A Review of Community Benefit Reporting by Critical Access Hospitals in Oregon

Prepared for:

The Oregon Office of Rural Health

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INTRODUCTION

This report was prepared by Verité Healthcare Consulting, LLC (Verité) at the request of The Oregon Office of Rural Health. The project was funded by the Rural Hospital Flexibility Grant Program, also known as the Flex Program, a federally-funded grant program established by the Balanced Budget Act of 1997.

The 2015-2018 Flex Program assists Critical Access Hospitals (CAHs) in four core areas: (1) Quality Improvement, (2) Financial and Operational Improvement, (3) Population Health Management, and (4) Emergency Services Integration. The overall goal of the program is to ensure the sustainability of CAHs and improve health in rural communities through targeted technical assistance and training.

This 2016 – 2017 scope of work included a project to provide strategic guidance and technical assistance to select Critical Access Hospitals to improve their community benefit reporting. This report summarizes how the project was carried out and provides findings and recommendations.

The report:

- Provides background on hospital community benefit reporting;
- Discusses the project's methodology;
- Compares Oregon's Community Benefit Reporting (CBR) Form and instructions with IRS Form 990, Schedule H and its instructions;
- Describes issues leading to under-reporting and over-reporting of community benefit by critical access hospitals that participated in the project;
- Identifies additional issues associated with federal tax-exemption requirements as described in section 501(r) of the Internal Revenue Code; and,
- Summarizes conclusions and recommendations.

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HOSPITAL COMMUNITY BENEFIT REPORTING

The first framework for hospital community benefit reporting was published by the Catholic Health Association of the United States (CHA) in 1989 in a document entitled *Social Accountability Budget: A Process for Planning and Reporting Community Benefit.* CHA developed this document for many reasons. Prior to its publication, questions were being raised by policy makers, academics, reporters, and others regarding why the federal government (and other levels of government) had granted tax-exemption to well over one-half of U.S. hospitals. Questions focused on the extent to which tax-exempt hospitals operated differently than for-profit, taxable facilities, and about whether tax-exempt hospitals were providing sufficient benefits to their communities in return for their exemptions. CHA observed that the field lacked a generally accepted definition of "community benefit" and lacked generally accepted methodologies for accounting and reporting expenses for community benefit activities and programs.

The *Social Accountability Budget* included a series of definitions, worksheets, reporting formats, and accounting guidelines to address these concerns. Since 1989, its methodologies have been adopted and adapted by states, including Oregon, that require hospitals to report their community benefits.

The CHA materials have been updated and refined over the years, including a substantial update published in 2006 as *A Guide to Planning and Reporting Community Benefit*, (*Guide*). The 2006 *Guide* provided revised reporting guidelines, including clarifications for "what counts as community benefit" and additional insights regarding investments in community benefit-related infrastructure, planning, evaluation, and communications. Revised editions of the *Guide* were published in 2008, 2012, and 2015, and an update to its chapters on "what counts" and accounting for community benefit will be published in 2017.

In 2007, the Internal Revenue Service developed IRS Form 990, Schedule H. Schedule H incorporated virtually all of the CHA community benefit reporting guidelines. As with the CHA *Guide*, since 2007, Schedule H also has been revised – including various instructions that affect how hospital community benefits are reported.[1]

Also in 2007, The Oregon Health Authority (OHA) was required by HB 3290 to "adopt a cost-based community benefit reporting program that is consistent with established national standards for hospital reporting of community benefits."[2]

In fulfilling that requirement, OHA (in cooperation with the Oregon Association of Hospitals and Health Systems) developed a Community Benefit Reporting (CBR) form and associated instructions. The form and instructions were aligned with community benefit reporting guidelines and schedules published by CHA as of 2006. The first CBRs

[1] Keith Hearle, President of Verité Healthcare Consulting and author of this report, was lead architect of CHA's community benefit accounting guidelines (in the *Social Accountability Budget* and all editions of the *Guide to Planning and Reporting Community Benefit*) and worked extensively with the IRS on instructions to Schedule H.

[2] Community Benefit Reporting Form Instructions, State of Oregon, page 1.

were submitted by each hospital to OHA in 2008, within 90 days of filing a Medicare Cost Report.

Hospital community benefit reporting thus has evolved from a voluntary activity to one required by federal and state government.

