

# COMMUNITY BENEFIT AND MISSED OPPORTUNITIES

## A CASE STUDY OF THREE SAN FRANCISCO HOSPITALS

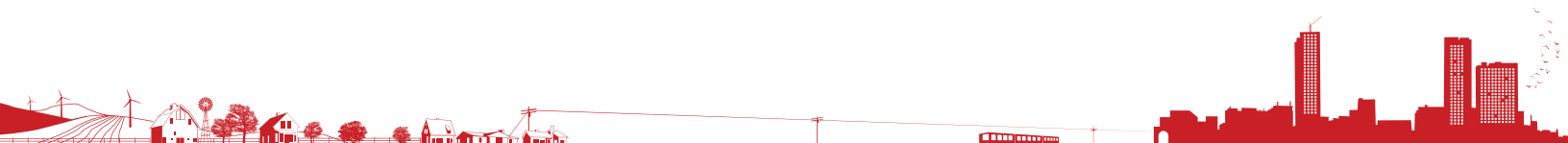
Lauren Valdez • Health Policy Associate    Carla Saporta, MPH • Health Policy Director



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# ACKNOWLEDGEMENTS

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## About The Greenlining Institute

Founded in 1993, The Greenlining Institute is a policy, research, organizing, and leadership institute working for racial and economic justice. We work to bring the American Dream within reach of all, regardless of race or income. In a nation where people of color will make up the majority of our population by 2040, we believe that America will prosper only if communities of color prosper.

## Greenlining Bridges to Health Program

Nothing is more essential than our health. Everybody should have access to good health regardless of race or income. Health care must be responsive to the nation's growing communities of color, but health care isn't enough. People also need access to the things that lead to good health such as safe neighborhoods, healthy foods, clean environments and decent jobs. Greenlining brings the voices of communities of color into critical decisions that affect all of our lives and health.

## About the Authors

### Lauren Valdez, Health Policy Associate

Lauren is currently pursuing a dual Master's in City Planning and Public Health at UC Berkeley. Coming from an environmentally burdened community in Los Angeles, Lauren's work focuses on improving health outcomes in low-income communities of color. She has worked in the Environmental Justice field as a community organizer and health correspondent in Wilmington, California. Lauren believes in using the power of multimedia and online tools for community storytelling, education, and advocacy. Professionally, Lauren has years of experience in producing new media, community development, and coordinating nonprofit projects, in the U.S. and internationally. Lauren holds a B.A. in Architecture from UC Berkeley and completed a Fulbright Fellowship in Brazil.

### Carla Saporta, MPH, Health Policy Director

Before joining Greenlining as Health Policy Director, Carla Saporta educated and mobilized community members on policy issues and worked with policymakers to create and implement policy that benefits the community. She currently represents the community's interest as an advisory member on Covered California's Small Business Health Options Program Advisory Group. In her role at Greenlining, Carla leads advocacy efforts to ensure that implementation of the Affordable Care Act will benefit communities of color. This entails working with policymakers to pass and implement state reforms, increasing health workforce diversity, increasing access to care for boys and young men of color, and finding solutions to covering those who will not benefit from the ACA. Carla also oversees Greenlining's community benefit advocacy, which focuses on increasing funding for upstream programs that improve public health. Carla received her B.A. from Occidental College and her Master of Public Health at Portland State University through the Oregon Master of Public Health Program.

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# EXECUTIVE SUMMARY

## Findings

### **Not-for-profit hospitals make a bargain with the public, but that bargain is unequal.**

In exchange for being exempt from most business taxes, these hospitals must provide community benefit in the form of activities that promote health and provide care to those unable to pay. In 2010, California not-for-profit hospitals received \$3.27 billion in total government subsidies and benefits, while only providing \$1.43 billion in community benefit. To better understand this exchange, Greenlining examined the 2013 community benefit activities of San Francisco hospitals operated by three major not-for-profit systems: Kaiser Foundation - San Francisco, Dignity Health St. Mary's Medical Center and Sutter Health California Pacific Medical Center.

