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POLICY, RESEARCH, & PRACTICE

Issue Brief • June 2014

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NEW YORK 2010 COMMUNITY BENEFIT PROVISION

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COMMENTARY

In order to achieve the "Triple Aim" for all New Yorkers, which is to improve health, lower costs, and provide better care, New York State has embarked on wide-ranging reform of its health sector. Key initiatives of the reform—including the Delivery System Reform Incentive Payment (DSRIP) Program,[1] the pending State Health Innovation Plan (SHIP),[2] and the Prevention Agenda[3]—are all elements of a future health system that focuses on the total health of the population and better aligns payment to reward higher quality care rather than simply more care. In this environment of reform, there is a new opportunity to leverage all existing resources to create a more efficient and effective health care system, and Hospital Community Benefit is one such promising example. With the increasing insurance coverage provided by passage of the Affordable Care Act (ACA), nonprofit hospitals can now use their community benefit programs to support broad-based community prevention rather than primarily focusing on charity or uncompensated care to qualify for federal tax-exempt status. The New York Academy of Medicine (NYAM), whose mission is to advance the health of people in cities, has started to explore this opportunity by commissioning the accompanying analysis of hospital community benefit investments by New York State hospitals.

As is true nationwide, the largest component of health spending in New York State is for hospital-based services. If the goals of health reform are to promote health and save costs, the prevention of unnecessary hospital and emergency room use is critical. To achieve these goals, we must realign the financial incentives for health care providers and invest in the community infrastructure needed to support health in the community. The DSRIP and SHIP programs, which will implement the vision developed through the NYS Medicaid Redesign Team process, will begin to realign the incentive component. The DSRIP will promote community-level collaborations and system reforms to reduce avoidable hospital use, while the SHIP strengthens primary care as a foundation for the health system. Additionally, the NYS Prevention Agenda provides a blueprint for action to address five health priorities aligned with the health care challenges identified under DSRIP. In fact, recent DSRIP guidance begins to integrate hospital and prevention activities by requiring DSRIP applicants to include Prevention Agenda activities in their plans. Implementing such population health activities will be new for almost all providers, and limited resources will continue to be an ongoing challenge. But, a potential source of support for population health improvement is the community benefit requirement for nonprofit hospital tax exemption.

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1 "Delivery System Reform Incentive Payment (DSRIP) Program," New York State Department of Health, accessed May 14, 2014 at http://www.health. ny.gov/health_care/medicaid/redesign/delivery_system_reform_incentive_payment_program.htm

2 "The New York State Health Innovation Plan," New York State Department of Health, accessed May 14, 2014 at https://www.health.ny.gov/technology/innovation_plan_initiative/

3 "Prevention Agenda 2013-2017: New York State's Health Improvement Plan," New York State Department of Health, accessed May 14, 2014 at https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/

Two questions immediately arise around community benefit. First, what is the evidence that investment in community-based prevention improves health while also contributing to cost savings in the health care system? Second, why should hospitals be asked to invest in an activity that, for many, has not been historically seen as their role?

To answer the first question, Sara Rosenbaum, JD, the Harold and Jane Hirsh Professor of Health Law and Policy at the George Washington University School of Public Health and Health Services, notes that numerous governmental reports and studies (such as the Centers for Disease Control and Prevention's *Guide to Community Preventive Services*[4] and the *National Prevention Strategy*[5]) provide conclusive evidence of the link between expenditure in evidence-based community interventions and health improvement.[6] Further, a report by Trust for America's Health (TFAH) and NYAM entitled *A Compendium of Proven Community-based Prevention Programs*[7] highlights 79 evidence-based disease and injury prevention programs across the country that have saved lives and improved health.

