To understand why nonprofit hospital organizations place greater or lesser reliance on the different community benefit categories, including the debated categories of bad debt, Medicare shortfalls, and community building activities
- Sub-Aim 2: To explore whether hospitals are currently meeting new 501(r) community benefit requirements in the Affordable Care Act
- Sub-Aim 3: To gain insights into the implications of a national policy setting minimum community benefit spending through a Tax Value, Grassley, or Expense model

AIM 4: To provide recommendations to policymakers on how to further national health policy regarding the community benefit activities of nonprofit hospital organizations
CHAPTER 3: Background

ASSESSING COMMUNITY BENEFITS

Early History

Although the policies related to community benefit have evolved over time, the paradigm of “charity” in relation to private, nonprofit hospitals remains statutorily ambiguous. The concept of a charitable hospital in America dates back to at least the 19th Century when nonprofit infirmaries were established to provide mostly free care to the underprivileged. Common laws prior to 1956 used a generally accepted, yet narrowly focused, definition that included only aid to the poor and suffering. The landmark 1956 IRS revenue ruling (Rev. Rul. 56 – 185, 1956 – 1 C.B. 202) was the first to establish that, as 501(c)(3) public charitable organizations, nonprofit hospitals have a legal obligation to provide free or below cost services to “those not able to pay.” Because such assistance had to be provided within the hospital’s financial ability, this nascent requirement became known as the "financial ability standard." Under this provision, hospitals could retain qualification for tax exemption if they operated to the full extent of their financial ability to provide as much charity care and reduced-cost medical services as possible. In order to qualify, the hospital must also be organized for the care of the sick, must not restrict the use of its facilities to a particular group of physicians, and its net earnings must not directly or indirectly benefit any private individuals or shareholders.

Following an extensive study by the IRS, the definition of charity was further expanded in 1959 to include relief of the poor and distressed, advancement of education or science, lessening of the burdens of government, and overall promotion of social welfare. However, according to the IRS, even these updated regulations proved to be “quite plastic” which necessitated further clarification.
Once the Medicare and Medicaid programs were established in 1965, Revenue Ruling 56-185 proved difficult to administer and received much criticism during congressional hearings since increased rates of insurance coverage decreased demand for charity care which, in turn, made it difficult for hospitals to satisfy the financial ability standard.26 Such imprecise and subjective criteria subsequently led to a second landmark Revenue Ruling in 1969 (69 – 545, 1969 – 2 C.B. 117) which removed the financial ability standard and replaced it with the updated "community benefit standard."23 The new, broader definition now recognized that the promotion of health, in and of itself, could be a charitable purpose. Although providing free or discounted care, educational and research services, and the other categories enacted in 1956 and 1959 would continue to count toward justifying tax exemption, Ruling 69-545 officially modified Ruling 56-185 to “remove therefrom the requirements relating to caring for patients without charge or at rates below cost.”28 p.4 Hospitals were no longer required to provide as much free or below-cost patient care as possible, but hospital investments and activities promoting community health could now count toward meeting a nonprofit hospital’s obligations for tax exemption.26 Operating an emergency room open to the public and providing hospital care to everyone in the community were given as examples of ways in which a nonprofit hospital promoted health within the community. Nevertheless, similar to the previous ruling, the new community benefit standard still allowed great leeway for individual hospitals to self-define which and how much of their many activities counted toward their charitable responsibilities.11

During this era, Congress also passed a law known as the Hill-Burton Act which provided loans and grants to hospitals and other medical facilities for construction and modernization.24 In return, hospitals agreed to provide a “reasonable volume” of free care for those who could not afford to pay. However, lack of regulations specifying necessary volumes
of free care coupled with eventual overcapacity of hospital beds led to most funding for Hill-Burton ending by the 1970s. Some health care facilities remain obligated to provide free or reduced-cost care today, but the program has effectively ended.

**Contemporary History**

Since the creation of the 1969 community benefit standard, which remains the broad ruling applied by the government today, much national attention has been directed toward the adequacy of hospital charity care services. In light of increased market pressure for nonprofit hospitals to grow their commercial activities and acquire increasingly businesslike attitudes and strategies, several U.S. congressional committees and state court cases in the 1980s and 1990s began to scrutinize what many viewed as the eroding distinction between for-profit and nonprofit hospitals.

Growing numbers of uninsured individuals together with concerns that charitable hospitals were expending inadequate resources to substantiate their tax exemptions ultimately led to a 1991 report by the U.S. General Accounting Office (GAO) which found that “the link between nonprofit hospitals' tax-exempt status and their provision of charitable activities for the poor or underserved is weak.” Furthermore, they found that over half of nonprofit hospitals provided health services that had a lower value than the worth of the tax break, that hospitals lacked proactive policies regarding reaching and serving the needy, and that the admissions policies of nonprofit hospitals often limited the majority of charity care to the emergency room (likely owing to the passage of the Emergency Medical Treatment and Active Labor Act of 1986 which required hospitals to provide care to anyone needing emergency healthcare treatment). Perhaps worse, since the IRS has no set definitions which directly relate to charitable services provided, “some (nonprofit) hospitals can and do take measures to avoid serving the indigent
population.”\textsuperscript{31} p.8 Remarkably, despite the need for more stringent accounting relating to appropriateness and enforcement, the community benefit standard remained legislatively unchanged for almost 20 years following the GAO report.

A decade and a half later, in 2006, a large-scale, government study called the “Nonprofit Hospital Project” was conducted so that the IRS and other stakeholders could better understand nonprofit hospitals and their community benefit practices and reporting.\textsuperscript{32} After investigating more than 500 nonprofit hospitals, the IRS found that there was considerable diversity and uneven distribution in community benefit activities and that “the size, complexity and importance of this segment [the nonprofit hospital industry] will continue to be a challenge to those who consider refining or revising the exemption standard.”\textsuperscript{32} p.4

Growing interest in health reform on the national agenda and controversy over whether nonprofit hospitals provide adequate community benefits to validate their tax exemptions also gave rise to Congressional considerations of the issue between 2005 and 2009 in the Congressional committees led by Senators Grassley (R-Iowa) and Baucus (D-Montana). Under their leadership, extensive testimony advocated for the adoption of a "higher standard for federal tax exemption, one which articulates meaningful behavioral expectations of tax-exempt hospitals.”\textsuperscript{7}

Although many health policy experts were hopeful to include a prescriptive, nation-wide policy definition of the actions that nonprofit hospitals must perform in order to justify their exempt status, the hearings lead by Senators Grassley and Baucus helped to enact smaller policy regulations in the health reform act. The original intention was to impose an excise tax on private-benefit transactions (contracts influenced by conflicts of interest) and set limits on executive compensation for hospital leaders.\textsuperscript{33} Perhaps more significant, the bipartisan group of
Senators were working on legislation to restore stricter conditions for nonprofit hospitals and reinstate the charity-care requirements that were undone by the IRS in 1969 by adding back in requirements relating to caring for patients without charge or at rates below cost. Even a requirement that nonprofit hospitals spend a minimum 5% of their revenue on charity care was proposed.\textsuperscript{16,33}

\textbf{501(r).} Despite such high expectations envisioned by the architects, the final law in Section 9007 (titled Additional Requirements for Charitable Hospitals) of the Affordable Care Act clarified community benefit requirements more incrementally by creating the new 501(r) IRS tax code with the four new provisions previously discussed in the Introduction. These nonprofit facilities must 1) establish financial assistance and emergency medical care policies, 2), ensure eligibility for financial assistance under such policies before engaging in collection activities, 3) limit amounts charged for emergency and medically necessary care for those who qualify for financial assistance to the average amount charged to those with insurance, and 4) conduct a community health needs assessment (CHNA) every three years to identify public health needs and develop an implementation strategy to meet those needs.\textsuperscript{13}

It took until 2013 to issue proposed 501(r) regulations which then went through a public comment period and it was not until December 2014 that the final rule on 501(r) was published in the Federal Register.\textsuperscript{13} Both the Treasury and the IRS have subsequently provided hospitals time to ensure compliance before officially reviewing hospitals for tax years beginning after December 29, 2015.\textsuperscript{13}

In addition to the four main requirements, there were new provisions requiring the IRS to review the tax-exempt status of each hospital every three years. For the first cycle of reviews,
based on fiscal years 2011, 2012, and 2013, the IRS identified 3,001 charitable hospitals and referred 13 organizations for examination and 14 organizations for compliance checks. According to the IRS, the ongoing review of issues included income tax, employment tax, and exempt purpose and, unless remedied, could result in a revocation of tax-exempt status.

Another new requirement is that the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, submit to Congress an annual report on the status of nonprofit hospital charity. After some delay, the first such report was released in 2015 for calendar year 2011 (the first complete year for which data from both departments was available) and showed that private, tax-exempt hospitals reported $62.4 billion in net community benefit expenses in Part I (Charity Care and Certain Other Community Benefits at Cost) of Form 990, Schedule H. The hospitals also reported $8.7 billion in bad debt and $6.9 billion in unreimbursed Medicare costs (shortfalls). The Treasury and Department of Health and Human Services are also required to provide a report in five years on the trends in these annual reports. Such tracking and reporting may eventually help inform the more prescriptive policies envisioned by Senators Grassley and Baucus.

When it comes to compliance, as written in the ACA, the 501(r) regulations apply to both hospital facilities and organizations. As clarified by the Department of the Treasury, a “hospital organization” is an entity recognized (or seeking to be recognized) as described in section 501(c)(3) that operates one or more hospital facilities while a “hospital facility” is an entity that is licensed, registered, or similarly recognized as a hospital by a state government. In addition, hospital organizations also include “any other organization that the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption” under section 501(c)(3).
Overall, measured against the hope to require nonprofit hospitals to spend at least 5% of revenues on charity care (the Grassley Requirement), the effect of 501(r) on charity care is likely to be mixed and requires further study. The ACA did not establish any specific minimum charity percent nor did it stipulate that hospitals needed to spend at least the equivalent value of their tax exemptions. Instead, as discussed in the Introduction, the most current language employed by the IRS is a facts and circumstances test (the Facts and Circumstances Requirement) to assess whether a hospital’s community benefit expenditures are sufficient to support its 501(c)(3) charitable status under the community benefit standard.26,35

**Form 990, Schedule H.** In order to go beyond previous ambiguities and obtain more accurate and complete data to measure the facts and circumstances, the IRS concurrently moved forward with the national measurement of community benefit through a redesigned tax form for nonprofit hospitals in 2009. As will be detailed in in the “Narrow Definition” section, this Form 990, Schedule H was intended to create a common reporting system within the nonprofit hospital sector to capture information on the various policies and practices related to the provision of community benefit. All 501(c)(3) hospitals and health systems are required to submit this IRS tax form and a $50,000 excise tax and possible civil and/or criminal consequences were established for hospitals that fail to report.36 The ACA requires IRS audits to ensure nonprofit hospitals comply with Form 990 and Section 501(r) regulations.37 Where the previous schedules simply asked open-ended and general questions regarding hospital community benefit activities, the new Form 990, Schedule H now asks specific, quantifiable survey-like inquiries related to many possible community benefit items. Some items also have a descriptive qualitative component.
Federal Actions  Enacting both 501(r) and Form 990, Schedule H reporting requirements allows for first-time national community benefit assessment which the US government says will help to build a baseline that will inform the ongoing conversation.\textsuperscript{35} As with many other health policy actions, it may only be a matter of time before the information currently being collected will result in a final policy ruling on what community benefit activities private, nonprofit hospitals must complete in order to fulfill their charitable mission, maintain their tax-exempt status, and make sure that the public is obtaining value for the loss of tax revenue.

Despite such a long lag time with IRS compliance reviews, there has already been Congressional interested in assessing the necessary circumstances to ensure that hospitals are meeting their charitable responsibilities through 501(r) specifically and through the community benefit standard generally. For example, following reports of aggressive billing of low-income patients in 2015, including thousands of lawsuits and paycheck garnishments, Senator Grassley formally requested a review of the billing and collections practices from the Missouri hospital. According to the senator, the hospital is “arguably not following the spirit of the law when it comes to providing a community benefit and adhering to the charitable hospital requirements” and “may not be meeting the requirements to be a nonprofit, tax-exempt hospital.”\textsuperscript{38 p.2} Not only did the hospital sue more patients than any other Missouri hospital, the majority of those sent to collections and pursued in the lawsuits were uninsured persons who were eligible for financial aid. A hospital spokesman said that many people do not receive charity care because it is reserved for patients who “seek it and legitimately work with us.”\textsuperscript{38} However, according to the senator, this is in direct contradiction to the 501(r) law requiring that nonprofit hospitals make reasonable efforts to determine whether an individual is eligible for assistance before engaging in extraordinary collection actions. Furthermore, many were charged full price for their medical
care (in addition to fines and late fees) which also seemed to break the law. The senator even called out the use of an in-house, for-profit debt collection agency as especially egregious and said that such “abusive billing and collection practices” were extremely punitive and unfair to both low-income patients and taxpayers who subsidize charitable hospitals’ tax breaks." 38 p.1

The hospital organization may ultimately fail the Facts and Circumstances Requirement and lose their tax-exempt status.

**State and Local Actions.** Concurrent to the federal policy debate regarding assessing the community benefit activities of private, nonprofit hospitals, there have been numerous developments within the individual states. While the IRS community benefit standards serve as the requirement for tax exemption on a federal level, nonprofit hospitals are also exempt from paying state and local taxes (including property taxes) with each municipality free to set up their own justifications for exemption. Most states and local governments have opted to either emulate the federal standards or use federal exemption in and of itself as a reason to grant tax exemption. Nevertheless, there exists variation among community benefit regulations on the state level that may influence charitable giving. 39, 40

Of the states that have distinct community benefit requirements, more than half have mandated that the hospitals make a public disclosure of their activities to government agencies and often to the public as well. 39 A few, however, have gone even further and have set minimum thresholds for charity. As of early 2016, this includes five states: Illinois, Nevada, Pennsylvania, Texas, and Utah. 41 Comparable to a Grassley Requirement based on having to spend a certain percent of every revenue dollar earned on community benefit, all nonprofit hospitals in Nevada must provide 0.6 percent of their annual net revenue to provide free care to indigent inpatients.
Similarly, Texas stipulates that charity care and government-sponsored indigent health care (such as Medicaid) must be provided in an amount equal to at least four percent of the hospital organization’s net patient revenue. However, Texas also allows hospitals to justify their tax-exempt status via a third policy model allowing nonprofit hospitals to justify their tax-exempt status by providing community benefit amounts equal to at least 100 percent of the worth of the hospital’s or hospital system’s tax-exempt benefits (the Tax Value Requirement). Illinois follows a similar model requiring nonprofit hospital organizations to contribute annual community benefits in an amount exceeding its annual property tax liability, while Utah contains a variant of the model requiring substantial gifts to the community to offset tax imbalances.

Texas also has an alternative option, similar to the Facts and Circumstances Requirement, since a nonprofit hospital may also qualify as tax-exempt if their community benefits are “reasonable in relation to the community needs, as determined through the community needs assessment, the available resources of the hospital or hospital system, and the tax-exempt benefits received by the hospital or hospital system.” Thus, it is possible to simultaneously employ more than one community benefit requirement model.

As another example of a hybrid model, Pennsylvania law permits nonprofit hospitals to choose from among seven community benefit standards with six specifying a minimum level of community benefits. Some of the options are based on the number of individuals receiving free care and/or the percent of net operating income. Pennsylvania law also allows for nonprofit hospitals to justify their tax-exempt status through an Expense Requirement model which stipulated that community benefit can be no less than 3% of total operating expense.

Although there is always apprehension that the federal government will revoke tax exemption, the policy movement to ensure nonprofit hospitals are truly acting charitably has
resided most recently with local municipalities. Whether state and local governments are seeking increased property revenue to cover budget deficits or ensure that the public receives concomitant benefit for the loss of tax revenue is up for debate. For certain, though, is that numerous localities have taken forceful action against these charities, including the complete revocation of their tax-free status. For example, a court case in June of 2015 pulled a Morristown, New Jersey medical center’s property tax exemption for acting too much like a for-profit business (including compensating $5 million to its CEO) and the hospital was told to reimburse the local town more than $1 million per year in taxes.\textsuperscript{42} The judge concluded that if all hospitals operated similarly then “for purposes of property tax-exemption, modern nonprofit hospitals are essentially legal fictions.”\textsuperscript{43 p.1} Within a short period of time, such precedent opened the door to similar challenges across the state and within months over a dozen New Jersey hospitals faced tax challenges in court. To stop a flood of lawsuits, the state legislature quickly drafted a bill to allow nonprofit hospitals to keep their tax exemptions if they paid their municipalities $2.50 per day for each hospital bed and $250 a day for each emergency-care facility. However, this was vetoed by the governor with experts saying that the bill was hastily written and may have singled out hospitals for special treatment in violation of the state constitution. The governor subsequently proposed a two-year freeze on lawsuit payments so that a property tax exemption commission can study the issue.\textsuperscript{42} The situation will likely prompt the state nonprofit hospitals to partner with state lawmakers to more clearly define how to preserve tax-exempt status, although many worry that the issue needs to be resolved now and not in two years.\textsuperscript{42}

Similarly, in a case that is almost certain to be heard before the Illinois Supreme Court or cause movement in the state legislature, the Illinois 4th District Appellate Court ruled in 2016
that part of a 2012 law that allows hospitals to avoid taxes is unconstitutional since the Illinois Constitution only allows lawmakers to exempt property "used exclusively" for "charitable purposes" and that many nonprofit hospitals have mixed-used property.\textsuperscript{44} The mayor of the Urbana lawsuit says the hospital will be the largest taxpayer in the city and that once the hospital properties are assessed their property taxes, Urbana residents could see their property taxes go down 11 percent or more. According to the mayor, "this is an issue in the whole country, that there are very large institutions that call themselves not-for-profit and don't pay taxes, when in fact they are making very large profits."\textsuperscript{45} p.1

The Urbana case dates back more than a decade when the Illinois Supreme Court found that some nonprofit hospitals were behaving like for-profit businesses and should therefore not qualify for tax exemptions. The state Department of Revenue subsequently denied tax exemptions to three hospitals in 2011 and signaled that more could follow. However, in 2012, the governor signed legislation that clarified the definition of charity care to allow hospitals to remain tax-exempt if they provided services at least equal to the estimated value of their property tax bill.\textsuperscript{44} Since the new ruling would now have state-wide application, the Illinois Attorney General is asking an appeals court to hold back enforcement of its ruling pending further appellate review in the state Supreme Court while others are looking for an amendment to the state Constitution itself.

Analogous to the cases in New Jersey and Illinois, the former mayor of Pittsburgh, Pennsylvania sued the University of Pittsburgh Medical Center (UMPC) in 2013 in order to revoke that system's tax-exempt status. In this case, the city argued that UPMC was not acting charitable since it donated less than two percent of revenues to community benefit, engaged in expensive advertising campaigns, and wantonly closed hospitals in low-income areas. In
addition, the suit said UMPC was not acting like a purely public charity since twenty of its executives collected million dollar salaries including the President and CEO who received nearly $6 million in compensation annually. These executives concurrently rented the most expensive office space in the tallest downtown building and had access to a dedicated chef, chauffeur, and private jet.\textsuperscript{46} UPMC is Pennsylvania’s largest nongovernmental employer and Pittsburgh’s largest property owner. The lawsuit sought to remove the hospital organization’s exemption from paying both payroll and property tax with an estimated value of $20 million a year for the city and $200 million a year for the state.\textsuperscript{46}

The lawsuit came five years after the health system successfully held off the city from filing similar litigation. At that time, UPMC remarkably pledged $100 million to a program called the Pittsburgh Promise which aims to provide every Pittsburgh Public School student with a college scholarship. The fund is open to all students enrolled in a public school since 9th grade with grade point average of at least 2.5 (out of 4.0) who graduated with a minimum attendance record of 90\%. UPMC helped to recruit other nonprofits to donate and, as of 2014, the program has spent over $55 million on 5,500 students. The scholarships for the class of 2012-2016 were $10,000 per year per student or $40,000 total over a four-year period. Impressively, the college retention rates of these public school students is approximately double what they were before the scholarship was established.\textsuperscript{47}

Nevertheless, despite such charity, the relationship between UPMC and the municipality quickly dissolved and the city was soon pressing forward with the lawsuit to force the hospital organization to do even more for the community. In the end, however, a judge dismissed the latest case saying that the city erred in suing the entire 21-hospital system and not its individual member entities. The city had the option of making its case against each individual subsidiary,
but has decided to focus instead on “other opportunities to really become a good neighbor” with UPMC which could include housing developments, job training, and youth programs.  

Other state legislatures across the country are continuing to examine laws that would toughen requirements to support tax-exempt status. For example, while the bill made no changes to how much community benefit must be provided, recently introduced legislation in California would have more clearly stipulated how spent amounts were to be allocated. Although the legislation failed to pass committee status, Senate Bill 346 specified that at least 90 percent of community benefit spending (expenses) were to be allocated to improving community health for underserved and vulnerable populations or to addressing a specific need identified in the community health needs assessment and that at least 25 percent should be allocated to community building activities (including physical environment improvements, housing, economic development, community health improvement advocacy, coalition building, and workforce development) geographically located within underserved areas. In order to meet such criteria, the law would have allowed community benefits projects to simultaneously satisfy both requirements. The bill also mandated the creation of a community benefit advisory committee to solicit community input, the transparent reporting of the approval process of the community benefit plan by the governing board, and more uniform reporting and accounting of the amount of community benefit being spent. The law also clearly stipulated that community benefits would not include the unreimbursed cost of providing services to those enrolled in Medicare (Medicare shortfalls) or accounts written off as bad debt.

Similar to what is playing out nationally with the American Hospital Association, the bill had strong opposition from the California Hospital Association who said the law would create an unnecessary layer of bureaucracy and that a narrowly-defined reporting system would limit a
hospital organization’s ability to tailor specific programs to population health needs. In addition, limiting spending to the poor or underserved could be problematic for hospitals located in affluent areas. Proponents of the legislation, including the California Nurses Association, contended that increased transparency would provide better public understanding of how such hospitals are investing in the communities they serve. Either way, the debate about reforming the way states regulate nonprofit hospitals is likely far from over considering that the bill fell just one vote short of passing the state Senate Health Committee and that the legislation resulted in highly publicized demonstrations at the state Capitol by the nurse’s union and other supporters.

ADDRESSING POLICY CONSIDERATIONS

Within the policy debate to perhaps enact the Grassley, Expense, or Tax Value Requirement to ensure nonprofit hospitals are providing sufficient community benefit, the two competing schools of thought (previously discussed in the Introduction) include: 1) the Catholic Health Association (CHA) which advocates for a “Narrow Definition” consisting only of the eight items found in Section I of Form 990, Schedule H and 2) the American Hospital Association (AHA) which believes that, in addition to these eight groups, the categories of bad debt expense and unreimbursed Medicare costs should also be counted toward an “Expanded Definition” of community benefit. Both sides agree that, if incurred, community building activities should be considered; however, the IRS is still investigating whether such expenditures should count as community benefit.

Narrow Definition. The Catholic Health Association (CHA) began publishing “A Guide for Planning and Reporting Community Benefit” in 2006 which has since developed into the
generally accepted spending categories that qualify as meeting the community benefit standard. According to the CHA community benefit guide, a community benefit is a planned, managed, organized, and measured approach to a health care organization meeting identified community health needs. It implies collaboration with a “community” to “benefit” its residents, particularly the poor, racial, cultural, or ethnic minorities, and other underserved groups, by improving health status and quality of life. The guide has six foundational beliefs:

- Those who live in poverty and are vulnerable have a moral priority for services.
- Nonprofit health care organizations have a responsibility to work toward improved health in the communities they serve.
- Health care facilities should work collaboratively with community members, organizations and agencies in their community benefit programs to achieve shared goals for community health improvement.
- Health care organizations must demonstrate the value of their community benefit programs.
- Commitment to community health improvement should be reflected throughout health organizations.
- Leadership commitment is required for effective community benefit programs.

This CHA classification includes eight items: 1) charity care (financial assistance) calculated at cost, 2) Medicaid shortfalls, 3) unreimbursed costs from other means-tested government programs (such as the State Children’s Health Insurance Program (SCHIP)), 4) community health improvement services and community benefit operations, 5) health profession education losses, 6) subsidized health services, 7) research losses, 8) cash and in-kind contributions for community benefit.

Together, these eight categories, captured on independent line items in Part I of Form 990, Schedule H called “Charity Care and Certain Other Community Benefits at Cost” comprise the central elements in the IRS’s effort to obtain a description of a nonprofit hospital’s
community benefit activities. They also comprise the “Narrow Definition” of community benefit that may someday define the Grassley Requirement that all hospitals spend at least 5% of their revenue on charity or the Expense Requirement that all hospitals must spend 3% of their expenses in charity. Below, detailed information for each of these eight items is provided.

1) Financial Assistance

The first category, financial assistance or charity care, is perhaps the easiest to justify as community benefit since it represents funds which go directly to providing either free or reduced-cost care to patients in need. This includes sums forgiven to persons who cannot afford to pay either all or part of their medical bills and who meet the criteria specified by each hospital’s own financial assistance policy (also known as a charity care policy).9

2) Medicaid Shortfalls

Medicaid, the state health program mostly for individuals and families with low incomes and disabilities, is commonly known to have low reimbursement rates and any loss (shortfall) incurred while delivering such services are also generally well accepted as charity.9

3) Means-Tested Program Shortfalls

Unreimbursed costs (shortfalls) from other means-tested government programs such as SCHIP or other Medicaid-like programs generally are uncontested as charity that benefits public health.9

4) Community Health Improvement

This category includes both community health improvement services and community benefit operations. The former includes programs that are carried out for the express purpose of improving community health such as childhood immunization efforts, health fairs, or other activities carried out to improve community health such as community education, outreach, and
prevention services. Support services to help individuals enroll in health insurance through the online health insurance exchanges (marketplaces) would count as would transportation provided to low-income persons to increase access to care. Such activities cannot generate inpatient or outpatient bills, although they may involve a nominal fee such as a small payment for flu shots provided in a community setting.\textsuperscript{12} To be reported, the community need must seek to achieve a community benefit objective as established through a community health needs assessment, a request from a public health agency or community group, or other documentation. The latter includes activities associated with conducting community health needs assessments and other community benefit planning operations such as the cost of software tools used to proactively assist decision support making for the granting of financial assistance. These, too, are generally accepted as activities that, if undertaken at a loss, should count as charitable deeds.\textsuperscript{9,12}

5) Health Professions Education

Any losses incurred while educating health professionals, such as medical residents, nursing students, and other health professionals, is viewed as benefitting the general public, so these categories are also noncontroversial. However, the purpose of the educational programs should be to educate professionals in the broader community who are seeking a degree, certificate, or training necessary to retain state licensure or certification. It should not include education or training programs available only to the organization’s employees and medical staff.\textsuperscript{9}

6) Research

Research includes studies or investigations that are designed to generate public knowledge. It indicates organizational concern for the long-term welfare of the community and/or the generation of knowledge used to enhance the future of healthcare.\textsuperscript{12} Allowable research activities include studies which seek to increase knowledge about underlying biological
mechanisms of disease, processes affecting health or illness, and studies of healthcare delivery system changes. It can include the costs of research equipment, staff salaries, animal facilities, data collection expenses, computer support, and dissemination of results such as publishing in a medical journal. However, only research funded by the government, such as through the National Institutes of Health or a tax-exempt source may be reported. Research that is funded by an entity that is not tax-exempt (such as pharmaceutical industry-sponsored research) cannot be included.9,12

7) Subsidized Health Services

Subsidized health services are clinical services provided despite a loss to the organization. Such services are provided because they meet a specific community need. If the services were no longer offered by the hospital organization, then the service would cease to be available altogether, would be supplied by others at a level below community need, or the provision of such services would fall to the government or another nonprofit organization.12 For example, a hospital that continues to operate an inpatient mental health unit that loses money would be placed into this category since closing the unit would be a detriment to public health. Outpatient clinics designed to assist low-income communities would also count as would hospital system-owned skilled nursing facilitates operated at a loss.9 In both instances, the difference between the revenue received and expenses incurred for these services (i.e. the loss) would be added as a community benefit.

8) Community Group Contributions

Cash and in-kind donations to community groups are another generally unchallenged way that nonprofit hospitals can give back to the community to justify their tax exemptions. These payments by the health care organization are used to support community benefits provided by
others and can include the value of space provided for support groups such as Alcoholics Anonymous or donation of food, equipment, and supplies. Grants to community groups to address community health needs, such as grant to a nonprofit children’s rehabilitation camp, may also be reported as a community benefit expense. Similarly, in-kind contributions may include the value of staff time spent helping a homeless shelter medical clinic as part of their work assignment. Any volunteer efforts off company time are not to be reported.⁹,¹²

According to the Instructions for Form 990, Schedule H, hospitals are to report the “total community benefit expense” for each category, or the total gross expense of the activity incurred during the year in both “direct costs” and “indirect costs.”⁹ Direct costs include salaries and benefits, supplies, and other expenses directly related to the actual conduct of each activity or program while indirect costs are expenditures that are shared by multiple activities or programs, such as facilities, administration, and infrastructure (for example space, utilities, custodial services, security, information systems, and materials management).⁹ Perhaps most important, any income generated by the activity or program, such as reimbursement for services provided to patients, is then subtracted to achieve the Net Community Benefit Expense for each category.⁹

**Expanded Definition.** On the other side from the Catholic Health Association, the American Hospital Association (AHA) and many of the hospital organizations they represent have taken the position that an expanded definition of community benefit should be used which would include all 8 categories in the narrow classification, but also include the categories of bad debt expense and unreimbursed Medicare costs, both of which are captured in Part III of Form 990, Schedule H called “Bad Debt, Medicare, & Collection Practices.” These two categories have been called by senior IRS officials as “the most controversial issues we sought input on”
because “some hospitals treat [them] as community benefit and some don’t.” Together, these ten items comprise an “Expanded Definition” of community benefit that may someday define the Grassley Requirement that all hospitals spend at least 5% of their revenue on charity or the Expense Requirement that all hospitals spend at least 3% of their expenses on charity.

