UNIVERSITY OF WISCONSIN
Population Health Institute
Translating Research into Policy and Practice

CAN HOSPITAL COMMUNITY BENEFIT IMPROVE POPULATION HEALTH?

David Kindig MD, PhD

LaFollette Institute April 25, 2013

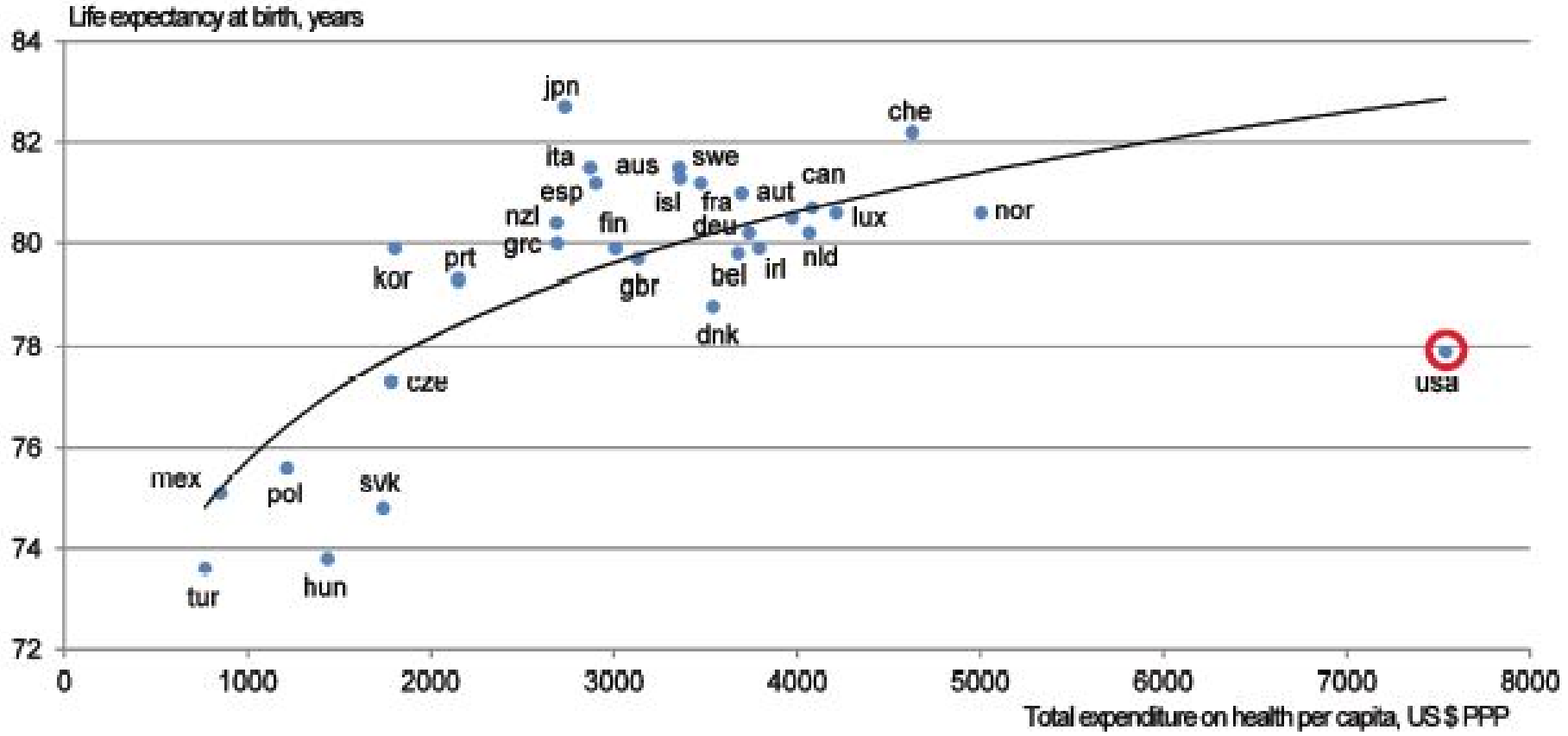
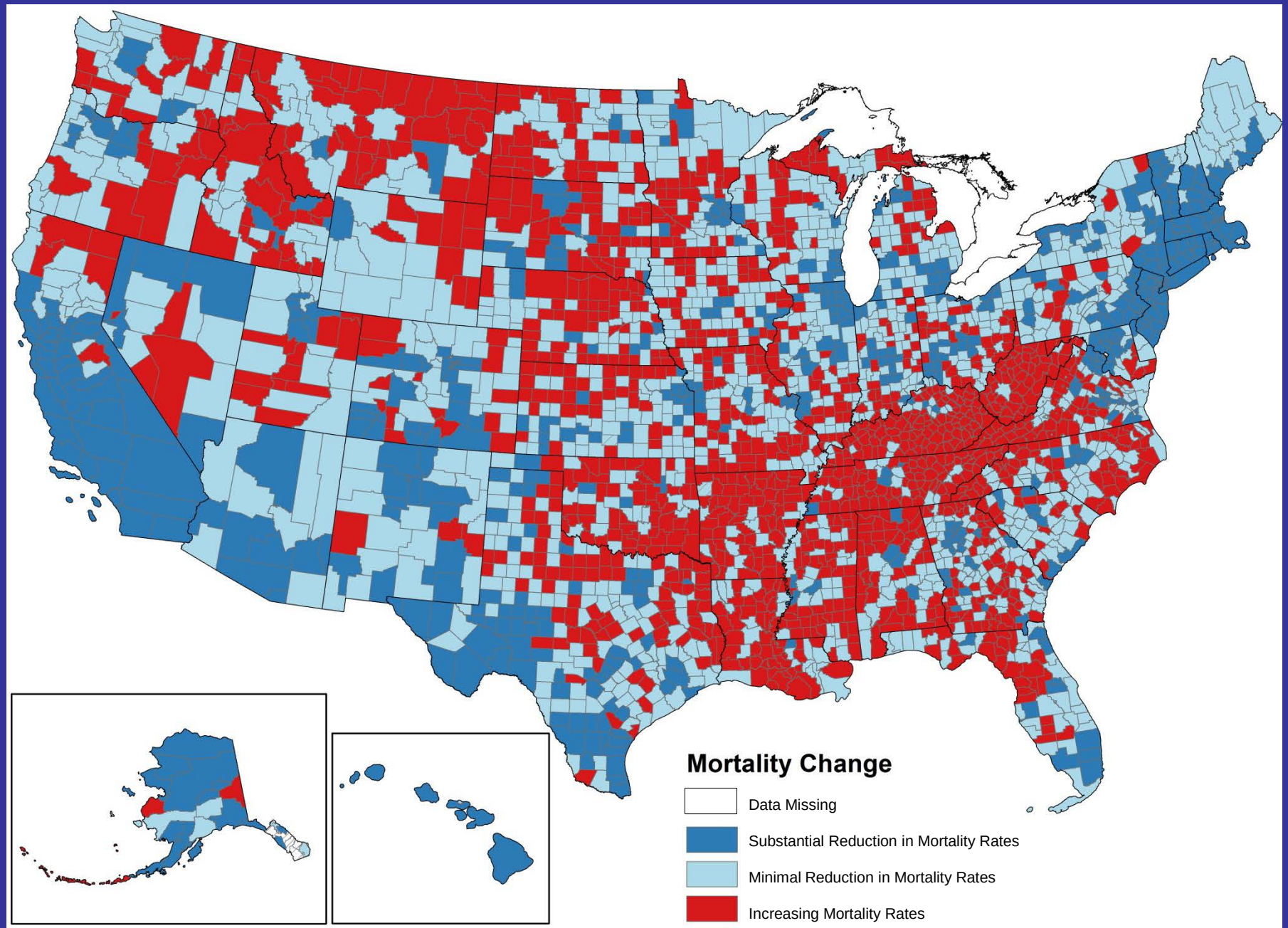