With regards to costs, in their 2008 study *Prevention for a Healthier America*,[8] NYAM, the Urban Institute, and TFAH estimated that all-payer net savings in New York State for proven interventions in physical activity, nutrition, obesity, and smoking cessation programs could range from $250m in one to two years to $1.3b in five years and longer term (10-20 year) savings of $1.4b. This data is especially important as it is estimated that 46% of all deaths in NYS are attributable to modifiable behaviors, with the highest numbers linked to tobacco use, poor exercise and diet, and alcohol consumption.[9] Even if there is evidence that investment in community-based prevention improves health and lowers costs, what involvement should hospitals have in these types of programs? Over time, the Internal Revenue Service (IRS) has given nonprofit hospitals seeking tax-exempt status under §501(c) (3) of the Internal Revenue Code stronger guidance to advance the health of the communities they serve in a capacity beyond medical treatment. Providing charity or uncompensated care was initially the typical way in which nonprofit hospitals could qualify for federal tax-exempt status until the IRS introduced "Community Benefit" in 1969 to include activities that advance population health. The IRS formally introduced Schedule H in 2009, and as Rosenbaum notes, it essentially "breathes life into the concept of community benefit"[10] as this addition clarified what hospitals could count as community benefit and provided them with a standardized template for doing so.

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4 "The Guide to Community Preventive Services: What Works to Promote Health," accessed May 14, 2014 at http://www.thecommunityguide.org/library/book/index.html

5 National Prevention Council. 2011. "National Prevention Strategy," accessed May 14, 2014 at http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf

6 Sara Rosenbaum, Amber Rieke, and Maureen Byrnes. 2014. "Encouraging Nonprofit Hospitals To Invest In Community Building: The Role Of IRS 'Safe Harbors,'" Health Affairs, accessed May 14, 2014 at http://healthaffairs.org/blog/2014/02/11/encouraging-nonprofit-hospitals-to-invest-in-community- building-the-role-of-irs-safe-harbors/

7 A Compendium of Proven Prevention Programs, accessed May 14, 2014 at http://healthyamericans.org/assets/files/Compendium_Report_1016_1131.pdf

8 Jeffrey Levi, Laura M. Segal, and Chrissie Juliano. 2008. Prevention for a healthier America: investments in disease prevention yield significant savings, stronger communities. Washington, D.C.: Trust for America's Health, accessed at http://healthyamericans.org/reports/prevention08/Prevention08.pdf

9 Actual Causes of Death in the United States, JAMA, March 2004, 291(10) and NYS 2009 death data (NYSDOH)

10 Sara Rosenbaum, Amber Rieke, and Maureen Byrnes. 2014. "Encouraging Nonprofit Hospitals To Invest In Community Building: The Role Of IRS 'Safe Harbors,'" Health Affairs, accessed May 14, 2014 at http://healthaffairs.org/blog/2014/02/11/encouraging-nonprofit-hospitals-to-invest-in-community- building-the-role-of-irs-safe-harbors/

Effective for tax years beginning after March 23, 2012, hospitals are to collaborate with local stakeholders to develop a community health needs assessment. The assessment must include input from community members and public health experts, and additional assessments are to be conducted every three years. In between, hospitals must implement strategies to address the identified needs.[11] The information from the hospitals' community health needs assessments is to inform the community health improvement activities that hospitals implement. The assessments may highlight community concerns they can help address, such as pedestrian and bicycle injuries related to inadequately designed intersections, and incidents of asthma related to housing infrastructure.

Activities supported in both the "community health improvement" and "community building" categories of Schedule H that advance the health of populations generally underscore the mission of nonprofit hospitals. Kaiser Permanente's leadership created a Community Benefit Committee of its Board of Trustees to oversee and steer their significant community benefit investing system-wide. The former CEO George Halvorson expressed that, "We believe that community benefit is too important to just be something we peripherally do as a side agenda with no board insight or involvement."[12] Key industry leaders, such as the Catholic Health Association, have also taken notice of the significance of community benefit. They sought to support and increase the role of hospital efforts to improve health because these activities are "integral to the mission of Catholic and other not-for-profit health care organizations."[13]

Consistent with the national directives from the ACA to support hospitals' ability to "take credit" for a wider range of community-based investments, former NYS Health Commissioner Nirav Shah charged hospitals and local health departments to collaborate when developing required community plans. Specifically, he directed that hospital Community Service Plans (2013-2015) and the Local Health Department Community Health Assessment and Community Health Improvement Plans (2014-2017) be developed together with local stakeholders and that communities identify and address two Prevention Agenda priorities, with one of those priorities addressing a health disparity.[14] The Community Service Plan mirrors the Community Health Needs Assessment and Improvement Strategy required for nonprofit hospitals per the ACA.[15] These plans were submitted in November 2013 and are serving as the basis for community action on the Prevention Agenda statewide.