Key to policymakers, the Catholic Health Association guide recommends that neither bad debt nor Medicare shortfall be counted as a community benefit. In terms of accounting, bad debt consists of services for which hospitals anticipated reimbursement (because the patient has been determined to have the financial capacity to pay) but did not receive payment. They are hospital bills that the organization is still trying to collect and will send to a collections agency (or pursue via other collection methods) if they are not paid. Charity care, in contrast, consists of services for which hospitals neither received, nor expected to receive, payment because of the patient’s determined inability to pay. It represents hospital bills that the organization is not trying to collect (i.e. they have forgiven the person of their debt because the person met the threshold of free/discounted care set by the hospital’s own financial assistance policy).

Amongst other reasons for exclusion, opponents say that bad debt should not be considered charity because allowing hospitals to “write off” bad debt as community benefit might lessen the incentive to collect upon debts from those who were deemed able to pay (i.e. had income too high to qualify for any discounts). In this situation, an IRS policy could be unintentionally rewarding poor collection efforts on the part of the hospital to recoup copays or deductibles. Such organizational inefficiency could then lead to patient accounts that do not need financial assistance being counted as community benefit.

Furthermore, allowing bad debt to count as community benefit may result in hospitals having less reason to separate bad debt from true charity care. They may simply bill everyone
(regardless of whether they could have qualified for charity care), wait to see who can and cannot pay, and then send the rest to collections. In this scenario, the hospital has less incentive to get patients out of bad debt and into charity care (they are both community benefit categories, so why bother?), so low-income patients who should have otherwise qualified for charity care may be unnecessarily sent to collections (which could gratuitously affect their credit score and/or needlessly push the individual toward bankruptcy). Thus, including the bad debt category toward a hypothetical Grassley or Expense Requirement could reduce incentives to actively collect upon debts, limit the proactive identification of charity care patients, and cause hospitals to “write off” more overall funds into the bad debt category. This is especially true if the marginal benefit of writing off the debt and showing a large community benefit amount (i.e. helping them to maintain their nonprofit status) is greater than the expected value of pursuing collection of the bill.

On the other hand, many advocate for the inclusion of bad debt as charity because at least some portion of what is categorized as bad debt will almost inevitably include charity care.\textsuperscript{53,54} For example, the sum may contain money owed by patients who qualify for public programs such as Medicaid or could have qualified for the hospital charity care program but do not end up applying.\textsuperscript{11} Consequently, in their regularly commissioned reviews of national Form 990, Schedule H reporting, the American Hospital Association consistently includes bad debt as part of total community benefit spending and has described patients who “are unwilling to provide documentation of their eligibility for charity care”\textsuperscript{55 p.9} and patients who would have qualified for financial assistance “if sufficient information had been available.”\textsuperscript{56 p.9} Forcing all hospitals to completely separate the portion of bad debt stemming from patients avoiding payment versus
those with true need could also be exceedingly difficult and place undue burden on hospital accounting systems.

Additionally, in an era of increasingly high deductibles and co-pays, bad debt is not limited to the uninsured and can include higher-income patients who refuse to pay.\textsuperscript{52} Such patients may consist of those with high deductibles who purchase a low-priced plans in an attempt to save money and are now caught off-guard when a health emergency occurs and they owe the entire deductible. Despite being sent to collections, some higher income individuals (who do not qualify for charity) may still refuse to satisfy their bills and such sums will end up in bad debt. Furthermore, whether a fund ends up in charity care or bad debt, any amounts not received by the hospital to cover provided services will still have to be incurred by the hospital and all uncollected funds could push the facility toward financial losses, bankruptcy, and even closure. For such reasons, the American Hospital Association and some in health services research have historically combined charity care and bad debt into a single category of community benefit.\textsuperscript{53,57}

As for the other debated category of unreimbursed Medicare, many dismiss such outlays as stemming from operational inefficiency rather than underpayment since hospitals with a focus on cutting costs may at least break even on Medicare payments.\textsuperscript{58} Medicare is also essentially universal and not means-tested, so it includes both the poor and affluent. Since separating the two would be exceptionally challenging, including all Medicare shortfalls may not meet the definition of community benefit.

The argument to include Medicare shortfalls embraces the notion that Medicare rates are not negotiable and are sometimes “out-of-line with the true costs of treating Medicare patients.”\textsuperscript{55,p.9} According to the American Hospital Association, hospitals have also claimed that
continuing to treat Medicare patients alleviates the federal government’s liability to directly provide medical services and that keeping Medicare payments lower than what most private insurers reimburse relieves the government of Hospital Insurance (HI) Trust Fund burden and extends the life of Medicare Part A. Also, similar to bad debt, any amounts left unpaid will still have to be incurred by the hospital and could push the facility toward bankruptcy or closure.

**Community Building Activities.** Besides the eight categories which make up the generally agreed upon Narrow Definition and the two additional categories captured in the Expanded Definition, the IRS is also gathering information in a third category called “Community Building Activities.” Collected in Part II of Form 990, Schedule H, this category includes actions not reported elsewhere that protect or improve community health and/or safety. Neither CHA nor AHA contested the inclusion of this grouping. Nevertheless, the IRS position on this grouping was that “there were some activities within community building that sure seemed like they should count as community benefit, and there certainly were some that didn't look to us like they should count, and then there was a large group of activities in between that would depend upon facts and circumstances.” Thus, whether deductions in these areas will be included in a future legislative definition of community benefit remains in question.

According to the IRS, community building activities include: 1) physical improvements and housing, 2) economic development, 3) community support, 4) environmental improvements, 5) leadership development and training for community members, 6) coalition building, 7) community health improvement advocacy, 8) workforce development, and 9) other activities. Although this section, and its subsequent categories, currently make up a fraction of most community benefit activities at nonprofit hospitals, there is the possibility that future legislative
action will place increased attention on these activities intended to address social determinants of health, especially as higher percentages of the public gain insurance through implementation of the Affordable Care Act.

Physical improvements and housing can include, but are not limited to, the provision of housing for vulnerable populations, neighborhood improvement and revitalization projects, and the development or maintenance of parks to promote physical activity. Economic development includes assisting small business development and creating new employment opportunities. Community support includes child care and mentoring programs, neighborhood support groups, violence prevention programs, and public health emergency activities such as community disease surveillance/ readiness beyond what is required by accrediting bodies or government entities. Environmental improvements can include activities to address ecological hazards that affect community health such as alleviation of water and air pollution. Leadership development and training for community members includes training in conflict resolution and civic matters. Coalition building includes participation in collaborative efforts with the community to address health and safety issues. Community health improvement advocacy includes efforts to support programs that improve access to health care services, housing, education, and transportation. Workforce development can include recruitment of physicians to medical shortage areas and training other health professionals needed in the community. Finally, funding used to support other activities that protect or improve the community’s health and safety that are not described in other categories may also be included as a community building activity.9

The issue with community building activities is associated with the IRS having difficulty determining how directly a specific hospital service connects to health outcomes. In designing Form 990, Schedule H, the IRS agreed that most of these activities were sources of primary
prevention which could help address the root causes of health problems.\textsuperscript{10} However, what was not clear to the IRS was whether they are consistent with the standard that applies to these hospitals which states that any community benefit activity must be directly related to a specific need identified in the community health needs assessment. For example, the IRS says that the connection between providing better housing to low-income people and the \textit{general} long-term health improvement for those individuals seemed plausible, but “there’s a much less \textit{direct} connection between that expenditure and promoting health.”\textsuperscript{10,49} In order to reduce ambiguity, the IRS Form 990, Schedule H instructions make an attempt to move as much of the community building activities as possible into the noncontroversial category of community health improvement.

Generally, community health improvements are activities that directly improve the overall health of individuals and populations while activities that strengthen the community’s capacity to promote the health and well-being of its residents are separated out as community building. While community health improvement is part of the narrow (non-controversial) definition of charity, what is left in community building activities currently may not be considered as community benefit. One example to clarify the difference would be physical housing improvements. According to the CHA, if funds are spent removing materials (such as asbestos or lead) that harm residents in public housing or providing specialized vacuum cleaners to low-income households of children with asthma to reduce exacerbations, then the spending should be allocated to community health improvement, one of the eight non-controversial categories of Part I of Form 990, Schedule H which make up the “Narrow” definition of charity.\textsuperscript{59} However, if the money was spent on a coalition aimed at efforts to address urban decay or revitalize a depressed community without a specific health issue in mind, then spending
would be community building activities and may not count as community benefit. The Catholic Health Association advocates that “an activity that might otherwise fit in one of the categories of community-building is reportable as community health improvement when the activity meets all IRS criteria for community health improvement.”¹² p.58

Ultimately, the IRS is looking to get a better understanding about a hospital’s responsibility for community building before they decide which ones might count as community benefit. The current standpoint is that while “certain of these community building activities might constitute community benefit or other exempt purpose activities, more data and study are required.”⁶⁰
CHAPTER 4: Public Health Policy Significance

From a fiscal standpoint, the overall significance of hospital community benefit contributions is immense. When accounting for tax forgiveness alone, the Congressional Budget Office found in 2002 that the estimated value of the various tax exemptions of the nonprofit hospital organizations was worth $12.6 billion.\(^3\) This figure included forgone taxes, public contributions, and the value of tax-exempt bond financing, and estimated that federal taxes accounted for about half of the value with exemptions from state and local taxes accounting for the remaining half.\(^3\)

More current approximations of the tax exemption value accruing annually to the roughly 3,000 nonprofit hospitals in the United States is much higher. For example, a 2006 Catholic Health Association commissioned study included the average federal income tax rate (35%), the average state income tax rate (5%), and the average local income tax rate (2.5%) on an organization’s profit along with the federal and state payroll unemployment taxes, the sales tax that would be incurred on supplies and equipment, real estate/property tax, personal property tax on fixed assets and inventory, the increased interest costs of taxable corporate debt, and the higher depreciation expense on equipment since sales tax would be added to equipment and other capital purchases. When totaled, the study estimated that the total national financial effect of losing the exempt status for all nonprofit hospital organizations is $20.7 billion annually.\(^6\)

Most recently, a study by Rosenbaum et al. (2015) which evaluated Form 990 tax returns from the year 2011 found that the estimated tax benefits for nonprofit hospital organizations included $6.3 billion in unpaid federal corporate income tax, $1.2 billion in unpaid state income tax, $3.3 in tax-exempt bond financing, $3.4 billion in charitable contributions, $6.1 billion in sales tax, and $4.3 billion in property taxes. In aggregate, the authors estimate that the total
value of the amount that the organizations would be required to pay should nationwide IRS Section 501(c)(3) charitable organization status be revoked was $24.6 billion in 2011.62

When measuring the benefits that a nonprofit hospital provides to its community, the potential public health impact of these sums is equally vast. With the introduction of the IRS Form 990, Schedule H, the kinds of activities hospitals might be able to provide to satisfy their community benefit requirement was greatly clarified. Since these documents are publicly available, the new transparency provides an opportunity for nonprofit hospitals and relevant stakeholders to re-evaluate the current approach to programming and assess how to better improve the health of communities and patient populations the hospitals serve.

With the ACA requirement for nonprofit hospitals to perform a community health needs assessment, hospitals across the country are also beginning to partner with state and local health departments and community groups like never before in order to improve community health and foster more coordinated policy and system changes.63 Additional ACA requirements that such hospitals must widely disseminate their charity policies coupled with regulations that hospitals must perform due diligence ensuring that qualified people are actually forgiven of their debt may reduce the number of cases that are sent to collections. Medical bills are the biggest cause of bankruptcy and millions struggle with health-care-related expenses, so reducing the anxiety, depression, shame, and inter-personal relationship issues that accompany financial troubles could similarly have a large public health benefit.64

St. Clair Hospital in Western Pennsylvania provides a good illustration of the way these efforts benefit the public and the inherent definitional complexities. According to its public tax documents, this single 328-bed hospital with a mission to “provide highly valued and service oriented healthcare for the community” had gross revenue receipts of $364M.65 The hospital’s
largest charity contributions included $4M in unreimbursed Medicaid expenses, $1.3M in free or
discounted charity care, and $1.1M in subsidized health services with a total of $7M being spent
on the generally accepted “narrow definition” categories of community benefit. These funds
went to myriad public health services, including donations to partnering agencies to provide
emergency food and clothing, a summer camp for kids, and early childhood education. The
hospital held Wellness Days including free health screenings and education, supported after-
school programs and other youth group activities, and provided numerous support groups free of
charge. They also donated to the local Boys and Girls Club, held food drives with the United
Way, and provided a courtesy van to provide free rides to and from the hospital. In total, these
non-controversial services accounted for 2% of their total revenue receipts.

While these activities certainly bring great public health benefit to the community, St.
Clair hospital also claimed $5M in Medicare shortfalls and $4.6M in bad debt. Together, these
debated categories more than double the hospital’s community benefit activities ($7M vs.
$16.7M) as well as their charitable percent of revenue (2% vs. 5%) which would subsequently
allow the hospital to meet a hypothetical Grassley Requirement. The inclusion of the extra
categories would similarly allow the hospital to meet an Expense Requirement. What factors are
associated with such spending, how these outlays compare to other hospitals nationally, and
whether this hospital is doing enough to justify its tax-exempt status (both in percent of charity
and type of activities) are amongst the research questions addressed by this dissertation.

Although St. Clair was not in the sample of hospitals in this research, speaking to
informants at such a facility could also help to determine the factors influencing the level of
Medicare shortfalls and bad debt, the organization’s ability to meet the 501(r) regulations, the
degree to which the community health needs assessment and the Form 990, Schedule H reporting
mandate have influenced their activities, and the challenges they experience in both assessing and addressing their community benefit requirements. Key informants from the hospitals could also help elucidate reasons why they would or would not be supportive of bad debt or Medicare shortfalls being included in any future legislative definition of community benefit, whether a minimum percent of spending should be established, how to account for community building activities, and other recommendations to policymakers.

Ultimately, through a mixed-methods study design including the IRS data and interviews with key informants, this dissertation provides a comprehensive, national view of how private, nonprofit hospitals are meeting the community benefit standard to improve public health. From the quantitative perspective, having a mandated and standardized tax record of how these hospitals justify their exemptions provides an accessible portrait of their activities and enables unparalleled comparisons on a national level. From the qualitative perspective, the ways hospitals view community benefit in relation to their mission and strategy, why organizations place greater or lesser reliance on the different categories, how they are actualizing new ACA requirements, and their insights into the possible policy implications of a federal ruling provide depth of insight beyond what is being publicly reported to the IRS.
CHAPTER 5: Literature Review

EARLY RESEARCH

The debate over the role of the hospital in the provision of charitable services is as old as the institution itself. However, discussions which formed the modern dialog only started to emerge after the 1969 community benefit ruling. For example, in a 1970 article, Newhouse discusses how “until very recently” the private nonprofit hospital was ignored by research theory.67 p.64 By this time, the sector had grown into a position of importance vis-à-vis revenue and total number of employed individuals which consequently produced increased scrutiny. Within a decade, health services researchers began to study the community benefit activities of nonprofit hospitals in much greater detail.

Hansmann (1980) agreed and also traced robust constructs of the effect of external stimuli on the nonprofit hospital industry to the early 1970’s.68 The character of the sector had now changed from independent charities which received most of their funding from donations to organizations whose structure and funding were more heavily dependent upon public policy. For example, with the advent of Medicare in Medicaid in 1965, nonprofit hospitals could increasingly generate revenue from billing practices similar to private businesses.69 The nursing home industry, which was small prior to World War II, also began to grow through large and growing public subsidies as did higher education and child care services.69 These industries, and others like them, started to blur the lines of traditional charities in a mixing of nonprofit, for-profit, and governmental partnerships; leading to new questions about the relative functions, appropriate behavior, and proper role of these organizations. Moreover, because of the increasing public funding, a deeper understanding of their underlying charitable nature became relevant for purposes of policy and research.69
Hansmann theorized that tax-exempt status is granted to nonprofits such as hospitals due to market failures. Hospitals and the physicians who staff these institutions have the advantage of asymmetric information vis-à-vis their patients and the power to act as their agents, which breaks down the rational purchasing decisions of the patient. Because of this, patients often prefer to deal with nonprofit hospitals because they are trusted to not exploit this advantage to make a profit. Hansmann found that the resulting “trustworthiness” is justification for the tax-exempt status of these institutions and suggested that public policy should be designed to further this goal.

Weisbrod (1980) developed a theory that laid a foundation for research related to the motivations of charitable giving using the concept of a public good to identify the types of activities that might be classified as community benefits. Since such services benefit all, whether one pays or not, he proposed that nonprofit organizations such as hospitals supply “public goods” which are undersupplied by the government and avoided by the for-profit sector. According to the model, the government only satisfies the need for the median voter which leaves excess demand within society. Similarly, the for-profit sector only provides services which will lead to profit which leaves additional demand for unprofitable services within the market. Thus, in order to meet community needs, the government should grant tax-exempt status to nonprofit hospitals which then allows them to provide services that would be left unfulfilled by for-profit and government-run hospitals.

Over the subsequent decades, the lack of a statutory definition of hospital charity also led to wide variation in the way community benefit was studied. As recently as 2009, only 15 states had community benefit requirements which tended to “vary substantially in scope and detail.” Subsequently, most explorations historically compared nonprofit hospitals to for-profit or
governmental hospitals on a state-by-state basis using inconsistent definitions to approximate whether the nonprofit institutions were justifying their tax-exempt status. As a result, most research prior to the advent of the Form 990, Schedule H was highly dependent on the ability to obtain usable data, how community benefit was constructed, and the methodological approach. Because researchers had such wide latitude in how they defined and measured these studies, inconsistent conclusions were a common finding.

In one early study comparing information available on Florida hospitals, Sloan and Vraciu (1983) found that the value of charity care provided at nonprofit hospitals and for-profit hospitals was similar and that all of the hospitals in their sample treated indigent and nonpaying patients to the same degree (both proxies for hospital charity care).\(^71\) However, the study examined only nonteaching hospitals under 400 beds. Interestingly, the same author included teaching hospitals in a later study (1988) and found that nonprofit institutions did provide significantly more charity care to self-pay patients than their for-profit counterparts.\(^72\)

In studying all short-term general hospitals in California from 1981-1986, Rundall, Sofaer, and Zellers (1990) evaluated trends in uncompensated care and other deductions from hospital revenues. The authors hypothesized that cost-containment efforts of the 1980s and the subsequent decline in reimbursements might reduce a hospital’s willingness or ability to provide uncompensated care. Defining uncompensated care as a combination of bad debt and charity care (since hospitals differ from each other and over time in whether and how they distinguish between these categories) minus gifts and subsidies for indigent care, the authors found that, even after adjusting for inflation, the amount of uncompensated care for all hospitals increased by nearly 50 percent during the period. The largest increase was in government nonteaching hospitals and the smallest increase was in voluntary (private, nonprofit) teaching hospitals.
Furthermore, uncompensated care represented a smaller portion of gross revenues for private facilities than government hospitals, especially government teaching hospitals. Thus, the authors ultimately conclude that the reimbursement pressures in California during this time may have limited the willingness or ability of nonprofit hospitals to expand their provision of community benefit (via the provision of uncompensated care), increasing the burden on governmental institutions and perhaps limiting the access of the uninsured to quality care.

By this time, community benefit pioneer Robert Sigmond was accusing nonprofit hospitals of being more concerned with generating income than the health of the community, offering the latest technology than avoiding unnecessary duplication of facilities, meeting the needs of professionals than serving the poor, and filling beds than responding to community problems affecting health status.\textsuperscript{73,74} Sigmond found that a hospital could “meet every legal and accreditation standard without any explicit consideration to the community, except in times of disaster.”\textsuperscript{73} p.1 Clear professional standards were in place for quality assurance and teaching programs and there were guidelines and ethical codes which contained community service responsibilities, but “these have never been translated into well-defined community benefit programs at any hospital.”\textsuperscript{73} p.1

In response, efforts began to expand the concept of community benefit beyond the simple provision of free services. A greater emphasis was placed on developing a planned approach to addressing community needs, in particular those of vulnerable populations and to coordinate efforts with community partners to implement effective programs.\textsuperscript{75} Education, health-related research, and other areas which benefit the greater community were added to the continually growing definition of community benefit as well. By the time the 2000s came along, studies of
community benefit were thus increasingly dependent upon a multifactorial construct of community benefit.

For example, Schneider (2007) found that the definition of community benefits can mean the difference between a nonprofit hospital justifying their tax-exempt status or not. He found that nonprofit hospitals provided significantly less community benefit than for-profit institutions when his own, self-derived narrow definition was utilized. Subsequently, his expanded definition of community benefit established that nonprofit hospitals met or exceeded the amount of charity being delivered by their for-profit counterparts. The author concluded that the results indicate the “need for a more explicit identification and minimum standard of the community benefits expected of nonprofit hospitals in return for their special tax treatment.”

Similarly, Ginn and Moseley (2006) found that nonprofit hospitals in states with independent community benefit laws reported significantly more community health orientation undertakings than did nonprofit hospitals in states without such laws. Interestingly, the same was true with for-profit hospitals in states with community benefit laws; indicating that having regulatory definitions of community benefit tends to increase charitable contributions and decrease ownership-related differences in community health activities.

Community benefit research outcomes are highly dependent upon the methodological approach as well. For example, Herzlinger and Krasker (1987) found that nonprofit and for-profit hospitals do not substantially differ in their contribution to community health needs when they studied hospital systems in 1977 and 1981. However, Arrington and Haddock (1990) used hospital data from the same time period (1982) that included both system and non-system hospitals and found that, combined, these nonprofits had more social benefit, access to care, and involvement in professional education than for-profit hospitals. Similarly, in a 1997 study of
all U.S. hospitals, Mann et al. found that nonprofits were spending more on uncompensated care than for-profits, although the difference was declining with non-profits spending approximately 25% more on uncompensated care than for-profits in 1983 and just 16% more by 1994.6

Private sector investigators are not the only ones with interest in studying the community benefit activities of private hospitals. For example, a 1994 Prospective Payment Assessment Commission (PROPAC) study of all U.S. hospitals found uncompensated care (charity care) at nonprofit hospitals amounted to four and a half percent of revenues while uncompensated care in for-profit hospitals amounted to four percent of revenues.79 A 2006 study by the United States Congressional Budget Office (CBO) found that nonprofit hospitals were significantly more likely than for-profit hospitals to provide unprofitable services such as intensive care for burn victims, emergency room care, high-level trauma care, and labor and delivery services.3

Also relevant, a 2008 Government Accountability Office (GAO) study found that nonprofit hospitals “may not be defining community benefit in a consistent and transparent manner that would enable policymakers to hold them accountable for providing benefits commensurate with their tax-exempt status.”2 They found that consensus exists to define charity care, the unreimbursed cost of Medicaid, and many other activities that benefit the community as being community benefit. However, the GAO did not find consensus in defining bad debt or unreimbursed costs for Medicare.2 Given the critical role of nonprofit hospitals to public health, the GAO ultimately stressed the importance of policymakers, industry groups, and researchers to continue the discussion addressing variability in defining and measuring community benefit activities.

CONTEMPORARY RESEARCH
In more recent times, Bazzoli et al. (2010) were one of the first to study advances in the national consensus regarding community benefit measurement using the categories in the current Form 990, Schedule H.\textsuperscript{11} However, national information still was not available at that point and the authors utilized only California and Florida data due to advanced reporting requirements in those states. Interestingly, the authors selected a baseline period of 2005, before the CHA published its 2006 guidelines and before the creation of Form 990, Schedule H. Thus, their research represents a time before reporting standards were nationally accepted and can be used as a baseline for future studies to compare changing hospital behavior.\textsuperscript{11}

Results from the study showed the adequacy of community benefit provisions were highly dependent on the definition of community benefits used. Both California and Florida nonprofit hospitals provided less community benefit per bed than for-profit hospitals when a narrow definition of community benefits was used. However, when allowing for bad debt costs and Medicare shortfalls, these hospitals provided statistically similar community benefit as for-profit hospitals. This suggests that many of the nonprofit hospitals may be very likely to advocate with the American Hospital Association for adoption of the expanded definition in order to justify their tax-exempt status.\textsuperscript{11}

Bazzoli et al. (2010) also showed that charitable contributions were related to specific hospital attributes. For example, nonreligious hospitals in Florida provided less community benefit as compared to for-profit hospitals. In both states, larger hospitals (by bed size) consistently provided more charity service than smaller hospitals regardless of how community benefits were measured (narrow or expanded). The same was true for teaching hospitals in California, but not in Florida. In addition, rural communities in Florida provided significantly
less charity under both definitions while no significant relationships were found for market variation such as Health Maintenance Organization (HMO) competitive market share. A 2013 Ernst & Young study commissioned by the AHA analyzed Form 990, Schedule H data on a sample of approximately 30% of nonprofit hospitals from tax year 2010. According to the publication, participating hospitals and systems reported an average of 11.6% of total expense providing benefits to the community. Such results led the AHA to conclude that “hospitals of every size, type and general location are not only meeting, but are exceeding, the community benefit obligations conferred by their tax-exempt status.” However, finding was based on the assumption that bad debt and Medicare losses should be included in determining total benefits to the community. This is unsurprising since the AHA is heavily advocating for the inclusion of these two categories in the definition.

Upon further examination, Ernst & Young found that hospitals spent just 8.2% of their total expenses on the non-controversial categories in Part I with another 2.8% and 0.5% going to Medicare loses and bad debt, respectively. Furthermore, using only the narrow definition, they found that large hospitals, urban/suburban hospitals, and children’s hospitals provided the greatest percentage of benefits to the community.

For their sample of 524 responding hospitals and systems, the study also found that over 80% of the hospitals reported bad debt expense attributable to charity care on their Schedule H submissions, indicating that they billed many patients who could not afford care. Although the study does acknowledge that the IRS provides minimal instruction on how to calculate this amount (which leaves much “wiggle room”), the average bad debt expenses in 2010 was found to be $1.8 million per institution. The study provides a single qualitative example about the rationale for including bad debts amounts in community benefit: “The Hospital believes that this
cost is a community benefit because patients, who would likely qualify for assistance under the Hospital's Charity Care policy, do not or are unwilling to provide documentation of their eligibility for charity care, and are therefore classified as bad debt." Yet, despite the fact that the hospitals indicated that only “about 5% of their bad debt expense would be attributable to charity care,” the AHA added the full national amount spent on bad debt percent (0.5%) to arrive at its countrywide average of 11.6% of expenses providing benefits to the community (the national total would have been 11.1% otherwise).

For losses on Medicare, the study found that 74% of participating hospitals and systems reported having shortfalls. The three examples that Ernst & Young provided to explain why some hospitals contend that Medicare shortfall should be treated as community benefit are: 1) “non-negotiable Medicare rates are sometimes out-of-line with the true costs,” 2) that “by continuing to treat patients eligible for Medicare, hospitals alleviate the federal government’s burden for directly providing medical services,” and 3) “if a hospital serves patients with government health benefits, including Medicare, then this is an indication that the hospital operates to promote the health of the community.”

Following the conceptual framework established by Bazzoli et al., Young et al. (2013) were among the first to use Form 990, Schedule H data to study the level and patterns of community benefit activities. In their publication in the April 2013 issue of the New England Journal of Medicine, the research used data from 2009 which was the first year that all nonprofit hospitals were required to report. Not only did the study aim to describe, for the first time, the level, pattern, and variation of charitable spending, it also aimed to discover whether any of the variation among the public charities was associated with any of the institutional-level, community-level, and market-level variables established by Bazzoli et al.
Using the publicly available filings in the GuideStar.org nonprofit database, the authors performed their study on approximately 1,800 hospitals which represented roughly two thirds of all private, tax-exempt hospitals that provide general, acute-care services. The remaining hospitals which represented nearly one-third of the market were selectively excluded because they represented a hospital system which filed a single report for all member hospitals (e.g., Kaiser Permanente). According to the authors, although the study “somewhat underrepresented system-affiliated hospitals,” the remaining hospitals “were generally similar to all private, tax-exempt hospital in the United States that provide general, acute care services.” This declaration was based on comparing the single-file hospitals used in the study to the entire population which was similar in aspects such as percent with religious affiliation, percent in urban areas, percent that were a teaching hospital, and size (as measured by number of beds).

For the analysis, Young et al. (2013) used all eight of the spending categories in Part I of the 990, Schedule H as outcome metrics. This included charity care (financial assistant at cost), community health improvement services and community benefit operation (such as childhood immunization programs), health professions education, subsidized health service (such as mental health programs operated at a loss), research, and financial contributions to community groups for the purpose of benefiting the community. The authors also combined two line items in Part I (losses from Medicaid and losses from the costs of other means-tested government programs) into a single category they called “unreimbursed costs for means-tested government programs.” Similar to other studies, the authors then normalized these outlays as a percent of total operating expenses reported on Form 990. The research did not examine any of the Community Building Activities included in Part II or the categories of bad debt and Medicare losses found in Part III of Form 990, Schedule H nor did it examine spending as a percent of income (revenue).
Young et al. (2013) did combine the spending in Part I into two constructs. The first comprised the first three line items of Part I (charity care, Medicaid losses, and costs of other means-tested government programs) which the IRS labeled “Financial Assistance and Mean-Tested Government Programs” and called it Direct Patient Care. The second construct contained the other five line items in Part I labeled by the IRS as being “Other Benefits” and was called Community Service. Two multiple-regression models were used with each of these measures as the outcome variables. The independent variables comprised institutional-level factors (such as number of beds, teaching status, church affiliation, and profit margin), community-level factors (such as community affluence and presence of state-level community benefit requirements), and market-level factors (such as market competition, percent of uninsured, and percent of for-profit hospitals in the county).