FIGURE 1-2 Health spending and life expectancy (2008* data).

Exhibit 3. Female Mortality Change between 1992-1996 and 2002-2006 among 3,140 U.S. Counties



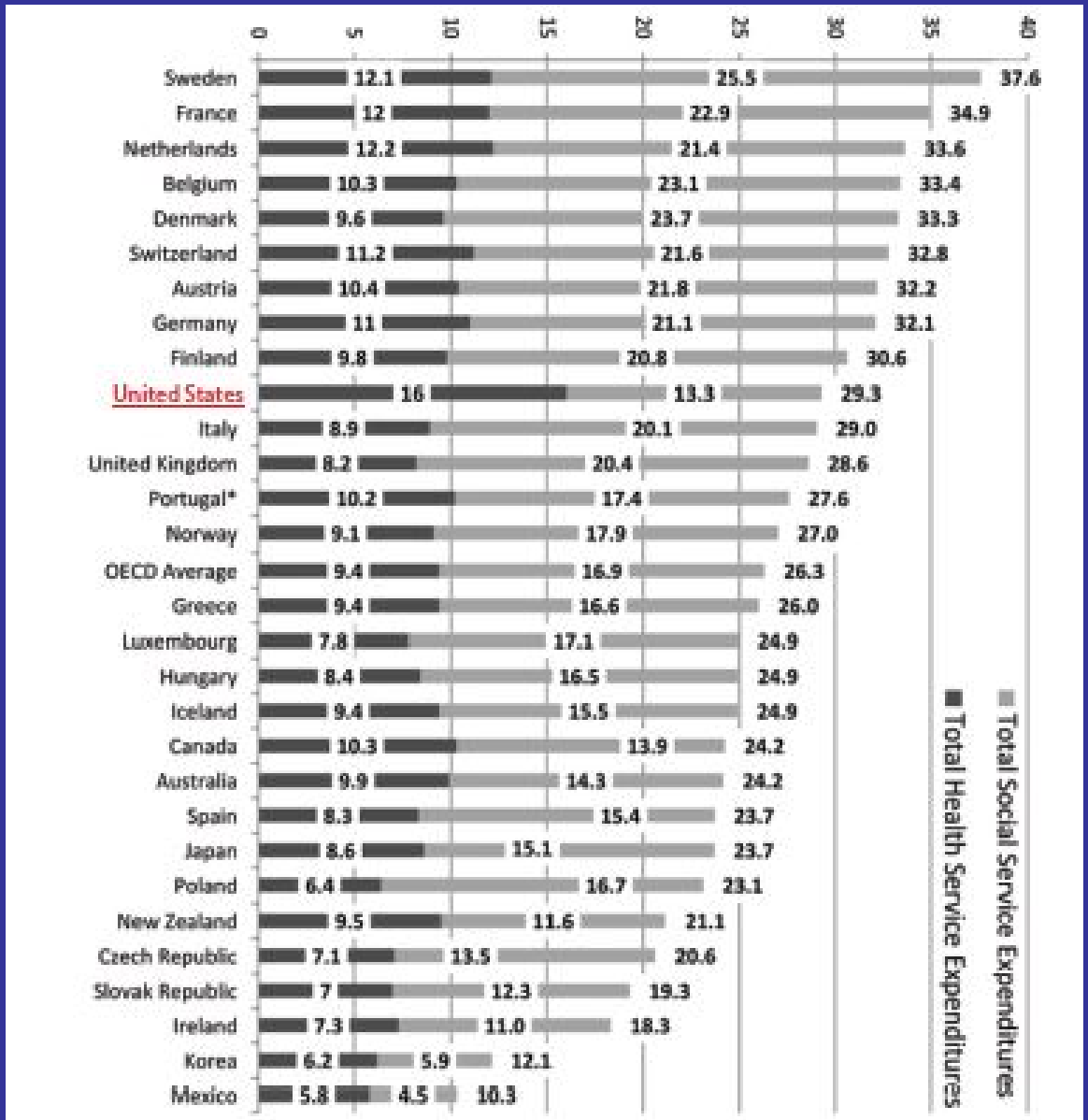
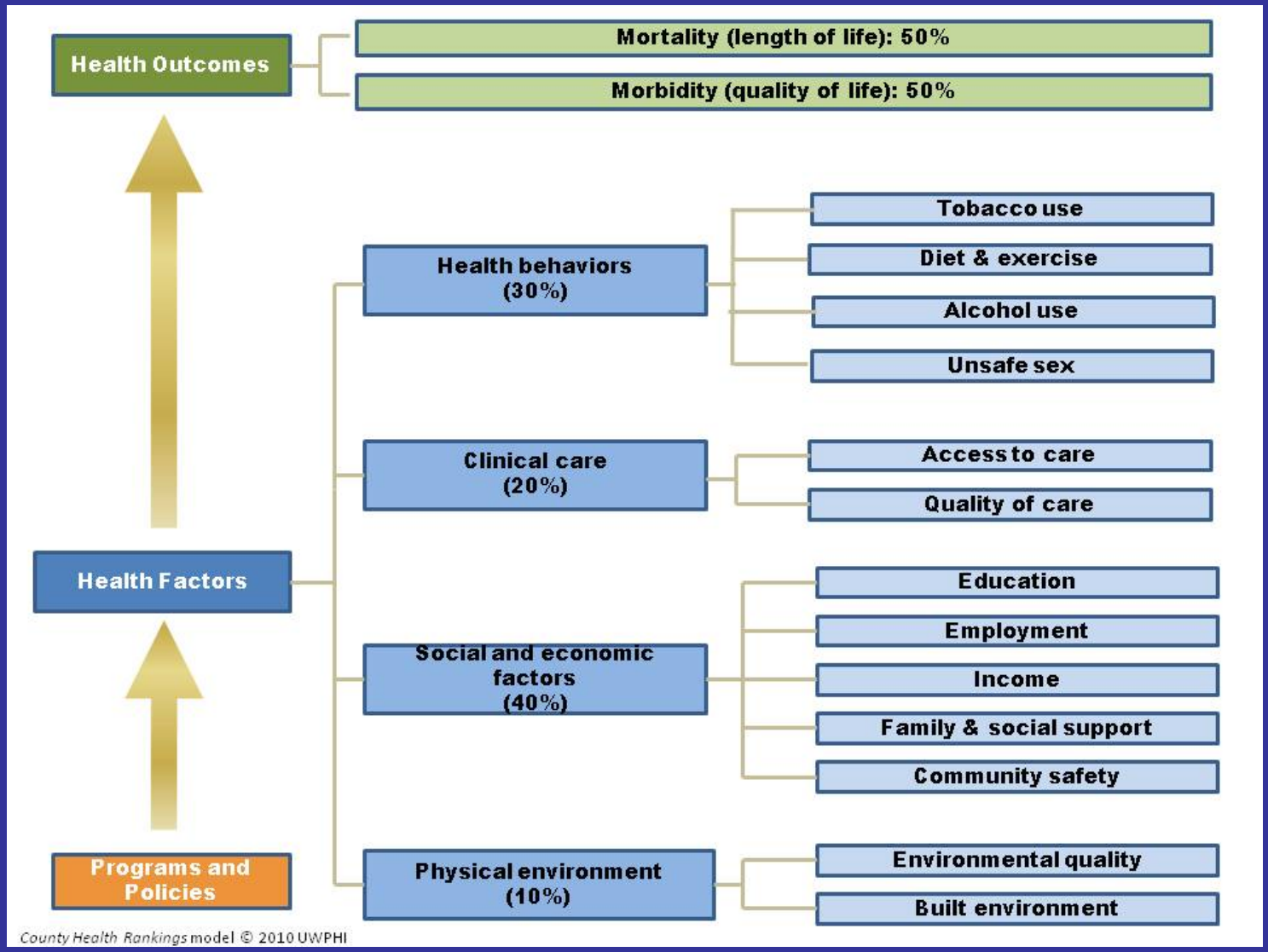
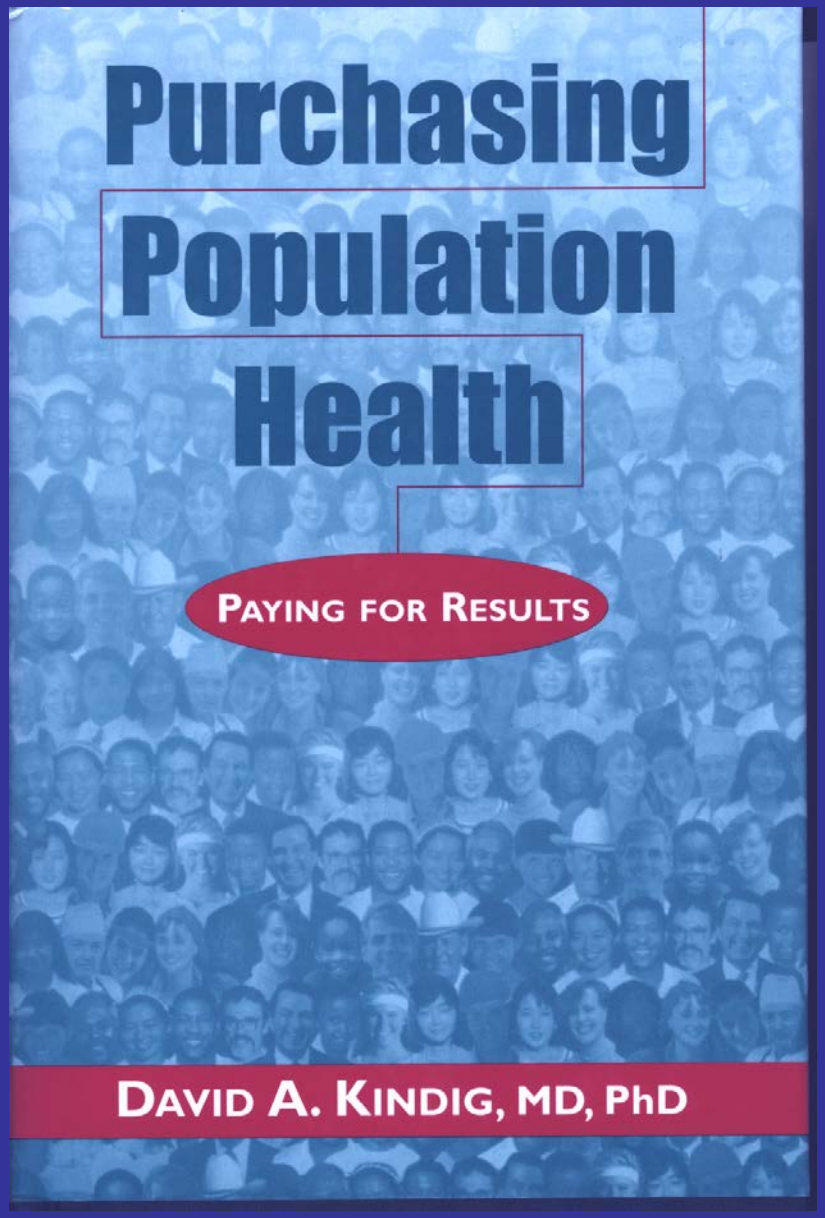


FIGURE 1-1 Average social-service expenditures versus average health-services expenditures as percentages of gross domestic product (GDP) from 1995 to 2005 by country.
SOURCE: Bradley et al., 2011, p. 3.

County Health Rankings: Factors Considered




Purchasing
Population
Health
Paying for Results
David A. Kindig, MD, PhD

“The fundamental assertion of this book is that population health improvement will not be achieved until appropriate financial incentives are designed for this outcome.”