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11 The Patient Protection and Affordable Care Act, accessed May 14, 2014 at http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

12 "Celebrating Our Community Benefit Outreach," December 2, 2011, accessed May 14, 2014 at http://share.kaiserpermanente.org/article/celebrating- our-community-benefit-outreach/

13 "Overview," accessed May 14, 2014 at http://www.chausa.org/communitybenefit/community-benefit

14 Nirav R. Shah. 2012. "Memo from Commissioner Shah," New York State Department of Health, accessed May 14, 2014 at https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/docs/cover_letter.pdf

15 "Community Planning Guidance," accessed May 14, 2014 at http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/docs/planning_guidance.pdf

Many hospitals across NYS are already active members of Prevention Agenda community coalitions.They are asked to address Prevention Agenda priorities in their DSRIP plans. In many cases the local coalitions will be tackling the same health issues as those selected by the hospitals. Over time, they can align their community benefit investments in these community-based activities to increase both their health care savings and improve the community's health. For example, a community that has a high prevalence of diabetes can increase enrollment in the CDC-recognized National Diabetes Prevention Program (NDPP), an evidence-based program that has been shown to help reduce participants' risk of developing diabetes. Hospitals can identify patients with pre-diabetes or at high risk for onset of diabetes and refer them to institutional or community NDPP delivery sites.[16]

In 2014, NYS will further reinforce the importance of increased hospital investments towards community health improvement by requiring nonprofit hospitals to report to the NYSDOH their expenditures in all categories of their Schedule H forms. These data will provide valuable information for tracking future "community health improvement" and "community building" investments.

The hospital community benefit program appears to be an important opportunity for hospitals to further advance New York State's path towards the Triple Aim. The following paper by Erik Bakken and David Kindig was commissioned by NYAM to better understand the extent and nature of the most recently available hospital community benefit investments by NYS hospitals. A companion analysis of NYS hospital community beneifit reports for 2013 will be produced over the summer to provide a potential baseline for reports to the Department of Health scheduled to begin for 2014.

The authors thank Shara Siegel, Policy Associate at The New York Academy of Medicine, for her diligent research support.

16 "New York State Delivery System Reform Incentive Payment Program Project Toolkit," accessed May 14, 2014 at http://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_project_toolkit.pdf

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METHODS

All data was provided through Guidestar, a nonprofit financial data clearinghouse, for the 2010 year. At the time of this study, this was the latest year for which a complete set existed for all hospitals. The information was obtained from direct PDF copies of the IRS 990 form, the annual tax-filing document required for nonprofit organizations. The time lag is due to the delay from the IRS in making the information public via Guidestar. In addition to general financial information (expenses, revenue, etc.), the 990 form contains Schedule H, a section mandated for hospitals dealing with community benefit provision for tax-exemption purposes.

For this New York analysis, 298 hospitals and satellite facilities were included, with two hospital facilities omitted due to unavailability. However, only 145 listings are contained in the data set, because hospital systems often file jointly with multiple facilities on the same form. The 990 form lists the hospitals included for joint filings, but it fails to differentiate community benefit allocation for each. In our experience working with multiple states, the degree of joint filing has diminished compared with the 2009 year.

Hospitals were split by size based on revenue, with large hospitals having revenues greater than $300 million, medium with revenues less than $300 million and greater than $150 million, and small hospitals with revenues less than $150 million. These categories were based on those used in a national study survey conducted by the American Hospital Association in 2012. The data set contains, in addition to individual hospital data, summary statistics (mean, median, variation, and confidence intervals) for the state and by size category. Negative figures (revenue greater than expenses) are not uniformly reported on the 990, with some hospitals subtracting these against their total amount reported, while others do not subtract the negatives. Due to this lack of uniformity, these figures are reported as listed.