### **The San Francisco Community Health Needs Assessment represents an unrealized opportunity.**

While hospitals must do a Community Health Needs Assessment (CHNA) to inform their community benefit work, some years ago San Francisco expanded the process to include the Department of Public Health and community groups. Unfortunately, many community representatives were not aware how their input would be used by hospitals, and many felt communication and information sharing was poor. Only two of the seven stakeholders interviewed who represented vulnerable community groups were familiar with community benefit requirements. One noted that if they had been given full information, the “questions and discussions would have been different.”

### **Data reported by the hospitals is fragmentary and incomplete.**

Kaiser, for example, claims \$24.3 million in community benefit spending, but only provides details of the \$568,000 given as grants to community groups. The Dignity Health St. Mary's Medical Center “2013 Community Benefit Report, 2014 Community Benefit Implementation Plan” accounts for much more of the claimed \$51,179,654 in community benefit, but details are often sketchy. The Sutter Health California Pacific Medical Center (CPMC) claims \$167,371,000 in community benefit contributions. Sutter's implementation plan includes descriptions of activities that align with the CHNA-identified health priorities, but gives no consistent financial reporting of resources committed to each activity. Overall, it remains unclear how community benefit activities align with funds claimed as community benefit and how hospitals calculate the financial benefits they claim to give.

	Total Community Benefit	Medi-Cal Shortfall	Community Grants Reported	Percent Spent on Vulnerable Population	Percent of Hospital Operating Revenue Spent on Community Benefit
Sutter CPMC	\$167,371,000	89,533,000	Not reported	74%	Not reported
Dignity SMMC	\$51,179,654	13,336,807	106,000	41%	13.2%
Kaiser SF	\$24,300,000	Not reported	568,000	Not reported	Not reported

### **Because reporting of charges is not standardized, no one can verify the amount of charity care or Medi-Cal shortfall claimed as community benefit.**

Hospitals set their own charges, which vary wildly. According to the chargemaster list for Sutter's California Pacific Medical Center (CPMC) one pill of 325 mg. acetaminophen (generic Tylenol) costs \$0.98, while the same pill at Kaiser Foundation Hospital in San Francisco cost \$19.00.

## Recommendations

- **Legislation should establish the Medicare reimbursement rate as the standard charge for services and supplies that can be claimed as charity care.** Present large differences in charges mean that two hospitals can claim vastly different amounts of charity care for the same services.
- **California should enact legislation creating a standard that requires hospitals to report in detail how community benefit dollars are spent and whom they help.** Clear, standardized regulations will increase transparency and hold hospitals accountable.
- **Other regions should emulate the model established by the San Francisco Health Improvement Partnership (SFHIP), which has potential to utilize community benefit as a tool for improving overall community health, and San Francisco should develop this model further.** The diversity of perspectives and expertise on SFHIP should be used to guide hospitals to make community benefit decisions that reinforce overall community health needs.
- **Hospitals must develop a process for meaningful community engagement in both the Community Health Needs Assessment (CHNA) process and the implementation plan in order to make the biggest impact with their community benefit dollars.** Community members should be included during all stages of hospital community benefit decision-making.
- **Hospitals should increase funding allocations for upstream investments to further address the root causes of health inequity, including investing in education, housing, environmental cleaning, community development and overall wellness.** If hospitals invested more in illness prevention programs, they could reduce the number of people who end up in the emergency room.
- **The Office of Statewide Health Planning and Development should have the authority to analyze community benefit plans and rate hospitals based on how well their community benefit plans address community health needs.** This would highlight hospitals that do great work, while pushing those with low ratings to improve.