Accurate and thorough community benefit reports are important. They are required by government agencies who stipulate that reporting instructions are to be followed; they demonstrate that hospitals are providing community benefits in return for tax-exemption benefits; they provide transparency for communities regarding programs that improve access to care, enhance public health, and advance generalizable knowledge; and in some states they are used to determine whether or not otherwise tax-exempt hospitals must pay property or other taxes.

The Oregon Office of Rural Health, supported by funding from the Flex Program, initiated this project to help small, rural, critical access hospitals in Oregon improve their community benefit reporting.

PROJECT METHODOLOGY

Six critical access hospitals were selected to participate in this community benefit reporting review. Criteria for identifying CAHs to participate included the following:

- At least two "Type A" rural hospitals (fewer than 50 beds and more than 30 miles from the nearest hospital) and at least two "Type B" rural hospitals (fewer than 50 beds and 30 miles or less from the nearest hospital).
- Hospitals located across Oregon rather than concentrated in one particular region in the state.
- Community benefit expenses based on the Oregon CBR that have been either well above or well below average.
- At least one hospital that is part of a multi-hospital health system.
- At least one hospital that files IRS Form 990, Schedule H.

The hospitals that were selected and that agreed to participate included:

- Two Type A and four Type B facilities located across the state.
- Hospitals with net community benefit expenses ranging from under one percent of total operating expense to almost ten percent (excluding Medicare), and ranging from under four percent to over 25 percent (including Medicare).
- One hospital that is part of a multi-hospital system.

- Two hospitals that either submit Schedule H on their own or are included in a Schedule H filing that includes multiple hospital facilities. Based on an IRS Revenue Ruling, the other four have not been required to file IRS Form 990 and Schedule H.

All six of the hospitals (at some point in their histories) applied for and were granted federal income tax exemption under 501(c)(3) of the Internal Revenue Code.

For reference, in 2015:

- There were twelve Type A and twenty Type B hospitals operating in Oregon. Net community benefit expense (as a percent of total expense) averaged 5.5 percent for Type A facilities and 6.0 percent for Type B (excluding Medicare – averages were 8.9 percent and 12.9 percent including Medicare).

- There also were 27 DRG hospitals, with net community benefit expense averaging 11.6 percent of total operating expense (excluding Medicare) and 18.0 percent including Medicare.

To conduct the review, introductory phone conversations were held with each of the six hospitals to learn more about the facilities and the communities they serve. The introductory calls were followed by a data/document request that included: CBR Forms and Worksheets, Schedule H filings (as available), Medicare and Medicaid cost reports, audited financial statements, and other supporting workpapers and materials. In addition, Verité staff downloaded information from each hospital's website, including financial assistance policies (FAPs) and community health needs assessments (CHNAs).

Values reported by each hospital on CBR Forms and on Schedule H were reviewed and assessed for possible under-reporting and over-reporting of community benefit. Unless otherwise stated, CBR Forms for each hospital's fiscal year 2016 were reviewed.

To assist with identifying possible under-reporting, Verité shared an Appendix from the most recently published CHA *Guide* that describes in some detail recommended "categories and definitions" of community benefit. The hospitals were asked to review this most recent CHA guidance to identify opportunities to report additional activities and programs as community benefit.

After reviewing materials from the hospitals, a series of phone and email interactions occurred to ask questions and provide recommendations regarding ways to enhance community benefit reporting. Additional conversations were held regarding alignment of FAPs and CHNAs with final federal regulations published in December 2014 (the 501(r) regulations) that must be met by hospital organizations exempt under 501(c)(3) of the Internal Revenue Code, starting with fiscal (tax) years beginning one year after the final regulations were published.

The project methodology also included reviewing the Oregon CBR Form and its instructions and comparing Oregon's CBR requirements to those associated with IRS Form 990, Schedule H.

Specific feedback on community benefit reporting and FAPs was provided to each hospital individually.

OREGON COMMUNITY BENEFIT REPORTING FORM INSTRUCTIONS

As previously mentioned, Oregon's CBR instructions, published shortly after enactment of HB 3290, "are largely based on standards developed by CHA." Pursuant to HB 3290, the instructions indicate that Oregon hospitals are to estimate the total and net costs associated with the following community benefits[3]:

- Charity care;
- Losses related to Medicaid, Medicare, State Children's Health Insurance Program or other publicly funded health care program shortfalls;
- Community health improvement services;
- Research;
- Financial and in-kind contributions to the community; and
- Community building activities affecting health in the community.