Since this was a new source of administrative figures, the authors took multiple steps to ensure the validity of the data including comparing the expenditures reported in the tax documents to other data sources. For example, they compared the amount claimed for health professions education to the number of medical residents and other trainees reported that year to the American Hospital Association. Such validations showed high correlation between what was reported to the IRS versus what was being reported to other organizations.

The overall results of the study showed that, in 2009, the nation’s single-file hospitals reported an average of 7.5% of their operating expenses going to the categories in Part I of Form 990, Schedule H with the top spenders (those in the top decile) allocating an average of 20.1% and the bottom spenders (in the bottom decile) spending 1.1% of their operating expenses on community benefit. Most this spending (45.3%) went to losses related to means-tested government insurance programs like Medicaid, 25.3% went to financial assistance at cost
(charity care), and almost 15% went to losses on subsidized health services (like mental health programs). Education and community health improvement were both allocated 5.3% of every dollar spent while 2.7% and 1.3% went to contributions to community groups and research, respectively.\textsuperscript{40}

Results from the regressions showed very few factors were associated with spending, regardless of how it was measured. For example, the provision of community benefit was not associated with any of the market-level characteristics and only one community factor, the presence of state-level policies requiring public reporting of spending, was positively associated with both constructs of spending (Direct Patient Care as well as Community Service). None of the institutional characteristics were associated with Direct Patient Care spending and only being a teaching hospital as well as being a Sole Community Hospital (a special Medicare designation for hospitals that meet certain criteria, including being located at least 35 miles from another like hospital) were associated with Community Service spending.\textsuperscript{40,80}

In their discussion, the authors noted that the amount of uninsured, the income level of the population, nor most of the institutional, community, or market-level variables had any bearing on hospital charity which suggests “a lack of correspondence between community need and the provision of benefits by hospitals” and raises questions about how hospitals decide which and how much community benefits to provide.\textsuperscript{40,p.1524} Furthermore, since only state-level requirements for public reporting were significantly and positively associated with overall spending in Part I, the authors also noted that the most important factor which could predict spending was related to the promotion of transparency. However, because their study only examined cross-sectional quantitative data, the authors suggested that the connection between reporting mandates and the provision of community benefit requires further investigation,
especially as the Affordable Care Act (ACA) increases requirements for accountability and transparency.

Other recent publications using Form 990, Schedule H data include a Federal Office of Rural Health Policy-funded study by Gale et al. (2015) which compared Critical Access Hospitals (CAHs) to other rural as well as urban hospitals in relation to their the charity care and bad debt activity.\textsuperscript{53} Under Medicare Conditions of Participation (COP), a CAH is a specially designated hospital which, among other requirements, must have no more than 25 beds, maintain an annual average length of stay of less than 4 days for acute inpatient care, and be located in a rural area at least 35 miles drive away from any other hospital.\textsuperscript{81} Certification allows CAHs to receive cost-based reimbursement from Medicare which tends to enhance the financial performance over the standard fixed reimbursement rates received at other hospitals.

Using data from the tax year 2009, a total of 2,074 hospitals who filed alone (as opposed to filing as part of a consolidated system) were examined. According to the authors, this figure included all non-profit CAHs (529), all rural hospitals (361), and all urban hospitals (1,184) that filed as individual that year.\textsuperscript{53} As with previous studies, their findings were highly dependent on methodology. For example, the authors combined both charity care (reported in Section I of Form 990, Schedule H) and bad debt (reported in section III of Form 990, Schedule H) into a category they called “Combined Uncompensated Care.” They then divided this total into the overall hospital expenses (as opposed to total revenue) and found that CAHs reported higher levels of Combined Uncompensated Care at 7.4% compared to other rural and urban hospitals at 5.9% and 5.1%, respectively.\textsuperscript{53} However, breaking this measure into its component parts reveals that the CAH facilitates provided less charity care (at 1.8%) than other rural (1.8%) and urban
hospitals (2.3%) as measured as a percentage of total expenses while they claimed greater levels of bad debt (5.6%, 3.6%, and 2.8% respectively).  

Although all of the charitable categories reported in Schedule H represent services that were provided without reimbursement or were delivered at a higher cost than they were reimbursed, the authors say that higher amounts in these two specific categories are noteworthy because “the challenge of disentangling charity care and bad debt makes it difficult to draw conclusions about the true extent of charity care provided by CAHs.”  

These two categories represent what Gale et al. (2015) refer to as “points on a continuum” which are influenced by “decisions involving the hospital’s income eligibility criteria for charity care; the operation of screening programs to identify charity care-eligible patients and the extent to which hospitals promote the availability of charity care to potentially eligible patients, implement more (or less) stringent application and income documentation requirements, and assess eligibility at different stages of the billing process.” Each hospital must essentially balance the potentially conflicting goals to ensure that all eligible individuals are served by the hospital’s financial assistant policy yet simultaneously prevent abuse of the system by removing those that merely elect to not pay.  

According to the authors, hospital administrators must ultimately adopt financial assistance policies that properly distinguish all patients who legitimately cannot pay their bills while concurrently fulfilling their fiduciary duty to ensure that those who can pay for services actually reimburse the hospital, a balance that is not well understood or applied.  

Further dissection of the 2009 CAH tax documents showed that these hospitals were less likely to report bad debt expense in accordance with the industry-recognized standard for classifying uncompensated care and bad debt known as Healthcare Financial Management Association (HFMA) Statement 15. The hospitals were also more likely to adopt restrictive
charity and discounted care eligibility criteria using lower ranges of the Federal Poverty Guidelines (FPG) to assess eligibility for free care. For example, 43.5% of CAH hospitals required the patient to be in the lowest income bracket (0-100% of FPG) for their bill to be completely waived compared to 33.8% of other rural requiring the lowest bracket and 18.8% of urban hospitals. The higher range of 151-200% was most commonly used at other rural and urban hospitals. Similarly, CAH facilities used more restrictive eligibility standards for the threshold for discounted care with over half of them not applying any discount for those making more than 200% of poverty.\textsuperscript{53} In their discussion, the authors noted that lower rates of charity care are likely related to these more restrictive eligibility requirements for discounted or free care which tend to catch less patients. However, the authors also noted that rural areas also experience higher rates of poverty and uninsured which could translate into greater charitable demand at lower levels on income.

Although the authors did not explore the associations in detail, other studies have shown that additional factors such as the complexity of the application process, the level of documentation required to demonstrate eligibility, and the extent to which hospitals actively promote the availability of financial assistance also affect the level of charity care provided and bad debt acquired.\textsuperscript{82} For example, hospitals that are less proactive in creating policies or have poorly implemented revenue/collection cycle management systems may incur lower levels of charity and perhaps higher levels of bad debt.\textsuperscript{53}

The authors state in their discussion that the “lower charity care and higher bad debt levels reported by CAHs do not mean that CAHs are not serving their tax-exempt missions” and cited struggling financial situations and often being the lone source of healthcare for the elderly, low-income, and other underserved populations with limited ability to seek care outside of their
communities as reasons why the hospitals may still justify their exempt status. Nevertheless, in light of increasing federal scrutiny, the authors provide numerous suggestions for how the hospitals may increase their charity care rates to those of other facilities. For example, they advised CAHs to expand their eligibility policies so that they are more reflective of the economic realities of their communities. The authors also advise CAH facilitators to simplify eligibility documentation, improve screening programs to identify patients eligible the hospital’s financial assistance program for public insurance coverage, and revise billing systems to capture and charity care charges at different stages of the billing process.

In another recent publication in the American Journal of Public Health, Singh et al. (2015) sought to investigate whether nonprofit hospitals consider community health needs when deciding how much and what types of community benefits to provide. According to the researchers, little is known about the patterns of community spending on the basis of the social, physical, and behavioral needs of a community. Building upon the growing body of literature surrounding modern community benefit spending, the authors desired to go beyond the Young et al. (2013) who found very little association between any hospital factors and spending patterns to perform a more comprehensive analysis of community health needs including indicators of socioeconomic status, clinical care outcomes, health behaviors, and the physical environment.

Using data from 2009 and following similar methodology as others, Singh et al. (2015) focused only on hospitals for which single hospital-level characteristics could be defined. The authors then combined multiple measures in various sections of the Schedule H into three outcome categories: total community benefit, direct patient care benefits, and community health initiatives. Total community benefit was defined as the sum of all categories of community
benefit reported in Part I of Form 990 Schedule H, direct patient care benefit was defined as the sum of financial assistance (charity care), unreimbursed costs for means-tested government programs (such as a state Children's Health Insurance Program), and subsidized health services (such as providing mental health services at a loss), and community health initiatives was the sum of expenditures of two categories including community health improvement services and community benefit operations (such as childhood immunization efforts and health fairs) and cash and in-kind contributions for community benefit (such as free telemedicine services to community hospitals). The research did not separate out spending in the remaining categories in Part I (such as Medicaid loses, health professions education) nor did they study the community building activities in Part II or the categories of bad debt and Medicare loses found in Part III. Similar to other studies, spending was standardized by dividing the community benefit expenditures by total operating expenses (not total revenue).

Singh et al. (2015) then divided this spending to four sub categories: community health behaviors, clinical care, socioeconomic factors, and physical environment. Health behaviors included smoking and obesity, clinical care included uninsured rates and hospitalization rates for ambulatory-sensitive conditions, socioeconomic factors included employment rates and the number of children in poverty, and physical environment included air quality and access to healthy foods. A global indicator was also created using the weighted sum of all measures in the analysis. Similar to Bazzoli et all (2010) and Young et al. (2013), the authors also compared institutional (number of beds, church affiliation, teaching status), community (geographic region), and market-level (percent of for-profit competition) characteristics of the hospitals.

Overall, the researchers found few associations between community health needs and community benefit expenditures. On the positive side, they found the global health indictor was
associated with greater spending on direct patient care. Because these direct patient care benefits made up 86% of the total spending, the authors were not surprised to see that the global health indicator was also associated with greater total community benefit spending. The study did not reveal any relationship between the global health indicator and hospital spending on community health improvement initiatives.

When breaking the association down between the sub-indicators of community needs (health behaviors, clinical care, socioeconomic factors, and physical environment), the study found that only a community’s socioeconomic status significantly predicted direct patient care spending and total community benefit spending. The worse the community was socioeconomically, the more the hospitals spend on direct patient care and, concurrently, total charity.

In relation to the other factors, none of the community or environmental health factors were related to hospital spending. The same was true for the institutional, market, or and community variables. This ultimately led the authors to conclude that there was “a lack of a relationship between community health needs and hospitals’ provision of community benefits aimed at broadly improving the health of their communities.” Instead, it seems that only hospitals located in the poorest areas displayed increased charity spending, due mostly to the increased provision of free care. The authors then called for hospitals to improve the alignment between charitable activities and the broader community needs. Since the research was prior to the implementation of the ACA, the authors also hoped that the new requirement that tax-exempt hospitals conduct periodic community health needs assessments may become a first step to refocus hospital charitable activities to address such needs as opposed to simply reacting to the poverty at their front door.
CHAPTER 6: Conceptual Framework

All hospitals treat a diverse mix of patients, contract with the same primary sources of payment, and operate under equal national health regulations. However, as opposed to for-profit organizations which are often viewed as being mainly responsible for wealth maximization and stockholder gain, nonprofit organizations are accountable for demonstrating that their charitable mission is being delivered. These institutions must generate enough revenue to remain in business, but nonprofit hospitals are public charities with complete tax exemption and therefore must reinvest all excess funds into supporting their mission, providing community benefits, and giving back to the public. Nevertheless, basic differences in the charitable motives and community benefit priorities within the nonprofit hospital market may be significant and important. Thus, understanding the organizational motivation and theoretical reasons for variation in philanthropic philosophy becomes an important exploratory topic.

In order to gain insight into the charitable actions and structures of nonprofit hospitals, concepts of organizational theory become important. Such philosophy often seeks to explain variation or uniformity among organizations in structure and behavior. For example, DiMaggio and Powell (1983) describe the initial stages of an organizational life cycle as displaying substantial diversity in approach and form. However, once a field becomes well established, there is “an inexorable push towards homogenization.”

Similar to the current evolution in the hospital industry, Coser, Kadushin, and Powell (1982) describe how the American college textbook industry progressed from a period of nascent diversity to the current hierarchy of only two models, the large generalist and the small specialist. Rothman (1980) describes the process of several competing models of legal education culminating into two dominant approaches. Barnouw (1966) described how
numerous standards developed into dominant forms in the radio industry while DiMaggio (1982) describes the emergence of dominant organizational models of high culture and pop culture in the late nineteenth century.

The emergence of structure and standardization in each of these organizational fields is related to what DiMaggio and Powell (1983) called institutional isomorphism (see Figure 6.1). This process of organizational homogenization is defined as “a constraining process that forces one unit in a population to resemble other units that face the same set of environmental conditions” and comes in three forms: coercive, mimetic, and normative. While it remains theoretically plausible for organizational homogenization to result from any one of these forms, the current model of nonprofit hospital community benefit offerings likely occurred from an intermingling of all three subclasses.

Coercive isomorphism results from dependence upon outside organizational and cultural pressures. For the hospital industry, such forces could be governmental mandates like the early legislative changes that reformed the definition of nonprofit hospital charity from only aid to the poor to include the promotion of health and the reduction of governmental burden or later legislative mandates related to charity care policies and assessment of community health needs. These changes can also occur from pressures within society. For nonprofit hospitals, this could include offering services that benefit society but may also be unprofitable, such as performing scientific research and educating health professionals.

Mimetic isomorphism tends to occur when organizations are faced with ambiguity. Here, uncertainty is a powerful force that often results in one institution (or a group of institutions) modeling itself after another. In the hospital field, the high stakes of losing one’s tax-exempt status coupled with limited regulation in the community benefit arena may result in
“benchmarking” and “best practice” sharing among the nation’s nonprofit hospitals. Those hospitals or health systems that are perceived to be more legitimate or successful in meeting community benefit standards may have been imitated by others. In addition, organizations also tend to choose from a relatively small set of consulting firms which could spread only a select number of organizational models throughout the industry. For example, the Catholic Health Association/ Voluntary Hospitals of America or the American Hospital Association guidelines might prove to be industry standards.

Finally, the current state of homogenization related to community benefit may have occurred from forces of normative isomorphism which stem from collective duty and obligation to an industry. Such professionalization tends to legitimize occupational autonomy and also creates uniformity. In the field of healthcare, accreditation agencies such as the Joint Commission and professional certification boards such as the Accreditation Council for Graduate Medical Education (ACGME) reinforce normative expectations and impose standards, rules and values on hospitals and health systems. Such standardization coupled with national interest in health reform could be advancing healthcare toward a single community benefit model which could become the law of the land in the future.
Figure 6.1 Conceptual Framework: The Institutional Isomorphism Model

Adapted from DiMaggio & Powell (1983)

Coercive
- Carrier: Rules, laws, sanctions
- Social Basis: Legally sanctioned
- Dependence

Isomorphic pressures
- Carrier: Innovation visibility
- Social Basis: Culturally supported, conceptually correct

Mimetic
- Uncertainty

Normative
- Duty, obligation
- Social Basis: Morally Governed

https://fairtrade315.wordpress.com/theoretical-perspective/entrepreneurial-theory-perspective/
CHAPTER 7: Methodology

APPROACH

For this research, the unit of analysis was the individual hospital. The cross-sectional design utilized a sampling frame of all non-governmental, non-profit short-stay, acute-care and critical access hospitals that filed IRS Form 990, Schedule H in the tax year 2012, a population of 2,904 entities. A stratified random sample of these hospitals was identified using the American Hospital Association’s 2012 Annual Survey of Hospitals (2012) to select the IRS Form 990 tax forms for 633 organizations (21.8% of the total population). To avoid oversampling of hospitals from less populous states, stratification was based upon each state’s proportionate population percent in the 2010 census. For example, New York State accounted for 6.28% of the total US population in 2010, so 6.28% of the sample of 633 hospital organizations which completed the American Hospital Association’s 2012 Annual Survey of Hospitals (40 organizations total) were randomly selected. As will be detailed in the sample summary statistics section, 156 of the tax forms did not meet inclusion criteria resulting in a final sample of 477 organizational returns representing 997 individual hospitals or 34.3% of all U.S. private, nonprofit hospitals in the year 2012. Using the free GuideStar.org online database, claimed revenue and expense dollar amounts from Parts I, II, and II of the Schedule H for each of the 447 publicly-available tax returns was then abstracted and used in the quantitative component of this research while the sample was also used to derive the selected organizations for the qualitative key informant interviews.

AIM 1. To use data from IRS Tax Form 990, Schedule H for the tax year 2012 to help policymakers assess whether nonprofit hospital organizations’ current community benefit spending would meet various national health policy models:
- Tax Value Requirement in which community benefit spending is at least equal to the value of the tax exemptions
• Grassley Requirement in which at least 5% of revenue goes to community benefit
• Expense Requirement in which at least 3% of expenses go to community benefit

Sub-Aim 1: To help policymakers better understand the charitable activities of nonprofit hospital organizations by providing descriptive summaries of the size, scope, and nature of community benefit claims

To address Aim 1, the Form 990, Schedule H data were used to provide descriptive summaries about the hospital organizations in the sample and their charitable activities. Geographic Information System (GIS) methodologies were used to map the headquarters of the sampled hospital organizations. The distribution and characteristics of the hospital organizations in the sample were then evaluated, including organizational size, profit margin, patient income thresholds to qualify for hospital charity care programs, accounting methods, and region.

The distribution of the amounts spent in the various Part I categories were described for the hospitals in the sample (997) and then estimated for all 2,904 nonprofit hospitals in the nation. These categories included Medicaid Shortfalls, Charity Care (Financial Assistance), Health Profession Education Losses, Subsidized Health Services, Community Health Improvement Services and Community Benefit Operations, Research Losses, Unreimbursed Costs from Other Means-tested Government Programs, and Cash and In-kind Contributions to Community Groups.

The individual category and overall (sum of all categories) spending was then broken down into how much each category represented as a percent of total Part I spending. The same methodology was used to summarize the spending in Parts II and III of the IRS Form 990, Schedule H. Part II- “Community Building Activities”- included 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.

Part III included Bad Debt Expense and Medicare spending.

The spending was then used to evaluate a policy based on the Tax Value Requirement vis-à-vis both the 997 hospitals in the sample and the estimated total spending for all 2,904 nonprofit hospitals in the nation. The methodology totaled the spending under the following definitions of community benefit: a) Narrow (only Schedule H, Part I categories), b) Expand 1 (the narrow spending plus bad debt), c) Expand 2 (narrow spending plus Medicare shortfalls), d) Expand 3 (narrow spending plus bad debt and Medicare shortfalls), e) Expand 4 (narrow spending plus bad debt, Medicare shortfalls, and community building activities). The analysis then compared the national spending (for all 2,904 hospitals) to the estimated value of national tax exemptions to determine whether nonprofit hospitals are providing sufficient community benefit under each definition.

For both the Grassley and Expense Requirements, the total community benefit spending that made up the dependent variables was normalized as a percent of total revenue received under the four definitions previously used. For example, if Hospital A spent $1,000,000 in total for Part I and had total revenue of $10,000,000, then the narrow spending percent of revenue for Hospital A would be 10%. The hospital organization was then assessed as to whether this percent could or could not meet the requirement (in this case, the organization is providing 10% of every dollar received on community benefit when narrowly defined and is therefore meeting the Grassley Requirement). It is important to normalize the amounts being spent on community benefit as a percentage of total revenue since larger hospitals will likely spend larger absolute amounts on charity.
According to the instructions for Form 990, total revenue is the total amounts received from fundraising contributions, financial gifts, grants, trusts, program service revenue (from government health insurance, private health insurance, and self-pay sources), interest income, bond proceeds, licensing royalties, rental income, sales of capital or inventory, the value of noncash contributions, and all other business and non-business income. Total expenses, on the other hand are defined as all dollars expended, either directly or indirectly, for program services, salaries, employee benefits, program services, fundraising activities, organizational memberships, capital equipment, land, buildings, supplies, provision of grants and other assistance, payroll taxes, legal fees, investment management fees, marketing services, information technology, travel, educational meetings, interest paid, depreciation, insurance, and any other business or non-business activity.

The analysis then compared the national spending (for all 2,904 hospitals) in each model to the estimated value of national revenue (in the case of the Grassley Requirement assessment) and national expenses (in the case of the Grassley Requirement assessment). The resulting percent of revenue or percent of expense, respectively, was then used to evaluate whether nonprofit hospitals, in aggregate, could meet a national policy based on the Grassley Requirement (in which 5% of revenue must go to community benefit) or the Expense Requirement (in which 3% of expenses must go to community benefit).

Finally, the research analyzed the spending ratios (community benefit spending as a percent of revenue and community benefit spending as a percent of expenses) against the Narrow, Expand 1, Expand 2, and Expand 3 definitions. This then enabled an evaluation of what threshold the federal government could set that would result in compliance by 50%, 75%, 90%,
and 99%, respectively, of hospital organizations under the various definitions of community benefit given the current amount of claimed spending.

**AIM 2.** To help policymakers better understand whether organizational size, geography, accounting methods, collection methods, and fiscal viability are related to current charitable spending using various plausible definitions of community benefit (including the debated categories of bad debt, Medicare shortfalls, and community building activities) should either the Grassley or Expense requirement models be enacted.

Utilizing IBM SPSS Statistics Software Version 23, the data from Parts I, II, and III of the IRS Form 990, Schedule H was used to better understand whether certain organizational attributes, such as organizational size, geography, accounting and collection methods, and fiscal viability, are related to charitable spending using various plausible definitions of community benefit (both narrowly defined and expanded to include the controversial categories of bad debt and Medicare shortfalls). With all the models, the analyses assumed no behavioral response to any future policy changes and used the current claimed spending.

The combined models of Bazzoli et al. (2010)\textsuperscript{11}, Nicholson et al.(2000)\textsuperscript{92} and Schneider (2007)\textsuperscript{5} were used as theoretical building blocks in order to develop the independent variables used in this study (see the taxonomy of independent variables on pp. 72-73 for additional detail). As theorized, certain features of hospitals and the hospital environment may work to increase or decrease community benefit offerings and may be of interest to those making community benefit policy. For example, hospitals with additional resources may behave more charitably. As such, the number of hospitals filing taxes together, the number of employees, and organizational profit margins were explored since larger organizations and ones with excess revenue over expenses (i.e. profit) may be associated with increased community benefit spending. Similarly, there may also be some unobserved spending factors related to geographic region. For example, variation in cultural influences or regional “benchmarking” might affect organizational behavior related to
community benefit spending. As opposed to state-level effects, census region was added as an independent variable to try to capture this construct.

There is also the possibility that any differences in spending could be related to differences in accounting practices between hospitals. The instructions for Form 990, Schedule H say that hospitals may account for charity care using a cost-to-charge ratio, a cost accounting system, or another cost accounting method. Essentially, the hospital organization knows how much money was spent in total for the year, so they have total costs (i.e. expenses) for the year. The hospital also knows how much they charged for all of these services through the Charge Description Master or “charge master,” which is an arbitrary, self-determined pricing list of items billable to a patient or a patient's health insurance provider. As such, the hospital can easily obtain a cost-to-charge ratio (e.g. the total expenses for the hospital in 2012 were $1,000,000 which arbitrarily “cost” $2,000,000 in the charge master, so the cost-to-charge ratio is 50%). Once the ratio/percentage is determined, the percentage is then applied (multiplied) by the charges associated with that payer or whatever group is being measured (e.g. Medicaid, transplants, etc.) to arrive at the cost of that care.

As can be seen in Table 7.1, using a cost-to-charge ratio is suitable for the larger entity, or if the overall utilization of resources is consistent across patient types, since the total expense recorded on Form 990, Schedule H is the same no matter how much the hospital charged for the services. However, accounting issues arise from the effort to allocate costs to the service level (e.g. transplant, orthopedic, etc.) or payer level (e.g. Medicare, Medicaid, Private Insurer, etc.) if different services used resources differently (e.g. the Medicaid population goes to the doctor more often than the Medicare population). For example, Table 7.1 shows that using a cost accounting system, which directly connects expenses to services, can result in the same overall
expenses being allocated very differently. Thus, variation between groups can cause the amount of expense allocated to Medicaid or Medicare in Form 990, Schedule H to be significantly dissimilar with a cost-to-charge methodology as opposed to a cost accounting system. Although the latter is certainly more labor intensive, use of the “more accurate” cost accounting method may cause variation in the total claimed community benefit activities of nonprofit hospital organizations and is thus worthy of study.\textsuperscript{9} p.12

<table>
<thead>
<tr>
<th>Cost</th>
<th>Chargemaster Charges</th>
<th>Cost-to-Charge Ratio</th>
<th>Schedule H Expense*</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000,000.00</td>
<td>$2,000,000.00</td>
<td>50%</td>
<td>$500,000.00</td>
</tr>
<tr>
<td>Medicare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Pay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$2,000,000.00</td>
<td>$2,000,000.00</td>
<td>50%</td>
<td>$250,000.00</td>
</tr>
</tbody>
</table>

**Option 2)** Cost-to-Charge Ratio with High Charges

<table>
<thead>
<tr>
<th>Cost</th>
<th>Chargemaster Charges</th>
<th>Cost-to-Charge Ratio</th>
<th>Schedule H Expense*</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000,000.00</td>
<td>$10,000,000.00</td>
<td>10%</td>
<td>$500,000.00</td>
</tr>
<tr>
<td>Medicare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
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<td></td>
</tr>
<tr>
<td>Private Pay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$10,000,000.00</td>
<td>$10,000,000.00</td>
<td>10%</td>
<td>$250,000.00</td>
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</tbody>
</table>

**Option 3)** Cost Accounting System

<table>
<thead>
<tr>
<th>Actual Costs Associated</th>
<th>Schedule H Expense*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>$450,000.00</td>
</tr>
<tr>
<td>Medicaid</td>
<td>$350,000.00</td>
</tr>
<tr>
<td>Private Pay</td>
<td>$200,000.00</td>
</tr>
<tr>
<td>$1,000,000.00</td>
<td>$1,000,000.00</td>
</tr>
</tbody>
</table>

* Represents the dollar amount that the organization would record on the Form 990, Schedule H
Furthermore, since charity care and bad debt are both components of uncompensated care, confusion in the classification of each becomes a reporting complication. According to the Healthcare Financial Management Association (HFMA), "the complexities of charity care policies and the difficult task of documenting charity care qualification have generally resulted in many charity care patients being classified as bad debt."\(^9^4\)\(^^p.1\) To account for this, Form 990 asks the hospitals whether the organization adhered to HFMA Statement Number 15 which stipulates how to distinguish between charity care and bad debt.\(^9^5\) According to the statement, charity care determinations should be made as early as is practical and that, in order to qualify for bad debt, "pervasive evidence exists of a payment agreement between the provider and the patient" and "collectability is reasonably assured" for an amount that is determinable.\(^9^6\)\(^^p.9\) This helps to determine whether a patient belongs in the category of financial assistance (charity care) or bad debt. Additionally, hospital charges become problematic since facilities with high self-determined charges could receive more credit for providing charity care than those with lower charges. According to the HFMA, “the practice of reporting bad debts at gross charge also has led to reported bad debt trends often significantly above revenue or expense growth.”\(^9^4\)\(^^p.1\) To help with this, the HFMA Statement 15 also stipulates that true \textit{costs} (less any related revenue on those accounts) should be the primary basis for reporting the amount of charity care provided; not a ratio of cost to charges.\(^9^6\) Thus, organizations that use HFMA Statement 15 could theoretically provide more accuracy when comparing claimed amounts of charity care versus bad debt and the resources consumed in providing those services. Moreover, the use of this method produces an important exploratory variable.

Another complexity comes with the fact that allocations between bad debt and charity care depend so heavily on the income threshold set by the hospital’s own financial assistance
policy. For example, it is plausible that, for the same services at the same production cost, organizations that have set a high income threshold for free care (e.g. at 400% of poverty or less) may claim no bad debt since many people are qualifying for free care while organizations that have set a very low income threshold for free care (e.g. at 100% of poverty or less) may claim lots of bad debt since very few people are qualifying for free care. Such variability could theoretically influence whether the organization would subsequently advocate for the inclusion or exclusion of bad debt in a national health policy definition of community benefit. Hence, whether income thresholds for free and discounted care are related to charitable spending using various plausible definitions of community benefit becomes an important parameter worthy of exploration.

Overall, the following taxonomy of independent variables was used to code each hospital organization:

- **US Census Region**
  - 1= South
    - Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia, Alabama, Kentucky, Mississippi, Tennessee, Arkansas, Louisiana, Oklahoma and Texas
  - 2= Midwest
    - Illinois, Indiana, Michigan, Ohio, Wisconsin, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota and South Dakota
  - 3= West
  - 4= Northeast

- **Adherence to HFMA Statement 15**
  - 0= No
  - 1= Yes

- **Filing Size**
  - 1= Single (One hospital filing alone)
  - 2= Small (Two to four hospitals filing together)
• 3= Medium (Five to nine hospitals filing together)
  • 4 = Large (Ten or more hospitals filing together)

• Accounting Method
  • 1= Cost Accounting System
  • 2= Cost-to-Charge Ratio
  • 3= Other

• Profit margin
  • Defined as the net profit (total revenue minus total expenses) normalized as a percentage of total revenue

• Free percent
  • Defined as patient income as a percent of poverty that qualifies for free care under each hospital organization’s self-determined charity care policy

• Discounted percent
  • Defined as patient income as a percent of poverty that qualifies for a discount on the hospital bill under each hospital organization’s self-determined charity care policy

• Number of employees
  • The number of full-time equivalent (FTE) employees claimed

To help inform a policy based on the Grassley Requirement, crosstabulations were conducted between the four community benefit spending models as a percent of revenue and the categorical independent variables: census region, adherence to HFMA Statement 15, the number of hospitals filing together (or “filing size”) under one tax return, and the utilized accounting method. The total count, raw percent, and standardized residual were then calculated for each component within the crosstabulation. For example, the 121 Midwest hospital organizations were broken down into 75.2% (N=91) that could meet the Grassley Requirement when community benefit is narrowly defined and 24.8% (N=30) that could not meet a Grassley Requirement when community benefit is narrowly defined.