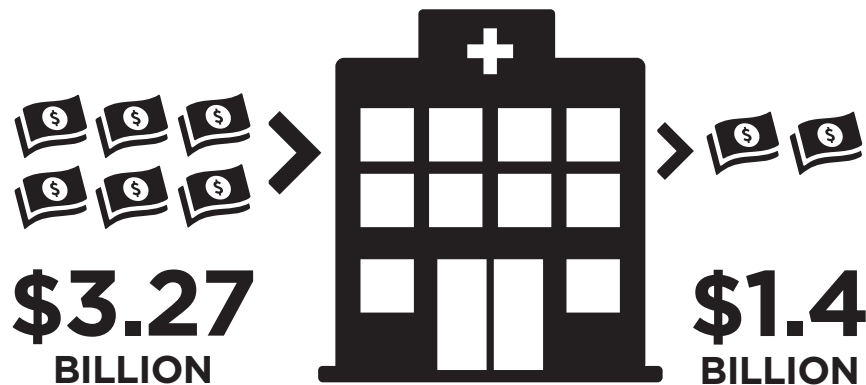
## INTRODUCTION

In exchange for large tax breaks, not-for-profit hospitals are required to provide programs, services, or other resources to address community health needs through “community benefit” activities. These include grants to community-based organizations, charity care (free or reduced-cost services for low-income individuals) and the un- or under-reimbursed costs of care for patients on Medicaid (called Medi-Cal in California) and other government programs. When a hospital receives not-for-profit status, it enters a pact with the public that it will provide community benefits in exchange for its tax exemption, but this exchange is not equal. Studies of community benefit programs show that the financial benefit hospitals get by not paying taxes greatly exceeds the amount of funds they invest in community benefit activities.<sup>1</sup> In California, not-for-profit hospitals received \$3.27 billion in total government subsidies and benefits, while only providing \$1.43 billion in community benefit in 2010 alone.<sup>2</sup> Questions have also been raised regarding how not-for-profit hospitals account for their community benefit investments and how these activities relate to the most pressing community health needs.

### Medicaid/Medi-Cal Shortfall

The state sets a reimbursement rate that it will pay hospitals for every service provided to Medicaid patients. This rate typically does not cover the full costs incurred by the hospital. The hospital will count its loss as “community benefit.”

**California hospitals receive more than twice as much in tax breaks as they give back in community benefit.**



Last year The Greenlining Institute released a report, “*Not-for-Profit Hospitals and Community Benefit: What We Don’t Know Can Hurt Us*,” demonstrating the lack of data to sufficiently evaluate the quality of hospitals’ community benefit programs. From the available information, Greenlining

... on average the largest California not-for-profit hospital systems spent about 7.2 percent of their annual operating revenue on community benefit activities. Of that amount, hospitals spent only 1.1 percent on average on improving community health outside of the hospital walls.

found that on average the largest California not-for-profit hospital systems spent about 7.2 percent of their annual operating revenue on community benefit activities. Of that amount, hospitals spent only 1.1 percent (i.e. 0.079 percent of their overall operating revenue) on average on improving community health outside of the hospital walls.<sup>3</sup>

To understand the landscape of community benefit at the local level, we examined in detail three hospitals in San Francisco that represent the largest not-for-profit health systems in California — Kaiser Foundation San Francisco, Dignity Health St. Mary’s Medical Center and Sutter Health California Pacific Medical Center.\*

**Why Community Benefit Matters for Health Equity**

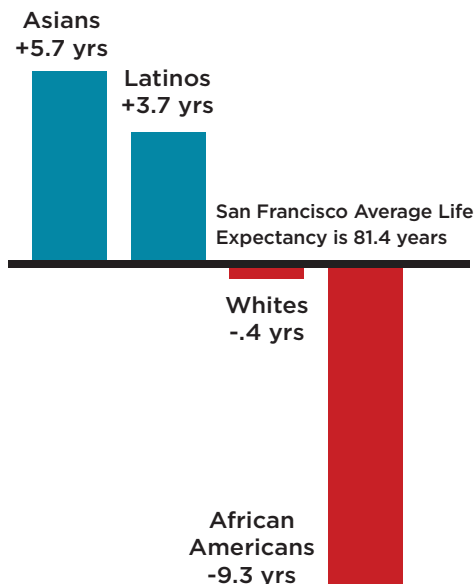
A productive, inclusive society depends on the health and well-being of all its people, but many barriers make it more difficult for low-income Americans and people of color to live healthy lives. For example, San Francisco has the highest life expectancy of any California metropolitan region and the

highest number of medical providers per person in the country,<sup>4</sup> but African Americans have a lower life expectancy in San Francisco than in the rest of California. African-Americans in San Francisco have a life expectancy nine years below the city’s average.<sup>5</sup> This does not appear to be due to lack of medical coverage, as the city’s Healthy San Francisco program has reduced the uninsured rate to just six percent.<sup>6</sup> To understand these unequal health outcomes, policymakers must examine additional factors and barriers to good health.

Nonmedical factors such as socioeconomic status, housing, educational attainment, environmental quality and access to nutritious food and recreational activity, known as the social determinants of health, all play a huge role in determining a person’s health outcomes.<sup>7</sup>

\*California Pacific Medical Center community benefit report includes total amounts from 5 different hospital campuses, while the other hospitals report community benefit per facility.

