IN BRIEF

CAN DATA FROM NONPROFIT HOSPITAL TAX RETURNS IMPROVE COMMUNITY HEALTH?

Erik Bakken and David Kindig
University of Wisconsin, Madison

Nonprofit hospitals play a key role in improving the overall health of their communities. New opportunities, though, are arising through Affordable Care Act’s (ACA) emphasis on community-level data for community health planning. The ACA requires nonprofit hospitals to draft a Community Health Needs Assessment (CHNA) triennially as part of their IRS tax-exempt status. The assessment researches and identifies the health needs of their communities and details plans to address these needs. The CHNAs could also improve efficiency, eliminate overlapping programs, and better coordinate community-wide health resources if they were jointly carried out with other hospitals or stakeholders. If aligned with other community-level data projects, CHNAs could coordinate investments from other key sources of community improvement, such as funds from Community Reinvestment Act–motivated banks, community foundations, socially motivated investors, and local governments. CHNAs could also ensure that community benefit dollars are better aligned with community health improvements. This essay summarizes the current status of such community benefit allocations recently made available through new IRS reporting.

IRS COMMUNITY BENEFIT POLICY

For nonprofit hospitals to qualify for tax exemption, they must provide charitable health-promoting activities (community benefit) to their communities. In 2007, the IRS announced new rules defining how hospitals must
report their community benefit allocations as part of their tax filing to qualify for exemption. Schedule H, a new section of the 990 tax-exemption form (Form 990) that was added for hospitals, codified and strictly defined what hospitals could count as community benefit. Hospitals now were required to report their annual community benefit provisions in total and by qualifying categories. In addition, certain qualitative information regarding internal hospital policies, organization, and mission was made mandatory. The definitions of community benefit categories have remained unchanged since their introduction in 2008 and can be defined as follows:

- **Financial assistance at cost**, commonly referred to as “charity care.” This is free or reduced-price care provided to those financially unable to afford treatment, such as the underinsured or those eligible but not enrolled in Medicaid.

- **Unreimbursed Medicaid**, which is the “net cost” to the organization for providing these programs. It is the disparity between cost of treatment for Medicaid patients and the government reimbursement rate.

- **Other unreimbursed means-tested government programs**, which is the net cost to the organization for providing these programs. It is the disparity between cost of treatment for these patients and the government reimbursement rate.

- **Subsidized health services** are clinical inpatient and outpatient services that are provided by the hospital despite a financial loss or that would be otherwise undersupplied to the community. Typically, these are services with thin or negative profit margins for the hospital, such as burn units, and they are meant to insulate the hospital financially for providing these services.

- **Community health improvement services** include activities or programs subsidized by the organization for the express purpose of community health improvement, documented by a Community Health Needs Assessment. Examples include immunization programs for low-income children or diabetes health education courses.

---

• **Health professional education** includes the net cost associated with educating certified health professionals.

• **Research** includes the cost of internally funded research and the cost of research funded by a tax-exempt or government entity.

• **Cash and in-kind contributions** include contributions, monetary or otherwise, to community benefit activities that the organization makes to community groups.²

The IRS also requires reporting in three supplemental, optional categories in the community benefit section of Form 990. These are not counted as community benefit because of IRS rulings, but must be reported if allocations exist. These supplemental categories are:

• **Bad debt**, which includes the portion of hospital billings that is unpaid and the organization believes could be of community benefit.

• **Unreimbursed Medicare**, which includes the surplus or shortfall from the organization’s Medicare Cost Report.

• **Community-building expenses**, which protect or improve community health and safety, including housing, economic development, environmental improvement, leadership development, and coalition building.³

**HOW IS COMMUNITY BENEFIT ALLOCATED?**

Even with the new standardized reporting, findings on how hospitals were allocating community benefit dollars were slow to emerge. Data is not directly available from the IRS, but individual hospital Schedule H filings can be viewed on the GuideStar website.⁴ There is however a several-year delay in data availability. In 2012, we published the first peer-reviewed results from the new Schedule H, examining community benefit levels in Wisconsin for 2009 (Figure 1). In a modestly sized state such as Wisconsin, reported community benefit totaled more than $1 billion for the 2009 financial year. Hospitals varied in their levels of community benefit spending, but on average community benefit amounted to 7.5

---


³ Ibid.

percent of total hospital expenditure (Figure 2). Interestingly, although hospital tax exemption stems historically from the provision of free care to the uninsured, traditional charity care amounted to only 9 percent of overall community benefit. More than one-half of the total came from the unreimbursed costs of Medicaid. Subsidized services were also a significant category, totaling 11 percent of the community benefit share. The community health improvement category amounted to only 4.4 percent of total community benefit dollars in the state. In addition, these dollars were asymmetrically distributed, with many hospitals allocating nothing to community health improvement, whereas others put considerable funds into this category.\(^5\)