In order to determine whether the mean differences were significant, a chi-square test was conducted to evaluate the null hypothesis that there is no relationship between the categorical
independent variables (e.g. census region) and a dichotomous dependent variable based on whether the tax return could meet a Grassley Requirement under the narrow, Expand 1, Expand 2, and Expand 3 policy definitions (0= No, the tax return could not meet the Grassley Requirement; 1=Yes, the tax return could meet the Grassley Requirement) at the p <.05 level.

Using the methodology of Haberman (1984) and Hinkle at al. (2003), the standardized residual (SR) was then used as a measure of the strength of the difference between observed and expected values with a residual less than -2 meaning that the cell’s observed frequency is less than the expected frequency and a residual greater than 2 meaning that the observed frequency is greater than the expected frequency.\(^{98,99}\) As such, the SRs in the crosstabulations were compared to any test which produced a p value < 0.05 in order to identify the variable contributing to the ability to meet or not meet the Grassley Requirement (i.e. by having a standardized residual absolute value of 2.0 or higher).

Furthermore, when a significant difference between the categories was found with a chi-square test, a binary logistic regression model was developed to further explore the extent of the relationship. In this methodology, dummy variables were created with 1 being that the organization could pass a Grassley Requirement and 0 being the organization could not meet the Grassley Requirement. Additionally, using the taxonomy of categorical independent variables described earlier, the reference group for Region was West, for HFMA Statement 15 was No (not adhering to HFMA Statement 15), for Filing Size was Single (one hospital filing alone), and for Accounting Method was having a Cost Accounting System. Logistic regression was then used to determine the strength of the model in terms of the amount of the variance and accounted for the odds of passing (or not passing) the Grassley Requirement as compared to the reference
group. By examining these predicted probabilities, the research can summarize the full effect independent variable on the dependent variable.

Next, with respect to the continuous independent variables (profit margin, free percent, discounted percent, and number of employees), descriptions of the ability to meet the Grassley Requirement under the various community benefit spending models (total narrow spending, Expand 1, Expand 2, and Expand 3) as a percent of revenue were also produced. The total count, mean percent, and standardized deviation (SD) were also calculated for each component within the evaluation. For example, when narrowly defined, 359 organizations could meet the Grassley requirement with a mean profit margin for this group being 3.34% (SD = 7.20%) and 118 could not meet a Grassley Requirement with a mean profit margin for this group being 4.21% (SD = 9.13%).

Independent-samples t-tests were then conducted to compare the mean values of the continuous independent variables (profit margin, free percent, discounted percent, and number of employees) for organizations that could or could not meet a Grassley Requirement under the Narrow, Expand 1, Expand 2, and Expand 3 policy definitions (0= No- the tax return could not meet the Grassley Requirement; 1=Yes-the tax return could meet the Grassley Requirement) at the p < .05 level. For example, as will be discussed in the Results section, the research showed that when community benefit was defined under an Expand 1 model (one that allowed bad debt to be included in the definition of community benefit), the income threshold to qualify for free care was significantly different for those that could (mean = 184.8% threshold for free care) and could not (mean = 209.1% threshold for free care) meet the Grassley Requirement (p < .05).

Similar to the methodology with the categorical variables, when the difference between the mean scores of the continuous variables was found to be significant, a binary logistic
A regression model was developed to further explore the extent of the relationship. In this methodology, dummy variables were created with 1 being that the organization could pass a Grassley Requirement and 0 being the organization could not meet the Grassley Requirement. The logistic regression model was then used to determine the strength of the association in terms of the explained variance as well as the relationship between point increases/decreases in the continuous independent variable (e.g. Free Percent) and the odds of meeting or not meeting the Grassley Requirement.

Finally, the same methodology used to assess associations between organizational attributes and community benefit spending with a Grassley Requirement model were employed with the Expense Requirement model. The same organizational size, geography, accounting and collection methods, and fiscal viability independent variables were tested against charitable spending using various plausible definitions of community benefit (both narrowly defined and expanded). The only difference is that the outcome for these models was whether the organization spent 3% of every expense dollar on community benefit instead of 5% of every revenue dollar.

AIM 3. To collect data from key informant interviews with nonprofit hospital administrators to help policymakers assess whether nonprofit hospital organizations could meet a Facts and Circumstances Requirement.

Sub-Aim 1: To understand why nonprofit hospital organizations place greater or lesser reliance on the different community benefit categories, including the debated categories of bad debt, Medicare shortfalls, and community building activities

Sub-Aim 2: To explore whether hospitals are currently meeting new 501(r) community benefit requirements in the Affordable Care Act

Sub-Aim 3: To gain insights into the implications of a national policy setting minimum community benefit spending through a Tax Value, Grassley, or Expense model.
The third aim was to identify, through key informant interviews with nonprofit hospital administrators, how organizations operationalize community benefit spending in relation to their mission and strategy, why organizations place greater or lesser reliance on the different categories when creating a justification for their tax-exempt status, and their insights into the possible policy implications of further defining the community benefit activities of private, nonprofit hospitals. This helped the research to go beyond the limitations of statistical inference from the secondary data used to address Aims 1 and 2 in order to obtain an in-depth understanding of organizational behavior and the rationale for decisions regarding community benefit activities. Without such a mixed-methods approach, the study would be left with only knowing what, where, and when, instead of the why and how different approaches to community benefit vary by hospital organization. Collecting qualitative information thus allowed the study to collect data not present in the Form 990, Schedule H and help provide deeper insight into the complexity of defining the community benefit activities at private, nonprofit hospitals.

What has been described as a “conversation with a purpose,”101 p.138 the in-depth interviews involved questioning select hospital administrators who have ideas and insights related to community benefit. Informants were not selected as being representative of a studied population in any statistical sense.103 Rather, they were chosen because they were knowledgeable about organizational handling of community benefit services. Additional characteristics of the key informants included having a role in community benefit decisions at the hospital, an awareness of the complexities of the definitions, and a willingness to candidly communicate such information.104 According to the Catholic Health Association, job qualifications for such a role included “a clear understanding of what constitutes community benefit, basic knowledge of public health, program planning and implementation, finance, and
good collaboration skills.\textsuperscript{12} p.24 For most of the interviews, this informant was a community benefit leader with titles such as Director of Community Relations or Vice President of Community Affairs.

Additional responsibilities of the community benefit leader included educating others in the organization about the importance of community benefit and tax-exemption requirements, conducting an inventory of programs and activities, managing the planning and implementation of community benefit programs, and developing partnerships both inside and outside the organization.\textsuperscript{12} Finally, for multiple interviews, more than one administrator per hospital was questioned with the second person having titles including Chief Financial Officer, Chief Human Resources Officer, and Director of Patient Access. Face-to-face interviews were not possible with a national sample, so most of the interviews took place via telephone. The interviews were approved and followed approved IRB protocols for human subjects research.

Following the approach described by Maxwell (1992), purposeful sampling was employed such that hospital types that are most associated with the current policy debate were explored from opposite ends of the spectrum pertaining to key community benefit characteristics.\textsuperscript{105} For example, hospitals that were amongst the most charitable in the national sample were interviewed as were hospitals that were the least charitable. Similarly, hospitals with the highest and lowest rates of bad debt expense, Medicare shortfalls, and community building activities similarly met inclusion criteria. The sample also ensured a mix of interviewees representing hospital organizations from all census regions, all accounting methodologies, a wide variety of positive and negative profit margins, and a wide variety in the patient income thresholds to qualify for free or discounted care. Omitted organizations were those which met the inclusion criteria yet were unable or unwilling to be interviewed due to non-
response. Overall, not only did this type of sampling help to make sure that the research has adequately assessed variation in the community benefit activities of nonprofit hospitals, it also helped to make the findings and policy recommendations of the overall study more valid and robust.\textsuperscript{105}

Thus, in order to understand the nuanced forces shaping the associations between charitable spending and hospital characteristics, 12 interviews were performed. Each interview was conducted using a semi-structured interview guide and followed the sequential case model interviewing method described by both Yin (2003)\textsuperscript{106} and Small (2009)\textsuperscript{103} in which the number of interviews (cases) was unknown until the study was completed. Each progressive interview provided more “subtle variations” in the way community benefit is actualized, including many that were not apparent at the onset of the investigation.\textsuperscript{103} Therefore, the interview guide began with a set of questions that were reshaped through an iterative process as the interviews proceeded.\textsuperscript{103,107,108} Thus, the design of a qualitative study emerged through what has been called by Watt (2007) as interpretation and reflexivity between theory and practice and cause and effect.\textsuperscript{107} Eventually, the last case provided little new or surprising information and led to the conclusion that saturation was likely achieved.\textsuperscript{107} Table 7.2 provides an over of interview guide questions.
### Table 7.2  Interview Guide Questions

<table>
<thead>
<tr>
<th><strong>Community Benefit Activities and Programs</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you describe your role when it comes to your hospital’s community benefit activities and programs?</td>
</tr>
<tr>
<td>What is are the biggest challenges and concerns that your hospital faces when it comes to provision of community benefits?</td>
</tr>
</tbody>
</table>

**Organizational Theories Related to Community Benefit Activities:**

How does community benefit relate to your organizational mission and strategy? (Possible probe: For example, do you see it increasing your yearly retained earnings, employee retention, and/or public perception?)

**Community Benefit Measurement:**

How well do you believe that the current Form 990, Schedule H provides a complete picture of your community benefit activities?

In determining “costs” in relation to the “losses” reported on the 990, what pros and cons do you see in using either a cost/charge ratio or a more detailed cost accounting system to measure the associated expenses?

**Bad Debt:**

How does your hospital define bad debt? (Possible probe: From your experience, what do you see as influencing the level of bad debt at your organization?)

What are some reasons why you would or would not be supportive of bad debt being included in any future legislative definition of community benefit?

**Medicare Loses**

From your experience, what do you see as influencing the level of Medicare loses at your organization?

What are some reasons why you would or would not be supportive of Medicare losses being included in any future legislative definition of community benefit?

**Recommendations:**

Do you have any recommendations for change related to the way community benefit is currently being measured on the 990? (Possible probe: Are there any charitable categories that you believe to be missing?)

As the US moves toward a national definition of hospital charity, what do you think about a possible national policy that includes:

- A certain percentage of revenue that must be spend on charity?
- A minimum number of the categories that must have charitable spending?
- The inclusion of Community Building Activities?
- Adherence to HFMA Statement 15?

Do you have any final recommendations to policymakers as they develop a national definition of community benefit?
The interviews were recorded and secured on a password protected computer. Once each interview was finished, the recordings were used to produce typed verbatim transcripts. The transcripts were also accompanied by personal notes and observations about the process and content of the interview.\textsuperscript{108} The texts of the transcripts were then organized and coded using Dedoose 7.0.23, a web-based application for managing, analyzing, and presenting qualitative and mixed-method research data.

During the coding process, repeating ideas, themes, and theoretical constructs that shed light on community benefit concerns were identified.\textsuperscript{109} Related passages of relevant text were grouped and organized into increasingly coherent categories through a process Luker (2008) calls “pattern recognition.”\textsuperscript{108p.173} As the research progressed, differentiation of idiosyncratic answers from patterns of theoretical interest emerged, constructs formed, and themes aligned into more concrete concepts. Following the Luker model, questions asked throughout this process included: “What is this a case of, what kinds of theories might explain what you are hearing in the interviews, and what kinds of variables seem to be emerging?”\textsuperscript{108}

Finally, all of the work was pulled together into a theoretical narrative, or the “culminating step that provides the bridge between the researchers’ concerns and the participants’ subjective experience.”\textsuperscript{109 p.41} This allowed for retelling the informant’s stories in terms of the community benefit issues and, when possible, supported interpretations with specific quotes regarding how organizations operationalize community benefit spending, why organizations place greater or lesser reliance on the different categories, and insights into the possible policy implications of defining the community benefit activities of private, nonprofit hospitals.\textsuperscript{108,109}
Codes were organically produced based on study findings and included:

- Bad Debt
- Medicare Shortfalls
- Community Benefit Activities
- Minimum Spending (Revenue or Expenses)
- Relation to Mission
- 501(r)
  - CHNA
  - Other 501(r)
- Policy Recommendations
- Community Benefit Targets
- Schedule H
- Thresholds for Free/Discounted Care
- ACA Impact
- Interesting Findings

**AIM 4.** To provide recommendations to policymakers on how to further national health policy regarding the community benefit activities of nonprofit hospital organizations

Through a combination of structure and flexibility, the final aim of this mixed methods study was to achieve deeper knowledge in terms of penetration, exploration, and explanation of the community benefit activities of private, nonprofit hospitals. Such an approach allowed for unanticipated findings beyond the immediate boundaries of the study and provided exceptionally rich, in-depth information that offered readily understandable and compelling recommendations to policymakers on how to further national health policy regarding community benefit. In total, ten recommendations were made to policymakers on how to further national health policy regarding the community benefit activities of nonprofit hospital organizations.
LIMITATIONS, RELIABILITY, AND VALIDITY

It is important to recognize that a tax form might not be able to capture the full benefits that a hospital provides to its community. Furthermore, the measured variables might not capture all factors which influence hospital provision of community benefit. The mixed-methods nature of this study does allow for analysis beyond what is reported to the IRS and beyond the tools of previous research, but it must be acknowledged that such a study design might still not capture all possible facets of community benefit. For example, hidden or unobserved factors such as state and local community benefit policies, differences in local economic environments, and variations of hospital management quality or style may have a direct and unmeasured effect on community benefit activities. To reduce such possible bias, stratified random sampling was employed, tests of model assumptions were performed, and data was interpreted based on scientific objectivity.

Another limitation is the possibility that the newly standardized categories on Form 990, Schedule H will create incentives for hospitals to skew their reporting regarding community benefit activities. As with any standardized measurement, incentives many develop for hospitals to begin to “manage to the measure” instead of managing actual outlays to the community. For example, hospitals might become more creative in accounting for costs related to losses from Medicaid or expenses related to health professional education without increasing the amount of community benefit provided in these categories. Nonetheless, measurement is always the first step toward good management and using data reported by every hospital with the same methodological instructions is vastly more reliable than the previous research environment where a lack of standard definitions of hospital charity led to wide variation in the way community
benefit was studied. Furthermore, hospitals regularly have their financial statements audited by outside agencies and short of tax fraud, the data in this study must be assumed to be correct.

With the key informant interviews, there is the chance that the person being interviewed does not represent the majority view or that the informant is unwilling to discuss politically or organizationally sensitive information. There is also the potential for the investigation itself to somehow influence the results. This can include interviewer bias (when the personal interests, experience or expectations of the researcher act to sway an interview), descriptive validity bias (when there is a lack of accuracy and objectivity of the information gathered), recall bias (when an informant under or over reports important facts), and social desirability bias (when respondents answer in a manner in which they think the questioner wants them to answer rather than according to their true beliefs.).

This can also include selection bias (a systematic error due to a non-random sample of a population) and analytical bias (when the personal preferences of the researcher affect the way outcomes are interpreted).

In light of this, the researcher engaged in exercises throughout data collection and analysis to minimize threats to the validity of the findings. For example, a neutral attitude and language was maintained with all personal opinions of the interviewer being withheld. More complex questions can increase the opportunity for recall bias, so simple and direct questions were employed, especially at the beginning of a series of related questions. The use of precise quotes also enhanced credibility. Thus, given the position and titles of the interviewees, the use of direct quotes, and the saturation achieved, the data collected in the key informant interviews is assumed to be correct.

Issues of generalizability were addressed through a robust and systematic sample selection. Similarly, while concepts of generalizability are not exchangeable (and should not be
used in comparison), McMillan and Schumacher (2006)\textsuperscript{114} and Small (2009)\textsuperscript{103} reason that transferability, or the extension of findings to other cases, is an important goal. The consideration is not whether the results can be generalized to everyone, but whether the research findings are transferable to other settings. To accomplish this, McMillan and Schumacher stress the importance of providing details of the study which will allow subsequent reviewers to determine under what conditions an extension of qualitative findings is appropriate. For this study, this included details of the hospital participants such as regional location, contextual background like the employed accounting method, the utilized data collection methods, and analysis strategies such as the coding process.\textsuperscript{114} This transparency subsequently enables transferability by allowing readers to correctly apply the findings or identify similar phenomena at other hospital settings.
CHAPTER 8: Results

QUALITATIVE RESULTS

Summary Statistics

Sample. Overall, 633 tax returns were randomly sampled and 156 were excluded resulting in 477 total organizations. Reasons for exclusion included hospitals that were captured twice, the inability to locate the tax forms in the GuideStar.org database, being a specialty hospital (e.g. rehab, long term acute care, orthopedic, birthing, research, and Indian Health Service hospitals), and facility closure. Since many organizations file jointly, the final sample of 447 hospital organizations actually represented 997 individual hospitals or 34.3% of all U.S. private, nonprofit hospitals in 2012. Table 8.1 provides a summary of the hospital organization sampling approach. The Geographic Information System (GIS) positioning of the sampled hospital organization headquarters is presented in Figure 8.1.

Table 8.1 Sampling Approach

<table>
<thead>
<tr>
<th>Description</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Private Nonprofit Hospitals in 2012</td>
<td>2,904</td>
</tr>
<tr>
<td>Total Tax Returns Selected in Sample</td>
<td>633</td>
</tr>
<tr>
<td>Total Excluded Tax Returns*</td>
<td>156</td>
</tr>
<tr>
<td>Total Tax Returns Included</td>
<td>477</td>
</tr>
<tr>
<td>Total Private Nonprofit Hospitals in Sample</td>
<td>997</td>
</tr>
</tbody>
</table>

* Reasons for exclusion: Duplicate (70); Unable to locate tax return (40); Rehab hospital (19); Long term acute care hospital (10); Missing 2012 tax return (7); Facility closed (5); Orthopedic hospital (2); Birthing hospital (1); Research hospital (1); Tribal/Indian Health Service hospital (1)
Hospitals in a system are free to file singly (with a different tax return for each facility) or jointly (with all the hospitals in a system filing a combined tax return). Since it not possible to distinguish individual hospital data within a pooled return, the random selection of a single hospital necessitated the abstraction of the entire jointly-filed return. The research could have categorically excluded all joint filers from the data; however, as can be seen in Table 8.2, this would have removed 124 (26%) of the 477 organizations in the sample. When accounting for the number of actual hospitals that would have been excluded, we see that removing the joint tax returns would have omitted 644 (65%) of the 997 sampled hospitals. Thus, to avoid eliminating most the hospitals (and potentially create a biased sample), joint filers were included and abstracted (e.g. randomly selecting one hospital as part of a joint filer of ten hospitals meant that the data representing all ten hospitals were abstracted). Such methodology consequently resulted in frequent incidents in which two or more hospitals within the same jointly filed return were selected. Since it only took one selected hospital to include the entire return, any subsequently selected hospitals within that same return would have already been included.
Further analysis of the sample is represented in Table 8.2 which shows that the mean tax filing size was 2.01 hospitals filing jointly. The largest return represented 37 hospitals and the smallest return represented one hospital. Most of the organizations were single filers (N=353), followed by small-sized filers representing 2 to 4 hospitals (N=80), then medium-sized filers representing 5 to 9 hospitals (N=30), and finally large organizations with 10 or more hospitals filing together (N=14).
Table 8.2  Characteristics of Nonprofit Hospital Organization Sample

<table>
<thead>
<tr>
<th>Hospitals in Tax Filing</th>
<th>mean (median; range)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.0 (1.0; 1-37)</td>
</tr>
<tr>
<td>Tax Filing Status</td>
<td>n (%)</td>
</tr>
<tr>
<td>Single Filers (1 hospital)</td>
<td>353 (74)</td>
</tr>
<tr>
<td>Small Filers (2-4 hospitals)</td>
<td>80 (17)</td>
</tr>
<tr>
<td>Medium Filers (5 to 9 hospitals)</td>
<td>30 (6)</td>
</tr>
<tr>
<td>Large Filers (10+ hospitals)</td>
<td>14 (3)</td>
</tr>
<tr>
<td>Profit Margin</td>
<td>mean (median; range)</td>
</tr>
<tr>
<td></td>
<td>3.6%, (3.6%; -30.6% - 46.8%)</td>
</tr>
<tr>
<td>Profitability</td>
<td>n (%)</td>
</tr>
<tr>
<td>Profitable</td>
<td>352 (75.5)</td>
</tr>
<tr>
<td>Unprofitable</td>
<td>114 (24.5)</td>
</tr>
<tr>
<td>Threshold for Free Care</td>
<td>mean (median; range)</td>
</tr>
<tr>
<td></td>
<td>186% (200%; 100% - 400%)</td>
</tr>
<tr>
<td>Threshold for Discounted Care</td>
<td>mean (median; range)</td>
</tr>
<tr>
<td></td>
<td>354% (375%; 100% - 1000%)</td>
</tr>
<tr>
<td>Accounting System</td>
<td>n (%)</td>
</tr>
<tr>
<td>Cost to Charge Ratio</td>
<td>317 (68)</td>
</tr>
<tr>
<td>Cost Accounting System</td>
<td>106 (23)</td>
</tr>
<tr>
<td>Other</td>
<td>43 (9)</td>
</tr>
<tr>
<td>Adherence to HFMA #15</td>
<td>n (%)</td>
</tr>
<tr>
<td>Adheres</td>
<td>320 (68)</td>
</tr>
<tr>
<td>Does Not Adhere</td>
<td>153 (32)</td>
</tr>
<tr>
<td>Region</td>
<td>n (%)</td>
</tr>
<tr>
<td>South</td>
<td>167 (35)</td>
</tr>
<tr>
<td>West</td>
<td>96 (20)</td>
</tr>
<tr>
<td>Midwest</td>
<td>121 (25)</td>
</tr>
<tr>
<td>Northeast</td>
<td>93 (19)</td>
</tr>
<tr>
<td>Filing Status</td>
<td>n (%)</td>
</tr>
<tr>
<td>Single Filer</td>
<td>353 (74)</td>
</tr>
<tr>
<td>Joint Filer</td>
<td>124 (26)</td>
</tr>
<tr>
<td>Number of Employees</td>
<td>mean (median; range)</td>
</tr>
<tr>
<td></td>
<td>3,152 (1,334; 1 - 67,410)</td>
</tr>
</tbody>
</table>
When looking at profitability (total revenue minus total expenses), the sample shows that the most profitable hospital organization finished the tax year with a profit margin of 46.8% while the least profitable hospitals experienced -30.6% profit. Both the mean and the median national profit margin was a positive 3.6% with approximately three fourths of the organizations posting positive profits and one fourth posting negative profits.

When it came to the self-established thresholds for free and discounted care, Table 8.2 shows that the most forgiving hospital organizations had charity care policies that provided free care to individuals whose income was 400% of the Federal Poverty Level (FPL) while the least forgiving hospitals only provided free care to those at or below 100% of FPL. The national mean income threshold to have hospital debt completely forgiven was 186% of FPL while the national median was 200% of FPL. Similarly, the threshold to begin qualifying for any sort of discount whatsoever at the most forgiving hospital organizations was 1,000% of FPL while the least forgiving hospitals only provided discounted care to those at or below 100% of FPL. The national mean income threshold for partial debt forgiveness was 354% of FPL while the national median was 375% of FPL.

Variations in accounting methodologies, including the type of accounting system utilized and adherence to Healthcare Financial Management Association (HFMA) Statement 15 can be found in Table 8.2. Results indicated that 68% of responding hospitals used a cost accounting system, 23% used a cost-to-charge ratio, and 9% used some other system. Roughly two thirds (68%) of the hospital organizations adhered to HFMA Statement 15 and one third (32%) did not adhere.

Census region and number of employees are also outlined in Table 8.2. Most the organizations were based in the South (35%), followed by the Midwest (25%), then West (20%),
and Northeast (19%). Finally, when it comes to the number of employees, the smallest hospital organization claimed 1 full time equivalent (FTE) in 2012 while the largest hospital organization claimed 67,410 FTEs. The mean filing had 3,152 FTEs and the median filing employed 1,334 FTEs.

**Narrow Definition.** When examining community benefit through the lens of the 8 categories in Part I of Form 990, Schedule H (“Charity Care and Certain Other Community Benefits at Cost”) which could comprise a narrow policy definition of a community benefit standard, table 8.3 shows that the 997 hospitals in the entire sample spent a total of $17.9 billion in 2012. When proportionally adjusting this total to account for all 2,904 nonprofit hospitals in 2012, the aggregate national community benefit expenditures using the narrow definition is estimated to be $52.1 billion.

The largest category of spending (34.6% of the total narrow community expenditures) went toward shortfalls between what was spent to care for Medicaid patients and what was reimbursed. The second largest category of spending (31.8%) was the amount provided to patients who received either free or discounted care through the organization’s charity care policy. The remaining spending was split between educating health professionals (12.1%), the subsidized cost of unprofitable services (7.0%), funds supporting community health improvements and community benefit operations (4.9%), funds for research activities (4.3%), and unreimbursed costs from other means-tested government programs (2.9%). Finally, when narrowly defined, the least amount of national community benefit allocations were cash and in-kind contributions to community groups (2.5%).
**Expanded Definition.** When examining community benefit through expanded definitions, the categories of community building activities found in Part II of Form 990, Schedule H (“Community Building Activities”) as well as bad debt and Medicare Shortfalls found in Part III of the Form 990, Schedule H (“Bad Debt, Medicare, & Collection Practices”) have significant policy interests in the debate between the Catholic Health Association and the American Hospital Association. As can be seen in Table 8.4, the largest category of community building activity spending went to costs associated with advocating for community health improvement which includes serving on government advisory committees and meeting with policymakers on important policy matters such as expansion of health care insurance, increasing

<table>
<thead>
<tr>
<th>Narrow Definition Categories</th>
<th>Sample Spending (997 Hospitals)</th>
<th>National Spending (Estimated Value for all 2,904 Hospitals)</th>
<th>Percent of Total Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Medicaid Shortfalls</td>
<td>$6,185,378,237</td>
<td>$18,016,387,563</td>
<td>34.6%</td>
</tr>
<tr>
<td>2) Charity Care (Financial Assistance)</td>
<td>$5,681,402,467</td>
<td>$16,548,438,078</td>
<td>31.8%</td>
</tr>
<tr>
<td>3) Health Profession Education Losses</td>
<td>$2,155,926,475</td>
<td>$6,279,649,432</td>
<td>12.1%</td>
</tr>
<tr>
<td>4) Subsidized Health Services</td>
<td>$1,258,737,678</td>
<td>$3,666,373,337</td>
<td>7.0%</td>
</tr>
<tr>
<td>5) Community Health Improvement Services and Community Benefit Operations</td>
<td>$868,461,962</td>
<td>$2,529,602,345</td>
<td>4.9%</td>
</tr>
<tr>
<td>6) Research</td>
<td>$765,416,846</td>
<td>$2,229,458,897</td>
<td>4.3%</td>
</tr>
<tr>
<td>7) Unreimbursed Costs from Other Means-tested Government Programs</td>
<td>$520,388,162</td>
<td>$1,515,754,486</td>
<td>2.9%</td>
</tr>
<tr>
<td>8) Cash and In-kind Contributions for Community Benefit</td>
<td>$444,165,152</td>
<td>$1,293,736,812</td>
<td>2.5%</td>
</tr>
<tr>
<td><strong>Total Narrow Spending</strong></td>
<td>$17,879,876,979</td>
<td>$52,079,400,950</td>
<td>100%</td>
</tr>
</tbody>
</table>
neighborhood safety so children can play outdoors, and expanding access to healthy foods (24.7%). The second largest area of spending went to direct community support such as public health emergency readiness training beyond federal requirements, assisting neighborhood support groups, and supporting violence prevention programs (23.9%). The next largest spending group was workforce development (19.7%) followed by coalition building (10.5%). Environmental improvements, such as efforts to eliminate the use of toxic materials, reduce overall waste, and go “green” were next (5.2%), then physical improvements and housing (4.9%) followed by other community building activities (3.6%). Finally, the least amount of national community building activity spending went to leadership development and training for community members (3.5%).

<table>
<thead>
<tr>
<th>Narrow Definition Categories</th>
<th>Sample Spending (997 Hospitals)</th>
<th>National Spending (Estimated Value for all 2,904 Hospitals)</th>
<th>Percent of Total Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Community Health Improvement Advocacy</td>
<td>$33,354,723</td>
<td>$97,153,576</td>
<td>24.7%</td>
</tr>
<tr>
<td>2) Community Support</td>
<td>$32,282,794</td>
<td>$94,031,328</td>
<td>23.9%</td>
</tr>
<tr>
<td>3) Workforce Development</td>
<td>$26,668,039</td>
<td>$77,677,016</td>
<td>19.7%</td>
</tr>
<tr>
<td>4) Coalition Building</td>
<td>$14,202,912</td>
<td>$41,369,365</td>
<td>10.5%</td>
</tr>
<tr>
<td>5) Environmental Improvements</td>
<td>$7,013,244</td>
<td>$20,427,744</td>
<td>5.2%</td>
</tr>
<tr>
<td>6) Physical Improvements and Housing</td>
<td>$6,634,439</td>
<td>$19,324,384</td>
<td>4.9%</td>
</tr>
<tr>
<td>7) Economic Development</td>
<td>$5,522,559</td>
<td>$16,085,769</td>
<td>4.1%</td>
</tr>
<tr>
<td>8) Other Community Building Activities</td>
<td>$4,831,928</td>
<td>$14,074,141</td>
<td>3.6%</td>
</tr>
<tr>
<td>9) Leadership Development and Training for Community Members</td>
<td>$4,659,748</td>
<td>$13,572,626</td>
<td>3.5%</td>
</tr>
<tr>
<td></td>
<td>$135,170,386</td>
<td>$393,715,949</td>
<td>100%</td>
</tr>
</tbody>
</table>
Table 8.5 contains aggregate spending outcomes for both bad debt and Medicare Shortfalls found in Part III of Form 990, Schedule H. Overall, the 997 hospitals in the sample claimed $7.9 billion went to bad debt and $5.2 billion was associated with Medicare shortfalls. When proportionally adjusting this total to account for all 2,904 nonprofit hospitals nationwide, the aggregate national expenditures were $23.1 billion in bad debt and $15.3 billion on Medicare shortfalls.

