Community Benefit Background and Analysis

Background

- Nonprofit hospitals in the United States qualify for federal tax exemption from the Internal Revenue Service (IRS) if they meet certain requirements. The exemption is based on the principle that the government's loss of tax revenues is offset by its relief from financial burdens that it would otherwise have to meet with appropriations from public funds, and by the benefits resulting from the promotion of general welfare. In addition to federal income tax exemption, these hospitals also have access to charitable donations that are tax deductible to the donor and tax-exempt bond financing. Nonprofit hospitals may also be exempt under state law from state and local income, property, and sales taxes.

- IRS has not specified that nonprofit hospitals have to provide charity care to meet this requirement, but they must provide a benefit to the community. This has become known as the community benefit standard. In addition to charity care, services and activities that can qualify as community benefits include the provision of health education and screening to specific vulnerable populations within the community and activities that benefit the greater public good, such as education for health professionals and medical research.

- Many of these community benefit activities—especially charity care—are intended to benefit individuals who need financial and other help to obtain medical care.

Current Community Benefits Requirements and National Health Care Reform

- In 2005, GAO indicated that nonprofit hospitals nationally may not be defining community benefit in a consistent manner that would enable policymakers to hold them accountable for providing benefits commensurate with their tax-exempt status. Over recent years, several changes have been required on the federal level to attempt to remedy this.

- IRS requires entire IRS Schedule H (Form 990) to be filed by non- profit hospitals for tax year 2009 that:

    - Summarizes charity care policies
    - Documents their community benefits and community building programs
    - Identifies how they meet community healthcare needs
    - Describes other activities or characteristics that IRS associates with tax-exempt status
    - Distinguishes between charity care and bad debt

- Under the tax –exempt provisions in Health Care Reform, hospitals must:
  - Perform a community health needs assessment during either Tax Year 2011, 2012 or 2013, and:
    - conduct a needs assessment once every three years afterward;
    - adopt an implementation strategy to meet the community needs identified;
    - describe how the hospital is addressing the community health needs, if any needs are not being addressed and why; and
    - May be subject to a $50,000 tax imposable by IRS for each tax year that a hospital fails to meet the requirement of the Community Health Needs Assessment.
  - Adopt certain financial assistance policies (written policy must include: eligibility criteria, basis for calculating amounts charged to patients, method for applying assistance, actions hospital can take for non-payment (if there is not a separate collection policy);
  - Provide, without discrimination, care emergency services regarding of eligibility under their financial assistance policy.
  - Meet certain requirement on charges (prohibit use of "gross charges" to uninsured to "amounts generally billed to those who have insurance"); and
  - Meet certain billing and collection requirements (hospitals may not engage in "extraordinary collections actions" before making "reasonable efforts" to determine if patient qualifies for assistance).

Analysis of Hospitals based on FY 2009 CB Reports

Utilizing the data reported to the Commission, the attached spreadsheet compares hospitals on the total amount of community benefits reported, the amount of community benefits reported less community benefits provided in hospitals' rate structures, the number of staff

dedicated to community benefit operations, and information regarding community needs assessments. From the attached spreadsheet, the following observations can me made:

- On average, hospitals dedicated 774 hours during FY 2009 on community benefit operations. Fourteen hospitals report zero hours for this purpose. There is wide variation in the number of community benefit operations hours logged compared to the number of hospital employees.

- Hospitals reported providing $946.2 million in community benefits in FY 2009. The total amount of community benefits as a percentage of total operating expense ranges from 1.62% to 13.64% with an average of 7.6%. Six hospitals provided community benefits in excess of 10% of operating expenses while 7 hospitals provided less than 3%. In FY 2008, community benefits expenditures comprised of 7.22% of total hospital operating expenses.

- Charity Care, NSPI and DME costs are reported as community benefit costs but are included in hospital rates. When offsetting these amounts from the amount of community benefits reported:

    - A total of $453 million in net community benefits were provided in FY 2009; and

    - The average percentage of operating expenses dedicated to charity care drops to 3.64%. This percentage ranges from 0.13% to 9.75%.

- Only one hospital reported not conducting a formal or informal community needs assessment, while 25 hospitals conducted a formal assessment, 20 hospitals conducted an informal assessment, and one did not report on this question. 17 hospitals conducted a formal or informal needs assessment during the last 3 years (2007, 2008 or 2009). 3 hospitals indicated that they had not contacted their local health department regarding community health needs, and 4 hospitals did not make a statement regarding this question.