Kindig 1997

SOLID PARTNERSHIPS AND REAL RESOURCES

"What is required is a coordinated effort across determinants between the public and private sectors, as well as financial resources and incentives to make it work."

Kindig JAMA 2006

Improving Population Health
Policy. Practice. Research.
Editor: David A. Kindig, MD, PhD

01/31/2012

Population Health Financing: Beyond Grants

By David A. Kindig, MD, PhD

My professional coming of age took place the late 1960s, in one of the original Office of Economic Opportunity (OEO) neighborhood health centers in the South Bronx. Because the health centers were a part of the larger federal antipoverty strategy, they were founded on a broad view of health (we would call it a population health framework even though that terminology didn't exist then). Health care innovation was the core, with community health workers, health care teams, and the understanding that the residents who didn't use the clinic contributed to overall neighborhood heath as much as those who did.

But the OEO funding paid for much more than health care, including job training, legal advocacy, school health programs, neighborhood built environments – what we now see as the multiple determinants of health. But one of the main lessons of my entire career was the following: when the grant goes away, the programs or innovations which it supported dwindle too. Don't get me wrong: federal and foundation grants are essential for innovation to occur, and I have served productively on both the giving and receiving ends of this equation. But initial funding almost always ends at some point (through change of political priorities or foundation leadership and priorities), and additional funds must be sought for sustainability or going to scale.

Sources of Dependable Financial Support

1. From savings from health care… **Community Benefit reform** and ACO shared savings… or IOM taxes on health care?
2. Health in All policies…more health from what we are already spending in other sectors
3. Government and foundations
4. Businesses understanding the “business case”

Kindig and Isham 2011 draft

RECENT COMMUNITY BENEFIT REFORMS

ACA 2012 Triennial Community Health Needs Assessment

IRS 2009 New Schedule H for Community Benefit Reporting

Current Categories

- Financial assistance at cost
- Unreimbursed cost of Medicaid
- Other means tested government program
- Subsidized health services
- Community health improvement services
- Health professionals education
- Research
- Cash and in-kind contributions

Is Hospital 'Community Benefit' Charity Care?

Erik Bakken, BA; David A. Kindig, MD, PhD

ABSTRACT

Context: The Affordable Care Act is drawing increased attention to the Internal Revenue Service (IRS) Community Benefit policy. To qualify for tax exemption, the IRS requires nonprofit hospitals to allocate a portion of their operating expenses to certain "charitable" activities, such as providing free or reduced care to the indigent.

Objective: To determine the total amount of community benefit reported by Wisconsin hospitals using official IRS tax return forms (Form 990), and examine the level of allocation across allowable activities.

Design: Primary data collection from IRS 990 forms submitted by Wisconsin hospitals for 2009.

Main Outcome Measure: Community benefit reported in absolute dollars and as percent of overall hospital expenditures, both overall and by activity category.

Results: For 2009, Wisconsin hospitals reported $1.064 billion in community benefits, or 7.52% of total hospital expenditures. Of this amount, 9.1% was for charity care, 50% for Medicaid subsidies, 11.4% for other subsidized services, and 4.4% for Community Health Improvement Services.

Conclusion: Charity care is not the primary reported activity by Wisconsin hospitals under the IRS Community Benefit requirement. Opportunities may exist for devoting increasing amounts to broader community health improvement activities.

exemption.[1] Prior to the enactment of the 1969 community benefit standard, hospitals were governed by a financial ability standard, which specified that nonprofit hospitals must provide free or low-cost services to those unable to pay.[2] Although no formal benchmarks existed for the amount of benefit a hospital was to provide, several tax exempt experts have stated that the IRS used a general standard of 5% of operating expenses to qualify for tax exemption.[3,4]

Previous reports have reviewed the history and importance of this policy in considerable detail.[5-9] The current policy environment for community benefit began with the IRS Revenue Ruling 69-545 of 1969, which allowed for more activities to be counted toward tax-exemption but failed to establish concrete standards.[2] In 2006 the Congressional Budget Office (CBO) estimated that in 2002 the total nati

Community Benefits 2009

	WI	US
TOTAL % EXP	7.5	7.5
TOTAL $$	$1B	??
MEDICAID	53%	45%
CHARITY CARE	17%	25%
COMM H IMPR	5%	5%

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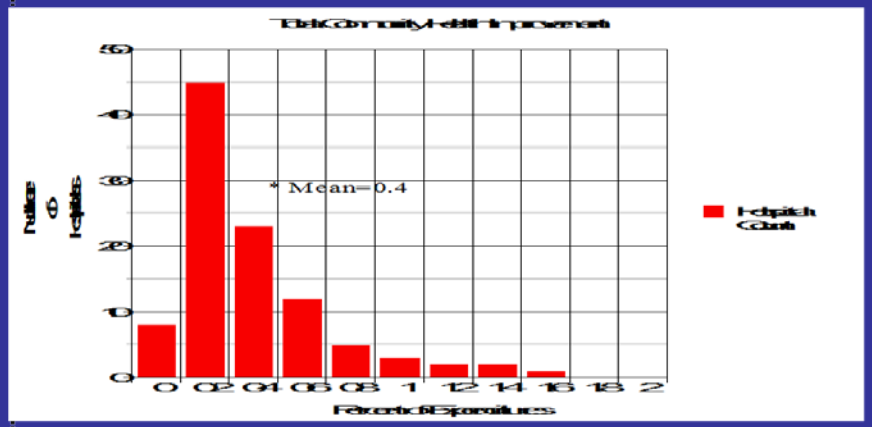