<table>
<thead>
<tr>
<th>Expanded Spending Categories</th>
<th>Sample Spending (997 Hospitals)</th>
<th>National Spending (Estimated Value for all 2,904 Hospitals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total National Bad Debt Spending</td>
<td>$7,933,584,639</td>
<td>$23,108,455,157</td>
</tr>
<tr>
<td>Total National Medicare Shortfalls Spending</td>
<td>$5,239,671,258</td>
<td>$15,261,790,705</td>
</tr>
</tbody>
</table>

**Evaluation of a Policy Based on the Tax Value Requirement**

A national policy based on the “Tax Value Requirement” would require that nonprofit hospitals must provide community benefit amounts equal to at least 100% of the worth of the hospital's tax-exempt benefits. When it comes to aggregate, national spending on nonprofit hospital community benefit in 2012, Table 8.6 outlines total spending from the 997 hospitals in the sample and uses this spending to estimate the total national spending for all 2,904 hospitals for the eight categories in the narrow definition as well as the totals for the Expand 1, Expand 2, Expand 3, and Expand 4 definitions.

Analysis of the spending shows that when comparing the narrowly defined estimated national spending for all hospitals ($52.1 billion) to the most recently available estimate of the
national value of the nonprofit hospital industry’s tax exemption ($24.6 billion), hospitals were claiming 212% of the amount needed to justify their tax breaks. Adding the categories of bad debt (to achieve an Expand 1 definition) increases it to 306% of the amount needed to justify the tax breaks and adding Medicare Shortfalls (to achieve an Expand 2 definition) increases it to 274% of the amount needed to justify the tax breaks. When adding all plausible categories of community benefit (bad debt, Medicare shortfalls, and community building activities) to achieve an Expand 4 definition, the national value of community benefit raises to 369% of the amount needed to justify the tax breaks. Thus, no matter how community benefit is defined, nonprofit hospital organizations, in aggregate, could satisfy a Tax Value Requirement and they would not need to rely on the inclusion of bad debt, Medicare shortfalls, or community building activities to meet this national policy model.

<table>
<thead>
<tr>
<th></th>
<th>Sample Spending (997 Hospitals)</th>
<th>National Spending (Estimated Value for all 2,904 Hospitals)</th>
<th>Estimated Value of National Tax Exemptions*</th>
<th>National Community Benefit Spending as a percent of the Estimated Value of National Tax Exemptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Narrow Spending</td>
<td>$17,879,876,979</td>
<td>$52,079,400,950</td>
<td>$24,600,000,000</td>
<td>212%</td>
</tr>
<tr>
<td>Expand 1 (Narrow + Bad Debt)</td>
<td>$25,813,461,618</td>
<td>$75,187,856,107</td>
<td>$24,600,000,000</td>
<td>306%</td>
</tr>
<tr>
<td>Expand 2 (Narrow + Medicare Shortfall)</td>
<td>$23,119,548,237</td>
<td>$67,341,191,655</td>
<td>$24,600,000,000</td>
<td>274%</td>
</tr>
<tr>
<td>Expand 3 (Narrow + Bad Debt + Medicare Shortfall)</td>
<td>$31,053,132,876</td>
<td>$90,449,646,812</td>
<td>$24,600,000,000</td>
<td>368%</td>
</tr>
<tr>
<td>Expand 4 (Narrow + Bad Debt + Medicare Shortfalls + Community Building Activities)</td>
<td>$31,188,303,262</td>
<td>$90,843,362,761</td>
<td>$24,600,000,000</td>
<td>369%</td>
</tr>
</tbody>
</table>

Evaluation of a Policy Based on the Grassley Requirement

A national policy based on the Grassley Requirement would require that nonprofit hospitals must provide community benefit amounts equal to at least 5% of the hospital organization’s total revenue. When it comes to collective, national spending as a percent of revenue in 2012, Table 8.7 outlines total spending per total revenue from the 997 hospitals in the sample and uses this spending to estimate the total national spending per total national revenue for all 2,904 hospitals for the eight categories that make up the narrow definition as well as the totals for the Expand 1, Expand 2, Expand 3, and Expand 4 definitions.

Analysis of the spending shows that when comparing the narrowly defined estimated national spending for all hospitals ($52.1 billion) to the total estimated national revenue received ($608 billion), hospitals were allocating 8.6% of income to community benefit activities. Adding the category of bad debt (to achieve an Expand 1 definition) increases it to 12.4% of revenue being allocated to community benefit and adding Medicare shortfalls (to achieve an Expand 2 definition) increases it to 11.1% being allocated. When adding either bad debt plus Medicare shortfalls (to achieve an Expand 3 definition) or adding all plausible categories of community benefit (to achieve an Expand 4 definition), the organizations were spending 14.9% of every dollar received on community benefit. Thus, similar to the Tax Value Requirement, no matter how community benefit is defined, nonprofit hospitals, in aggregate, could meet a national policy based on the Grassley Requirement with or without the inclusion of bad debt, Medicare shortfalls, or community building activities.
**Narrow Definition.** Looking only at national, aggregate spending may hinder a policymaker’s ability to assess the ability of individual hospital organizations to meet each of these requirements. As such, Table 8.8 breaks the spending ratios into percentiles for the eight categories in the Narrow definition as well as the totals for the Expand 1, Expand 2, Expand 3, and Expand 4 definitions. For example, the table shows that basing a federally mandated minimum community benefit standard on a percent of revenue and using only the narrow definition, the IRS could set the threshold at no more than 7.3% to capture at least half of the hospital organizations. In order to capture at least 75% of the organizations, the policy threshold could be no more than 5.0% of revenue and the threshold could be no more than 3.9% in order to capture at least 90% of hospital organizations. As shown in the table, the federal government could not mandate that more than 0.4% of every dollar be spent on community benefit if the goal were to capture 99% of hospital organizations. Thus, using only the narrow categories of

<table>
<thead>
<tr>
<th>Sample Spending (997 Hospitals)</th>
<th>National Community Benefit Spending (Estimated Value for all 2,904 Hospitals)</th>
<th>Total Revenue of Sample</th>
<th>National Revenue (Estimated Value for all 2,904 Hospitals)</th>
<th>Total Community Benefit Spending as a Percent of Total Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Narrow Spending</td>
<td>$17,879,876,979</td>
<td>$52,079,400,950</td>
<td>$208,730,407,330</td>
<td>$607,977,033,988</td>
</tr>
<tr>
<td>Expand 1 (Narrow + Bad Debt)</td>
<td>$25,813,461,618</td>
<td>$75,187,856,107</td>
<td>$208,730,407,330</td>
<td>$607,977,033,988</td>
</tr>
<tr>
<td>Expand 3 (Narrow + Bad Debt + Medicare Shortfall)</td>
<td>$31,053,132,876</td>
<td>$90,449,646,812</td>
<td>$208,730,407,330</td>
<td>$607,977,033,988</td>
</tr>
<tr>
<td>Expand 4 (Narrow + Bad Debt + Medicare Shortfalls + Community Building Activities)</td>
<td>$31,188,303,262</td>
<td>$90,843,362,761</td>
<td>$208,730,407,330</td>
<td>$607,977,033,988</td>
</tr>
</tbody>
</table>
community benefit, approximately 75% of the nonprofit hospital organizations in the sample would be able to meet a hypothetical Grassley Requirement mandating they spend at least 5% of every revenue dollar on community benefit.

<table>
<thead>
<tr>
<th>Table 8.8  Total Community Benefit Thresholds as a Percent of Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Total Narrow Spending</td>
</tr>
<tr>
<td>Expand 1 (Narrow + Bad Debt)</td>
</tr>
<tr>
<td>Expand 2 (Narrow + Medicare Shortfall)</td>
</tr>
<tr>
<td>Expand 3 (Narrow + Bad Debt + Medicare Shortfall)</td>
</tr>
<tr>
<td>Expand 4 (Narrow + Bad Debt + Medicare Shortfalls + Community Building Activities)</td>
</tr>
</tbody>
</table>

* Threshold would meet Grassley Requirement; ** Threshold would not meet Grassley Requirement
When examining specific attributes of the organizations that could or could not meet a Grassley Requirement, the cross-tabulation in Table 8.9 shows that the West region has the highest rate of failure (28.1%), followed by the South (26.9), then Midwest (24.8), and Northeast (17.2). A chi-square test was conducted to evaluate the null hypothesis that there is no relationship between region and the ability to meet a narrow definition of the Grassley Requirement. As shown in Table 8.10, a significant interaction was not found ($\chi^2(3) = 3.864, p = .277$). Thus, when narrowly defined, the region of the country in which the organization was

<table>
<thead>
<tr>
<th>Census Region</th>
<th>Midwest</th>
<th>Northeast</th>
<th>South</th>
<th>West</th>
</tr>
</thead>
<tbody>
<tr>
<td>n, (%)</td>
<td>30 (24.8)</td>
<td>16 (17.2)</td>
<td>45 (26.9)</td>
<td>27 (28.1)</td>
</tr>
<tr>
<td>S.R.</td>
<td>.0</td>
<td>-1.5</td>
<td>.6</td>
<td>.7</td>
</tr>
<tr>
<td>Rate of Failure</td>
<td>91 (75.2)</td>
<td>77 (82.8)</td>
<td>122 (73.1)</td>
<td>69 (71.9)</td>
</tr>
<tr>
<td>n, (%)</td>
<td>15 (12.4)</td>
<td>89 (95.7)</td>
<td>20 (12.0)</td>
<td>69 (71.9)</td>
</tr>
<tr>
<td>S.R.</td>
<td>106 (87.6)</td>
<td>147 (88.0)</td>
<td>147 (96.7)</td>
<td>147 (96.7)</td>
</tr>
<tr>
<td>Rate of Success</td>
<td>116 (95.9)</td>
<td>89 (95.7)</td>
<td>162 (97.0)</td>
<td>87 (90.6)</td>
</tr>
<tr>
<td>n, (%)</td>
<td>4 (3.3)</td>
<td>3 (3.3)</td>
<td>5 (3.3)</td>
<td>5 (3.3)</td>
</tr>
<tr>
<td>S.R.</td>
<td>.1</td>
<td>.1</td>
<td>.1</td>
<td>.1</td>
</tr>
</tbody>
</table>

** Standardized residual with chi-square $p < .05$ and absolute value of 2.0 or higher

---

** Table 8.9 Crosstabulation of Community Benefit Spending Models as a Percent of Revenue and Census Region, Adherence to Healthcare Financial Management Statement No. 15 (HFMA #15), Filing Size, and Accounting Method using the Grassley Requirement**

<table>
<thead>
<tr>
<th>Total Narrow Spending</th>
<th>Expand 1 (Narrow + Bad Debt)</th>
<th>Expand 2 (Narrow + Medicare Shortfall)</th>
<th>Expand 3 (Narrow + Bad Debt + Medicare Shortfall)</th>
<th>Expand 4 (Narrow + Bad Debt + Medicare Shortfalls + Community Building Activities)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No (n, %)</td>
<td>Yes (n, %)</td>
<td>No (n, %)</td>
<td>Yes (n, %)</td>
<td>No (n, %)</td>
</tr>
<tr>
<td>S.R.</td>
<td>S.R.</td>
<td>S.R.</td>
<td>S.R.</td>
<td>S.R.</td>
</tr>
<tr>
<td>Census Region</td>
<td>Midwest</td>
<td>Northeast</td>
<td>South</td>
<td>West</td>
</tr>
<tr>
<td>Adheres</td>
<td>81 (25.3)</td>
<td>34 (10.5)</td>
<td>45 (26.9)</td>
<td>28 (26.6)</td>
</tr>
<tr>
<td>Not Adhere</td>
<td>35 (22.9)</td>
<td>118 (77.1)</td>
<td>122 (73.1)</td>
<td>69 (71.9)</td>
</tr>
<tr>
<td>Filing Size</td>
<td>Single</td>
<td>Small</td>
<td>Medium</td>
<td>Large</td>
</tr>
<tr>
<td>No (n, %)</td>
<td>Yes (n, %)</td>
<td>No (n, %)</td>
<td>Yes (n, %)</td>
<td>No (n, %)</td>
</tr>
<tr>
<td>S.R.</td>
<td>S.R.</td>
<td>S.R.</td>
<td>S.R.</td>
<td>S.R.</td>
</tr>
<tr>
<td>Accounting Method</td>
<td>Cost Accounting</td>
<td>Cost-to-Charge</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10 (23.3)</td>
<td>82 (25.9)</td>
<td>26 (24.5)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>.2</td>
<td>.4</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>33 (76.7)</td>
<td>235 (74.1)</td>
<td>80 (75.5)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 (0.9)</td>
<td>1.2</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>95 (99.1)</td>
<td>275 (86.8)</td>
<td>99 (99.1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>105 (99.1)</td>
<td>40 (93.0)</td>
<td>105 (99.1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>41 (95.3)</td>
<td>3 (7.0)</td>
<td>5 (1.0)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>.0</td>
<td>.3</td>
<td>.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>49 (96.0)</td>
<td>315 (88.2)</td>
<td>315 (88.2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>38 (10.8)</td>
<td>315 (88.2)</td>
<td>315 (88.2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7 (2.0)</td>
<td>346 (98.0)</td>
<td>346 (98.0)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>.0</td>
<td>1 (0.9)</td>
<td>1 (0.9)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>105 (99.1)</td>
<td>.1</td>
<td>.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>41 (95.3)</td>
<td>39 (93.0)</td>
<td>39 (93.0)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>.0</td>
<td>5 (0.0)</td>
<td>5 (0.0)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>105 (99.1)</td>
<td>.1</td>
<td>.1</td>
<td></td>
</tr>
</tbody>
</table>

SR = Standardized Residual

** When examining specific attributes of the organizations that could or could not meet a Grassley Requirement, the cross-tabulation in Table 8.9 shows that the West region has the highest rate of failure (28.1%), followed by the South (26.9), then Midwest (24.8), and Northeast (17.2). A chi-square test was conducted to evaluate the null hypothesis that there is no relationship between region and the ability to meet a narrow definition of the Grassley Requirement. As shown in Table 8.10, a significant interaction was not found ($\chi^2(3) = 3.864, p = .277$). Thus, when narrowly defined, the region of the country in which the organization was...**
located was not associated with the ability to meet a national policy based on the Grassley Requirement.

In looking for associations between organizational adherence to HFMA Statement 15 and the ability to meet a narrowly defined Grassley Requirement, Table 8.9 shows that more organizations could meet the community benefit requirement when they did not adhere to HFMA Statement 15 (77.1%) than those who did adhere (74.7). However, as shown in Table 8.10, a chi-square hypothesis test showed that there was no relationship between adherence to HFMA Statement 15 and the ability to meet a narrowly defined Grassley Requirement \((\chi^2 (1) = 0.332, p = .564)\).

Evaluating associations between the filing size of the tax document (single filing with just one hospital, and small joint filing with two to four hospitals, and medium joint filing with five to nine hospitals, and a large joint filing with ten or more hospitals filing together) and the ability to meet a narrowly defined Grassley Requirement, Table 8.9 shows that 71.4% of large filers could meet a Grassley Requirement, 86.7% of medium filers could meet the requirement,
72.5% of small filers, and 75.1% of single filers. Yet, as shown in Table 8.10, a chi-square test showed that there was no relationship between filing size and the ability to meet a narrowly defined Grassley Requirement ($\chi^2 (3) = 2.541, p = .468$).

When looking at the relationship between the utilized accounting method and the ability to meet a narrowly defined Grassley Requirement, Table 8.09 shows that 76.7% of organizations that used a cost accounting system, 74.1% of those who used a cost-to-charge ratio accounting system, and 75.5% of those who used another accounting system could meet the requirement. As shown in Table 8.10, a chi-square test showed that there was no relationship between the utilized accounting system and the ability to meet a narrowly defined Grassley Requirement ($\chi^2 (3) = 3.886, p = .274$).

Independent-samples t-tests were conducted to compare additional organizational factors that may affect the ability to meet a narrowly definition of the Grassley Requirement including profit margin, the income percent to qualify for free care, the income percent to qualify for discounted care, and the number of employees at the organization. As can be seen in Tables 8.11 and 8.12, there was no significant difference in the profit margins between organizations which could meet the requirement (Mean= 3.3%, S.D. = 7.2%) and those which could not meet the expense requirement (Mean= 4.2%, S.D. = 9.1%); $t(475) = 1.060, p=.290$. Similarly, while the mean income percent threshold to qualify for free care at organizations that could meet the requirement is slightly larger (Mean = 186.4% of poverty, S.D. = 56.1%) compared to those who could not meet a Grassley Requirement (Mean = 184.4% of poverty, S.D. = 56.8%), an independent sample t-test failed to show that the two groups are statistically different ($t(465) = -3.31, p=.741$. There was also no significant difference in the percent threshold to qualify for discounted care for those organizations that were able to meet the requirement (Mean = 358.0%,
S.D. = 109.3%) and those who could not (Mean=342.5%, S.D. = 130.6%); t(434) = -1.222, p=.222.

Finally, while the mean number of employees at organizations that could pass the Grassley Requirement is higher (Mean = 7,555.8; S.D. = 5,904.2) compared to organizations that could not meet the requirement (Mean= 2,575.4, S.D. = 3,341.5), an independent sample t-test (p=.266) failed to show that the two groups are statistically different (t(455) = -1.113 p=.266).

Table 8.11  Descriptions of Community Benefit Spending Models as a Percent of Revenue with Respect to Profit Margin, Free Percent, Discount Percent, and Number of Employees using the Grassley Requirement

<table>
<thead>
<tr>
<th></th>
<th>Total Narrow Spending</th>
<th>Expand 1 (Narrow + Bad Debt)</th>
<th>Expand 2 (Narrow + Medicare Shortfall)</th>
<th>Expand 3 (Narrow + Bad Debt + Medicare Shortfall)</th>
<th>Expand 4 (Narrow + Bad Debt + Medicare Shortfalls + Community Building Activities)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meets Requirement?</td>
<td>No (mean)</td>
<td>Yes (mean)</td>
<td>No (mean)</td>
<td>Yes (mean)</td>
<td>No (mean)</td>
</tr>
<tr>
<td></td>
<td>(count; SD)</td>
<td>(count; SD)</td>
<td>(count; SD)</td>
<td>(count; SD)</td>
<td>(count; SD)</td>
</tr>
<tr>
<td>Profit Margin</td>
<td>4.2%</td>
<td>3.3%</td>
<td>3.1%</td>
<td>3.6%</td>
<td>2.0%</td>
</tr>
<tr>
<td></td>
<td>118; 9.1%</td>
<td>359; 7.2%</td>
<td>23; 6.7%</td>
<td>454; 7.8%</td>
<td>13; 7.7%</td>
</tr>
<tr>
<td>Free Percent</td>
<td>184.4%</td>
<td>186.4%</td>
<td>209.1%</td>
<td>184.8%</td>
<td>187.5%</td>
</tr>
<tr>
<td></td>
<td>114; 56.8%</td>
<td>353; 56.1%</td>
<td>22; 71.8%</td>
<td>445; 55.2%</td>
<td>12; 77.2%</td>
</tr>
<tr>
<td>Discount Percent</td>
<td>342.5%</td>
<td>358.1%</td>
<td>326.0%</td>
<td>355.5%</td>
<td>306.4%</td>
</tr>
<tr>
<td></td>
<td>108; 131.6%</td>
<td>328; 103.1%</td>
<td>20; 91.0%</td>
<td>416; 115.9%</td>
<td>11; 76.2%</td>
</tr>
<tr>
<td>Employees</td>
<td>2,575.35</td>
<td>7,555.76</td>
<td>1,601.04</td>
<td>3,234.26</td>
<td>756.23</td>
</tr>
<tr>
<td></td>
<td>113; 3341.5</td>
<td>344; 5904.2</td>
<td>23; 1854.3</td>
<td>434; 6495.2</td>
<td>13; 880.9</td>
</tr>
</tbody>
</table>

SD = Standard Deviation
**Expand 1 Definition.** In allowing bad debt to be added to the narrow definition of community benefit in a plausible Expand 1 definition of the Grassley Requirement, Table 8.8 shows that hospital organizations spent an average of 14.1% of every dollar received on community benefit. Furthermore, table 8.8 shows what percent of revenue could be mandated if the goal was to capture 50%, 75%, 90%, and 99% of the hospital organizations, respectively.

Table 8.09 shows the rate of failure by region, adherence to HFMA Statement 15, filing size, and accounting method when examining whether the organizations that could or could not meet an Expand 1 definition of the Grassley Requirement. Chi-square hypothesis tests were then conducted to evaluate the null hypothesis that there is no relationship between these independent variables and the ability to meet an expanded definition of the Grassley Requirement. As shown in Table 8.10, no significant interactions were found.

Independent-samples t-tests were conducted to compare additional organizational factors that may affect the ability to meet an Expand 1 definition of the Grassley Requirement including profit margin, the income percent to qualify for free care, the income percent to qualify for...
discounted care, and the number of employees at the organization. As can be seen in Tables 8.11 and 8.12, there was no significant difference between organizations which could meet the Expand 1 requirement and those which could not regarding profit margin, the income percent to qualify for discounted care, and the number of employees at the organization. There was a significant difference in the mean percent threshold to qualify for free care for those organizations that were able to meet the expanded requirement (Mean = 184.8%, S.D. = 52.2%) and those who could not (Mean = 209.1%, S.D. = 71.8%); t(465) = 1.98, p = .047. Furthermore, because there is a significant difference between the means, a logistic regression model was developed to further explore this relationship. Although the model was fairly weak and explained just 2.5% (Nagelkerke R²) of the variance, Table 8.13 shows that the logistic regression model was statistically significant (p = .048). Additionally, the model indicates that for every one full point increase in Free Percent (every 100% that is added to the FPL), the odds of meeting the Expand 1 Grassley Requirement are decreased by a factor of 0.497 (Confidence Interval .248 - .993). As the Free Percent increased, the odds of meeting the Expand 1 Grassley Requirement decrease.

From the previous models, we know that there is no difference in the thresholds for free care between organizations that do and do not pass the Grassley Requirement when bad debt is not included (i.e. the narrow definition). However, when bad debt is added as a category that can be “written off,” we now see that organizations which set lower thresholds for free care (i.e. are less generous with forgiving people of their medical debt) are more likely to pass a Grassley Requirement than those which have set higher thresholds for free care (i.e. are more generous with forgiving people of their medical debt). Since organizations making the requirement under this model are associated with having a lower threshold for free care, a policy that adds bad debt
as a community benefit category may not help hospital organizations to become more generous with forgiving people of their medical debt given the current levels of spending.

**Table 8.13** Logistic Regression Results of the Federal Poverty Threshold for Free Care and the Ability to Meet an Expand 1 Definition of the Grassley Requirement (inclusive of Bad Debt).

<table>
<thead>
<tr>
<th>Factor</th>
<th>Odds Ratio (Confidence Interval 95%)</th>
<th>p</th>
<th>Standard Error</th>
<th>Explained Variance (Nagelkerke R Square)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free Percent</td>
<td>.497 (.248 - .993)</td>
<td>.048</td>
<td>.345</td>
<td>.025</td>
</tr>
</tbody>
</table>

**Expand 2 Definition.** In allowing Medicare shortfalls to be added to the narrow definition of community benefit in a plausible Expand 2 definition of the Grassley Requirement, Table 8.8 shows that hospital organizations spent an average of 11.7% of every dollar received on community benefit. Furthermore, table 8.8 shows what percent of revenue could be mandated if the goal was to capture 50%, 75%, 90%, and 99% of the hospital organizations, respectively.

Table 8.09 shows the rate of failure by region, adherence to HFMA Statement 15, filing size, and accounting method when examining whether the organizations that could or could not meet an Expand 2 definition of the Grassley Requirement. Chi-square hypothesis tests were also conducted to evaluate the null hypothesis that there is no relationship between these independent variables and the ability to meet an expanded definition of the Grassley Requirement. No significant interactions were found except for adherence to HFMA Statement 15, filing size, and accounting method. As shown in Table 8.10, a significant interaction was found with the region chi-square test ($\chi^2(3) = 8.33, p = .04$) with organizations in the Northeast contributing to the significance. With a standardized residual of negative 2.1, we see that fewer organizations were
not able to meet the requirement than expected (we expected more to fail the requirement than were observed).

Furthermore, because there is a significant difference between the categories, a logistic regression model was developed to further explore this relationship. Although the model was fairly weak and explained just 3.8% (Nagelkerke $R^2$) of the variance, Table 8.14 shows that, as compared to the West region, the Northeast was statistically different ($p = .007$) with the Northeast having 4.79 the odds of passing the Expand 2 Grassley Requirement as compared to the West.

From the previous models, we know that there was no statically significant regional difference between organizations that do and do not pass the Grassley Requirement when narrowly defined (i.e. the narrow definition) or when bad debt was added (i.e. Expand 1). However, when Medicare shortfalls were added as a category that can be “written off,” we now see that organizations in the Northeast are failing the requirement at a lower than expected rate. Thus, a policy that adds Medicare Shortfalls as a community benefit category may help organizations in the Northeast more easily pass the requirement given the current levels of spending.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Odds Ratio (Confidence Interval 95%)</th>
<th>$p$</th>
<th>Standard Error</th>
<th>Explained Variance (Nagelkerke R Square)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwest</td>
<td>1.521 (.716 - 3.229)</td>
<td>.275</td>
<td>.384</td>
<td></td>
</tr>
<tr>
<td>Northeast</td>
<td>4.788 (1.546 - 14.830)</td>
<td>.007*</td>
<td>.577</td>
<td>.038</td>
</tr>
<tr>
<td>South</td>
<td>1.582 (.784 - 3.191)</td>
<td>.201</td>
<td>.358</td>
<td></td>
</tr>
</tbody>
</table>

* $p < .05$
Independent-samples t-tests were conducted to compare additional organizational factors that may affect the ability to meet an Expend 2 definition of the Grassley Requirement including profit margin, the income percent to qualify for free care, the income percent to qualify for discounted care, and the number of employees at the organization. As can be seen in Tables 8.11 and 8.12, there was no significant difference between organizations which could meet the Expand 1 requirement and those which could not meet the expense requirement for any of these independent variables.

**Expand 3 Definition.** In allowing bad debt and Medicare shortfalls to be added to the narrow definition of community benefit in a plausible Expand 3 definition of the Grassley Requirement, Table 8.8 shows that hospital organizations spent an average of 17.1% of every dollar received on community benefit. Furthermore, table 8.8 shows what percent of revenue could be mandated if the goal was to capture 50%, 75%, 90%, and 99% of the hospital organizations, respectively.

Table 8.09 shows the rate of failure by region, adherence to HFMA Statement 15, filing size, and accounting method when examining whether the organizations that could or could not meet an Expand 3 definition of the Grassley Requirement. No significant interactions were found expect for adherence to HFMA Statement 15, filing size, and accounting method.

Chi-square hypothesis tests were also conducted to evaluate the null hypothesis that there is no relationship between these independent variables and the ability to meet an expanded definition of the Grassley Requirement. No significant interactions were found.

Independent-samples t-tests were also conducted to compare additional organizational factors that may affect the ability to meet an Expend 3 definition of the Grassley Requirement.
including profit margin, the income percent to qualify for free care, the income percent to qualify for discounted care, and the number of employees at the organization. As can be seen in Tables 8.11 and 8.12, there was no significant difference between organizations which could meet the Expand 1 requirement and those which could not meet the expense requirement for any of these independent variables.

**Expand 4 Definition.** Allowing all three debated community benefit categories (bad debt, Medicare shortfalls, and community building activities) to be added to the narrow definition of community benefit in a plausible Expand 4 definition of the Grassley Requirement, Table 8.8 shows that hospital organizations spent an average of 17.2% of every dollar received on community benefit. Furthermore, table 8.8 shows what percent of revenue could be mandated if the goal was to capture 50%, 75%, 90%, and 99% of the hospital organizations, respectively.

The same hospital organizations that could not meet an Expand 3 definition of community benefit were not able to meet an Expand 4 definition. Thus, since there were no associations between being able to meet an Expand 3 definition and the various independent variables, there were also no associations with an Expand 4 definition.

**Evaluation of a Policy Based on the Expense Requirement**

A national policy based on the Expense Requirement would require that nonprofit hospitals must provide community benefit amounts equal to at least 3% of the hospital organization’s total expense. When it comes to aggregate, national spending as a percent of expenses in 2012, Table 8.15 outlines total spending per total expenses from the 997 hospitals in the sample and uses this spending to estimate the total national spending per total national
revenue for all 2,904 hospitals for the eight categories in the narrow definition as well as the totals for the Expand 1, Expand 2, Expand 3, and Expand 4 definitions.