There are seven categories of allowed community benefit activity reported on the 990 filings. These are defined in IRS guidelines as follows:

- *Financial assistance at cost,* commonly referred to as charity care
- *Unreimbursed Medicaid and other means tested government programs,* which is the "net cost" to the organization for providing these programs
- *Subsidized health services* are clinical inpatient and outpatient services provided by the hospital despite a financial loss, which would be otherwise undersupplied to the community

- *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
- *Health professional education* includes the net cost associated with educating certified health professionals
- *Research* includes the cost of internally funded research as well as costs related to research funded by a tax-exempt or government entity
- *Cash and in-kind* contributions include contributions to community benefit activities made by the organization to community groups

There are three additional supplemental categories that are reported but not allowed to be counted as community benefit. These are:

- *Bad debt,* which includes the portion of bad debt that 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 include activities not reportable in other parts of the Schedule H but which protect or improve community health and safety, including housing, economic development, environmental improvement, leadership development, and coalition building

RESULTS

Table 1 shows that in 2010, nonprofit hospitals in New York State reported almost $4 billion of expenditures on community benefits. On average, this constituted 9.81% of total hospital expenditures, with a range of 0.55% to 46.33%. One-and-a-half billion dollars of community benefit expenditures were the costs of unreimbursed Medicaid expenses. However, this category averaged 37.9% of total community expenditures, due to negatives (reimbursement greater than costs). Education of health professionals was the second greatest expense at 1.3 billion dollars in total, or 31.5% of total community benefit share. Charity care and subsidized services had similar portions of average overall community benefit share at 11.0% and 12.2% of total share, respectively. Only 166 million was reported for community health improvement, which constituted 4.2% of total community benefit.

Considerable variation was seen across the hospitals as shown by the ranges in Table 1. Total community benefit varies across the three with large hospitals reporting an average of 10.9% of expenditure, medium 8.0%, and small 6.7%.

New York hospitals allocate an additional 583 million dollars on supplemental activities, or 1.46% of expenditures. This figure is artificially deflated, again due to negatives (hospitals profited), chiefly in the reimbursement rate of Medicare. These categories were not deemed allowable by the IRS when the Schedule H was designed, though many hospital groups lobbied for the inclusion of one or more to be counted as a legitimate benefit. However, these were deemed by the IRS to be important for research purposes, and thus included on the form in a separate section of Schedule H. These categories are included in Table 2 below.

Particular focus was paid to the community-building category, due to its public health potential. These allocations were only 17.7 million statewide, or 0.04% of total expenditures for nonprofit hospitals. On a positive note, the 2010 form differentiates these dollars with nine subcategories. However, due to the small amount of dollars toward community building and the large number of subcategories, this spending appears only in total in the data set.

Table 1. New York 2010 Community Benefit Reporting

Category	Total (millions of dollars)	Percent (of total expenditures)	Percent Range
Charity care	437	1.09%	(-2.41) - 23.17%
Unreimbursed Medicaid	1,498	3.72%	(-7.80) - 30.35%
Other means-tested government programs	40	0.10%	(-3.25) - 55.0%
Community health improvement services	166	0.41%	0 - 10.62%
Health professionals education	1,245	3.09%	(-2.02) - 8.62%
Subsidized health services	485	1.20%	(-0.09) - 13.98%
Research	89	0.22%	0 - 2.96%
Cash and in-kind contributions	14	0.04%	0 - 0.78%
Community benefit total	3,949*	9.81%	0.55 - 46.33%

Table 2. New York 2010 Form 990 H Supplemental Category Reporting

Supplemental categories	Total Expenditures (millions of dollars)	Average Percent of Expenditures	Percent Range
Community building expenses	18	0.04%	0 - 3.22%
Bad debt attributive to charity care	158	0.39%	(-1.38) - 3.29%
Unreimbursed Medicare	414	1.03%	(-34.31) - 53.16%
Supplemental measures total	590	1.46%	(-26.74) - 56.75%

* Note: the overall total differs from the total derived from adding the individual categories due to the inconsistencies in the treatment of negative figures. The few negative listings in the data are uncommon, but warrant explanation. These can occur from time lag in reimbursement or carry over in government programs (Medicare, Medicaid, other programs, or educational subsidies), or from the accumulation of small profits in certain categories (charity care or subsidized services). For example, if a hospital is providing chiefly reduced care for charity care, which does not exceed the total collection, a profit (negative figure) is produced.

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