## Health Disparities in Life Expectancy by Race/Ethnicity in San Francisco



Source: A Portrait of California: California Human Development Report 2011

saves lives and reduces health care costs for taxpayers.<sup>11</sup> Although many public health institutions and community health organizations try to address these barriers, there remains a significant need for greater investment in upstream health programming. Hospital community benefit programs represent a major opportunity to increase such investment.

### Upstream Investments

Upstream public health approaches address the root causes of disease and disability and focus on prevention rather than treatment. Just as changes in the upstream portion of a river — like building or tearing down a dam — affect everything that happens downstream, upstream spending on community health needs can impact the root causes of illness and help to promote wellness.

Communities just a few miles apart can have large differences in life expectancy. Research from the Robert Wood Johnson Foundation shows that a person’s ZIP code is a better predictor of life expectancy than their genetic code.<sup>8</sup> In the U.S., the lasting legacy of our history of racial community segregation continues to keep affluent, non-diverse communities separate from communities of color, creating a big hurdle to overcoming health disparities.<sup>9</sup> Low-income communities are more likely to be plagued with underperforming schools, high crime rates, and high concentration of fast food outlets, liquor stores and toxic polluting facilities, which all contribute to poorer health outcomes.<sup>10</sup>

To address these inequities, it is crucial to make what are known as “upstream investments” that address the root causes of poor health in low-income communities and communities of color — preventing people from getting sick in the first place. Research shows that money spent on prevention

Low-income communities are more likely to be plagued with underperforming schools, high crime rates, and high concentration of fast food outlets, liquor stores and toxic polluting facilities, which all contribute to poorer health outcomes.

## Not-for-Profit Hospital Community Benefit Requirements

Hospitals are required to follow both federal and state requirements for community benefit.<sup>12</sup> California enacted its own community benefit standards in 1994, requiring not-for-profit hospitals to, “assume a social obligation to provide community benefits in the public interest” in exchange for favorable tax treatment.<sup>13</sup> The Affordable Care Act (ACA) in 2010 and the IRS 2013 proposed rules, “Community Health Needs Assessment for Charitable Hospitals,” updated federal community benefit requirements.



Under both California and federal requirements, each not-for-profit hospital facility must complete a Community Health Needs Assessment (CHNA) every three years and create a community benefit implementation strategy that responds to those needs.<sup>14</sup> The CHNA must define the community the hospital serves and identify its current health needs. Hospitals have significant flexibility in designing and conducting their CHNAs, and must take into account input from those who represent the community served, including community organizations and public health departments.<sup>15</sup> The CHNA must also be “widely available” to the public. The implementation plan should describe the hospital’s community benefit plans, commitment of resources, and methods for evaluating impact. In California, not-for-profit hospitals are required annually to submit a copy of their community benefit implementation plans to the Office of Statewide Health Planning and Development (OSHPD).<sup>16</sup> At the federal level, not-for-profit hospitals must make their CHNA, but not their implementation plans, publically available.<sup>17</sup>

In 2011, the IRS Form 990, Schedule H — required for not-for-profit hospitals — expanded the definition of community benefit to include some community-building activities, though not all. However, the form allows for hospitals to report on community building activities outside the scope of community benefit as a way to encourage hospitals to invest in more upstream community development efforts like physical improvements, housing, economic development, and environmental support.<sup>18</sup> California does not count community-building activities as community benefit. These federal updates highlight the importance of incorporating community involvement, transparency, evaluation, and upstream investments into community benefit practices.

### **Examples of Community Benefit Activities**

These categories show how the IRS defines community benefit on the hospital Form 990, Schedule H. These categories are vague for all parties, which adds confusion and limitations for reporting community benefit.

**Financial assistance at cost (also called “charity care”)** – Hospitals may provide services for free or at reduced costs for low-income and/or underinsured people.

**Unreimbursed costs from Medicaid and other government programs** – Because hospitals are typically reimbursed below their costs for treating Medicaid patients, they can count the shortfall as community benefit.

**Community health improvement services and community benefit operations** – This can include money given to clinics or community based organizations as well as overhead costs of providing community benefit.