Oregon's CBR Form, designed to capture the above information, is portrayed on the next page.

[3] Source: HB 3290 (2007)

Section 1: Costs

	Hospital Name					
	Hospital System					
	Reporting Period					
	Contact Information	Name of Person Completing This Form:			Title:	
			Phone Number:		Email:	
			Reviewed By:		Title:	

	Please indicate what type of cost accounting system is being used for this reporting. (Check all that apply and explain.)	**Cost accounting system**	**Cost to Charge Ratio**	**Other (explain)**

	Community Benefit Categories	**Column A**	**Column B**	**Column C**	**Column D**	**Column E**
Row	**Charity Care and Public Programs**	**Patient Visits**	**Total community benefit expense**	**Direct offsetting revenue**	**Net community benefit expense (B-C)**	
1	Charity care at cost				$0	
	Unreimbursed costs of public programs:					
2	Medicaid/Managed Medicaid Plans				$0	
3	Medicare/Managed Medicare Plans				$0	
4	Other public programs				$0	
5	Charity Care and Public Programs Total (sum of lines 1 through 4)	-	$0	$0	$0	
6	What percentage of Charity Care dollars granted represented a discount of 100% of charges?					
	Other Benefits	**Encounters**	**Total community benefit expense**	**Direct offsetting revenue**	**Net community benefit expense (B-C)**	**Description of Activities**
7	Community health improvement services				$0	
8	Research	n/a			$0	
9	Health professions education	n/a			$0	
10	Subsidized health services	n/a			$0	
11	Cash and in-kind contributions to other community groups	n/a			$0	
12	Community building activities	n/a			$0	
13	Community benefit operations	n/a			$0	
14	Other Benefits Totals (sum of lines 7 through 13)	-	$0	$0	$0	
15	**Community Benefits Totals** (line 5 plus line 14)	**-**	**$0**	**$0**	**$0**	

Please note: If the amount in Column E is equal to or greater than the amount in Column D, leave Columns D, E and F blank.

The Oregon CBR instructions state that "at the same time Oregon developed the CBR form, the Internal Revenue Service (IRS) developed a new Form 990, Schedule H for nonprofit hospitals to quantify community benefits as part of the annual federal tax exemption process. The Schedule H and its reporting categories are also largely based on CHA guidance."[4]

As Schedule H was developed and refined by the IRS, certain refinements to CHA's community benefit reporting framework were made. Part I, Line 7 of Schedule H is commonly referred to as the "community benefit table" and is portrayed on the next page. The CBR Form and Schedule H table share elements in common, but several differences (e.g., the exclusion of community building and Medicare) are readily evident.

[4] Community Benefit Reporting Form Instructions, State of Oregon, page 2.

7 Financial Assistance and Certain Other Community Benefits at Cost						
Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)						
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs						
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)						
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j **Total.** Other Benefits						
k **Total.** Add lines 7d and 7j						

For Paperwork Reduction Act Notice, see the Instructions for Form 990. Cat. No. 50192T **Schedule H (Form 990) 2016**

There are material differences between the Oregon CBR form and instructions, and the Schedule H and its instructions. These differences, some of which (thanks to edits incorporated after the instructions first were published) are identified within the CBR instructions themselves, have contributed to some of the issues found in community benefit reporting by Oregon CAHs – particularly for those hospitals required to file both the CBR with OHA and Schedule H with the IRS.

The differences include:

- **Reporting entity.** The Oregon CBR is reported by "individual hospital located within Oregon, and includes all activities within Oregon that are under the governance of the hospital." Oregon requires all hospitals to submit a separate CBR form, including for-profit and governmental hospitals (e.g., those operated by hospital districts). Schedule H is filed by "hospital organizations" that are tax-exempt under 501(c)(3) of the Internal Revenue Code. "Hospital organizations" may include multiple hospital facilities (including those in other states) and certain non-hospital activities that are accounted for under the Employer Identification Number (EIN) under which the organization obtained federal exempt status.

- **Treatment of joint ventures.** IRS Form 990 and Schedule H instructions clarify that if the filing hospital organization owns a proportionate share of a joint venture (e.g., 50 percent) and that venture does not file its own return, then the hospital organization is to include its share of the venture's total operating expense and community benefit across the 990. The Oregon CBR instructions are silent regarding the treatment of joint ventures.