A Profile of Exemplary Community Benefit Programs

- Over the past five years, the quantitative community benefit reporting has made it difficult for policy makers to determine if community benefit spending was tied to needs identified within the community being served, whether the programs had been updated to meet the changing needs within the community, and whether hospitals were evaluating the effectiveness of their programs.

- Based on the addition of narrative reporting requirements beginning in FY 2009, hospitals are now required to answer specific questions about their community benefit activities. The narrative is focused on (1) how hospitals determined the needs of the communities they serve, (2) initiatives undertaken to address those needs, and (3) evaluations undertaken regarding the effectiveness of the initiatives. The intent was to encourage hospitals unable to answer questions about their programs, due to lack of process or evaluation, to begin to focus their attention on planning and evaluation.

- Most hospitals were able to report that they used a needs assessment process, either formal or informal, in determining what community benefit activities would be undertaken. Many of those hospitals were able to identify the initiatives they have undertaken, however only some hospitals were able to report that they had completed evaluations of their initiatives.

- Five hospitals whose reports stand out as exemplary are:

  1. Calvert Memorial Hospital
  2. Carroll Hospital Center
  3. Franklin Square Hospital Center
  4. Holy Cross Hospital
  5. Johns Hopkins Bayview

- See highlights attached

Hospital Name	Employees	Total Staff Hours CB Operations Reported	Total Hospital Operating Expense	Total Community Benefit	Total CB as % of Total Operating Expense	FY 2009 Amount in Rates for Charity Care, DME and NSPI	Total Net CB Benefit minus Charity Care, NSPI, DME in Rates	(minus Charity Care, NSPI, DME in rates) as % of Op. Expense	CB Reported Charity Care	formal/ Informal needs Assessment by hospital or health department	Year of Most Recent Needs Assessment	contact with local health department
Anne Arundel	3000	312	$392,109,000	$9,813,130	2.50%	$5,198,679	$4,614,451	1.18%	$4,872,100	informal	not stated	yes
Atlantic General	698	89	$78,925,917	$4,025,228	5.10%	$871,169	$3,154,059	4.00%	$1,016,205	informal	2005	yes
Baltimore Washington	2578	60	$273,937,000	$6,697,686	2.44%	$6,339,523	$358,163	0.13%	$4,892,037	formal	2008	yes
Bon Secours	847	0	$135,615,987	$15,054,505	11.10%	$6,691,935	$8,362,570	6.17%	$8,647,745	informal	1998	yes
Calvert Memorial	1074	205	$116,764,179	$9,450,809	8.09%	$1,436,065	$8,014,744	6.86%	$1,500,565	formal	2007	yes
Carroll Hospital	1763	5870	$187,169,454	$18,089,190	9.66%	$6,262,908	$11,826,282	6.32%	$5,210,626	formal	2005	yes
Chester River	479	0	$56,362,775	$5,449,333	9.67%	$2,026,384	$3,422,949	6.07%	$2,825,000	formal	2008	yes
Civista	674	2866	$103,915,231	$3,370,461	3.24%	$1,643,760	$1,726,701	1.66%	$1,727,048	formal	2006	yes
Doctors	1356	80	$174,268,710	$3,514,706	2.02%	$851,574	$2,663,132	1.53%	$793,669	informal	not stated	no
Fort Washington	446	0	$43,524,509	$991,509	2.28%	$458,567	$532,942	1.22%	$664,274	informal	2006	yes
Franklin Square	3260	3962	$382,897,946	$28,153,523	7.35%	$17,700,956	$10,452,567	2.73%	$8,355,104	formal	2008	yes
Frederick Memorial	2062	0	$288,949,000	$16,975,445	5.87%	$5,308,737	$11,666,708	4.04%	$5,877,400	formal	2007	yes
Garrett County	341	163	$35,576,162	$2,217,305	6.23%	$1,596,736	$620,569	1.74%	$1,898,950	informal	2008	yes
GBMC	3000	0	$370,628,005	$14,929,004	4.03%	$7,623,830	$7,305,174	1.97%	$3,116,159	informal	2006	no
Good Samaritan	2411	2507	$289,772,684	$18,204,682	6.28%	$9,671,720	$8,532,962	2.94%	$4,268,699	informal	not stated	yes
