Non-Profit Hospitals and Community Benefits: A Comprehensive Analysis

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Non-Profit Hospitals and Community Benefits: A Comprehensive Analysis

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Abstract

Purpose: The provision of community benefits in exchange for tax-exemption status for Not-for-Profit (NFP) Hospitals has been a topic of scrutiny for decades; many of the adequacy of benefits provided relative to the amount of foregone governmental tax revenue. In light of recent policy enactments, most notably the Affordable Care Act (ACA), there has been a resurgence of this issue back into the healthcare agenda due to the predicted subsequent decline of uninsured persons within the U.S. This is the purpose of this study to analyze the patterns of community benefits as well as non-uncompensated care such as Medicaid Shortfalls and Bad Debt. In addition, this study will attempt to interpret environmental factors that are believed to also contribute to community benefit provision relating to the theory of Organizational Legitimacy. These levels will then be compared against For Profit (FP) and Government Owned (GO) hospital’s benefit levels to determine the relative importance of their benefit provisions.

Methods/Data: This study analyzes a unique longitudinal dataset derived from the Form CMS-2552-96 Cost Report Data files of the Centers for Medicare & Medicaid Services (CMS). The dataset contains 8 years of observations covering fiscal years 2003-2010 on various individual hospital characteristics, costs, and ownership type. Panel regression methods will be used to evaluate the determinants of hospital community benefits.

Discussion/Conclusions: The extant empirical literature on how to properly measure and evaluate the level of community benefits provided by hospitals remains unclear if not limited in its methodological scope and geographic coverage. By using a nationwide longitudinal analysis, this study attempts to contribute additional insight into the factors that affect the hospital provision of community benefits by utilizing a more comprehensive analytical framework. We also expect to find that other socioeconomic and community-level factors may have a larger influence in the provision of these benefits than previously thought.

Introduction

Community Benefits Defined

Activities considered community benefits up until the introduction of IRS Form 990 and Schedule H were all but clear as to what should be included; however, two predominant viewpoints seemed to present themselves. The conservative definition typically included uncompensated care, other public goods services that are not billed, medical research, and taxes for FP hospitals. A more inclusive definition included Medicare shortfall, Medicaid shortfalls, price discounts to privately insured patients, and medical education. In addition, the Attorney General’s Office in Massachusetts compiled a list of acceptable community benefit activities but stated that the list was not all-inclusive. Due to the varied definition of community benefits the effectiveness and levels of its provision varied widely among studies. As a result of the inconsistent nature of community benefit measures and reporting the IRS redesigned Form 990 to include Schedule H, which set community benefit standards adopted from the Catholic Health Association’s (CHA) reporting standards. In effect, the form looks at both qualitative and quantitative information to remedy the inconsistent methods historically used to calculate the monetary value of charity care provision. NFP hospitals must file Form 990 annually to maintain their IRS Revenue Code 501(c)(3) tax-exempt status. The code requires disclosure of community benefit practices as well as hospital demographic information for tax-exempt organizations. Hospitals must disclose patient mix, emergency rooms, board of directors, medical staff privileges, medical research, professional education and training, uncompensated care and community programs. Form 990 and Schedule H are an important tool to, “Combat the lack of transparency surrounding the activities of tax-exempt organizations that provide hospital or medical care.” Form 990 and Schedule H are an important tool to, “Combat the lack of transparency surrounding the activities of tax-exempt organizations that provide hospital or medical care.” Below is a list of the subsections required by the IRS:

1. Charity Care and Certain Other Community Benefits
2. Community Building Activities
3. Bad Debt, Medicare, and Collection Practices
4. Management Companies and Joint Ventures
5. Facility Information
6. Supplemental Information