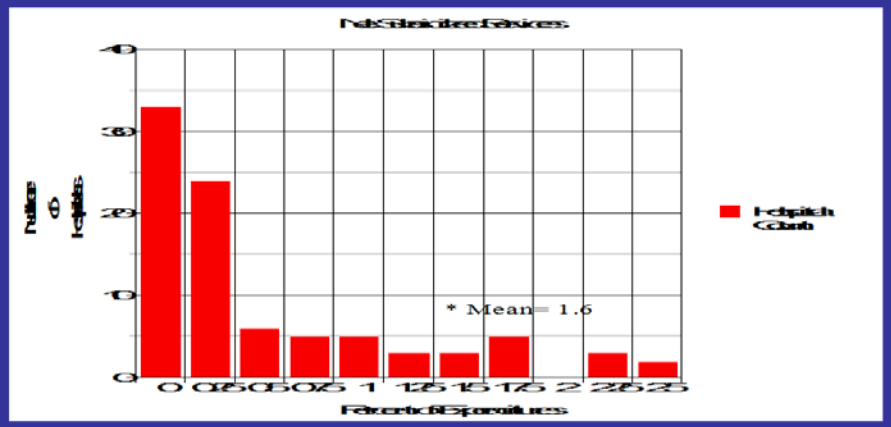

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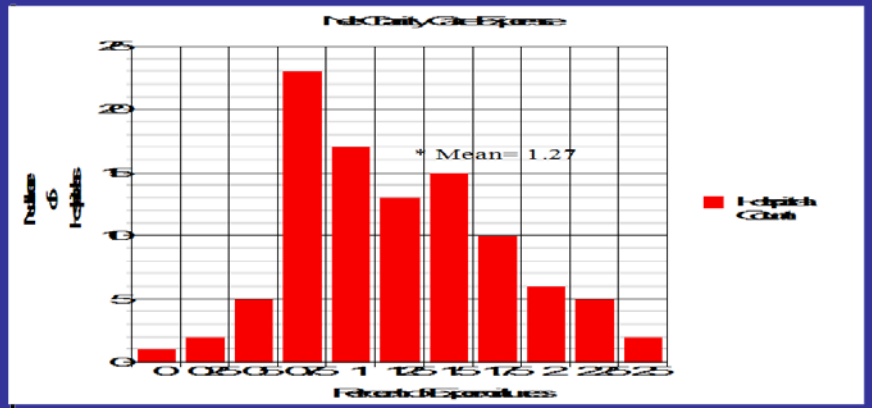

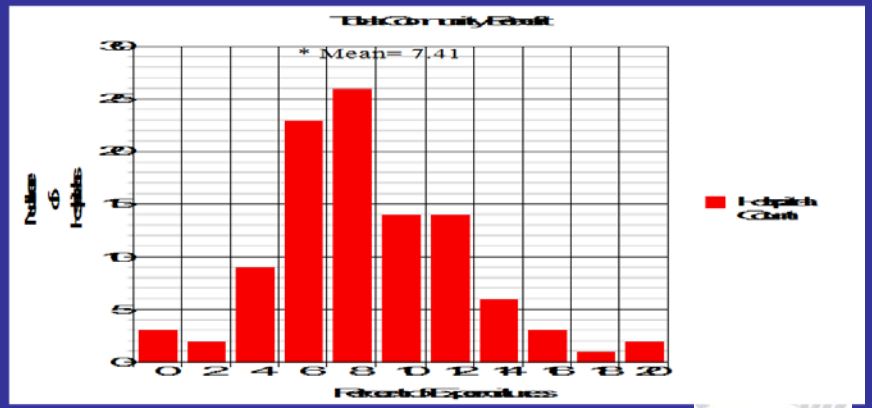

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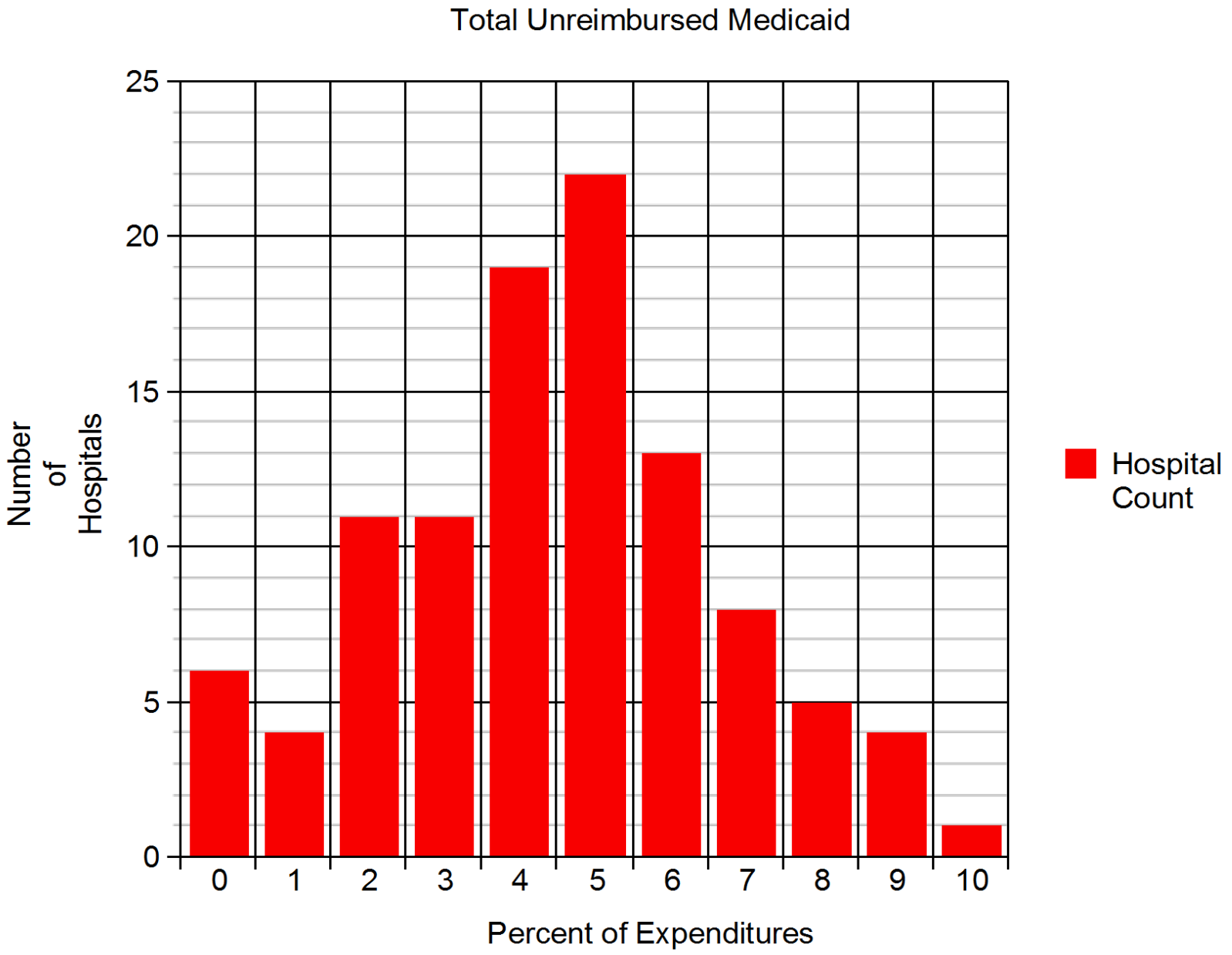
Total Unreimbursed Medicaid
Number of Hospitals
25
20
15
10
5
0
0
1
2
3
4
5
6
7
8
9
10
Percent of Expenditures
Hospital Count