Harbor Hospital	1495	353	$188,476,023	$16,275,390	8.64%	$9,117,770	$7,157,620	3.80%	$4,734,700	informal	not stated	yes
Holy Cross	3068	4109	$367,349,737	$30,076,895	8.19%	$12,401,502	$17,675,393	4.81%	$12,358,868	formal	2006	yes
Howard County	1744	152	$207,441,000	$12,492,416	6.02%	$1,837,044	$10,655,372	5.14%	$1,665,942	formal	2001	yes
JH Bayview	3531	320	$518,619,000	$56,434,372	10.88%	$42,483,497	$13,950,875	2.69%	$28,265,000	formal	2008	yes
Johns Hopkins	9600	3890	$1,556,118,000	$145,328,708	9.34%	$106,484,109	$38,844,599	2.50%	$37,024,000	formal	2005	yes
Kernan	655	116	$95,194,646	$5,291,660	5.56%	$3,614,799	$1,676,861	1.76%	$547,000	informal	2005	not stated
Laurel Regional	562	0	$90,274,400	$8,811,405	9.76%	$410,197	$8,401,208	9.31%	$338,565	no	n/a	none
Maryland General	1060	552	$183,911,000	$12,614,678	6.86%	$8,489,187	$4,125,491	2.24%	$4,830,000	informal	2008	yes
McCready	300	35	$14,619,162	$1,241,040	8.49%	$605,390	$635,650	4.35%	$968,730	formal	2005	yes
Mercy	3304	200	$344,923,000	$41,018,475	11.89%	$14,129,383	$26,889,092	7.80%	$9,829,267	informal	2008	yes
Montgomery General	1340	3	$122,776,400	$9,260,951	7.54%	$4,960,483	$4,300,468	3.50%	$4,809,700	informal	2006	yes
Northwest	1561	0	$190,488,000	$8,842,633	4.64%	$4,860,821	$3,981,812	2.09%	$5,295,000	formal	2005	yes
Peninsula	2683	115	$357,978,000	$14,452,339	4.04%	$6,947,716	$7,504,623	2.10%	$8,145,900	formal	2005	yes
Prince George's	1591	27	$244,485,900	$18,529,658	7.58%	$4,634,292	$13,895,366	5.68%	$1,032,020	formal	2006	yes
Saint Agnes	3307	0	$358,103,038	$29,791,139	8.32%	$18,738,638	$11,052,501	3.09%	$13,158,163	formal	2007	yes
Saint Joseph	2633	0	$358,442,985	$5,801,060	1.62%	$3,054,692	$2,746,368	0.77%	$4,018,865	formal	2006	yes
Saint Mary's	1136	53	$114,970,861	$6,936,725	6.03%	$4,259,296	$2,677,429	2.33%	$3,365,310	informal	2007	yes
Shady Grove	1942	823	$275,607,577	$29,585,432	10.73%	$8,341,197	$21,244,235	7.71%	$9,373,977	informal	2007	yes
Shore Health - Easton	1290	0	$134,106,845	$8,571,170	6.39%	$2,609,773	$5,961,397	4.45%	$3,109,636	informal	not stated	not stated
Shore Health -Dorchester	617	0	$43,095,616	$3,191,311	7.41%	$1,254,054	$1,937,257	4.50%	$1,220,210	informal	not stated	not stated
Sinai	4350	2808	$632,373,000	$30,633,923	4.84%	$23,426,941	$7,206,982	1.14%	$10,634,840	formal	2005	yes

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Southern Maryland	1636	0	$222,131,545	$16,410,869	7.39%	$1,228,201	$15,182,668	6.83%	$1,469,042	not stated	not stated	not stated
Suburban	1600	1426	$230,094,500	$15,783,345	6.86%	$4,250,567	$11,532,778	5.01%	$4,337,800	informal	not stated	yes
UCH-Harford	773	153	$87,176,000	$2,425,992	2.78%	$1,100,816	$1,325,176	1.52%	$1,451,597	formal	2005	yes
UCH-Upper Chesapeake	1724	356	$179,314,000	$3,258,554	1.82%	$1,861,960	$1,396,594	0.78%	$2,045,004	formal	2005	yes
Union Cecil County	1022	210	$124,492,414	$4,027,521	3.24%	$1,403,035	$2,624,486	2.11%	$1,690,600	formal	2004	yes
Union Memorial	2420	85	$392,085,514	$32,579,081	8.31%	$20,831,264	$11,747,817	3.00%	$8,141,892	informal	not stated	yes
University of Maryland	5937	3622	$1,119,376,000	$152,667,507	13.64%	$84,567,844	$68,099,663	6.08%	$43,218,000	formal	2008	yes
Washington Adventist	1550	634	$257,235,122	$33,062,153	12.85%	$7,989,907	$25,072,246	9.75%	$9,862,543	informal	2007	yes
Washington County	2211	231	$243,536,900	$21,825,141	8.96%	$7,575,529	$14,249,612	5.85%	$10,028,718	formal	2008	yes
WMHS -Cumberland	1025	0	$103,074,694	$5,076,058	4.92%	$3,520,688	$1,555,370	1.51%	$2,365,487	formal	2009	yes
WMHS-Braddock	1315	0	$154,440,387	$7,004,047	4.54%	$2,602,149	$4,401,898	2.85%	$4,719,883	formal	2009	yes
total	92971	36387	$12,442,727,824	$946,238,164	7.60%	$493,275,288	$452,962,876	3.64%	$309,721,840			
Average	1978	774										