In 2013, the first national study of Schedule H was published in the *New England Journal of Medicine* from the same 2009 GuideStar data set, 

---

with generally similar results for the entire country (data not shown).\(^6\) Total community benefit was 7.5 percent of expenditures. Twenty-five percent was reported for charity care, while only 5 percent was reported for community health improvement. Forty-five percent was reported for unreimbursed Medicaid, and 15 percent was reported for subsidized clinical services.\(^7\)

**USING SCHEDULE H INFORMATION FOR POLICY**

As this data becomes more widely available, it may be more actively used for hospital and local public health decisions. Specifically, it would allow hospitals to better link dollars toward the triennial CHNA required by the Affordable Care Act (ACA). The CHNA defines the community that the hospital is serving, identifies the particular needs of that community, and must contain a plan to address these established needs.\(^8\) A fine-based compliance mechanism will be imposed for those failing to meet CHNA requirements.

---


7 Ibid.

8 E. Bakken and D. A. Kindig, “Is Hospital ‘Community Benefit’ Charity Care?”
The IRS community benefit requirements represent a potentially unique, dedicated funding stream for activities that meet the needs identified in a CHNA and yield real public health improvement. More transparent access to data about community health needs and improvement activities would allow hospitals to better coordinate community benefit dollars to tackle large projects or improve efficiency by eliminating redundant programs. In some markets, community health needs are likely to be similar among facilities. With better access to information, hospitals in multi-facility markets would be able to coordinate their public health pursuits to jointly address a single issue, or agree to address different programs in overlap areas. Recent policy changes indicate policymakers’ growing awareness of the need for community benefit to extend beyond the traditional boundaries of health care to support community development activities. Although the supplemental community-building category remains uncounted as a community benefit broadly, hospitals can now count some community-building activities in certain circumstances. An activity is now eligible for the community health improvement category if the activity addresses an identified CHNA issue and directly improves health outcomes.

As we have indicated, however, retrieving information about how hospitals are allocating community benefit dollars from the GuideStar website is burdensome. To help communities obtain and use this data more easily, the Department of Health Policy at George Washington University, with support from the Robert Wood Johnson Foundation, will be working to develop a web-based database for Form 990. This database is intended for public health practitioners, researchers, community stakeholders, policymakers, and others to have ready access to community health investment by hospitals. The project will allow users to search by hospital, geographic area, size of facility, and other factors. A major hindrance to linking community benefit dollars to community health improvement is lack of information. With this database tool, the Department of Health Policy at George Washington University intends to improve information access so that community benefit dollars may be better spent in each community. Better tools and more transparent information may also push hospitals to allocate more funds away from covering Medicaid shortfalls or subsidizing unprofitable services to community health improvement activities.

---

9 Personal communication with Sara Rosenbaum, principal investigator.

10 Ibid.
Whereas the authors of the recent national study commented that “the availability of new sources of data and research... will at least make the debate an informed one,” we conclude that community benefit policy is too important, and the needs for population health improvement resources are too great for there not to be more explicit allocation standards.\textsuperscript{11} The need for additional resources for tackling upstream health determinants has been recently underscored by the documentation of our shockingly poor health outcome performance compared with other high-income countries.\textsuperscript{12} Although other financing mechanisms, such as increased state and federal categorical funding, shared savings from Accountable Care Organizations, and global budgeting approaches need to be fully examined as well, community benefit policy seems like an unusually appropriate opportunity. The information now being made available by Schedule H should assist in aligning these needs with much-needed resources.

---

EROIK BAKKEN is a project assistant at the Department of Population Health Sciences at the University of Wisconsin. Erik’s previous work has focused on public health policy, non-profit hospital policy, and alternative funding mechanisms for public health programs. He received his Master of Public Affairs at the La Follette School of Public Affairs at the University of Wisconsin-Madison and his BA in Political Science from the University of Wisconsin-Madison.

DAVÍD KINDIG, MD, PhD, is emeritus professor of Population Health Sciences at the University of Wisconsin-Madison School of Medicine and Public Health. He is co-chair of the Institute of Medicine Roundtable on Population Health Improvement. He co-directs the Wisconsin site of the Health and Society Scholars program, and was founder of the University of Wisconsin Population Health Institute which produces the County Health Rankings and the Culture of Health Prize for the Robert Wood Johnson Foundation.

---

\textsuperscript{11} Wright, Clancey, and Smith, “Unraveling the New Form 990: Implications for Hospitals.”