- **Medicaid and other public health programs.** The Oregon CBR includes losses related to Medicare and "other publicly funded health care program shortfalls" (for example, losses for services provided to individuals with Tricare or Veterans

Administration benefits or with coverage provided by the Indian Health Service). On Schedule H, only "means-tested" government programs such as Medicaid, SCHIP, and local government indigent care programs are reportable as community benefit (in Part I). Medicare revenues, expenses, and shortfalls are not reported in the Part I, Line 7 community benefit table; instead, these values are reported in Part III.

- **Treatment of community building.** The Oregon CBR includes expenses for community building programs in community benefit. On Schedule H, community building programs are not reported as community benefit, but are reported in Part II.

- **Inclusion of subsidized health services.** Even though not listed in HB 3290, both the Oregon CBR and Schedule H allow reporting "subsidized health services" as community benefit; however, as described further below the two forms treat Medicare-funded clinical programs differently.

- **Reporting categories with gains (revenue greater than expense).** The Oregon CBR instructs hospitals only to report "categories for which costs exceed revenue." In other words, if Medicaid revenue exceeds cost (indicating that the hospital generated a surplus rather than a loss), hospitals are to leave the Medicaid information blank. On Schedule H, all categories of community benefit are to be completed even if surpluses have been generated (however, as of Tax Year 2015, any such surpluses are to be set to zero).

- **Reporting patient visits.** The Oregon CBR instructs hospitals to report patient visits (in Column A). On Schedule H, reporting such information and also the number of programs within each category is optional.

- **Definition of "total community benefit expense" – including indirect (overhead) costs.** The Oregon CBR instructs hospitals to report "the total cost of providing those programs that generate a negative margin" (in Column B). On Schedule H, hospital organizations are to report information regarding all community benefit activities regardless of margin, and the Schedule H instructions define "total community benefit expense" as including both direct and indirect costs (e.g. hospital overhead). The Schedule H instructions also provide definitions for "direct costs" and "indirect costs."

- **Adjusting the "patient care cost-to-charge ratio."** Both the Oregon CBR and Schedule H instructions indicate that the "patient care cost-to-charge ratio" used to determine the cost of charity care (financial assistance), Medicaid, and certain other community benefits should be adjusted to avoid double counting; however, the Schedule H instructions clarify that such adjustments are to be made only if the amounts in question are included in total operating expense.

- **"Count" and "do not count" guidance.** The Oregon CBR includes "count" and "do not count" guidance within each category of community benefit regarding

programs and activities. This guidance is based on information published by CHA prior to publication of the CBR instructions. CHA guidance has evolved since the CBR instructions were published – including information on programs that should and should not be reported as community benefit. CHA guidelines, for example, have clarified that social determinants of health "with evidence-based association with health improvement" should be reported within "community health improvement services." This includes environmental activities, violence prevention, and other programs operated or funded by hospitals. The Schedule H instructions provide criteria for activities and programs that should and should not be reported, but very few examples.

- **Definition of reportable research.** The Oregon CBR indicates that hospitals should include costs "for research that is made publicly available and is consistent with community need." Schedule H instructs a hospital organization to "include the cost of internally funded research it conducts, as well as the cost of research it conducts funded by a tax-exempt or government entity." The definitions thus are different.

- **Definition of reportable health professions education.** The Schedule H and Oregon CBR instructions take different approaches to defining reportable "health professions education" costs, with Schedule H clarifying that "health professions education means educational programs that result in a degree, certificate, or training necessary to be licensed to practice as a health professional, as required by state law, or continuing education necessary to retain state license or certification by a board in the individual's health profession specialty." The Oregon CBR instructions indicate that high-school student job shadowing and costs for staff education that is linked to community services and health improvement are to be reported in this category.

- **Medicare and subsidized health services.** The Oregon CBR instructions indicate that "subsidized health services" are to be determined after removing costs and offsetting revenue for Medicare and other public programs that already have been reported as community benefit. On Schedule H, Medicare amounts are included subsidized health services. Medicare funded clinical programs that generate losses and meet community needs thus are reportable on Schedule H but not on the Oregon CBR.

- **Schedule H restrictions on cash donations.** Schedule H instructions only allow cash "contributions for community benefit" that have been restricted by the hospital organization in writing to a community benefit purpose to be reported as community benefit. The Oregon CBR instructions include no such requirement, and instead state "as a general rule, count donations to organizations and programs that are consistent with your organization's goals and mission."

