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How Hospitals Can Hold Local Economies Down and the Case for Reforming Community Benefit

The purpose of the CCS Center for Medicaid Policy (CMP), from its founding in 2015 is to increase the capacity of Northeast Ohio's health delivery system to effectively engage in Medicaid policy making at the local and state levels through effective and timely research and analysis

Loren Anthes, MBA, CSSGB
Senior Fellow
William C. and Elizabeth M. Treuhaft Chair for Health Planning

www.communitysolutions.com

Key Insights

- **THE HOSPITAL INDUSTRY, DEVELOPED THROUGH GOVERNMENTAL INVESTMENT, REPRESENTS NEARLY 1 IN 3 DOLLARS SPENT ON HEALTHCARE AND IS LARGELY TAX EXEMPT**

- **COMMUNITY BENEFIT POLICY, WHICH ENABLES THIS EXEMPTION, HAS EVOLVED OVER TIME, BUT THE IMPACT IS MINIMAL AND THE VALUE CREATES PERVERSE INCENTIVES**

- **STATE AND LOCAL GOVERNMENTS SHOULD REFORM THE PROGRAM TO CREATE MORE TRANSPARENCY AND EFFECTIVENESS IN ACHIEVING BETTER HEALTH OUTCOMES**

The birth of the modern hospital industry

In 1946, the 79th United States Congress passed the Hospital Survey and Construction Act, commonly known as the Hill-Burton Act, sponsored by Senator Harold Burton of Ohio and Senator Lister Hill of Alabama. The legislation was partly a response to the combination of market forces stemming from the industrial revolution and World War II, where the advent of health coverage became an important outgrowth of the labor movement, and employer benefits became normalized at a time of wage freezes. With the scarcity of hospital services nationally, the legislation intended to increase the number of "beds", with particular focus on areas with little medical access or high concentrations of poverty. The program itself lasted until 1997.[i]

When looking at the data, the legislation was effective. In 1948, 22 percent of counties had no hospital beds, and the total number of facilities was 4,375. By 1975, there were 5,875 hospitals (a 34 percent increase), and over 70,000 additional beds were created, particularly in impoverished parts of the United States, notably the southeast. With this growth came the growth of hospital-delivered care as a part of the economy. Just in terms of total expenditures, hospitals represent about 31 percent of all health spending.[ii] That includes total spending from private insurance and public sources like Medicare and Medicaid. And while that sum is significant, governmental expenditure on health and hospital services is also substantial, with 10 percent of state and local funds, making it the third largest expenditure, roughly equal to higher education.[iii] In Ohio, this translates to approximately $500-1000 per capita.

As we have written, Hill-Burton was also the starting point for national conversations about the lack of racial integration in hospital settings. Sen. Burton advocated for the inclusion of desegregation as a mandate of the legislation. With the predominant need in the American southeast, southern legislators opposed to integration prevented that provision from being adopted. Indeed, it wasn't until Simkins v. Cone (1963) and the passage of the Medicare Act in 1965 that racial integration was a requirement of hospitals in the United States.[iv] Still, while the guarantee was made available, there were ongoing concerns even into the 1990s to ensure hospitals receiving Hill-Burton complied with civil rights laws regarding access and equal treatment.[v]