Analysis of the spending shows that when comparing the narrowly-defined estimated national spending for all hospitals ($52.1 billion) to the total estimated national expenses disbursed ($569 billion), hospitals were allocating 9.2% of every dollar spent to community benefit activities. Adding the categories of Bad Debt (to achieve an Expand 1 definition) resulted in 13.2% being allocated to community benefit and adding Medicare shortfalls (to achieve an Expand 2 definition) resulted in 11.8% being allocated. When adding all plausible categories of community benefit (bad debt, Medicare shortfalls, and community building activities) to achieve an Expand 4 definition, the organizations were spending 15.9% of every dollar received on community benefit. Thus, similar to the Tax Value Requirement and the Grassley Requirement, no matter how community benefit is defined, nonprofit hospitals, in aggregate, could meet a national policy based on the Expense Requirement.
Narrow Definition. Looking at only national, aggregate spending may hinder a policymaker’s ability to assess the ability of individual hospital organizations to meet each of these requirements. As such, Table 8.16 breaks the spending ratios into percentiles for the eight categories in the narrow definition as well as the totals for the Expand 1, Expand 2, Expand 3, and Expand 4 definitions. For example, the table shows that that 8.9% of every dollar spent at hospital organizations went to community benefit. Furthermore, table 8.16 shows what percent

<table>
<thead>
<tr>
<th>Sample Spending (997 Hospitals)</th>
<th>National Community Benefit Spending (Estimated Value for all 2,904 Hospitals)</th>
<th>Total Expenses of Sample</th>
<th>National Expenses (Estimated Value for all 2,904 Hospitals)</th>
<th>Total Community Benefit Spending as a Percent of Total Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Narrow Spending</td>
<td>$17,879,876,979</td>
<td>$52,079,400,950</td>
<td>$195,365,783,063</td>
<td>$569,049,382,161</td>
</tr>
<tr>
<td>Expand 1 (Narrow + Bad Debt)</td>
<td>$25,813,461,618</td>
<td>$75,187,856,107</td>
<td>$195,365,783,063</td>
<td>$569,049,382,161</td>
</tr>
<tr>
<td>Expand 2 (Narrow + Medicare Shortfall)</td>
<td>$23,119,548,237</td>
<td>$67,341,191,655</td>
<td>$195,365,783,063</td>
<td>$569,049,382,161</td>
</tr>
<tr>
<td>Expand 3 (Narrow + Bad Debt + Medicare Shortfall)</td>
<td>$31,053,132,876</td>
<td>$90,449,646,812</td>
<td>$195,365,783,063</td>
<td>$569,049,382,161</td>
</tr>
<tr>
<td>Expand 4 (Narrow + Bad Debt + Medicare Shortfalls + Community Building Activities)</td>
<td>$31,188,303,262</td>
<td>$90,843,362,761</td>
<td>$195,365,783,063</td>
<td>$569,049,382,161</td>
</tr>
</tbody>
</table>
of expenses could be mandated if the goal was to capture 50%, 75%, 90%, and 99% of the hospital organizations, respectively.

<table>
<thead>
<tr>
<th>Table 8.16 Total Community Benefit Thresholds as a Percent of Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
</tr>
<tr>
<td>Total Narrow Spending</td>
</tr>
<tr>
<td>Expand 1 (Narrow + Bad Debt)</td>
</tr>
<tr>
<td>Expand 2 (Narrow + Medicare Shortfall)</td>
</tr>
<tr>
<td>Expand 3 (Narrow + Bad Debt + Medicare Shortfall)</td>
</tr>
<tr>
<td>Expand 4 (Narrow + Bad Debt + Medicare Shortfalls + Community Building Activities)</td>
</tr>
</tbody>
</table>

* Threshold would meet Expense Requirement; ** Threshold would not meet Expense Requirement

Table 8.17 shows the rate of failure by region, adherence to HFMA Statement 15, filing size, and accounting method when examining whether the organizations that could or could not meet an Expand 1 definition of the Grassley Requirement. Chi-square hypothesis tests were then conducted to evaluate the null hypothesis that there is no relationship between these independent variables and the ability to meet an expanded definition of the Grassley Requirement. As shown in Table 8.18, no significant interactions were found.
Table 8.17  Crosstabulation of Community Benefit Spending Models as a Percent of Expenses and Census Region, Adherence to Healthcare Financial Management Statement No. 15 (HFMA #15), Filing Size, and Accounting Method using the Expense Requirement

<table>
<thead>
<tr>
<th>Census Region</th>
<th>Total Narrow Spending</th>
<th>Expand 1 (Narrow + Bad Debt)</th>
<th>Expand 2 (Narrow + Medicare Shortfall)</th>
<th>Expand 3 (Narrow + Bad Debt + Medicare Shortfall)</th>
<th>Expand 4 (Narrow + Bad Debt + Medicare Shortfalls + Community Building Activities)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Midwest</td>
<td>11</td>
<td>(9.1)</td>
<td>.1</td>
<td>110</td>
<td>(90.9)</td>
</tr>
<tr>
<td>Northeast</td>
<td>2</td>
<td>(2.2)</td>
<td>.2</td>
<td>91</td>
<td>(97.8)</td>
</tr>
<tr>
<td>South</td>
<td>20</td>
<td>(12.0)</td>
<td>1.4</td>
<td>147</td>
<td>(88.0)</td>
</tr>
<tr>
<td>West</td>
<td>9</td>
<td>(9.4)</td>
<td>.2</td>
<td>87</td>
<td>(90.6)</td>
</tr>
<tr>
<td>HFMA #15</td>
<td>Adheres</td>
<td>30</td>
<td>(9.4)</td>
<td>.6</td>
<td>290</td>
</tr>
<tr>
<td></td>
<td>Not Adhere</td>
<td>10</td>
<td>(6.5)</td>
<td>.8</td>
<td>143</td>
</tr>
<tr>
<td>Filing Size</td>
<td>Single</td>
<td>31</td>
<td>(8.8)</td>
<td>.0</td>
<td>322</td>
</tr>
<tr>
<td></td>
<td>Small</td>
<td>9</td>
<td>(11.3)</td>
<td>.7</td>
<td>71</td>
</tr>
<tr>
<td></td>
<td>Medium</td>
<td>2</td>
<td>(6.7)</td>
<td>.4</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Large</td>
<td>0</td>
<td>(0.0)</td>
<td>-.1</td>
<td>14</td>
</tr>
<tr>
<td>Accounting Method</td>
<td>Cost Accounting</td>
<td>2</td>
<td>(4.7)</td>
<td>.9</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>Cost-to-Charge</td>
<td>30</td>
<td>(9.5)</td>
<td>.4</td>
<td>287</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>10</td>
<td>(9.4)</td>
<td>.2</td>
<td>96</td>
</tr>
</tbody>
</table>

SR = Standardized Residual

** Standardized residual with chi-square p <.05 and absolute value of 2.0 or higher
Independent-samples t-tests were conducted to compare additional organizational factors that may affect the ability to meet a narrowly-defined Expense Requirement including profit margin, the income percent to qualify for free care, the income percent to qualify for discounted care, and the number of employees at the organization. As can be seen in Tables 8.19 and 8.20, there was no significant difference in the profit margins between organizations which could meet the expense requirement (Mean= 3.7%, S.D. = 7.6%) and those which could not meet the expense requirement (Mean= 1.6%, S.D. = 8.5%); t(475)= -1.71, p=.087.

<table>
<thead>
<tr>
<th>Expense Requirement as a Percent of Expenses</th>
<th>Total Narrow Spending</th>
<th>Expand 1 (Narrow + Bad Debt)</th>
<th>Expand 2 (Narrow + Medicare Shortfall)</th>
<th>Expand 3 (Narrow + Bad Debt + Medicare Shortfall)</th>
<th>Expand 4 (Narrow + Bad Debt + Medicare Shortfalls + Community Building Activities)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Census Region</td>
<td>Chi-square</td>
<td>DF*</td>
<td>p</td>
<td>Chi-square</td>
<td>DF*</td>
</tr>
<tr>
<td>7.271</td>
<td>3</td>
<td>.064</td>
<td></td>
<td>5.74</td>
<td>3</td>
</tr>
<tr>
<td>HFMA #15</td>
<td>Chi-square</td>
<td>DF*</td>
<td>p</td>
<td>Chi-square</td>
<td>DF*</td>
</tr>
<tr>
<td>1.078</td>
<td>1</td>
<td>.196</td>
<td></td>
<td>0.201</td>
<td>1</td>
</tr>
<tr>
<td>Filing Size</td>
<td>Chi-square</td>
<td>DF*</td>
<td>p</td>
<td>Chi-square</td>
<td>DF*</td>
</tr>
<tr>
<td>2.118</td>
<td>3</td>
<td>.548</td>
<td></td>
<td>12.765</td>
<td>3</td>
</tr>
<tr>
<td>Accounting Method</td>
<td>Chi-square</td>
<td>DF*</td>
<td>p</td>
<td>Chi-square</td>
<td>DF*</td>
</tr>
<tr>
<td>2.21</td>
<td>3</td>
<td>.530</td>
<td></td>
<td>2.859</td>
<td>3</td>
</tr>
</tbody>
</table>

DF, degree of freedom

*p < .05

**p < .005
Table 8.20  Independent Samples \( t \)-tests of Community Benefit Spending Models as a Percent of Expenses and Profit Margin, Free Percent, Discount Percent, and Number of Employees using the Expense Requirement

<table>
<thead>
<tr>
<th>Expense Requirement as a Percent of Expenses</th>
<th>Total Narrow Spending</th>
<th>Expand 1 (Narrow + Bad Debt)</th>
<th>Expand 2 (Narrow + Medicare Shortfall)</th>
<th>Expand 3 (Narrow + Bad Debt + Medicare Shortfall)</th>
<th>Expand 4 (Narrow + Bad Debt + Medicare Shortfalls + Community Building Activities)</th>
</tr>
</thead>
<tbody>
<tr>
<td>t-test</td>
<td>DF*</td>
<td>p</td>
<td>t-test</td>
<td>DF*</td>
<td>p</td>
</tr>
<tr>
<td>Profit Margin</td>
<td>-1.710</td>
<td>475</td>
<td>-0.878</td>
<td>-1.469</td>
<td>475</td>
</tr>
<tr>
<td>Free Percent</td>
<td>-2.170</td>
<td>465</td>
<td>-0.380**</td>
<td>-0.909</td>
<td>465</td>
</tr>
<tr>
<td>Discount Percent</td>
<td>-4.120</td>
<td>434</td>
<td>-0.009**</td>
<td>-0.518</td>
<td>434</td>
</tr>
<tr>
<td>Employees</td>
<td>-2.360</td>
<td>455</td>
<td>-0.180**</td>
<td>-0.951</td>
<td>455</td>
</tr>
</tbody>
</table>

*DF, degree of freedom
**p < .05

SD = Standard Deviation
There was, however, a significant difference in the percent threshold to qualify for free care for those organizations that could meet the requirement (Mean = 187.6%, S.D.= 56.1%) and those who could not (Mean=167.2%. S.D. = 54.9%); t(465) = -2.17. p=.03. Furthermore, because there is a significant difference between the means, a logistic regression model was developed to further explore this relationship. Although the model was fairly weak and explained just 2.4% (Nagelkerke $R^2$) of the variance, Table 8.21 shows that the logistic regression model was statistically significant ($p = .030$). Furthermore, the model indicates that for every one full point increase in Free Percent (every 100% that is added to the FPL), the odds of meeting the Expand 1 Expense Requirement are increased by a factor of 2.012 (Confidence Interval 1.071 – 3.781). As the Free Percent increased, the odds of meeting the Expand 1 Expense Requirement increase. Such results suggest that, when narrowly defined, organizations which set higher income thresholds for free care are more likely to meet the expense requirement and suggests that a narrow policy (without bad debt and Medicare shortfalls) may help hospital organizations to become more generous with forgiving people of their medical debt.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Odds Ratio (Confidence Interval 95%)</th>
<th>$p$</th>
<th>Standard Error</th>
<th>Explained Variance (Nagelkerke $R^2$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free Percent</td>
<td>2.012 (1.071 - 3.781)</td>
<td>.030*</td>
<td>.322</td>
<td>.240</td>
</tr>
</tbody>
</table>

* $p < .05$

Table 8.21 Logistic Regression Results of the Federal Poverty Income Threshold for Free Care and the Ability to Meet a Narrow Definition of the Expense Requirement

There was also significant difference in the percent threshold to qualify for discounted care for those organizations that could meet the requirement (Mean = 361.0%, S.D.= 115.4%) and those who could not (Mean=280.1%. S.D. = 81.7%); t(434) = -4.12. p < .001. Furthermore,
because there is a significant difference between the means, a logistic regression model was developed to further explore this relationship. Although the model was fairly weak and explained 10.4% (Nagelkerke $R^2$) of the variance, Table 8.22 shows that the logistic regression model was statistically significant ($p < .000$). Additionally, the model indicates that for every one pull point increase in Discount Percent (every 100% that is added to the FPL), the odds of meeting the Narrow Expense Requirement are increased by a factor of 2.285 (Confidence Interval 1.555 – 3.358). As the Discount Percent increased, the odds of meeting the requirement increase. Similar to the threshold for free percent, such results suggest that, when narrowly defined, organizations which set higher income thresholds for discounted care are more likely to meet the expense requirement. This suggests that a narrow policy (without bad debt and Medicare shortfalls) may help hospital organizations to become more generous with providing a discount on their medical debt.

<table>
<thead>
<tr>
<th>Table 8.22</th>
<th>Logistic Regression Results of the Federal Poverty threshold for Discounted Care and the Ability to Meet a Narrow Definition of the Expense Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor</td>
<td>Odds Ratio</td>
</tr>
<tr>
<td>Discount Percent</td>
<td>2.285 (1.555 - 3.358)</td>
</tr>
</tbody>
</table>

* $p < .05$

Independent-samples t-tests were conducted to compare the ability to meet a narrowly-defined Expense Requirement and the number of employees at the organization. In this analysis, there was a significant difference in the mean number of employees at organization’s that could meet the requirement (Mean = 3,371.5, S.D.= 6,611.6) and those who could not (Mean=925.4, S.D. = 957.7); t(455) = -2.36. $p=.018$. Furthermore, because there is a significant difference
between the means, a logistic regression model was developed to further explore this relationship. Although the model was fairly weak and explained 10.2\% (Nagelkerke R^2) of the variance, Table 8.23 shows that the logistic regression model was statistically significant (\(p=.002\)). Additionally, the model indicates that for every one point increase (of 10,000) in the number of employees, the odds of meeting the Narrow Expense Requirement are increased by a factor of 1.001 (Confidence Interval 1.000 – 1.001). As the number of employees increases, the odds of meeting the requirement increase. However, with the odds ratio being close to 1.0 coupled with a confidence interval range that is also close to 1.0, the number of employees does not have much effect on the odds of an organization meeting the Expense Requirement.

<table>
<thead>
<tr>
<th>Table 8.23 Logistic Regression Results of the Number of Employees and the Ability to Meet a Narrow Definition of the Expense Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Factor</strong></td>
</tr>
<tr>
<td>Employees</td>
</tr>
</tbody>
</table>

* \(p < .05\)

**Expand 1 Definition.** In allowing bad debt to be added to the narrow definition of community benefit in a plausible Expand 1 definition of the Expense Requirement, Table 8.16 shows that hospital organizations spent an average of 14.5\% of every dollar on community benefit. Furthermore, table 8.16 shows what percent of revenue could be mandated if the goal was to capture 50\%, 75\%, 90\%, and 99\% of the hospital organizations, respectively.

Table 8.17 shows the rate of failure by region, adherence to HFMA Statement 15, filing status and accounting method when examining whether the organizations that could or could not meet an Expand 1 definition of the Grassley Requirement. Chi-square hypothesis tests were then conducted to evaluate the null hypothesis that there is no relationship between these independent
variables and the ability to meet an expanded definition of the Grassley Requirement. As shown in Table 8.18, no significant interactions were found with region, adherence to HFMA Statement 15, and accounting method. Although a chi-square hypothesis test showed that there was a relationship ($\chi^2 (3) = 12.77, p = .005$) between filing size and the ability to meet an Expanded definition of the Expense Requirement, three cells (37.5%) had expected count less than 5 and some individual expected values were as low as 0.5 and 0.2. Since more than 20% of the expected counts are less than 5 and many individual expected counts are less than 1, the association is not valid.\footnote{115} Such results are further exemplified in the logistical regression results of Table 8.24 which shows that, as compared to large filing sizes, none of the other filing sizes show significant difference in the ability to meet the requirement.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Odds Ratio (Confidence Interval 95%)</th>
<th>$p$</th>
<th>Standard Error</th>
<th>Explained Variance (Nagelkerke R Square)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>.000 (.000 - .000)</td>
<td>.999</td>
<td>10741.960</td>
<td></td>
</tr>
<tr>
<td>Small</td>
<td>.000 (.000 - .000)</td>
<td>.999</td>
<td>10741.960</td>
<td>.134</td>
</tr>
<tr>
<td>Medium</td>
<td>.000 (.000 - .000)</td>
<td>.999</td>
<td>10741.960</td>
<td></td>
</tr>
</tbody>
</table>

Independent-samples t-tests were conducted to compare additional organizational factors that may affect the ability to meet an Expand 1 definition of the Grassley Requirement including profit margin, the income percent to qualify for discounted care, and the number of employees at the organization. As can be seen in Tables 8.19 and 8.20, there was no significant difference between organizations which could meet the Expand 1 requirement and those which could not meet the expense requirement for any of these independent variables.
**Expand 2 Definition.** In allowing Medicare shortfalls to be added to the narrow definition of community benefit in a plausible Expand 2 definition of the Expense Requirement, Table 8.16 shows that hospital organizations spent an average of 12.0% of every dollar on community benefit. Furthermore, table 8.16 shows what percent of revenue could be mandated if the goal was to capture 50%, 75%, 90%, and 99% of the hospital organizations, respectively.

Table 8.17 shows the rate of failure by region, adherence to HFMA Statement 15, filing status and accounting method when examining whether the organizations that could or could not meet an Expand 2 definition of the Grassley Requirement. Chi-square hypothesis tests were then conducted to evaluate the null hypothesis that there is no relationship between these independent variables and the ability to meet an expanded definition of the Grassley Requirement. As shown in Table 8.18, no significant interactions were found.

Independent-samples t-tests were conducted to compare additional organizational factors that may affect the ability to meet an Expand 2 definition of the Grassley Requirement including profit margin, the income percent to qualify for discounted care, and the number of employees at the organization. As can be seen in Tables 8.19 and 8.20, there was no significant difference between organizations which could meet the Expand 1 requirement and those which could not meet the expense requirement regarding profit margin, and the number of employees at the organization.

There was significant difference in the percent threshold to qualify for discounted care for those organizations that were able to meet the requirement (Mean = 357.638%, S.D. = 115.88%) and those who could not (Mean=294.09%. S.D. = 76.32%); t(434) = -2.531, p=.012. Furthermore, because there is a significant difference between the means, a logistic regression
model was developed to further explore this relationship. Although the model was fairly weak and explained just 5.3% (Nagelkerke $R^2$) of the variance, Table 8.25 shows that the logistic regression model was statistically significant ($p = .009$). Additionally, the model indicates that for every one full point increase in Discount Percent (every 100% that is added to the FPL), the odds of meeting the Expand 2 Expense Requirement are increased by a factor of 1.855 (Confidence Interval 1.170 – 2.941). As the Discount Percent increased, the odds of meeting the requirement increase.

From the previous models, we know that there is no difference in the thresholds for discounted care between organizations that do and do not pass the Expense Requirement when bad debt was added. However, when either narrowly defined or when Medicare shortfalls is added as a category that can be “written off,” we see that organizations which set higher thresholds for discounted care (i.e. are more generous with forgiving people of their medical debt) are more likely to pass an Expense Requirement than those who have set lower thresholds for free care (i.e. are less generous with forgiving people of their medical debt). This suggests that a policy that is either narrowly defined or one that adds only Medicare shortfalls (not bad debt) may help hospital organizations to become more generous with providing discounts on medical debt.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Odds Ratio (Confidence Interval 95%)</th>
<th>$p$</th>
<th>Standard Error</th>
<th>Explained Variance (Nagelkerke $R^2$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discount Percent</td>
<td>1.855 (1.170 - 2.941)</td>
<td>.009*</td>
<td>.235</td>
<td>.053</td>
</tr>
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</table>

* $p < .05$
**Expand 3 Definition.** In allowing bad debt and Medicare shortfalls to be added to the narrow definition of community benefit in a plausible Expand 3 definition of the Expense Requirement, Table 8.16 shows that hospital organizations spent an average of 17.6% of every dollar on community benefit. Furthermore, table 8.16 shows what percent of revenue could be mandated if the goal was to capture 50%, 75%, 90%, and 99% of the hospital organizations, respectively.

Table 8.17 shows the rate of failure by region, adherence to HFMA Statement 15, filing status, and accounting method when examining whether the organizations that could or could not meet an Expand 3 definition of the Grassley Requirement. Chi-square hypothesis tests were then conducted to evaluate the null hypothesis that there is no relationship between these independent variables and the ability to meet an expanded definition of the Grassley Requirement. As shown in Table 8.18, no significant interactions were found with by region, adherence to HFMA Statement 15, and accounting method. Although a chi-square hypothesis test showed that there was a relationship ($\chi^2(3) = 18.65, p < .000$) between filing size and the ability to meet the Expanded definition of the Expense Requirement, four cells (50.0%) had expected count less than 5 and some individual expected values were as low as 0.1. Since more than 20% of the expected counts are less than 5 and many individual expected counts are as low as .8, .3, and .1, the association is not valid.\textsuperscript{115} Such results are further exemplified in the logistical regression results of Table 8.26 which shows that, as compared to large filing sizes, none of the other filing sizes show significant difference in the ability to meet the requirement.
Independent-samples t-tests were conducted to compare additional organizational factors that may affect the ability to meet an Expend 3 definition of the Grassley Requirement including profit margin, the income percent to qualify for discounted care, and the number of employees at the organization. As can be seen in Tables 8.19 and 8.20, there was no significant differences.

**Expand 4 Definition.** In allowing bad debt, Medicare shortfalls, and Community Building Activities to be added to the narrow definition of community benefit in a plausible Expand 4 definition of the Expense Requirement, Table 8.16 shows that hospital organizations spent an average of 17.6% of every dollar on community benefit. Furthermore, table 8.16 shows what percent of revenue could be mandated if the goal was to capture 50%, 75%, 90%, and 99% of the hospital organizations, respectively.

The same hospitals that could not meet an Expend 3 definition of community benefit not able to meet an Expand 4 definition. Thus, any associations between being able to meet an Expand 4 definition and the various independent variables are the same as associations with an Expand 3 definition.
QUALITATIVE RESULTS

Summary Statistics

Table 8.27 contains summary statistics of the number of hospital organizations interviewed. Overall, the purposeful sampling resulted in fourteen people representing eighty-four nonprofit hospitals meeting inclusion criteria who were willing and able to be interviewed. The hospitals whose staff were interviewed represented those that were amongst the most and least charitable in the nation, those with the highest and lowest rates of bad debt expense, those with the highest and lowest Medicare shortfalls, and those with the highest and lowest community building activities. The hospitals also represented a mix of regions, cost-accounting methodologies, profit margins, and self-determined income thresholds for the patient to quality for free or discounted care.

<table>
<thead>
<tr>
<th>KII</th>
<th>Profit Margin</th>
<th>Free Percent</th>
<th>Discount Percent</th>
<th>Narrow Community Benefit Percent*</th>
<th>Bad Debt Percent*</th>
<th>Medicare Shortfalls Percent*</th>
<th>Community Building Activities Percent*</th>
<th>Accounting Method</th>
<th>Filing Size</th>
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<tr>
<td>1</td>
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<td>2</td>
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<td>0.46%</td>
<td>4.75%</td>
<td>0.00%</td>
<td>0.00%</td>
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<td>West</td>
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<td>200%</td>
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</tr>
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<tr>
<td>Entire Sample Mean</td>
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<td>N/A</td>
<td>2.09</td>
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* Community benefit giving was normalized as a percent of total organizational revenue
Minimum Community Benefit Requirements

A national health policy based on the Grassley, Expense, or Tax Value Requirement would require nonprofit hospitals to spend at least a minimum amount on community benefit. While such a policy could help to ensure that such organizations are providing sufficient resources to cover the loss of governmental tax revenue, responses from key informant interviews as to whether a mandated “minimum percent” would be supported leaned toward opposition. Hospitals amongst the least charitable (as a percent of revenue or expenses) were often against such a policy. For example, one hospital who donated less than one half of one percent of every dollar they generated to community benefit when narrowly defined said they are strongly against any federal minimum for community benefit. Although they would like to say that it would result in more care being provided, their stated reality of “limited resources” meant that a federal minimum would only result in more “creative accounting.” The small hospital in the rural Midwest operated on such a slight margin that there was just not enough money to support extra programs. They only had one doctor and “there are days in which the hospital is empty.” Thus, the hospital claimed that they would not be able to meet any minimum threshold. Instead, if such a policy would become law, the hospital would likely try to write-off items like “$15,000 windows which would not truly benefit patients.”

Similarly, a large hospital system in the Northeast was also against a policy minimum for hospitals, especially those with low profit margins. “We were bleeding so badly years ago and… I had to lay off people in my [community benefit] department. So, do you stand and pout and cross your arms and say ‘no you shouldn’t do this when there’s 40 million in red ink?’ I think that’s really hard.” The system director spoke of the high financial demands on healthcare
systems and wondered how they even stay in business. “I’ve known CEO’s who have said the mere fact that we have the doors open is a community benefit.”

Additional opposition for a national minimum include the argument that “not all facilities are the same and that not all communities are the same, and so, to just put a finite number out there and say ‘this is what everybody needs to do’ [is wrong].” Instead, the suggestion was that the expectation should be more relative to each hospital’s situation. “I just think it has to be somewhat flexible based on the demographics of the individual area” said one hospital administrator. Another said “If [they are the] only hospital in that community, and they can make a case for why they don’t have the resources to do any more, I do think the facts and circumstances are probably legitimate.” A third informant agreed and said, “I think they should set standards, I think they should set guidelines, and I think they should be transparent about those; [however], I would be disinclined to speculate about any appropriate percentage.” Yet another suggested that looking at “facts and circumstance make so much more sense” and argued that governing charity through policy can become too political:

Every piece of legislation I’ve seen that tries to make a one-size fits all; it depends on the interest of the organizations who are sponsoring the legislation. In hospitals, nurses want us to do more charity care. Other people want us to serve certain communities or want to have certain elected officials to have input into the process. I think they can be a little parochial, and they tend to look backwards and identify current needs of stakeholders.

Informants from the most generous hospitals in the country (donating over 10% of every dollar in revenue to community benefit- even when narrowly defined), were similarly against a minimum, but for a different reason: the risk of a race to the bottom. “No, I mean absolutely not; then you’ve erased the bottom, right? Then people will say ‘[if all] we have to do is some percent, then why we have to do all this?’” The concern was, should the federal government enact a 5% minimum revenue spending or 3% minimum expense spending, then hospitals above
that threshold may quickly start to reduce their overall spending, especially ones that are currently spending a much higher amount. The informant said a minimum percent would cause them to ask themselves: “Why are we providing this high level of care because we now have regulations saying we have too big of a number?” They concluded that “it would encourage us to provide less care.”

Some healthcare administrators were supportive of a minimum threshold for community benefit spending and advised that hospitals with low charitable percentages “need to look at not treating it so much as commerce, but treating it more as a public health issue.” An informant from a hospital organization that donated well above 5% of their revenue (or expenses) to the community also concurred. “If it would streamline things for me, then absolutely,” said the Director of Community Benefit Programs at small hospital in the South. “I mean, I have no doubt that we meet that.” Instead, the worry for these hospitals was that the policy would come with a lot of extra work. “It’s just the question of how do we prove that. If it’s easy for us to prove that, and it doesn’t require a lot of bureaucracy, then I would be totally in favor of it.”

A community benefit leader at a large health system in the Midwest concurred, although the responses were focused more toward the need for standard reporting than the need to mandate minimum spending. “When I go to the national association of community health improvement conference every year, I’m beginning to see a greater divide between those hospitals that are new to all this and those that are light years ahead.” Furthermore, “because we don’t have that sort of national standard, everybody has to adjust locally in ways that I don’t think are as helpful, it’s not productive.” The director further quipped, that in their state, “we don’t have a standard, so we’re all sort of muddling.” Whereas, if there were standards, the hope is that obligations would be clearer. “Even within the [area market], there’s vast differences in
how we’ve interpreted… the categories and how we’ve interpreted levels to which things need to be reported, and I’d like to see some of those results [standardized]."

Finally, some who were already providing larger community benefit than the current policy proposals were more ambiguous. “I’ve never been asked that question. I’ve never even had that discussion with the finance team that works in this area with me.” Such hospitals said that a minimum threshold would generally not change much practice: “I don’t see [a minimum threshold] as a big change for what we’re doing anyways.” These hospitals did not have a strong opinion either way.

Setting Targets

When it came to setting community benefit targets, most hospital systems did not set specific objectives, either in total or as a percent of revenue or expenses. Instead, community benefit spending was determined through a variety of mechanisms. There were some organizations, such as a large health system in the Northeast, which were familiar with policy proposals to mandate a minimum percent of spending and knew that “at one point things had been suggested nationally.” However, the representative said that “we don’t go by five percent of patient revenue or anything like that.” Instead, the system has a top-down approach where they have “a certain amount of funding that’s been allocated to address community benefits” which they then “try to align that with our [Community Health Needs Assessment] and our internal hospital plan and then decide what is it that we’re going to fund.”

Some hospital representatives, such as an informant from a children’s hospital in the West, used the opposite approach which was more bottom-up. In this model, the representative spoke about letting the Community Health Needs Assessment determine the amount necessary to affect the health need. “It is just really just ad hoc through the budgetary process, so we request
what we need” and “you kind of get what you want if the need is able to be justified.” A large system in the South took a case-by-case approach which looked at “our financial ability to either continue the existing program or expand it” and “the target set is based really on financial ability” of the institution.

A representative from a large Midwestern hospital system said they used to set spending targets, but stopped since “the feeling was we do not want to give the appearance that we are either a) trying to give away money where we should not or b) that we were kept [at a certain spending level].” Instead, the hospital has set goals including ones in which "we want our bad debt to be less than our charity care” and “we are trying to hit 2012 numbers as far as dollars and number of patients we are assisting.” The year 2012 was chosen since this was the start of most policies in the Affordable Care Act which resulted in a drop in the number of people applying for charity care.