COMMUNITY BENEFIT REPORTING ISSUES

As described in the methodology section, CBR Forms and supporting workpapers and Schedule H worksheets were reviewed to identify potential issues with community benefit reporting. A number of issues were identified – including five that have contributed to under-reporting, and four leading to over-reporting.

The findings below were based on reviewing materials for six Oregon CAHs. The findings thus may not be representative of how other Oregon hospitals compile and report their community benefits.

A. Issues contributing to under-reporting community benefit

The following issues led CAHs reviewed in this project to under-report their community benefits.

1. Not including indirect (overhead) costs for community health improvement and community building programs

Five of the six critical access hospitals reported only direct costs for community health improvement services, community building programs, and health professions education activities. The Oregon CBR instructions indicate that "total costs" are to be reported, but unlike the Schedule H instructions do not explicitly state that "total costs" include both direct and indirect (overhead) amounts.

The one CAH that included indirect costs is part of a large, multi-hospital system with centralized community benefit reporting expertise and resources.

For the categories mentioned (community health improvement services, community building programs, and health professions education), including indirect costs generally increases the amount of community benefit reported by 25 to 40 percent. For the five CAHs, the increase would represent over $400,000 annually.

2. District hospitals: excluding interest expense from total operating expenses (and the ratio of cost to charges used to value the cost of charity care, Medicaid, and other community benefits)

Four of the six CAHs are hospital districts. As such, all follow Generally Accepted Accounting Principles (GAAP) for municipalities. All also report interest expense on long-term debt as a "non-operating" expense. As a result, all four have not allocated interest expense to the cost of charity care, Medicaid, and other community benefits in Oregon's CBR.

The cost of charity care (Financial Assistance) is determined by multiplying charges written off pursuant to each hospital's Financial Assistance Policy (FAP) by a "ratio of patient care cost to charges." The numerator of this ratio is "total operating expense,"

and because the district hospitals omitted interest expense, their ratios have been understated. Interest expense is included in Medicare and Medicaid as allowable, operating expenses for reimbursement purposes, and appropriate portions of this expense should be allocated to community benefits.

For these four district CAHs, this adjustment would have increased the ratio of patient care cost to charges from a weighted average of 0.72 to 0.74. Charity care cost would have been about $20,000 higher, and Medicaid shortfalls about $680,000 higher.

3. Not reporting programs that are community benefit

As described above, Verité shared an Appendix from the most recently published CHA *Guide* that describes in some detail recommended "categories and definitions" of community benefit. The CAHs were asked to review this guidance to identify opportunities to report additional activities and programs as community benefit.

Four of the CAHs responded to this request, and three of the four identified a number of community benefit and community building programs they provide that historically have not been reported. Examples include:

- Community health education and outreach services;
- Patient support groups (e.g., for cancer survivors and their families);
- Community health fairs;
- Costs for language translation services that go beyond minimum requirements of law/regulation;
- Incremental time that employed nurses spend while precepting nursing students;
- Clinical programs that might qualify as "subsidized health services";
- Health care support services, such as enrollment assistance in Medicaid;
- Recruitment costs to attract health professionals to underserved areas; and,
- Time donated on an in-kind basis by executives to local community health related groups, and chambers of commerce.

The assistance provided by this project and materials published by CHA have encouraged these CAHs to include activities and programs like those above in their CBR Forms.

4. Not reporting community benefit for entities and ventures under common governance

Pursuant to the CBR Form instructions, the multi-hospital system that includes the one CAH that participated in this project prepares an extensive analysis that allocates charity

care costs, Medicaid losses, and expenses for other community benefits provided by non-hospital affiliates to each Oregon hospital. These affiliates include physician groups and the system corporate office.

Another CAH participates in a joint venture, and was provided clarification as to how to include its proportionate share of the venture in its Schedule H and also its CBR Form.

Oregon's CBR Form instructions would be enhanced if additional clarifications were provided regarding how to include community benefits provided by affiliated organizations.

5. Not including revenues and expenses for all government payers

Unlike Schedule H, Oregon's CBR Form instructs hospitals to include "other publicly funded health care program shortfalls" (for example, losses for services provided to individuals with Tricare or Veterans Administration benefits or with coverage provided by the Indian Health Service). Only one of the six CAHs that participated in this project reported shortfalls in this category.