Hospitals as community anchors

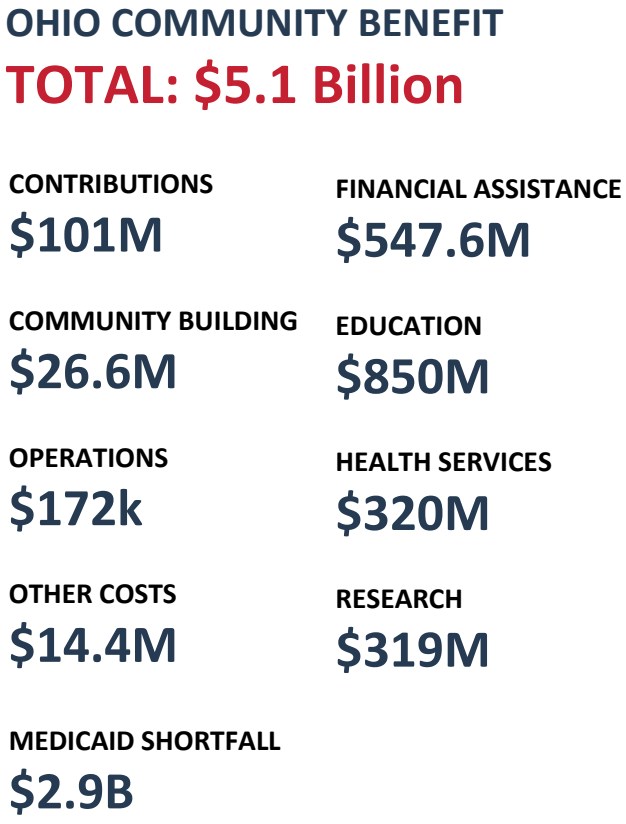
As hospitals developed in communities, so did their relationship with the community. Often, hospitals frame this relationship where the hospitals as an "anchoring" institution, wherein the facility acts as an economic and organizing center for the communities they serve.[vi] Indeed, hospitals and healthcare are a significant industry in Ohio, with over 780 thousand employees (including 67,500 in Cleveland hospitals alone) and are often the main driver of local economies as we have documented previously in our research, "Big City Problems in Ohio's Small Towns".[vii] Beyond that, in many Ohio cities, they are often a major input of municipal income tax revenue, where hospitals often provide the single largest source. And while this is an intentional peripheral benefit of Hill-Burton, this has also evolved over time, with hospitals expanding their presence further into exurban areas to maximize the revenue associated with private pay patients and moving key, high-paying administrative positions closer to the bedroom communities they inhabit.

Interestingly, many hospital executives often see themselves as leaders in the community, centering themselves as the stewards of the benefits promised in this relationship. However, within this seemingly charitable context, the average nonprofit hospital chief executive makes over $600 thousand per year, with the top 10 making more than $7 million. As a result, many have criticized this given the recent wave of closures and pay cuts to many employees delivering services directly.[viii] While Hill-Burton was creating the hospital industry as we know it, its relationship to communities as a public benefit was also taking hold. In 1956, the Internal Revenue Service (IRS) recognized that hospitals could qualify as tax-exempt charities. Then, in 1969, with new public coverage options in Medicare and Medicaid, the Nixon administration revised the set by the IRS to develop the "community benefit" standard, which included the "promotion of health" as a charitable measure. And while there have been several tweaks since 1969, it wasn't until 2009 and the passage of the Affordable Care Act (ACA) that led to the program today.

Community benefit creates a deficit

The community benefit standard established by the ACA requires several activities of hospitals that are largely documented in schedule H of their IRS filing and enables hospitals to avoid paying over $60 billion in property taxes annually.[ix] The law also established Community Health Needs Assessments (CHNAs), which must be conducted every three years. These processes, which require hospitals to document the qualitative and quantitative health needs of their service areas, must be tied back to the spending associated with the community benefit reporting of the hospital and be publicly posted.[x] At this point, it should be noted that the Center for Community Solutions has been contracted by hospitals to perform this work.

In addition, the ACA required hospitals to provide a written financial assistance policy and discouraged "extraordinary collection actions" on medical debt. And while medical debt has decreased significantly after the expansion of Medicaid to non-disabled adults in states that have enacted that coverage option, it is still the



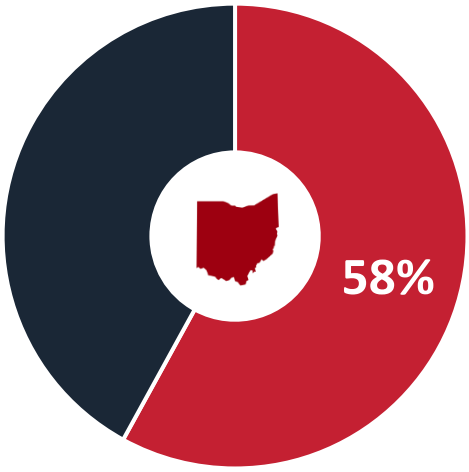
single largest source of financial burden for Americans representing the largest share on credit reports (58 percent) and nearly $88 billion annually.[xi] As a result, many Americans saddled with this debt cannot manage basic needs with the diminished credit created by these collections practices. As credit is often used to determine a person's ability to access transportation, housing, and even a job, this situation can inhibit upward economic mobility. It can even lead to worse physical and behavioral health outcomes, thereby paradoxically leading to greater delivery costs.