	Calvert Memorial Hospital
Identification of Needs:	**comprehensive community health assessment**
	community health forum
	surveys
	updated medical staff plan with analysis
	strategic planning process
	involvement of local health department
Decision Making Process:	**Board of Directors, CEO, Department directors, President's Panel (staff representative of all major hospital departments), Executive Team**
Program:	**Need: Lack of Pediatric Dental Care for Medicaid Population**
	Program: Contract dental providers in existing underutilized dental space with hospital as billing agent and program coordinator.
	Evaluation: grant received FY09; program guidelines completed; relationships with area dentists developed; contracts for leasing space completed; staff hired and trained; targed advertising; patients identified and provided services; formal evaluation after one year of grant funding, informal evaluation after each session; patients are now receiving dental care.
Program:	**Need: Care for uninsured.**
	Program: Calvert HealthCare Solutions - utilizes existing medical resources in the community to provide primary care to the uninsured who meet income qualification guidelines. Patient is provided a case manager, basic lab and xray diagnostic tests at no cost. (provided over 70,339 in services fy09.
	Evaluation: 16 specialty providers recruited; 213 new clients enrolled; 362 physician office visits; 32 sliding scale patients initiated care at clincs; 613 patients from ER contacted by case management and 85 obtained follow-up care; 1 patient received 7 mental health visits. Evaluation led to incorporation of RN care coordinator to provide medication, wellness, and nutrition counseling; disease prevention coaching; diabetic self management classes; improvements to database and tracking system.

	Carroll Hospital Center
Identification of Needs:	**health status assessment projects with Partnership for a Healthier Carroll County**
	Healthy Carroll Vital Signs-Measures of Community Health -data collection
	Elder Needs Health Assesment
Decision Making Process:	**Patients; Partnership for Healthier Carroll County; The Learning Center; The Women's place; Marketing and Business Development; hospital's multidisciplinary Community Benefit Planning and Review Team; hospital's executive team and Board of Directors**
Program:	**Need: Adult education regarding obesity and associated health risks.**
	Program: Lose to Win Program - twelve week collaborative community program to promote weight loss and wellness. 12-week program - unlimited access to exercise sessions at Merritt Athletic Club; weekly group nutritional classes at Martin's Food Market; Weekly weigh-ins and blood pressure checks; pre and post program blood profiles.
	Evaluation: 20 out of 21 people completed 12 week program; group lost total of 340 lbs; 15 people had reduction in body fat; 13 people had reduction in total Cholesterol, LDL - 8, Triglycerides - 14 people; 3 significantly reduced blood surgar and blood sugar control
Program:	**Need: access to high-quality prenatal, labor and delivery, and in-hospital newborn care at affordable cost.**
	Program: Best Beginnings Program-provide women without health insurance access to quality prenatal, labor and deliver and newborn care to those who would not have access to such services. Joint effort between hospital and affiliated physicians.
	Evaluation: 35 patients provided care in FY 2009; all mothers had successful deliveries with newborns at or over normal birth weight; increase from 2008 - 2009 of women treated in first trimester instead of later in pregnancy. FY 2009 -66 % enrolled in first trimester vs. FY 2008 - 16% enrolled in first trimester.