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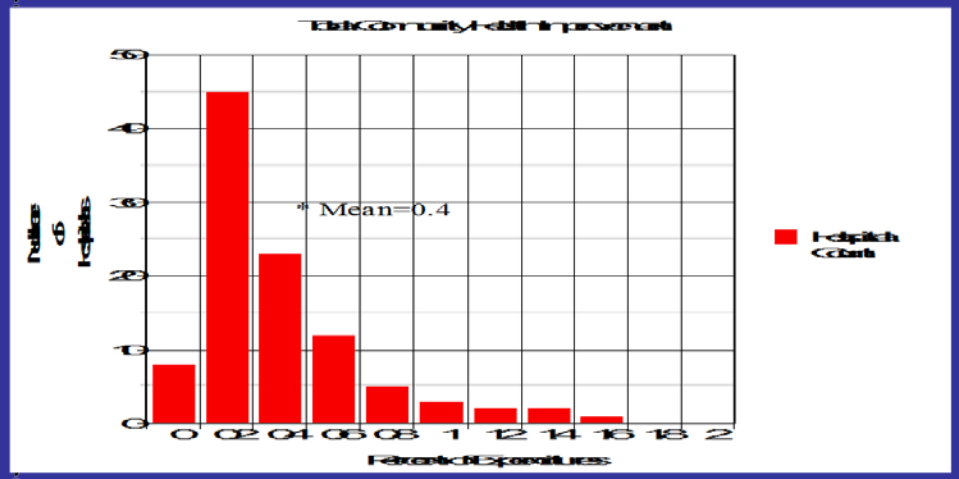

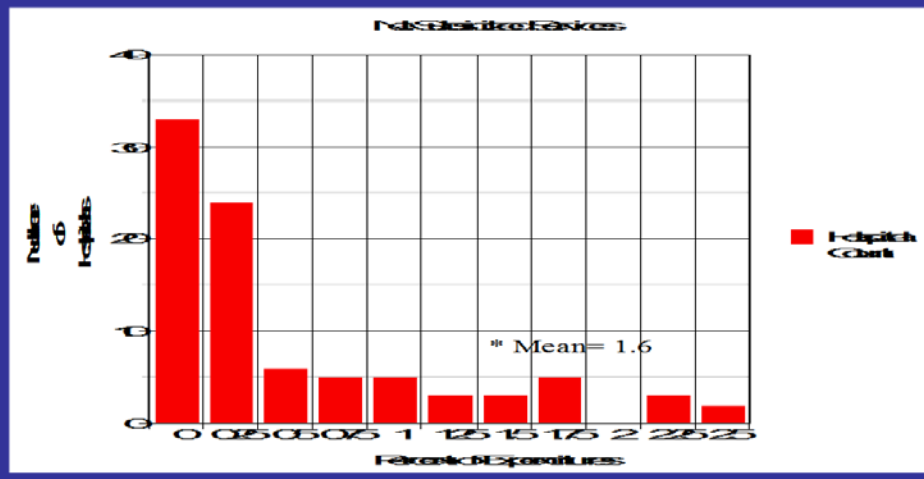

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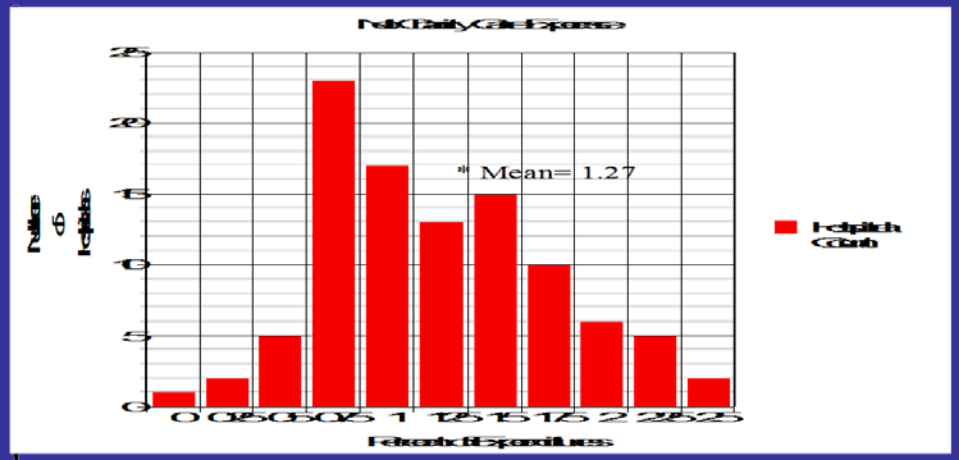