Does current spending improve health or meaningfully impact the social determinants of health?

Unfortunately, there is still a significant lack of transparency in community benefit programs and how they integrate and collaborate with communities in executing their obligations to avoid paying taxes. In a recent survey by the American Hospital Association, more than a quarter of US hospitals did not have any community partnerships as a part of the CHNAs. More than that, the reporting associated with the schedule H provision is often inconsistent and distorts the hospital's impact on a community.[xii] Together, community benefit spending, financial assistance (services for the uninsured), community health services, medical education and in-kind contributions comprise less than 20 percent of community benefit reporting. Community health services, in fact, only represent 2.3 percent of total community benefit spending as of 2021, and there is no evidence current spending is improving health or meaningfully impacting the social determinants of health.[xiii] If it weren't for "Medicaid shortfall, (described in the subsequent section), many hospitals community benefit spending would be negative relative to total expenses.

Medicaid shortfall or inflation incentive?

Medicaid shortfall, in broad terms, is the difference between the reimbursement and the cost of a service provided to a Medicaid recipient.[xiv] Local trends, which reflect national ones, show that Medicaid shortfall drives growth in community benefit spending.[xv] And, across Ohio, Medicaid shortfall represents nearly $3 billion of the $5 billion claimed. The policy issue is that "cost" is not well defined, and the difference does not account for the hundreds of millions paid in supplemental payment programs like Disproportionate Share (DSH) or Upper Payment Limit (UPL). Additionally, as it relates to DSH, there has been increased federal scrutiny given the scant oversight of how the program is applied.



MEDICAID SHORTFALL IS NEARLY 58% OF OHIO'S COMMUNITY BENEFIT BUT IS NOT WELL-DEFINED

Specifically, there are instances of hospitals claiming services for the uninsured on their "professional fees" to receive DSH payments while sending that same patient to collections on the "facility fees" associated with their care. This means the hospital is simultaneously receiving a tax benefit and a supplemental fee for services to an uninsured patient while being paid by a collections agency for selling that same patient's debt. As a result, the difference not only foregoes those resources in calculating Medicaid shortfall, but there is no requirement defining how the cost is derived. In other words, it is unclear if cost reflects the actual resources used or, what's more problematic, if it is a function of

price. If it is the latter, that means a hospital's tax exemption is incentivized to raise prices on patients.

Three actions legislators, hospital leadership and the State should take

Given the role of the government in developing the industry, the government could explore ways to reformat the community benefit obligations hospitals have to promote community health better. From Nixon to Obama to current legislative bipartisan efforts in Congress, this concept has garnered attention and energy in meaningful ways. Some concepts and ideas that Congress, hospitals, and the state of Ohio should explore to reform the program.

Establish Better, Meaningful Local Partnerships

There is good analysis of the needs of communities effectuated through CHNAs, community participation in the process of making investments is significantly limited. What's more, given the size of the capital resources of hospital systems, they could replicate the role banks have played since the Community Reinvestment Act and serve as a community development intermediary, partnering with those same institutions to magnify the investments already being made.

Hospitals could also seek to work directly with public health departments beyond the typical relationship of assessment and obligate a portion of their funding to be explicitly under the control of the public health department or for local government appropriation based on needs established in the CHNA.

Support Changing the IRS Reporting

The evidence is clear that the standard is foggy and primarily a function of accounting for a definition of Medicaid cost that is, at best, specious. Every level of government should want to see this changed so that the investment made in tax dollars directly and through abatement results in better health. The Lown Institute, in particular, has some recommendations on how community benefit can be changed.

Statehouse Action

While there is a federal standard, Ohio does not require a specific level of benefit, does not require CHNAs, does not require implementation strategies, does not require the adoption of financial assistance policies and exempts hospitals from commercial, property and sales taxes as is the case in other states. These should all be examined. If the IRS does not change the standard, the General Assembly should and may want to think through licensure as a pathway for enforcement.

Several states have also introduced and passed legislation to define reporting and allowable expenditures better. Montana conducted an audit to evaluate its hospitals' spending and the impact of that spending on improving health. Ohio should do the same. For more information, the National Academy of State Health Policy has a compendium of resources.

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