	Franklin Square Hospital Center
Identification of Needs:	**Community needs assessment of southeastern portion of Baltimore County; development of action plan; consultation with health department**
Decision Making Process:	**Hospital Board Community Awarness Committee; community service line director; community outreach manager; community RN education specialists.**
Program:	**Need: Domestic Voilence prevention**
	Program: Child Abuse Prevention Services - over 300 children suspected of being abused per year are evaluated at Franklin Square. Evaluations based on comprehensive approach developed by Department of Pediatrics. Instituted CPT (child protection team) with a social worker coordinator, medical director, on-call social work and medical staff; 24/7 coverage and evaluated any child suspected of being abused. Abusive Head Trauma prevention education; Infant safe sleeping program
	Evaluation: Increased number of infants presenting at ED are evaluated for abuse; 84 % of cases referred to Social services have been accepted for investigation due to improved evaluative process much higher than on national level; increased parental education and committment to learning coping mechanisms to lower rate of shaken baby syndrome. - Plan: Continue program and use as a model for new programs.
Program:	**Need: Healthcare for the Homeless**
	Program: Partnered with Baltimore County and Healthcare for the Homeless in Baltimore City to establish a new access point for primary care for people experiencing homelessness in Baltimore County. In recent years, 7000 people have been identified as homeless in Baltimore County with 71% being women and children and 45% reporting no health insurance; Chronic issues include: mental and addictive disorders, hypertension, diabetes, HIV/AIDS;
	Evaluation: partnership establishes a medical home for vulnerable county residents; provides preventive health services before health issues escalate into an emergency. Additional funding is being sought to meet needed resources (space, specialty care, medications). Since inception in 2006, over 700 people have benefitted from over 3,500 primary care visits. 55% are temoporarily housed in the family shelter.

	Holy Cross Hospital
Identification of Needs:	**participation in community coalitions, partnerships, boards, committees, commission, advisory groups, panels; quarterly analysis of internal patient surveys and public market data; review of local needs assessments and reports; consultation with local health department**
Decision Making Process:	**Hospital's interdepartmental leadership, executive management, board of trustees plan monitor and evaluate hospital's community benefit effort; chief executive officer review committee on community benefit(internal, interdepartmental committee) Community leaders**
Program:	**Need: provide health education, disease prevention and chronic disease management (including obesity)programs to improve the health status of the community.**
	Program: Maternal and Child Health Initiative: Kids Fit. In partnership with Housing Opportunities Commission of Montgomery County, - free multi-component exercise class specially designed for children ages 6-12. One hour class meets 2x a week includes: tips on healthy lifestyle, evidence-based fun exercise program, nutritious snack. 125 children enrolled in program at five sites.
	Evaluation: Biannual fitness assessments in fall and spring utilize evidence-based President's Challenge Program. In comparing results from June 2009 to December 2008, average scores declined for girls in push up test, curl up test, shuttle run; remained same in sit and reach. average scores for boys declined in push up test, remained same for curl up test, and improved in shuttle run and sit and reach. Plan: use results to increase activity in areas that showed decline.
Program:	**Need: Diabetes Prevention**
	Program: Chronic Disease Management Initiative: Diabetes Prevention and Self-Management Class. Designed to help pre-diabetic make lifestyle changes (weight loss, exercise) to prevent or delay onset of diabetes or cardiovascular disease. Free 12 week classroom program followed by 6 months of telephone support. Blood tests indicating risk are required for inclusion in program.
	Evaluation: Monitoring of class attendance, weight control, exercise regimen, AC1 count, lipid profile; 23 out of 27 completed classes. 86% attended at least 80% of classes; 47% attended 100% of classes; weight loss achieved by 93% of attendees; 47% increased exercise level from pre-program levels; AC1 count improved in 100%; Lipid profile improved in 80-100% of participants

	Johns Hopkins Bayview
Identification of Needs:	**community health assessments, health department statistics, direct community contact, analysis of hospital programs**
Decision Making Process:	**Hospital Board of Trustees, executive and clinical leadership, community relations staff, community advisory boards, Johns Hopkins Hospital, primary care physicians serving immediate community**
Program:	**Need: Cardiovascular disease prevention**
	Program: Food Re-Education for School Health cardiac disease prevention program in the elementary schools.
	Evaluation: Annual evaluation - Pre and post measurement of children's knowledge, Teacher evaluations. Based on results, plan to continue program
Program:	**Need: Cardiovascular disease prevention**
	Program: Community Health Action program - a partnership with the community to promote health, smoke-free families effort in place for several years providing a resouce guide for distribution at the hospital and in the community.
	Evaluaton: Self-assessment by participants; strategic planning. Based on evaluation, focus has been shifted to diabetes and obesity.