In 2015, twenty-six (26) of Oregon's hospitals reported shortfalls for these other government payers, including one of twelve Type A and nine of twenty Type B hospitals. Because Schedule H only allows "means-tested" government payers to be reported as community benefit, a number of Oregon hospitals most likely are not including these "other publicly funded health care program shortfalls" in Oregon's CBR Form.

B. Issues contributing to over-reporting community benefit

The following issues led to CAHs over-reporting their community benefits.

1. Not adjusting the patient care ratio of cost to charges accurately

The Oregon CBR Form and the Schedule H instruct hospitals to adjust the "patient care ratio of cost to charges" – first to remove "non-patient care expenses" from the numerator – and second to remove community benefit and community building expenses that are reported in full elsewhere on the forms/schedules. These adjustments are made so that charity care, Medicaid, and other patient care losses are based on clinical costs only, and to address double counting.

According to this review, five of the six CAHs did not adjust their ratios accurately (because the adjustment for non-patient care expenses either was left blank or was too low and/or some community benefit/building expenses were left out of the calculations). Across the five hospitals, the increases in the ratios associated with including interest expense in the numerator more than offset the decreases associated with fully eliminating non-patient care expenses and community benefit/building costs.

2. Counting unrestricted contributions as community benefit

Five of the six hospitals included cash and/or in-kind contributions as a community benefit in their Oregon CBR Forms. One of the five included two amounts: first an amount that followed Schedule H requirements that cash contributions must be restricted by the organization to a community purpose, and second an amount allocated from affiliated entities. This hospital only included the first amount in its Schedule H filings, and included the second amount pursuant to the Oregon CBR Form instructions.

None of the other hospitals that reported contributions placed restrictions on the amounts reported, because this is not required by the Oregon CBR Form. Based on recommendations provided during this project, one of these hospitals adjusted its draft Schedule H filing to assure that only restricted cash contributions are reported. This one hospital also reclassified amounts considered contributions to another community benefit category (community health improvement services), because the expenses were incurred by the hospital in providing "health care support services" – e.g., certain types of transportation for low-income patients. A number of contributions reported by other hospitals represent sponsorships that under strict interpretations of instructions would not be considered community benefit.

Recommendations provided as part of this project reduced the amount to be reported as contributions for community benefit, both on the Oregon CBR Form and on Schedule H.

3. Reporting programs that are not community benefit

This project also identified a few examples of programs reported as "community health improvement services" that instead should be reported as community building (e.g., a program that provides high school students an opportunity to observe hospital operations and hopefully become interested in the health professions), programs with revenue exceeding expense – leading to a negative community benefit amount which means the program is not reportable on the Oregon CBR Form, and a few other programs for which the primary purpose may be marketing rather than community benefit.

On balance and at a programmatic level the review indicated more under-reporting of potential activities and programs than over-reporting.

4. Misalignment between values reported in CBR and in audited financial statements

For three of the hospitals, amounts reported in the CBR Form did not align with values published in footnotes to audited financial statements (AFS). For example, in its AFS, one hospital reported Medicaid net patient revenue about $300,000 greater than the amount included in its CBR Form for the same time period. Misalignment can occur if, for example, patient revenue from a prior period is recognized in the current year, or because reports are based on alternative data sources that may or may not have been audited. For the three hospitals mentioned, Medicaid net patient revenue (and in one case Medicare net patient revenue) is higher in the AFS than in the CBR Form.

501(R) COMPLIANCE ISSUES

The Affordable Care Act (ACA, 2010) materially changed the requirements that hospitals must meet to obtain or maintain tax-exempt status under 501(c)(3). The ACA created Section 501(r) in the Internal Revenue Code (IRC), which requires each hospital facility exempt under 501(c)(3) of the IRC to:

- Conduct a community health needs assessment (CHNA) every three years
- Adopt an implementation strategy to meet the community health needs identified through the CHNA
- Establish a written financial assistance policy (FAP) that includes eligibility criteria and the method for applying for financial assistance, among other provisions
- Establish a written emergency medical care policy (EMCP) that requires the provision of care to individuals for emergency medical conditions regardless of their eligibility for financial assistance
- Limit amounts charged for emergency or other medically necessary care provided to individuals eligible for financial assistance to not more than *amounts generally billed (AGB)* to insured patients
- Refrain from engaging in *extraordinary collection actions (ECAs)* before making "reasonable efforts" to determine whether individuals are eligible for financial assistance

The ACA left the meaning of important terms such as *AGB*, *ECA*, and *reasonable efforts* to be clarified through regulations. Proposed regulations were published in 2012 and 2013. The IRS received hundreds of comments on these proposals before publishing final regulations on December 29, 2014.