**Setting Income Thresholds for Free and Discounted Care**

Although the income thresholds to qualify for free and discounted care can have a significant impact on the total amount of charity care given, the consensus amongst the interviewed hospital administrators was that a charity care target was not the driving force behind whether a patient received free care at 100% or 400% of poverty. Instead, the interviewees spoke about other mechanisms such as benchmarking within the state, within the surrounding states, and against their closest competitors. For example, a large system in the Midwest spoke about having “conversations where this organization varies from others in the market and others across the state.” Some hospitals, like a children’s hospital in the West, said it was based mainly on “historical precedent” while others, such as a small hospital in the rural
South, said it benchmarked against “other agencies in our area to determine what the criteria looks like” such as state Medicaid thresholds and qualifications for free housing or subsidized housing.

A representative from a large hospital system in the West spoke in detail about the high cost of living in certain areas and how “our medical financial assistance policy tries to be cognizant of the cost of care.” This system allowed individuals with incomes many times the federal poverty level to qualify for free and discounted care because “our policies are consistent with trying to understanding the demands on families lives” and how it can be “exceedingly costly to live.” Similarly, hospitals in rural or Southern areas often set lower income thresholds based on higher levels of poverty and lower cost of living in the area.

Some hospitals set their income thresholds based on their unique circumstances. For example, a small hospital in the rural Midwest with one of the highest percentages of bad debt in the country believed that their thresholds for charity were “harsh,” especially since one had to make at or below 100% of poverty to quality for free care in a community that used to be “fairly wealthy” due to the oil boom. However, the hospital spoke about many temporary workers coming for the jobs when the oil market was high and leaving when the market was low. They believed that much of their bad debt was due to patients who left the area once they lost their job and never paid their bills. Thus, since the income levels of the community are so volatile, the hospital has maintained a very low income threshold for free care.

**Inclusion or Exclusion of Debated Categories**

**Bad Debt.** A decision as to whether to include bad debt as a community benefit category that can be used to justify a hospital organization’s tax-free status is one of the more
controversial aspects of the policy debate. Bad debt, which consists of services for which hospitals anticipated reimbursement (because the patient has been determined to have the financial capacity to pay) but did not receive payment is inherently associated with the category of charity care, which consists of services for which hospitals neither received, nor expected to receive, payment due to the patient’s determined inability to pay. Bad debt results in hospital bills that the organization is still trying to collect and will send to a collections agency (or pursue via other collection methods) while charity care, in contrast, represents hospital bills that the organization is not trying to collect and has forgiven (either in part or in full). In order to thoroughly explore the topic, hospitals with a comparatively high (bad debt accounting for >10% of every dollar earned in revenue) and comparatively low (bad debt accounting for <0.5% of every dollar earned in revenue) were asked to weigh in on the debate.

Many informants from organizations that claimed higher bad debt expenses supported the inclusion of the category as community benefit with the most often cited reason being insufficient patient income information. “Yes, I think bad debt should be included as a part of charity care,” said an independent hospital administrator in the South, “because you don’t know, you have no determination.” The hospital representative claimed that “there’s a lot of judgment in what one counts and what one doesn’t, and we don’t have all of the information to be making those judgments.”

Similarly, while many acknowledged they do a poor job of separating charity care from bad debt and that these cases are often intermingled, some said that it would be a “monumental task” for hospitals to accurately capture these patients. Another informant said, “I would say we maybe [catch] around 50 percent probably. I really do feel like there are people who are eligible and, as much as we try, we’re still not able to get them.” Respondents cite reasons patients do
not apply for charity care generally surround patient lack of personal responsibility and included: patient pride (“for some of our older population on fixed incomes, I think it’s a pride kind of thing honestly”), patient privacy (“they think it’s none of your business—I don’t want to give you my bank statements or how much money I make”), and a lack of patient prioritization (“it’s not a priority to them, they’re not concerned about what happens to that account. If you send it over to collections, so be it. They’re not concerned about it.”).

For some hospitals, the difference between including bad debt and not including bad debt meant the ability to meet a national policy such as the Grassley Requirement. For example, four interviewed hospitals provided less than 5% of every dollar received to community benefits when narrowly defined, however, exceeded that threshold if bad debt was included. One hospital went from spending less than one half of one percent on community benefit to over 5% while others went from spending less than 4% to well over 20% once bad debt was added. When interviewed, such hospitals struggled with this reality as exemplified by one key informant remarking: “My community/public health side says, no, that bad debt should not be included and that it would be great to do more. However, my professional/administrator side says that it’s just not possible for a small, rural hospital to meet any threshold without it.” Others said that they were “not surprised at all” by their high levels of bad debt and claimed that it was because of where the hospital is located: “we have the most poverty…the number one most poverty-stricken neighborhood track.”

Other reasons cited by some hospitals for the inclusion of bad debt as a category was unlawful immigration and indifference from an accounting perspective. For example, one hospital in the Midwest said that “another thing that’s really tough for us is patients who can’t apply through the Affordable Care Act because of their immigration status. Trying to get those
patients to talk to us to try to get them on charity care, and give us information; they’re scared.” Another hospital administrator, this time in the Northeast, said “I really do think [bad debt] should be considered. At the end of the day it’s services that were provided to individuals where there was no compensation for. So they’re free services. Whether they’re free and you don’t ever expect to get paid for them or they’re free and you just aren’t lucky enough to get paid for them, they’re still free.”

On the opposite end of the spectrum, some claimed that “it would be a bad thing by allowing that percentage of people [in bad debt] who just don’t want to pay their bills and really are taking dollars away from the hospital when they certainly are within their means.” They said that bad debt should not count as charity because “we’ve seen enough people who come in here who get really upset because they make $150,000 a year and they expect that their bills should be paid.” These informants spoke about “somebody who had an event, had an appendicitis attack, and decided to carry a high deductible, owns a $750,000 house, and brings in a $150,000 in income, and just doesn’t want to pay.” In such cases, the individual’s income would be too high to qualify for charity care and writing off their accounts would not be truly fulfilling a community need.

Similarly, some hospitals with very low bad debt and “huge commitment to making sure that people are in the right program” coupled with a sufficient infrastructure of counselors to get patients into financial assistance programs that will cover the cost of their care was not in favor of bad debt being considered community benefit. “I can’t imagine that bad debt should be counted as community benefit. It seems that bad debt is a business practice. It seems, from what I understand, not being a financial person, it’s unintentional. Whereas, for us, community benefit
is intentional, it’s directed. Bad debt doesn’t necessarily reflect a program that was offered in response to a need."

Furthermore, hospitals that were against being able to write off bad debt as a community benefit category were most aware of the new 501(r) law in the ACA which states that hospital organizations must make efforts to ensure eligibility for financial assistance before engaging in collection activities. Apparently, such hospitals are becoming “a lot more aggressive” in the process of advising patients of the opportunities to get free or reduced care:

One of the things is that we now have interpreters with like nine languages that are on demand that if you walk in and you say, ‘I speak, I don’t know, I’m Russian,’ we have access to Russian interpreters. Before that they’d say, hopefully down the line, ‘someone has some questions,’ and we can get someone to help. If they come in and say, ‘person x here is Russian and this is their husband or family member,’ they’ll [now] immediately say ‘get the Russian interpreter on the phone and explain what’s happening!’ ‘You don’t need insurance, we’ll have someone with you to fill it out,’ and that’s something we weren’t doing five years ago.

Others agreed and said that, since 501(r), “we now have a really good system of being fair.” For example, interviewees spoke about how the new ACA changes are starting to push people out of bad debt and into charity care. One informant said “I think the publicizing of financial assistance for charity care has changed so much over the last five years or four years that in 2012 I know it wasn’t publicized as heavily. So, we were not capturing as many people.” Others spoke at length about a program called “presumptive charity” in which even if the individual does not complete a financial assistance application, the hospital uses a variety of data to see if the person could be presumed eligible. Some are using a tool with credit agencies, such as Experian, to look at credit bureau reports and IRS filings to help estimate financial need while others are using databases to match patient addresses to subsidized housing to estimate income.

On the extreme end, there was a children’s hospitals which claimed zero bad debt since “we don’t claim it at all anymore.” They cited reasons such as being cognizant of where the
conversation is nationally and wanting to “stay ahead of the curve.” This hospital had high thresholds for free care (individuals could make up to 400% of poverty and still have their bill absolved) and spoke of having “a fund for charity care that is bigger than a lot of organizations.” The hospital would still bill insurance for claims; however, any excess amounts would be universally forgiven. “We don’t even have to oversee if someone applies for and meets our requirements for financial assistance because the funding is there, so we’re lucky to have that.”

**Medicare Shortfalls.** Many of the interviewed hospital representatives supported the inclusion of Medicare shortfalls, or the difference between what it costs to provide care to Medicare recipients and what is reimbursed, as a community benefit tax category. Some were supportive since they did not see it any differently than Medicaid. “I don’t know why we would differentiate [Medicare from Medicaid] quite honestly,” said a representative from a large Midwestern hospital organization. Others supported the inclusion of the losses since Medicare reimbursement may not be enough to cover all costs. “I am surprised that anyone would be close to breaking even on Medicare. I would have thought that [most hospitals] would be somewhere between a 5-10% loss on Medicare,” said a representative from a small hospital in the South. Similarly, this hospital also spoke about the difficulties associated with “the smaller the hospital, the harder it is when you have got high fixed costs.” Larger hospitals and health systems can distribute costs of high-end technology and equipment which is, per the informant, “why you are seeing a lot of consolidation of hospitals. Because what you are able to do is start sharing overhead expenses in order to cut the cost, there is then more chance of making money on Medicare and other payers.”
A representative from a large Midwestern hospital system said that their losses on Medicare were likely due to having a higher overall cost structure and that the decision to have higher costs had a quality component since “we are going above and beyond the minimum services provided.” The individual added that “it’s a cultural thing” and said they believe in having larger nursing staffing ratios and other expenses incurred to improve care. The person was in favor of including Medicare shortfalls as a community benefit category, but warned that “if it got so prescriptive, I think the quality of [the health system] might go down.” The individual said that if inclusion of the category means that Medicare shortfalls were more highly regulated, then there would be risk associated with hospital leaders more heavily scrutinizing the reason for “providing this high level of care.”

On the other hand, a children’s hospital administrator in the West said that they did not want to count Medicare shortfalls “because we just do not think it should be included.” Pediatric patients such as those with End Stage Renal Disease (ESRD) may have Medicare insurance; however, the hospital representative said, “I think that we are doing a good job of accurately capturing what we are doing for the community without it.” The individual said that “our overall community benefit evaluation is more credible because we do not include the Medicare evaluation” and mentioned that for-profit hospitals similarly see Medicare patients and cannot claim any losses on their taxes. The informant spoke at length about the mission of the organization as a charity and said that categories such as Medicare shortfalls are “basically accounting issues” and “the point is a non-profit hospital should be contributing to the community in specific ways that are really reflective of the health needs of the community.” The informant lamented, if most of a hospital’s claimed community benefit comes from Medicare shortfalls, bad debt, or other questioned categories, “then I do not know how you are
really responding to the needs of the community other than the need for care which is really is not that specific of a need.”

An informant from a large hospital system in the West agreed that Medicare shortfalls should not be counted as Medicare is not a means-tested program. “I do not think it makes sense for it to be included within community benefit just because it’s paid for by the government.” This individual concluded that this view is “consistent with what the Catholic Hospital Association says.” A representative from a large hospital system in the South said that more research was needed before a decision could be made since “the numbers that they put on their form are not representative” of the actual Medicare shortfalls. The informant questioned their methods for allocating Medicare costs and said that “from my perspective, our facility thinks about it in a much bigger way than just line items on a form.” The hospital could do a “better job” of accounting for Medicare expenses; however, instead of concentrating on the “administrative functions” of meticulously tracking and calculating costs, the representative said that their limited resourced should be focused more on specific programs aimed at improving public health.

**Community Building Activities.** Within all of the section of the Form 990, Schedule H, perhaps the most nebulus are Community Building Activities which includes potentially charitable actions not reported elsewhere that protect or improve community support and/or safety. As previously discussed, the IRS has stated difficulty in determining how the activities directly connect to designated health outcomes. The IRS agreed that most of these activities were sources of primary prevention which could help resolve the root causes of health problems. However, what was not clear to the IRS was whether they are consistent with the
current standard that applies to these hospitals in which the expenditure must directly relate to a specifically identified health need in the community.

When asked via key informant interviews, most hospital administrators were unambiguous in their support for inclusion of such expenditures in a policy definition of community benefit. “I have no question,” said a leader of a large health system in the Midwest, “that one I feel pretty strongly about; it should be included. It goes back to the understanding to those social determinants of health. If you cannot support jobs and healthy homes and safe places to exercise and all of those things that are currently sort of community building, we are not going to be successful long term in improving people’s lifestyles and health.” Similarly, a small Southern hospital representative said these activities “are essential to community capacity building, community building economic development; they are absolutely essential to the livelihood and health of our community, and I absolutely think they should be counted.”

One administrator from a large hospital in the West went as far as to say that “I think the IRS made a mistake. I don’t think they actually understood public health very well.” The individual mentioned that although “they got a lot right” with the community health needs assessment mandate, “I think there’s no advantage to the community or to the hospital or to anyone else to try to create a bright line between really downstream and addressing upstream social determinants of health, which seems what they are characterizing as community building.” The individual lamented that the IRS has made it exceedingly difficult to allocate funds to community benefit activities and that “I think it is an artificial construct and kind of a useless category.” The suggestion was that instead of separating overarching public health initiatives (which may not be reportable) from more proximal activities (which are likely reportable), all efforts to improve health should be captured and included.
Despite such support, many hospital organizations claimed either very little or no community building activities on the Schedule H. “It is not as if we didn’t want to, but I don’t know [if] we had the funds to be able to do that,” said an administrator at a small Southern hospital. Another informant in the South said that they likely participated in such activities, however “it’s not included because it’s very difficult to keep track of that.” The representative spoke about the hospitals in the system offering support groups for various types of cancers which use hospital space and staff time; however, the community benefit director did not find it worthwhile to track and report such expenditures. The individual explained that the recordkeeping would be costly and difficult. Instead, “I would rather actually do the work than figure out how to report on it.”

A large system representative in the Midwest agreed, saying that “we basically told people: ‘that’s not reportable,’” so the category is “highly under reported.” They further explained that even though the system’s senior leadership is highly involved in a low-income neighborhood collaborative to work on job readiness skills and neighborhood safety, that the community benefit software they use does not include such activities as community benefit so these activities are not recorded. Nevertheless, the hospital still invested in such endeavors because “if we’re ever going to make headway on health equity and social determinants, you have got to make those investments.”

Effect of the Affordable Care Act (ACA)

As previously discussed, section 501(r) was added to IRS law by the Affordable Care Act on March 23, 2010 and imposes additional requirements that all charitable hospitals must meet to justify their tax-exempt status. Although they were not as sweeping as some policy advocates
had hoped, they nevertheless represent a move toward helping nonprofit hospital organizations to more clearly articulate how they give back to the community. Interpretation of the law took some time with a final rule published in 2014 and full enforcement of all parts of the law starting in 2016. These nonprofit facilities must now establish written financial assistance policies and make efforts to ensure eligibility for financial assistance under such policies before engaging in collection activities. Furthermore, any amounts charged for emergency and medically necessary care for those who qualify for financial assistance must be no more than the average amount allowed by insurance payers such as Medicare. Finally, nonprofit hospitals must conduct a community health needs assessment (CHNA) every three years to identify public health needs and develop an implementation strategy to meet those needs.

**Developing and Confirming Eligibility of Financial Assistance Policies.** Due to the new ACA law, most hospital organizations have reevaluated their financial assistance, billing, and collection policies and practices. For example, many hospital administrators spoke about developing new plain language summaries of their aid programs that are now handed to every patient, sending multiple letters to patients with outstanding balances, and making phone calls to patients before sending them to collections. Prior to the ACA, one representative said, “we never had anything that informed patients of our program aside from a sign saying ‘if you need charity care, you can ask.’” However, since the enactment of 501(r), new outreach practices are creating an increase in both the number of people inquiring earlier in the process and the overall volume of people applying.

In another example, one small hospital informant in the South spoke about how they “recently put signage throughout the hospital that’s basically saying ‘uninsured, need help paying your bill? Call this person that can help you with financial assistance’” and how they
have a new brochure that is not only available in all hospital waiting rooms and registration areas, but that the material has now been placed at the local health department and the local community health centers. “I hope that publicizing it and going to the health departments and going to the community health centers and providing the information—we all see the same patients—that it will help to get those people with a need. That’s at the end of the day what we should be doing.” Finally, this hospital representative said that, prior to the ACA, “I don’t think we had advertised it as much or in the community at all” and that these new outreach activities were “definitely driven by the regulation.”

A few hospitals are going even further to catch as many patients as possible. For example, a representative from a large system in the Midwest spoke about a “shocking” reduction in the number of un- or under-insured individuals since the implementation of the ACA. “What we found was when [the health insurance exchange] came into place, that we did not have nearly as many people applying.” In order to maintain the current levels of charity care, the system has hired a consulting firm who has been helping them to reach more patients including “sending them out under bridges, and that, to try and find people.” Per the representative, “our dollars and our percentages dropped tremendously; we were actually going out hunting” and “we were literally going out trying to get people, mainly under-insured.” The informant also spoke about how “our emergency room volumes have shot up year-to-year-to-year with the Affordable Care Act” and, as a result, they have also focused efforts on this department since “that’s where you’re usually finding patients who don’t have coverage or who have problems.” Finally, although the interviewee mentioned that Medicaid was expanded to anyone making less than 133% of poverty in the state and such efforts would likely take dollars that would have otherwise been in bad debt and add them to Medicaid, there were still people
who did not qualify for Medicaid and were thus able to be newly captured in the hospital charity care program.

Other hospitals are working even more upstream and using a “patient estimator tool” to review a patient’s health insurance benefits, estimate the out-of-pocket costs, and then inquire on the front end whether they may need financial assistance. Furthermore, to ensure eligibility for financial assistance, most of the interviewed hospitals are engaging in the type of “presumptive charity” previously discussed in which even the organization looks at soft scores to see if the person would have been eligible had they filled out an application.

Despite such advances, there were some hospitals that were not very engaged in ensuring compliance. For example, one small rural hospital in the Midwest had very little community benefit dollars in any of the categories and what little was captured in the charity care category was due to the interviewed hospital director sitting down with patients and helping them to fill out the charity program forms. The informant said that many patients likely qualified for their charity care program; however, “many are not actually completing the forms” nor were they providing the necessary documents like proof of income. Instead, many of the cases were placed into in bad debt and went to collections if left unpaid.

**Normalizing Hospital Charges.** Hospitals used to charge different amounts to insurance companies (who could negotiate large discounts) than they would to individuals (who had little negotiating power). However, the law is now helping to normalize what they charge to uninsured patients. “Regardless of whether they are self-pay or whether it is Medicare or whether it is insurance, we charge the same amount” said a representative from a large system in the Midwest. As such, this administrator said that all patients who lacked health insurance and
paid out of pocket were automatically given a 50% discount from charges “based on the fact that we’re trying to match that up where Medicare and our commercial carriers are [in terms of a discount from charges].” Furthermore, while the law states that this normalization of charges applies to only emergency and medically necessary care, the interviewee said that almost all hospital care was being covered. “If the doctor says it’s medically necessary, not the insurance companies, we go with what the doctor says. If the doctor says that this person has a medically necessary thing, and even if Medicare says it is not, we would still consider it,” said the Midwest hospital representative. Similarly, a smaller hospital administrator in the South said “basically about the only thing that we would exclude would be if an individual were to come in for strictly cosmetic services.”

**Community Health Needs Assessment.** One of the major updates to community benefit policy was the requirement in the ACA mandating that nonprofit hospital organization conduct a community health needs assessment (CHNA) every three years to identify the most demanding public health needs and develop an implementation strategy to meet those identified needs. All interviewed hospitals had participated in such an activity at least once and reactions to the process were mixed.

Larger health systems with sufficient resources tended to praise the value of the CHNA and said that it created unprecedented alignment between the strategic priorities of the organization and the work being done in the community. They spoke about becoming better at implementing and tracking programs that are directly related to community health needs. “I think the CHNA process as it’s outlined in the standards is really comprehensive, and I think it requires us to be in tuned to what’s going on in our communities in a way that wasn’t necessarily there prior to the Affordable Care Act,” said a community benefit representative from a large
hospital system in the Midwest. A representative from a large system in the Northeast agreed, saying “I think it’s very good. It gives us an opportunity to not just get a pulse on what providers and hospital systems think is important, but it gets what community [thinks]… It gives a holistic perspective on priorities.” Such informants said the process helps them to determine the highest needs of the community and combine the findings with their specific expertise and resources which then become the focus for the next three years of the hospital’s community benefit activities.

_I think that’s what the CHNA does, I think it brings well rounded perspectives in the community, not just what the data is saying from the data banks or what the ED is saying, but what the neighborhood conversation is. I think it also helps prioritize what you think is important. What’s important to us isn’t necessarily important to them.

The Affordable Care Act and all of that embedded within has really helped us bring more focus to what it is we do, and that’s a good thing. It’s forced us to go from, as I said, random acts of kindness in our communities to focusing around these priorities; and our next step is being much better about: what were the results and how do we evaluate our programs?

In addition, informants also spoke of new programs that either would not have existed or would not have been funded were it not for the CHNA, including mental health first-aid classes, workforce development for inner city youth, and healthy weight education. A representative from a large system in the Northeast spoke about top priorities changing from obesity/healthy weight in the last assessment to mental health in the new assessment. This resulted in “our CEO was locked in a room with his top guy and the director of public health” to figure out how to address the newly identified need.

Another large system administrator spoke about priorities changing from environmental health with projects to improve walking and biking trails in the last assessment to the new assessment identifying chronic disease, access to care, and mental illness as the top priorities and how the CHNA enabled the funding. “For me to be able to go my leaders and to say from a
community perspective, ‘this is a high need,’ I think strengthens ...my case; we need to be in this market doing this work.”

On the other side, some hospitals, especially the smaller facilities or ones that operated at a loss, said that the CHNA had little influence on their community benefit programs. As opposed to the large systems which either outsourced the process to consulting firms or had a large staff to help implement, smaller systems with less funds tended to have individual staff performing the assessment. Furthermore, due to limited resources, programs such as the need for alcohol and drug counseling, cardiac rehab, and more advanced cancer care were identified, but no new programs were implemented. Others said that the CHNA did not show them much new information: “Honestly, it’s a lot of work to tell what other studies have already shown” said a representative from a small hospital in the south with operating losses and high bad debt. Their CHNA did a great job identifying that they “can we do better to deal with top five causes of death,” however, they added that “it’s stuff we’re already dealing with.” Hospitals spoke of community gardens to benefit food banks, locating clinics in specific neighborhoods to improve access, an academic outreach program in local schools to increase interest in health care fields, telemedicine programs, and stroke prevention programs; all of which existed well before the CHNA mandate. “There are no major ‘a-ha’s’ after the assessment has been done. Even with the community perception piece. There’s rarely anything surprising about it” said another hospital representative with operating loss and high bad debt. Due to lack of resources, this hospital even acknowledged that the requirement was more of an administrative task than a beneficial undertaking. “I get it done as efficiently as I can because I don’t have a whole team here at the hospital that is going to help me plan interventions out in the community. Often times, I will write the implementation strategy to the successes I know I can carry off. You following me?”
Many of the hospitals, both large and small, also discussed the need for greater collaboration. “We all have to do assessments. Public health does them every five years. Health plans in the [state] have to submit legislature every four years, and we now have to do them every three years. That’s an awful lot of redundant work because we’re all working in the same communities, and we’re all identifying the same priorities,” said a community benefit director from a large Midwest health system. A representative from a smaller hospital in the south added “I think there’s so many different assessments done in the county by different agencies every year that people don’t see the results of them they don’t see anything coming of them.” Within each survey, the individual also lamented the lack of standardization and said that everyone is asking different questions without any coordination of efforts. As some put it, “I think it would be great if we all had the same survey questions” and “I think until we make it larger with a larger approach like on a regional or state-wide effort, we’re not going to see [improved] outcomes.”

However, this is exactly the kind of collaboration which is occurring in other parts of the country. For example, an informant from a one small hospital in the South said that they have been partnering with the county health department for years on a community health assessment and that “hospitals, prior to the Affordable Care Act, were natural partners to assist health departments in doing community health diagnosis.” They spoke of “outstanding relationships” with the health department which, with the ACA requirement to perform a hospital-based assessment every three years, the health department agreed to move from a four to three-year cycle for improved collaboration. Furthermore, to coordinate ongoing efforts, a county-wide health committee now meets monthly to review and implement the community health needs process.
Similar organization is occurring in other areas, including an informant from a large system in another southern state which said “our region is looking at doing a regionalized community health needs assessment process” with the hope that they can “identify better what our issues are to tap into grants and interventions that will help the whole region.” An informant from the Midwest also spoke of positive change and said “what it has also done is as it has raised the flag within health systems to build partnership with our public health departments and with other industry partners like health plans and others. Once there’s been a greater understanding of what the community benefit requirements are for hospitals; how do we align?” The hospital representative spoke about being in a silo for a long time that, since the CHNA mandate, greater alignment is being promoted “so that the skills and resources and the strategic priorities of [my health system] can be aligned with what the community has defined its needs and our CHNA process.” They concluded that the CHNA has helped to connect the hospitals to the larger health system in a meaningful way and believed that more and more states across the country would be undertaking such partnerships. “That number is growing and we’re just getting there.”

Similarly, an informant from a large hospital system in the Northeast spoke about how the CHNA was being used to form a partnership between the health system and the public health department. “We had a city manager reach out to the CEO and say ‘you have to help me, we’re going to have to cut back public health.’” As a result, the health system pulled representatives people from the hospitals, from academia, and from the public health department to use the data collected in the CHNA to “fill the gaps in the workforce for public health infrastructure.” The individual went on to discuss how the hospital system provided direct funding to the public health projects and helped to better coordinate resources across industries. The health system
even provided faculty and students to “work on projects with public health; and some, when they graduate, are hired by the public health department.”

Another issue that was often raised included the timing of the CHNA; specifically, that having one every three years was too often. “You’re like on this hamster wheel,” said a regional vice president from a large system in the West, “[We] no sooner finalize the needs [assessment], begin to start implementing, then you got to start it again a year and a half later.” Another, representative from the South said that “it’s awfully hard to show the outcomes that are effective in terms of seeing the needle move in the short time periods” while an individual in the West agreed and said “if you’re using secondary data that’s public reported, you’re not going to see major changes in health status outcomes.” Because of such a quick turn-around, informants lamented that the focus was often disproportionately concentrated on simply identifying needs versus creating collaborative strategies to achieve outcomes. As a Southern hospital representative put it, “I think that the cycle time is probably too close for us to really make traction in a community to really be able to move the needle on things.”

Besides the timing of the CHNA, other issues that arose in relation to the key informant interviews included the mandate for each hospital to submit their own assessment as well as a perceived inability for a hospital organization to address every identified need. An administrator from a larger system in the South said “the fact that we have to develop a separate needs assessment and plan for every single hospital” means that there is no room for a system-wide plan. “In my [perfect] world, there would be a system plan, and there’d be a chapter for every hospital, but that’s not how they look at it.” Similarly, some said that hospitals, as providers of acute care, may not be situated to address every identified need. “With the survey, we get more information about the food deserts in the community and other stuff that the hospitals really can’t
have a large part in” said an informant from a small hospital in the South. Similarly, a representative from a larger system in the South said “I think it did tell us some needs that we weren’t going to be able to meet. I mean mental health is on everybody’s needs assessment.”

Overall, all the informants were knowledgeable about the CHNA regulations and collected both primary and secondary data to identify community health needs. Some representatives found the needed programs to be similar to what they were doing for decades while others said the results from the CHNA offered new concepts. Regardless, most of the hospital administrators were at least starting to connect the dots between current programs and current community needs to identify opportunities for programmatic improvement. Lack of collaboration, standardization, and infrastructure were cited as complications of the policy; however, there was mostly optimism that the CHNA would help to improve community health.

**Validity and Reliability of Schedule H**

When asked whether the Form 990, Schedule H has improved the ability to validly and reliability capture the community benefit activities of their nonprofit hospital system, the consensus was that the standardized forms have helped the hospitals to report in a more transparent and comprehensive way. For example, informants spoke about now having “an easier forum” for people to see their varied activities and how the overall documentation of events has become clearer.

Many informants spoke about difficulty in properly tracking all the community benefit work being performed. For example, although an informant from a large system in the Midwest felt that the Schedule H reflected most of the system’s charitable activities, the person acknowledged that “I think there is some underreporting in certain categories” and cited money
spent on health professions education as an example. They added that much of the recorded activity is difficult and time-consuming to track.

Other informants agreed with a small Southern hospital director who said, “quite honestly, we probably do not do as good a job of capturing as much as what we do” and listed community educational speaking engagements as an example. Similarly, a small rural hospital representative in the Midwest admitted that they did not completely understand certain categories such as community building activities and were not completely capturing funds for all programs such as grief counseling, telemedicine, and drunk driving education classes. Ultimately, the informant held their hired consulting firm responsible for such under-reporting.