**Health professions education** – This includes residency programs and health education.

**Subsidized health services** – Such subsidies reduce the cost of bills for the underinsured.

**Research** – Surprisingly, in addition to a hospital’s own funds spent on research, spending credited as community benefit can include external research funds received from grant making organizations like the National Institutes of Health.<sup>19</sup>

**Cash and in-kind contributions for community health** – This can include grants given to community-based organizations and clinics.

## METHODOLOGY

We analyzed community benefit spending and activities using publicly available data from each hospital, including 2013 community benefit reports, community benefit implementation plans, community health needs assessments, and websites.

In addition, we reviewed relevant research and interviewed 12 stakeholders involved with the joint hospitals' Community Health Needs Assessment (CHNA) through the San Francisco Health Care Services Master Plan (HCSMP) Task Force and/or the San Francisco Health Improvement Partnership (SFHIP) Steering Committee. The stakeholders represented a broad range of community interests and community health expertise, including representatives of the Latino, African American, Asian Pacific Islander, LGBTQ and chronically homeless communities. Other stakeholders represented community health clinics, university hospitals, public schools, and local government departments. Representatives from each hospital studied declined our request for interviews, but a spokesperson from the Hospital Council of Northern and Central California spoke on behalf of the hospitals in question. Key themes from these interviews were identified, synthesized and used to provide a local perspective on not-for-profit hospitals' community benefit.

## FINDINGS

### **San Francisco Not-for-Profit Hospitals Community Benefit**

Our findings show a wide variety in community benefit reporting and accounting methods, which makes it difficult to assess how well not-for-profit hospitals are serving the needs of the most vulnerable populations.

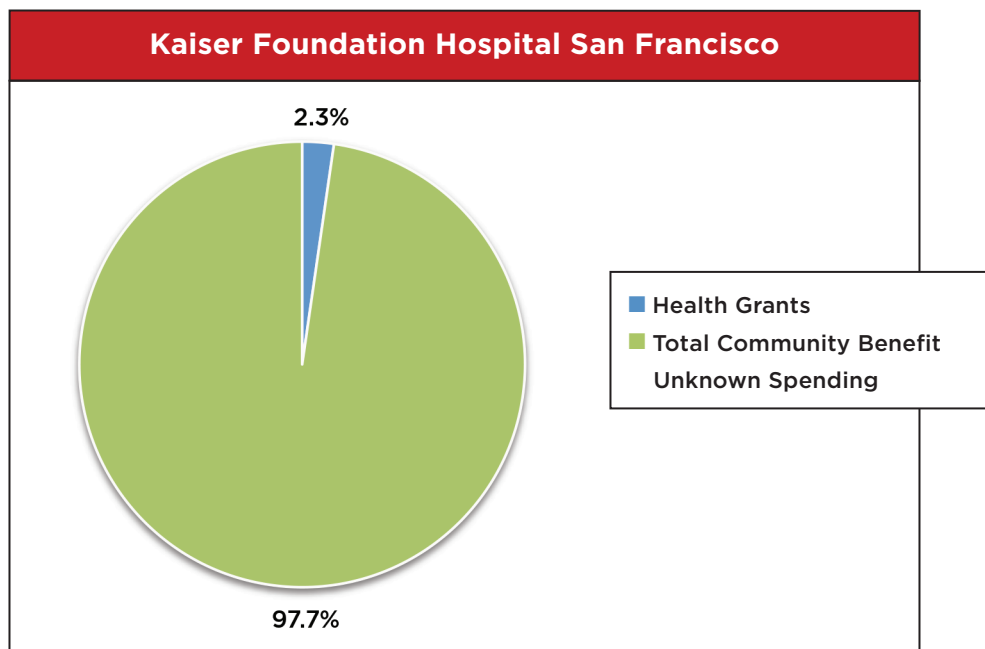
### **San Francisco Community Health Needs Assessment (CHNA)**