To preserve tax-exempt status and avoid certain excise taxes, 501(c)(3) hospitals were to have complied with the final regulations by the start of the tax year that began on or after December 29, 2015. For most hospitals, that meant by January 1 or July 1, 2016.

FAPs for each of the six hospitals participating in this project were reviewed. Two were found to be well aligned with the 501(r) regulations. Because four were not, The Oregon Office of Rural Health, together with the Oregon Association of Hospitals and Health Systems, sponsored a webinar for Oregon's rural hospitals to assure that all are aware of the 501(r) requirements and work proactively to assure compliance. FAPs for the four non-compliant hospitals either have been or are in the process of being updated.

CONCLUSIONS AND RECOMMENDATIONS

Community benefit reporting guidelines have evolved over the years, and seek to assure that hospitals account accurately and comprehensively for the community benefits they provide. Accurate reporting is important, both to assure compliance with government rules but also to demonstrate that hospitals are investing in programs that improve access to care, enhance public health, advance generalizable knowledge, and otherwise are devoting resources to benefit the communities they serve.

Based on a review of community benefit reporting by six critical access hospitals, some CBR Forms filed with the Oregon Health Authority and some IRS Form 990, Schedule H filings with the IRS have been inaccurate. These reports include both under-reporting and over-reporting of community benefit.

Possible reasons for these findings include:

- Material differences exist between Oregon's CBR Form and instructions and Schedule H instructions. The differences contribute to confusion and misinterpretations as to how community benefits are to be reported.

- Many small, rural, critical access hospitals have limited resources to devote to community benefit reporting. One CAH participating in this project is part of a large, multi-hospital system, with centralized resources dedicated to accurate accounting and reporting both on the Oregon CBR Form and on Schedule H. Reports for this hospital uniformly were found to be very well aligned with both sets of requirements.

- Several hospitals participating in this project experienced recent turnover in their finance staffs and in other management positions. Individuals who invested time in understanding the community benefit guidelines left, and new staff had limited time to become familiar with the requirements before reports were due.

- Governmental accounting for District hospitals appears to be leading to a different definition of "total operating expenses" – which affects several categories of community benefit.

The project also led to findings regarding compliance with IRC 501(r) requirements. One primary reason for a lack of compliance, is that many (if not most) small district hospitals are not required to file IRS Form 990, Schedule H. Schedule H includes twenty-four (24) questions regarding 501(r) compliance. These small district thus have not been required to answer these questions and thus have not been receiving an annual reminder regarding compliance with 501(r).

The following recommendations are made to help address the findings in this report:

- The Oregon Health Authority (with authorization from the Oregon Legislature) should seek to align Oregon's CBR Form and instructions with IRS Form 990, Schedule H. This would require reconciling the material differences between the

two sets of forms and instructions, as described in the report. As this work proceeds, social determinants of health certainly can be included in the Oregon CBR Form as a separate line item.

- OHA, ORH, and/or OAHHS should conduct an annual training regarding community benefit reporting a few months before the majority of CBR Forms are due to be submitted. Opportunities for CAH staff to participate in webinars or trainings conducted regionally or nationally also should be marketed to rural hospitals to encourage participation, particularly for individuals new to the reporting process.

- Technical assistance on community benefit reporting could be offered to small, rural hospitals by Oregon's larger, multi-hospital systems – as a community benefit provided by those systems to their colleagues. Alternatively, such assistance could be provided by OAHHS.

- The CBR Form and instructions should be modified to align accounting principles for non-governmental hospitals with governmental accounting principles that apply to hospital districts.

- CAHs should encourage their external audit firms to review their CBR data. Larger tax-exempt systems now include a community benefit footnote within their audited financial statements. Including a similar footnote in audited financial statements for rural hospitals would facilitate additional review of the CBR data prior to submission.

- OHA, ORH, and OAHHS should encourage the IRS to communicate proactively with governmental hospitals with 501(c)(3) status to provide them the opportunity to comply with 501(r) without experiencing penalties. A periodic review of 501(r) compliance by OAHHS and/or ORH of all Oregon hospitals would be constructive.