State Regulations

Prior to the implementation of the redesigned Form 990 several states enacted legislation to ease the transition of heightened disclosure for hospitals. Of these state regulations, 14 required some level of mandatory reporting with seven of these requiring only charity care (AL, GA, MS, NM, VA, WV, WI).27 Of the 20 states that have voluntary reporting; community benefits are reported to the State Hospital Association, the State Attorney General or both.28 Ten states have a mix of mandatory and voluntary requirements and seven states have no reporting legislation at all (AZ, AK, LA, NY, SD, VT, ME).29 A review of the efficacy of these laws found that states with specific benefit requirement levels yielded NFP hospitals with increased volumes of charity care and other community benefit activities and the provision of these benefits were largest in states with the most strict requirements.30

Organizational Legitimacy

An intriguing topic related to the controversy surrounding community benefits, which is the idea that in order for hospitals to be perceived as a legitimate organization by the community they serve they must in turn provide some level of benefit to that community.17 It is environmental pressures and hospital interests that dictate the level of community benefit that is provided.11 Examples of these include gov. regulations, community expectations, and competition from other NFP, FP, and GO hospitals.31

Gaps in the Literature

The literature lacks a comprehensive nature; a study that looks at all states, over time, and includes diverse community benefit measures. It is the purpose of this study to analyze patterns of community benefits for NFP, FP, and GO hospitals in an attempt to better shed light on the dynamic factors that play into community benefit provision.

Methods/Data

This study analyzes a unique longitudinal dataset derived from the Form CMS-2552-96 Cost Report Data files of the Centers for Medicare & Medicaid Services (CMS). The dataset contains 8 years of observations covering fiscal years 2003-2010 on various individual hospital characteristics, costs, and ownership type. Panel regression methods are used to evaluate the determinants of hospital community benefits.

Preliminary Results

The general econometric model is specified as follows:

**Level of Community Benefits = f (hospital level characteristics, community characteristics, hospital market concentration in health service area, state level regulations)**

Where the level of community benefits is indicated by the cost of uncompensated care as reported in the Form CMS-2552-96 Cost Report Data Files. Data on hospital level characteristics are also taken from the CMS Cost Data files. Data on community characteristics and state level regulations are still being collected.

Early empirical analyses of the CMS cost data though have provided some initial insights into the determinants of uncompensated care costs. Once data collection is completed, a more thorough and comprehensive econometric analysis will be undertaken.

Panel Regression Results: Determinants of Hospital Community Benefit Levels, FY 2003-2010 (Panel N=32,733 hospital-year observations)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>OLS</td>
<td>Fixed Effects (FE)</td>
<td>HSA, FE</td>
</tr>
<tr>
<td><strong>Hospital Bed-Days</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In_beds</td>
<td>0.334*** (0.060)</td>
<td>-0.396*** (0.062)</td>
<td></td>
</tr>
<tr>
<td>HSA_pr10k_bed_days</td>
<td></td>
<td>0.001 (0.001)</td>
<td></td>
</tr>
<tr>
<td><strong>Total Costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In_hcost</td>
<td>0.708*** (0.054)</td>
<td>1.561*** (0.068)</td>
<td></td>
</tr>
<tr>
<td>HSA_per capita cost</td>
<td>0.035*** (0.006)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ownership</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reference category is non-for-profit hospitals</td>
<td>0.062 (0.051)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td>0.466*** (0.066)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Market concentration</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>r2</td>
<td>0.108 (0.016)</td>
<td>12.009 (7.767)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.454</td>
<td>0.131</td>
<td>0.055</td>
</tr>
</tbody>
</table>

Three panel regression models are presented. Model 1 is a simple OLS model, Model 2 is a fixed effects model that controls for all unobserved hospital-level time-invariant variables. The dependent variable for Models 1 and 2 is the natural logarithm of individual hospital uncompensated care costs in dollars. Model 3 is a fixed effects model where the dependent variable is the health service area (HSA) level uncompensated care costs in dollars. The preliminary results suggest hospital size (as indicated by both beds & total cost) and ownership type are significant determinants of uncompensated care costs. Model 1 results also show a positive relationship between hospital market concentration and uncompensated care costs.

References