PPACA and Expectations for Nonprofit Hospitals

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Some Basics

- Nonprofit not same as governmental
- Nonprofit hospitals are part of a much larger nonprofit sector
- Basis for tax exemption often misunderstood
- Meaning of “charitable” is important

Why the Focus on Hospitals?

- Their prominence
- Their commerciality
- Because of for-profit counterparts
- Because charitability of hospitals is a health policy issue as well as a tax policy issue

Meaning of “charitable”

- 1956 IRS: free or discounted care to those needing it, to “extent of its financial ability”
- 1969 IRS: community benefit
- 2009 IRS: Schedule H

About Schedule H

- A huge positive step toward improved accountability
- Treatment of “community building” a major mistake
- Pertains to organizations that operate hospitals rather than hospitals themselves

The Maryland Experience

- Has had a reporting requirement similar to Schedule H since 2004
- My 2009 Study
  - Of filings
  - Interviews at 20 hospitals
- Published in
  - Health Affairs 2009
  - Inquiry 2009

Some Findings from Maryland

- CB expenses @ 7% of total expenses
- Mostly charity care, health professional education, & subsidized ("mission driven") services
- Variation from 1.3% to 13.5% in 2007, due mostly to charity care & health professional education
- Community building less than 2% of CB expenses
- Reports affected hospitals' thinking about CB—Accounting vs. Managerial approaches

Dimensions of a managed community benefit approach among 20 Maryland nonprofit hospitals

Dimensions of managerial approach	Number of hospitals		
	Total (n=20)	Managerial (n=8)	Accounting (n=12)
Hospital has undertaken CB "initiatives"	16	8	8
Community benefit is in hospital's strategic plan	13	8	5
Hospital made use of a needs assessment for CB	13	8	5
Hospital has goals for CB program	12	8	4
Someone is responsible for CB activities	9	7	2
Hospital has an organized CB program	9	6	3
There is overall or departmental budget for CB	9	6	3
Board is involved in planning/oversight of CB	9	5	4
There is a community benefit work group	6	5	1
CB projects (not just events) have been evaluated	4	4	0

Source: BH Gray and M Schlesinger, "The Accountability of Nonprofit Hospitals: Lesson's from Maryland's Community Benefit Reporting Requirements." Inquiry 46 (Summer 2009): 130. Based on Gray's interviews with hospital officials in Maryland, 2008.

The Post-PPACA World

(Assuming implementation as passed)

- Need for charity and subsidized care will decline but not disappear (very large growth in Medicaid); CB patterns will change
- Reduced resources for hospital charity care
- ACO has incentives to reduce hospital use, BUT….
- Triple aim logic comes to CMS, *BUT*….

Concluding Points

- IRS should recognize link between community building and population health. But better evidence is needed.
- Schedule H and needs assessment provisions of PPACA will push hospitals toward managerial approach to CB. Give it time.
- Temptation to use tax policy to pursue health policy goals should be approached with caution.

Conclusions regarding Community Health

- Hospitals are important resource—financial, expertise, commitment, data
- But hospitals & communities vary in ways important to community benefit
- IRS policy should focus on reporting, not substantive requirements.

Questions for Future

- Will reduced focus on charity care increase focus of CB on outcomes? Measures needed.
- Will more hospitals adopt managerial approach to CB?
- Will logic of community benefit reporting extend beyond hospitals? If not, why not?
- Will logic of addressing unmet community need lead to more collaborative efforts?

More Questions

- Can hospitals be successfully pushed to take community health improvement as their mission, when incentives reward admissions? (Or, will ACOs work?)
- Can we be thoughtful about using the tools of tax policy to pursue health policy goals?
  - Applying requirements only to nonprofits
  - Recognizing variations in missions, resources, etc.