Another validity issue is that hospitals may record expenses differently on their tax returns. When asked about the legitimacy of the reported expenses, many representatives spoke about the Form 990 being an incomplete measurement tool. “It is not all inclusive,” said a director from a small Southern hospital, “but there’s always a tradeoff of how much do you spend documenting something or just doing it.” Similarly, a director from a large hospital system in the Midwest said that a similar-sized teaching hospital reported twice as much medical education shortfalls, but that “it’s not because they have twice as many services or more students, it’s because they have systems in place that they can capture everything.” However, the person did say that enhanced scrutiny of the data through public transparency and board involvement in community benefit activities is helping to improve the data collection process. Similarly, a representative from a Children’s hospital in the West said “the form 990 probably doesn’t give the best overall picture in terms of a narrative of what we’re doing if a layman is trying to read, but it does capture the dollars we spent. It’s an IRS form. Is the IRS form 990 the
best place to articulate the work we’re doing in the community? No. But does that form accurately capture the financial evaluation of what we’re doing? Yes.”

An informant from a large system in the Midwest spoke about “the bulk of what is reported is related to charity care,” but that investment in programming that impacts public health in a more direct way “is pretty small.” The representative said “the investment that [the system] has made has been in the people who lead those programs: salaries paid,” but that “the actual program costs are grant funded” by outside agencies including a distinct nonprofit fundraising foundation dedicated to the hospitals. As such, the validity issue here was that much of the actual programmatic expenses were not able to be counted in Schedule H. If the federal government ever established a minimum threshold, then many of the current programs would not count towards justifying the organizations tax-exempt status.

A representative from a large system in the West went a step further and said that “if you want to look at impact, there are probably other things that hospitals as institutions can do and should be encouraged, but not required, to do that would probably have a much bigger on the health of their communities.” The individual then listed activities that could impact public health yet do not fit into any of the current reporting categories such as purchasing “green” products, pursuing contracts with women-owned and local businesses, having hospital architects providing pro-bono technical consulting to community health centers, and selective hiring of minority populations. Many of the items “have a huge impact on the economic vitality of those communities and therefore on jobs and education and therefore health” yet are not currently captured in the dollars of the current categories.

A final validity issue raised in the interviews was the complexity of having a system with a parent organization that may or may not be included in the tax form for a hospital organization.
“If you look at the return for [one of our hospitals], that’s only for their hospital. They don’t capture a lot of their expenses because they’re shared services on the [parent organization] return.” Since the parent company is not actually providing patient care, it is not considered a hospital organization and “they don’t have to file a Schedule H.” Thus, some hospital organizations are not publicly reporting the full extent of their revenue and expenses.
CHAPTER 9: Discussion and Policy Recommendations

Over a decade ago, Kindig and Stoddart (2003) set out to define a “relatively new term that has not yet been precisely defined” called population health. According to the authors’ proposal, population health is “the health outcomes of a group of individuals, including the distribution of such outcomes within the group” and argued that the field should consider patterns of health determinants that can cause health outcomes as well as with the policies and interventions that link the two. Subsequently, this definition sparked what Woodcock and Nelson (2003) deemed a “spirited debate” among researchers and policymakers which provided “a needed framework for public policy.” This framework subsequently guided the conceptualization of many of the laws in the Affordable Care Act, including the community benefit changes intended to increase access to charity and focus hospitals on the health needs of the community.

Even before the term existed, improvement of population health was also the driving force behind earlier policy efforts, such as the revenue rulings in the 1950’s and 1960’s which codified how nonprofit hospitals could meet obligations for tax exemption; including providing free or discounted care, providing educational and research services, and funding activities promoting community health. Nevertheless, as with any policy, the law is constantly fluid and merely reflects the values of society at any given moment.

For instance, replacing the requirement that nonprofit hospitals provide as much free or below-cost patient care as possible with a policy granting discretion for individual hospitals to self-define which and how much of their many activities counted toward their charitable responsibilities may, on the outside, seem like a poor policy decision. However, as was shown in this research, most nonprofit hospital organizations are providing sufficient community benefit
no matter how the construct is measured. Even with a mean profit margin of 3.56%, such organizations, in aggregate, could satisfy a Tax Value, Grassley, or Expense Requirement regardless of community benefit definition. When narrowly defined, a high proportion of hospitals were allocating more than double the value of their tax breaks while approximately 75% and 90% of organizations could meet a requirement to provide 5% of their revenues or 3% of their income to community benefit, respectively. Adding bad debt, Medicare shortfalls, and community building activities to any of these models only increased the number of hospitals who could meet such standards.

The findings that most nonprofit hospitals are fulfilling their public health duty is remarkable given the relatively loose community benefit regulatory environment. Despite progress in helping hospital organizations to clarify their activities through the advent of Form 990, Schedule H and focus their efforts through mandates in 501(r), there remains a lot of flexibility. Hospitals are free to self-determine the minimum income thresholds to qualify for their charity care policies and it remains possible that, for the same services at the same production cost, organizations may claim widely different charity care costs. As was shown in the key informant interviews, hospitals also differ in their dedication to thoroughly and accurately accounting for costs associated with community benefit activities. However, the organizational theory of DiMaggio and Powell (1983) offers a theoretical construct for such a discovery.

Through the lens of institutional isomorphism, the pathway through which nonprofit hospital organizations of all sizes and regions and with all accounting methods could satisfy such requirements becomes theoretically plausible. For example, through coercive isomorphism, both the early revenue rulings and the later health reform legislations were discussed by the key
informants as influencing their community benefit policies and practices. Similarly, the provision of unprofitable services, such as community health education, often resulted from pressures to fulfill a discovered health need. Mimetic isomorphism was found through national adherence to the Catholic Health Association guidelines as well as use of standard community benefit reporting software while much normative isomorphism was found to stem from the moral duty to serve the mission of the organization. Thus, whether it be through coercive, mimetic, and normative pathways, the result is organizational homogenization across an industry that is largely meeting their community benefit requirements.

Should some of these national health policies (such as the Grassley or Expense Requirement) become law, the research was also able to find associations between the various ways to define community benefit and institutional factors of interest. For example, with the Grassley Requirement, a policy that adds bad debt as a community benefit category may not help hospital organizations to become more generous with forgiving people of their medical debt. Hospitals self-select whether they would like to be generous and allow people with higher incomes to be forgiven of their debt or less generous and only allow people with lower incomes to be forgiven of their debt. Since adding bad debt can greatly increase the community benefit total for a given hospital, a policy which includes the questionable category provides little incentive for a hospital to increase their threshold for free care and move patients from the bad debt bucket to the charity care bucket.

The research also found that with the Grassley Requirement, a policy that adds Medicare Shortfalls as a community benefit category may help organizations in the Northeast more easily meet the requirement. Hospital organizations in this region of the country could have a high cost structure which is not fully recognized by Medicare reimbursement, so enough hospitals may
have Medicare shortfalls significant enough to help them more easily pass a hypothetical
Grassley requirement. Alternatively, hospitals in this area of the country may be less efficiently
managed so otherwise sufficient reimbursement is not enough to cover their higher costs. Either
way, it would not be surprising for hospitals in this region of the country to advocate for the
inclusion of Medicare shortfalls to be counted as community benefit should federal policy
require them to allocate at least 5% of their revenue to community benefit.

For the Expense Requirement; the research found that a narrow policy (without bad debt
and Medicare shortfalls) may help hospital organizations to become more generous with
forgiving people of their medical debt or providing discounts on medical debt. Similarly, a
policy that adds only Medicare shortfalls (and not bad debt) may help hospital organizations to
become more generous with providing discounts on medical debt. Medical debt is the leading
cause of bankruptcy affecting nearly 2 million people annually with serious health effects
including suicidal ideation, depression, and poorer health-related behavior. Thus, considering the effects to public health, the findings of this study would suggest that congress
may want to consider either a narrow definition (without bad debt or Medicare shortfalls) or one
that only adds Medicare shortfalls (yet still excludes bad debt) should the Expense Requirement
be enacted.

As possibly important as these finds may be, perhaps a more important finding from this
research is that, when interviewed, many industry experts across the country rejected policy
changes mandating a minimum amount of spending (such as a Grassley, Expense, or Tax Value
Requirement) and, instead, supported the continuation of the Facts and Circumstances
Requirement which weighs the philanthropic activities of a hospital against their unique set of
circumstances. The research found that most hospital organizations interviewed are adhering to
the 1969 community benefit standard and the new ACA 501(r) laws with some going significantly beyond. Thus, given, the size, scope, and significance, nonprofit hospitals require flexibility in justifying their tax-exempt status. Instead of enacting more prescriptive policy changes, the following community benefit policy changes are recommended:

1) **Assess community benefit with the Facts and Circumstances Requirement and not the Grassley, Expense, or Tax Value Requirement**

- Not all community benefit will have a tangible dollar allocation and not all expenditures fit into the current community benefit categories. While most of the existing federal community benefit regulation has focused on reporting requirements and financial assistance policies, hospitals should receive credit for all hospital community benefit dollars, including those which address social determinants of health. Whether it is investments in neighborhood collaborative to work on job readiness skills or neighborhood safety, any efforts to promote community health should be evaluated on a case-by-case basis.

  o A director from a children’s hospital in the West spoke in detail about a partnership with a large department store chain to offer child safety services such as free car seats and car seat installations. The program is highly successful and services the community every day, yet only the expense of the hospital staff time can be claimed since the program is grant funded by the department store. The director acknowledged that the department store would not offer such services alone and that “the program probably wouldn’t exist without the hospital.” The hospital can leverage their uniquely situated facilities, their expert staff, and their influential position in the community to
bring unique services to the public. Thus, a policy based solely on funds spent by the hospital alone might cause hospitals to redirect staff time away from programs which do not provide a lot of community benefit on paper yet have real public health value. Instead, the total value of a circumstance in which a non-profit hospital is successfully soliciting assets to improve public safety should be recognized as community benefit through the assessment of all facts and circumstances.

- Setting a minimum threshold for spending either through a Grassley, Expense, or Tax Value Requirement may not actually increase expenditures to improve public health. Instead, hospitals may be incentivized to dissolve a parent company or a separate hospital foundation to add those revenues (or expenses) to the hospital organization’s tax return. Alternatively, organizations which currently under-report their community benefit activities may become increasingly skillful at capturing current expenses. Overall, the effect could be showing adherence to community benefit law through pure accounting without the hospital changing the mix of services provided. As a representative form a large Midwestern system said “if we were aggressive about [community benefit reporting], and got people out to look at it, we could move that number up.”

- Federal health policy must avoid a “race to the bottom” and ensure that hospitals providing a high level of community benefit maintain such provisions. Setting a threshold such as 5% of revenue or 3% of expenses could incentivize nonprofit hospitals to spend down to that minimum and provide less overall charity. As one children’s hospital administrator put it, “Are there bad actors? Well, yes I’m sure
there are. If that’s the issue, then further legislation from this point on should go after that actor and really not affect people that are doing, quite honestly, a really good job.”

2) Audit more hospitals

- Although, when narrowly defined, hospitals were allocating more than double the value of their tax breaks and approximately 75% and 90% of organizations could meet a Grassley or Expense Requirement, the reciprocal is that approximately 25% and 10% could not meet such requirements.

- The IRS performs a “desk audit” of approximately 1,000 tax-exempt hospital tax filings each year and has assigned 30 IRS agents to examinations of hospital tax-exempt issues. Nevertheless, most of the hospital reviews are initiated on a non-contact basis and, as a member of the Exempt Organizations (EO) subcommittee of the IRS Advisory Committee on Tax Exempt and Government Entities said, “it takes a lot of manpower to pull a 990, review it, and decide if there are things on it that should be questioned or looked at further.” As such, just 166 “field examinations” occurred in fiscal year 2016 with issues mainly related to a lack of a Community Health Needs Assessment (CHNA), lack of financial assistance policies, and/or lack of appropriate billing and collection requirements.

- Despite progress, there is still opportunity for hospitals to do a better job of meeting the needs of the community; both in developing programs to meet identified health needs and in ensuring they fully capture everyone who could
qualify for free of discounted care. For example, according to a representative from a large system in the Midwest:

*There is recognition in this organization that we have not invested in the function or the programs to the level that we could. I do believe that at some point that there’ll be greater investment. I think part of the issue, quite frankly, right now is that we’re so immersed in all that is going on within the organization that we haven’t been able to take a step back and say ‘are we doing the right thing?’*

- When asked to how they would rate their ability to make sure that no patients slip through the cracks, many organizations acknowledged that there was an opportunity to improve:
  - A representative from a large system in the Midwest said “on a scale of 1 to 5 we’re probably somewhere between a 2.5 and a 3. I think that we could do better.”
  - A representative from a small hospital in the South said “I really do feel like there are people who are eligible and, as much as we try, we’re still not able to get them.”
  - A representative from a rural hospital in the South was “not surprised” by their high bad debt due to being the poorest county in the state. However, if they were truly poor, the patient should have qualified for the organization’s charity care program, should not have been under bad debt, and should not have been sent to collections.
  - Another representative from a large system in the Midwest said that “right now we scrutinize [our community benefit programs], but, you know, it’s not to the level that an IRS audit; we’ve never been audited.”
individual went on to say that, currently, “there’s no real threat that the IRS would come in.”

3) Mandate competency training which clarifies the role of the hospital organization vis-à-vis improving population health

- Community benefit activities need to be integrated into key organizational plans and initiatives such as the organization’s strategic, financial, and communication plans to ensure that the programs receive sufficient resources and leadership commitment. Nevertheless, this research found significant variation in the way hospitals actualize the function of community benefit departments. Some hospitals, especially staff at smaller or stand-alone institutions with many job roles, treat community benefit more as a charity function with most of the focus being on forgiving needy patients of their billed charges. The hospitals may participate in small activities such as coat drives or health fairs, but the hospital is not necessarily partnering with the community to improve health in a meaningful way. Alternatively, there are hospitals, especially larger systems with sufficient resources, which are heavily focused on implementing larger public health initiatives that address social determinates of health. These hospitals are taking a close look at the root causes of community health issues, making community partnerships, and then leveraging their resources to create impacting public health projects.

- There needs to be more education on the importance and role of community benefit, especially for the individual in charge of the programs; the hospital CEO and board
members. Some informants spoke about having very involved senior administration while others did not seem to fully grasp the concept.

- According to a representative from a large system in the Northeast with high community benefit provisions (even when narrowly defined) and low bad debt:

*I think that there’s still a lot of people who don’t understand community benefits. I think it’s not about just doing the clothing drive- that’s not a community benefit in my opinion- it’s more about bringing the resources, linking the community resources internally and to opportunities—that’s how I see it, that’s my function: linking opportunities to address those needs that are really going to make the health of the community better... You should be asking how engaged is your board... do you have an identified committee on your board of trustees that you’re reporting to? I think that’s so critical.*

4) **Maintain Tax Code 501(r) added by the Affordable Care Act and not implement the American Health Care Act of 2017**

- Hospitals in some states have now been adhering to the standards in the ACA long enough to see a decline in charity care before and after the national reduction in uninsured citizens. The decrease in charity care demand is sufficient for hospitals to become more effective and creative with helping the needy. Not only are hospitals starting to hire people to find patients under bridges and utilizing credit agencies and public housing records to preemptively forgive people of their debt, some hospitals are beginning to give away care that was previously not possible.

- One representative spoke about adding transplant services, rehabilitation services, outpatient infusion services, and psychiatric services to the list of
care that could be offered for free. “There’s a lot of heavy cost” to those services and they have “always been excluded because of the fact that we’ve only had so many dollars that we could use in our charity care funding,” said the representative. However, since the ACA, the hospital has expanded the array of services offered for free or at a discount, services that certainly benefit the public at large.

- Most of the interviewed hospitals have rebuilt their financial assistance and collection policies and practices to include more clarity and enhance outreach. Such efforts are increasing the volume of people applying and qualifying for assistance. Charity care policies may not be as important in states that have elected to expand their Medicaid programs (since most individuals making under 133% of poverty will be covered), but they remain a crucial safety net for patients in states with stricter income qualifications for Medicaid. This is especially true for the strictest hospitals which only forgave the patient of their medical bills with incomes below 100% of poverty.

- The CBO in combination with the Joint Committee on Taxation (JCT) have estimated the effects of H.R. 1628, also called the American Health Care Act of 2017, and have projected that enacting the current version of the bill would increase the number of uninsured by 14 million more people in 2018 than under current law. The increase would reach 19 million in 2020 and 23 million in 2026. With so many more uninsured patients, the advancement of presumptive charity and overall willingness to go above and beyond to help the needy could decline as more people would likely qualify for free or discounted care through
less proactive practices. Since nonprofit hospital informants acknowledge that many patients “slip through the cracks,” bad debt would also likely increase. Medical debt is already the leading cause of bankruptcy affecting nearly 2 million people annually with serious health effects including suicidal ideation, depression, and poorer health-related behavior.⁶⁴,¹¹⁸,¹¹⁹ Thus, under current CBO projections, implementing the American Health Care Act of 2017 would likely not improve such outcomes.

5) Include community building activities as community benefit and encourage innovation and participation in activities that effect the health of communities in both an up-stream and down-stream manner

- Besides the standard community benefit efforts to forgive the needy of the cost of care, activities that develop economic viability, create jobs, and/or improve access to education are key to improving health.

  - A representative from a large hospital system in the Northeast said “I mean, if all we’re doing is treating the people and sending them back out to the community and not really—say I’m treating you as a diabetic and tell you, ‘you need to eat better food because your blood sugar is 300, 400,’ but I’m not figuring out how you get good access to food and have exercise—what good is it for me to treat you? That’s the kind of thing that has to be done.”

  - Similarly, a small Southern hospital informant said “it’s a wonderful idea that a hospital that has a not-for-profit status and is not being taxed has
some obligations to serve the community in a more expanded way. I agree with that totally.”

• Although the largest category of community building activity spending went to costs associated with advocating for community health improvement which includes serving on government advisory committees and meeting with policymakers on matters which affect public health, overall spending for such advocacy was only a small fraction of overall spending. Considering a hospital organization’s wide-reaching influence and ability to impact the health of so many in a community, they should be encouraged to contribute to community benefit by serving as policy advocates; either on their own or in coalitions.

• As the health system continues to reform and moves toward value and away from volume, numerous hospital pay-for-performance innovations are being tested. For example, Delivery System Reform Incentive Payment (DSRIP) Programs are a new type of Medicaid supplemental payment program promoting value-based purchasing and positive health outcomes for Medicaid enrollees and the uninsured.\textsuperscript{123,124} DSRIP programs have been approved in six states (CA, TX, MA, NJ, KS, and NY) and offer great structure for community building activities since the projects are led by hospitals and often involve collaborations with non-hospital community providers.\textsuperscript{123} Although community benefit efforts are uncompensated charitable acts, any difference between programmatic costs and reimbursements should be used to justify a nonprofit hospital organization’s tax-exempt status.
6) Exclude bad debt as community benefit and, instead, concentrate on minimizing Form 990, Schedule H, Part III, Section A, Line #3 and provide bad debt credit for the number of non-citizens living in a community

- During the interviews, there were discussions about the current health insurance system pushing more cost onto the individual. Either through personal choice or through employer choice, many individuals carry plans with extremely high deductibles (some greater than $5,000) and may not have resources, such as health savings accounts, to pay the deductible if catastrophe occurs. In this case, even individuals with sufficient income may refuse to pay their deductible. If that (bad) debt is then counted as charity and the hospital feels that it needs those funds to have high enough community benefit to justify their tax-exempt status, then the hospital may not actively pursue payment. The unintended consequence could be more and more people taking higher deductible health plans because nonprofit health systems will just forgive them of any owed funds in the name of community benefit.

- Form 990, Schedule H, Part III, Section A, Line #3 says to enter the amount of the organization’s bad debt expense attributable to patients eligible under the organizations’ financial assistance policy. Essentially, this line item puts a dollar amount on the patients who “fell through the cracks,” patients who should have been given free or discounted care per the hospitals charity care policy yet somehow were not forgiven of the debt. Focusing on this line item would help reinforce practices like presumptive charity and discourage hospitals from blaming the patients for not filling out the proper paperwork. It would also
increase the revenue allocated to charity care while helping to ensure that the funds left in bad debt were truly patients who could have paid their bills yet refused. According to one Midwest hospital representative, “we know that the majority people who are sitting in bad debt can’t afford to pay [for their care], we’re going to write it off to bad debt [and] we’d rather write it off to charity.”

- The IRS should provide nonprofit hospitals bad debt credit for the number of undocumented immigrants living in a community. Similar to hospitals receiving funds for servicing a disproportionate share of uninsured individuals, community benefit policy should anticipate that some hospitals will have a percentage of people whose incomes are unavailable and not federally trackable due to citizenship and/or immigration status.

7) Include Medicare shortfalls as community benefit

- Many of the interviewees argued that, unlike private insurance plans, Medicare rates are not negotiable and can be much lower that the true cost of treating Medicare patients. Accepting these lower payments helps to relieve the government of Hospital Insurance (HI) Trust Fund burden and extends the life of Medicare Part A.

- Interviewed hospital representatives spoke about the difficulties that small hospitals have with fixed costs. They also spoke about how larger hospitals and health systems can distribute the expenses of high-end technology and equipment and share overhead expenses related to administrative support. Thus, without being able to “write off” losses on Medicare, hospitals who cannot cover their
expenses might be incentivized to merge or consolidate. Such consolidation could lead to hospital organizations becoming “supra-competitive” with large negotiating power against insurance companies which could, in turn, lead to price increases of five percent or more.\textsuperscript{125, 126, 127}

8) Grant nonprofit hospitals access to income data

- Most citizens file income tax returns and the government knows their legally-earned incomes. Due to privacy concerns, the federal government does not need to supply the exact amount, but can set up an arrangement with a trusted third party vendor (such as Experian credit agency) who can match each hospital’s charity care program to individual incomes and simply inform the hospital whether the person would quality for a discount. “In a perfect world, we would be pre-qualifying people” and “I think there are a large percentage of individuals that would qualify for charity care if we could get them to give us the information” were quotes repeated in many ways.

- Allowing access to income data could help a hospital to reclassify their bad debt as charity care and assist them in meeting community benefit requirements as a stand-alone hospital. Providing such a service free of charge would help to avoid incentivizing further mergers between health systems and the related possibility of damaging competition. For example, when asked about the possibility of a policy mandating a minimum threshold for community benefit, a small hospital in the South with very large bad debt said “I think it’s very difficult for a facility our
size in a community like ours to remain sort of an independent facility” and that “you have to affiliate or in some way merge or combine resources.”

9) **Encourage partnerships between public health departments, hospital organizations, and academia in the development and implementation of a regional CHNA**

- Many interviewees either discussed the need for better collaboration or extolled the benefits of collaboration. Representatives from hospitals that lacked a coordinated CHNA process often criticized the current environment and said things like “there’s so many [needs assessments] that were done by so many different agencies, I think there needs to be a lead agency.” Hospitals that had seen the benefits of collaboration said “public health needs to be working closely with hospitals” and “you need to have a strategy of working closely with local health departments.” According to a representative from a large hospital system in the Northeast, “I also think [the IRS] should ask the public health organizations, I think you should ask ‘are they working on initiatives that are really bringing community and clinical world together to address issues?’ I do think that is the new wave. I think that’s where prevention is going to meet health needs in healthcare, increasing hospital roles here.”

  o An industry standard template should be encouraged to avoid situations in which “the questions that [our] county asks are not the same that [the next] county asks.” However, to not stifle innovation, the IRS should still allow hospital organizations room to adapt as needed.
Hospitals alone should not be expected to solve larger public health initiatives (such as homelessness), but hospital organizations can partner with others to figure out how they might be able to support such initiatives and advocate for policy change should they be discovered in the joint needs assessment. According to a small hospital representative in the South, “[the hospital’s] not responsible for fixing everything in the community. We can’t. We can’t do that. It has to be the entire community, and everybody partnering together to move the issue forward.”

10) Modify the CHNA cycle from three to five years

- As opposed to the current policy which mandates the hospital CHNA be performed every three years, a new policy should allow for five years between cycles. The longer cycle time will allow for better implementation of actions to address the needs identified in the plan and will allow for more time to assess whether the actions have resulted in desired change.

- Under the current model, “you’re like on this hamster wheel, no sooner finalize…the needs begin to start implementing…then you got to start it again a year and a half later,” said a hospital informant. A second said “you get your [CHNA] done and you get your [implementation plan] and then it’s two years and you have to start all over again. It’s insane.” A third said “it’s awfully hard to show the outcomes that are effective in terms of seeing the needle move in the short time periods.”
Overall, this research has summarized the community benefit activities of nonprofit hospital organizations and has offered insight into possible consequences of various national health policy models. It has made policy recommendations that consider definitional and measurement options, patterns of organizational behavior, and practices that can influence population health improvement. As our nation continues to make legislative decisions regarding tax-exempt hospitals, research such as this will help to bring better understanding into the current state of nonprofit hospital charity efforts and allows for more informed policymaking. This should be a useful study for upcoming Congressional reports by the Treasury and the Department of Health and Human Services (DHHS) and for federal lawmakers as they continue the work of Senator Grassley and others to further define the community benefit activities of private, nonprofit hospitals. It may also help inform existing controversy over whether bad debt and Medicare shortfalls should count as community benefit, how to account for community building activities, and help the industry move away from focusing on how to measure community benefit to focusing on how to improve nonprofit hospital contributions to public health.
CHAPTER 10: Future Research Directions

As Hansmann concluded almost 40 years ago in what has become a seminal influence in the study of the nonprofit sector, “it is the responsibility of lawmakers to review and reform the hodge-podge of organizational and regulatory law that applies to nonprofits to ensure that it is well-designed to assist nonprofits in serving those needs.”68 While this study has helped to inform national health policymaking related to the nonprofit hospital sector, additional research is both important and necessary. For example, a useful future research direction would be to take the lessons from this study and expand the key informant interviews to include those at the very top of the hospital organizational hierarchy: chief executive officers and board members. Understanding the requirements of tax-exemption and what constitutes community benefit have become critical to those leading today’s hospitals. Community benefit affects every aspect of a healthcare leader’s responsibilities, from evaluating the needs of the community to planning programs to effectively improve the public’s health. Furthermore, hospital and health system leaders with a strong dedication to the community will include attention to community health needs in their strategic plans and their day-to-day actions intended to meet specific population health needs.

Additional research is also needed to investigate the effect of for-profit physician groups and outpatient services that are connected to nonprofit hospital system in terms of charity care. This research found that most nonprofit hospitals have adhered to the ACA mandate to have a robust charity policy and are increasingly doing a better job to ensure that qualified people obtain assistance, even those with low to moderate incomes and high deductible health plans. However, many nonprofit health systems grant privileges to physicians who work under a for-profit group practice who are not subject to the same community benefit laws. Emergency doctors,
anesthesiologists, and obstetrics were cited as examples. “We might forgive the hospital bill,” said a representative from a large Midwestern hospital organization, “but it’s up to them whether or not they even have a policy or even a desire. If they’re for profit, that’s probably not going to happen.” As a result, there are often patients who are forgiven of the hospital portion of their medical bill but not the physician portion. The public health results of this disparity are worth researching.

Another research direction would be to investigate the need for nonprofit hospitals altogether. This research made an a priori assumption that there is need within society for such organizations and did not assess the current reality against a counter-factual reality in which the very existence of nonprofit hospitals is questioned. For-profit hospitals may be more or less efficient and effective with fulfilling the needs of the community and, given various policy options, an updated head-to-head comparison with nonprofit hospitals could be useful.

As community benefit policy becomes increasingly scrutinized, it will also be important for policymakers remain informed of possible consequences related to hospital mergers. While there is some evidence to indicate that hospital consolidation may produce cost savings for the hospital and that these cost savings can be significant when hospitals consolidate their services more fully, Vogt and Town (2006) clarify that such savings does not mean a savings in cost to insurers, employers, and the public.\textsuperscript{125} In fact, the authors found that “the great weight of the literature shows that hospital consolidation leads to price increases” and that “consolidation raised prices by at least five percent and likely by significantly more.”\textsuperscript{125}p.4 Furthermore, the mechanism for such price increases likely comes from greater bargaining power with insurance companies.\textsuperscript{126} As Julie Brill Commissioner of the Federal Trade Commission said in a 2014 address at an antitrust conference focused on competition in health care markets, higher hospital
prices were not explained by higher quality of services or underlying costs, but rather were the result of greater bargaining leverage with health insurance plans.\textsuperscript{127} “If a merger among providers that are close substitutes increases the merged provider’s leverage with health plans because of inadequate alternatives, the provider gains the ability to obtain supra-competitive pricing.”\textsuperscript{127} p.\textsuperscript{3} Thus, future research should consider the effects of community benefit policy on market competition.

It would also be helpful for future research to investigate the community benefit activities of nonprofit hospitals in a longitudinal study. For example, the research presented here was cross-sectional and is not able to fully assess policy effects over time. Further research is also needed to evaluate the possible reasons for hospitals experiencing Medicare shortfalls. Knowing whether such shortfalls were due to insufficient reimbursement or hospital inefficiencies leading to high cost structures is an important exploratory topic.

Finally, an area for future research would be to investigate why some hospitals have more excess revenue available for community benefit than others and the interaction between for-profit and non-profit hospitals vis-à-vis competition. In a competitive market, a business would charge prices equal to their marginal cost (including some rate of return). However, health economists have argued that healthcare is a broken market incapable of being normalized by competition for reasons including asymmetry of information (patients lack the skills, time and resources to make rational decisions) and the barriers to market entry (high technology and education costs make it hard for competition to enter the healthcare market).\textsuperscript{128} For-profit hospitals are outlawed and nonexistent in states such as Minnesota and New York; however, in the states that allow them, for-profit hospitals may cherry pick high profitable services (such as cardiology) and avoid unprofitable services (like mental health) which may help to push non-
profits out of the market. Similarly, for-profit hospitals may have a lower cost structure and could obtain preferred contracting network arrangements with private health insurers to the detriment of the less competitive nonprofit hospitals. On the other hand, for-profits must take out loans at market interest rates and nonprofit hospitals can sell tax-exempt bonds at below-market interest rates. Thus, in an environment dominated by nonprofits who enjoy complete tax exemptions coupled with the competition of for-profits, an exploration of why nonprofits do not drive for-profits out of the market (or vice versa) is warranted.
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