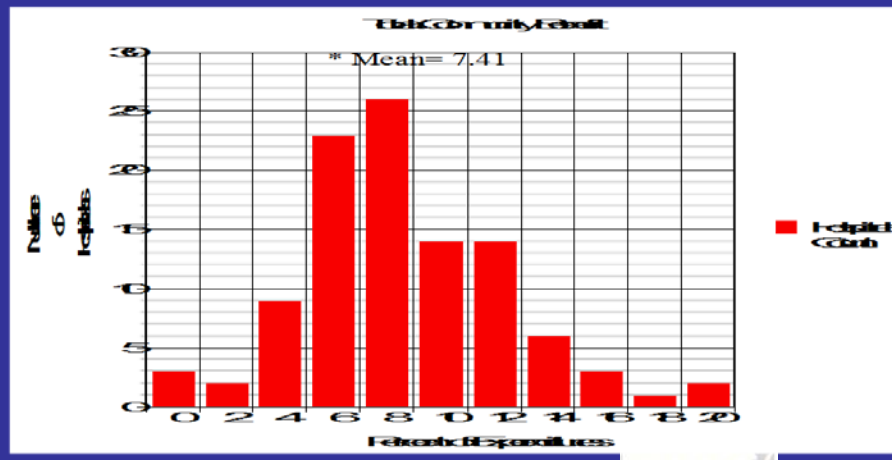

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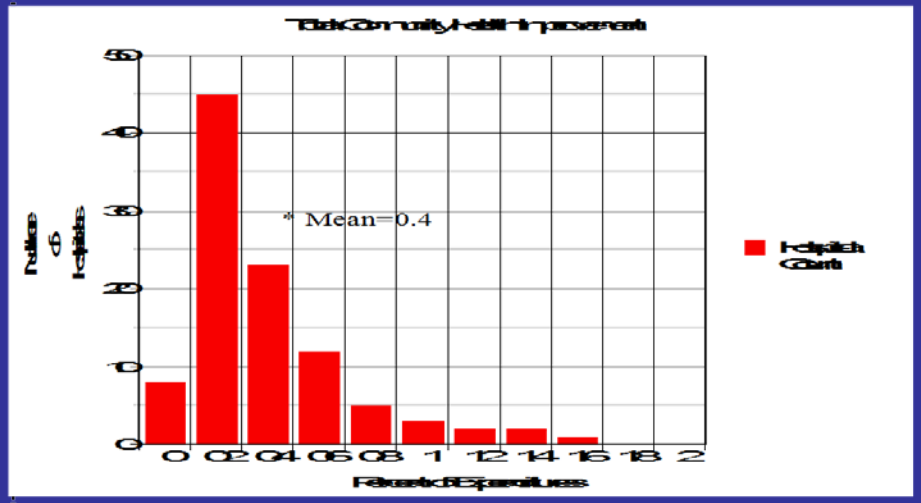
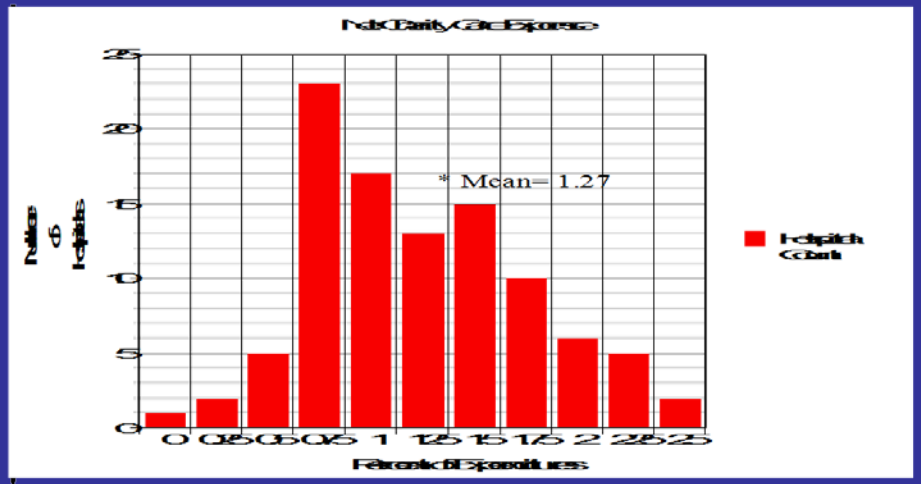
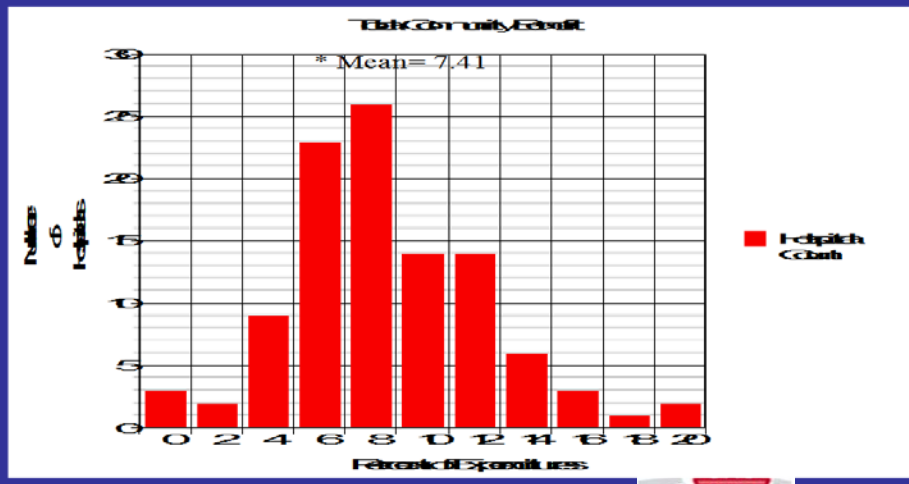






HOSPITAL COMMUNITY BENEFIT:

FROM REPORTING STANDARDS TO EXPENDITURE STANDARDS

County Health Rankings: Factors Considered

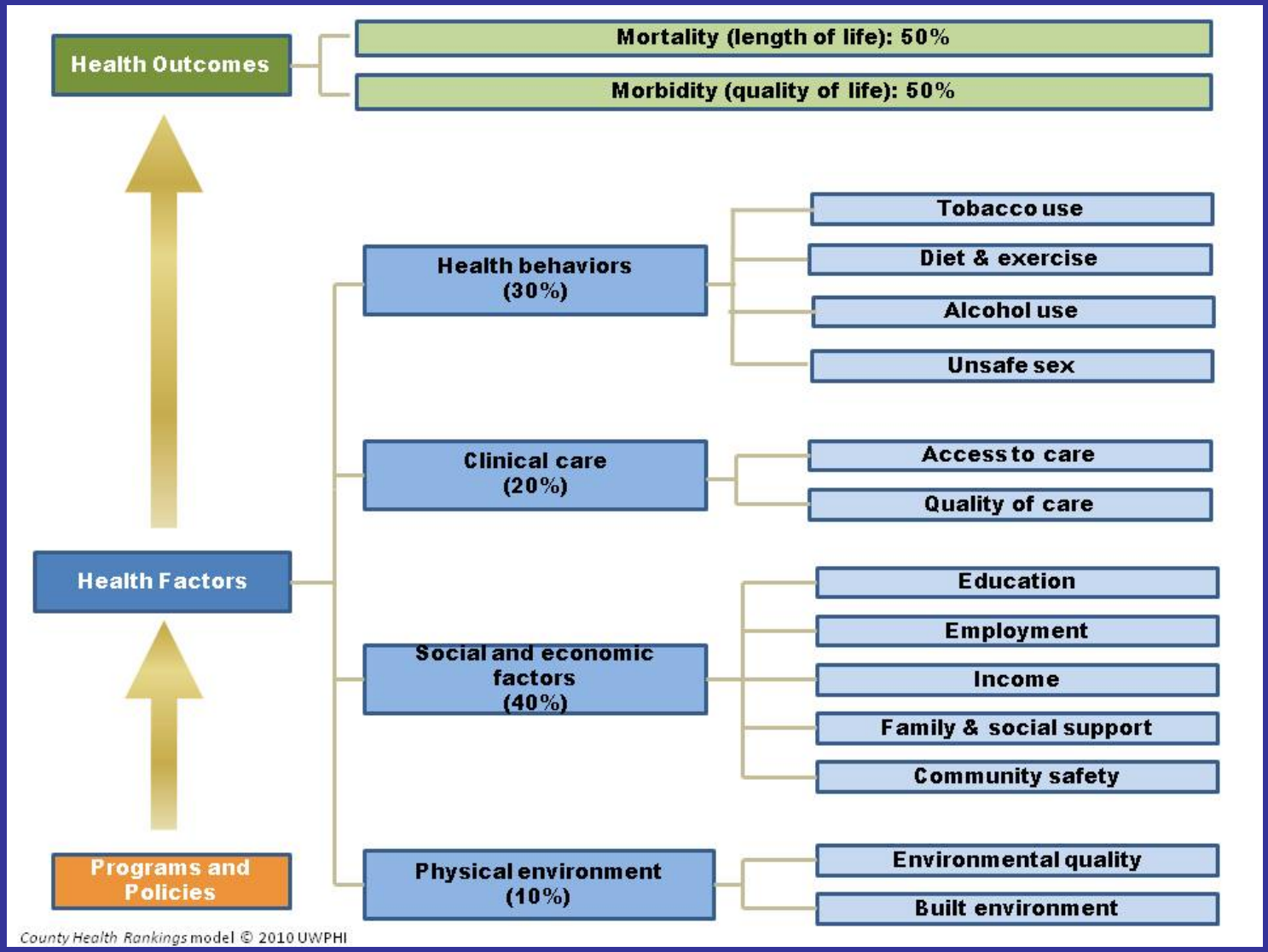
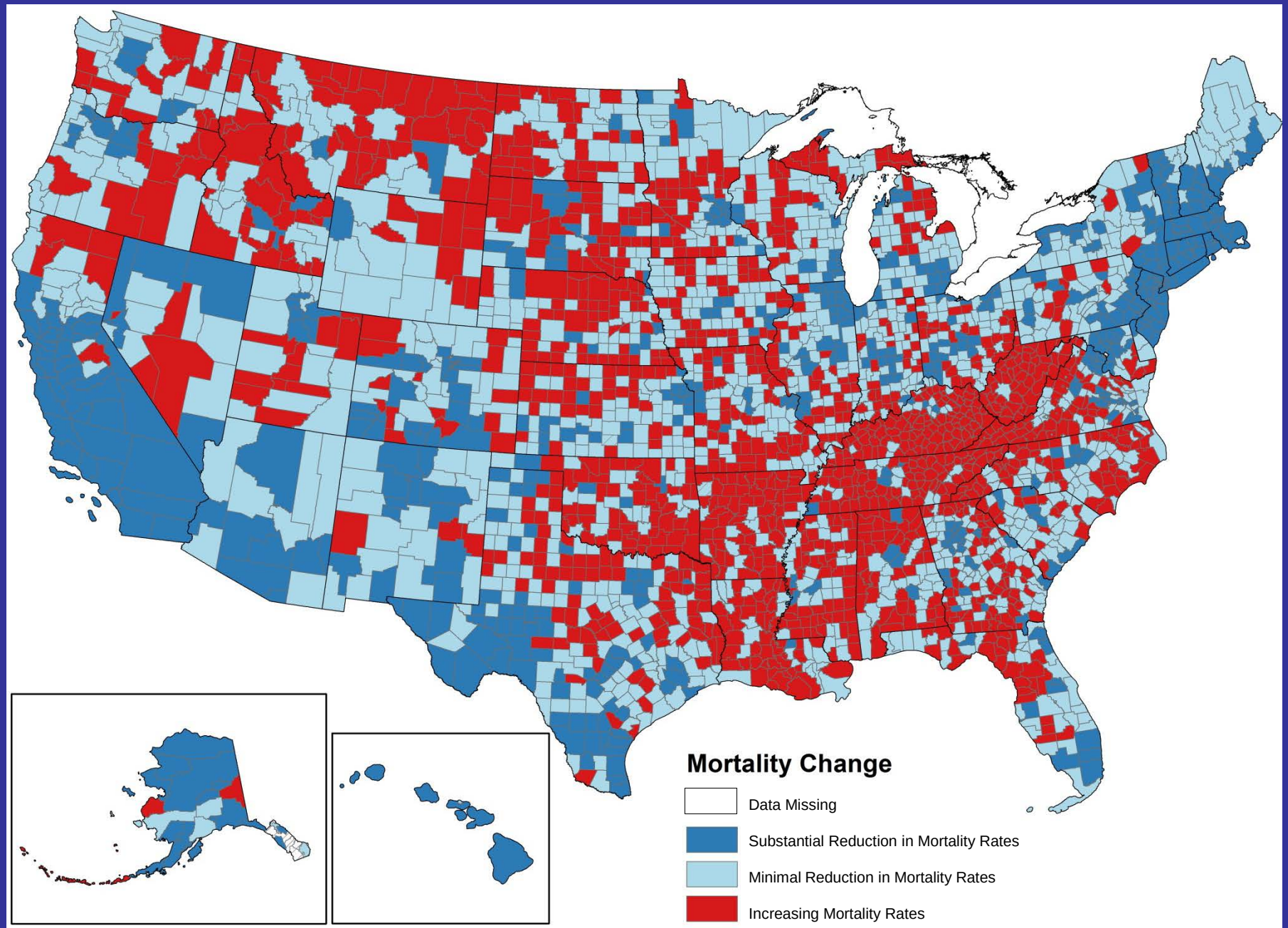


Exhibit 3. Female Mortality Change between 1992-1996 and 2002-2006 among 3,140 U.S. Counties



Results Total

Table 1. Wisconsin 2009 Community Benefit Reporting

State Totals	Total (US dollars)	Average Percent (of total expenditures)	Percent Range
Charity care	96,629,458	1.26	0-9.50
Unreimbursed Medicaid	536,292,658	3.95	-3.77[a]-9.02
Other means tested government programs	12,908,862	0.11	0-2.70
Community health improvement services	47,137,597	0.40	0-7.10
Health professionals education	136,358,971	0.37	0-6.38
Subsidized health services	121,300,534	1.29	0-17.78
Research	15,951,185	0.04	0-1.48
Cash and in-kind contributions	18,194,501	0.16	0-1.14
Community benefit total	1,064,802,784	7.52	-2.59*-20.50

[a]These negative numbers come from 4 hospitals due to 2009 hospital tax assessment revenues and differences between calendar year and fiscal year dates. However, negative figures were listed on only 2 of the 108 forms examined, with a negligible effect of the overall data.