San Francisco not-for-profit hospitals have conducted a joint CHNA in collaboration with the San Francisco Department of Public Health (SFDPH) since 1994,<sup>20</sup> bringing increased resources into the CHNA process. For example, the IRS only requires secondary data (data collected not specifically for the research, like census data) to be used for a CHNA, but doing a joint CHNA with the Public Health Department allows for inclusion of primary source data collected from focus groups, public forums, and a broad stakeholder taskforce.<sup>21</sup> In 2012, the public health department underwent a national accreditation process and conducted an in-depth study of health care services and needs in San Francisco to inform its Health Care Services Master Plan (HCSMP). All these efforts were fed into the countywide CHNA. The public health department put together a 41-member task force for the HCSMP, representing broad and diverse community, government, and professional perspectives. The information gathered for the study informed the HCSMP, the SFDPH accreditation requirements, and the hospitals' CHNA. Although the health needs assessment was a joint effort, each hospital was required to produce its own CHNA report and implementation plan to identify how it would address the CHNA developed priorities. The three priorities identified were:

- 1. Safe and Healthy Living Environments**
- 2. Healthy Eating and Physical Activity**
- 3. Access to Quality Health Care and Services**

### Kaiser Foundation Hospital San Francisco

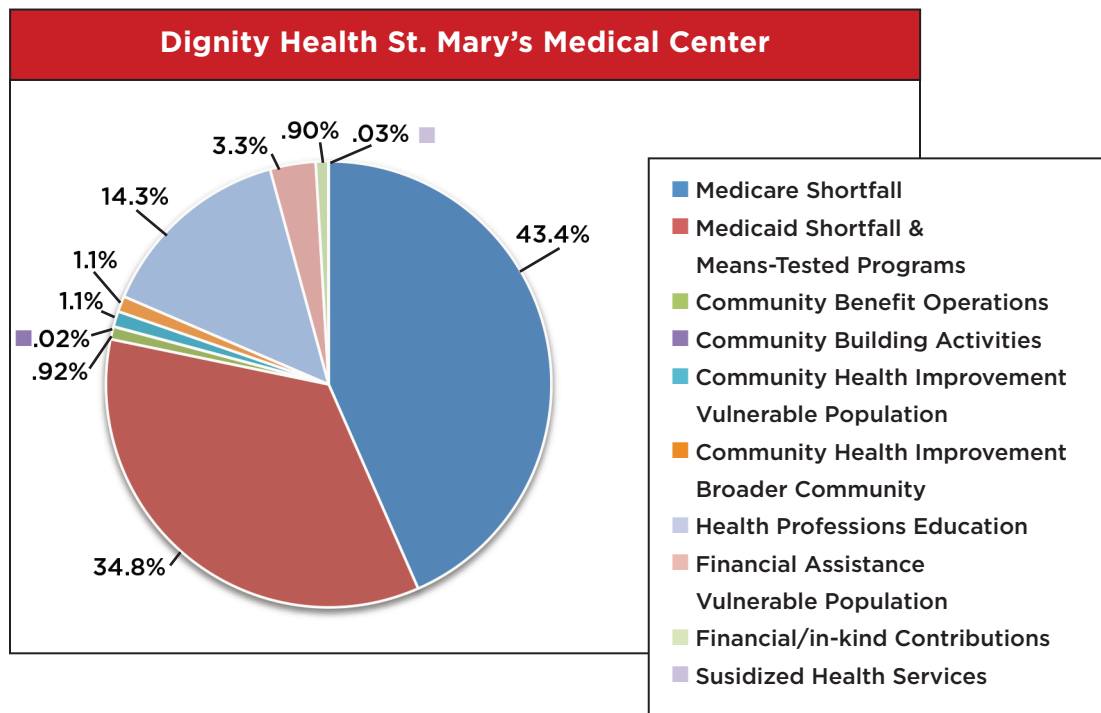
The total amount of community benefit claimed by Kaiser for its San Francisco hospital is \$24.3 million, but this online report does not provide details of the reported spending.<sup>22</sup> In the 2013 “Community Investment Report” for Kaiser Foundation Hospital - San Francisco, a description of grants made to 18 community organizations totals \$568,000.<sup>23</sup> Thus the Community Investment Report only describes two percent of the community benefit dollars, leaving the public in the dark about the other 98 percent. While the Community Investment Report does break out grant spending, it is not a required document and therefore not subject to federal and state guidelines for community benefit reporting. Meanwhile, the hospital did not submit a community benefit implementation plan\* by the May 31, 2014 due date required by these guidelines.<sup>24</sup>



\*As of Sep 9, 2014 Kaiser had still not released its community implementation plan.

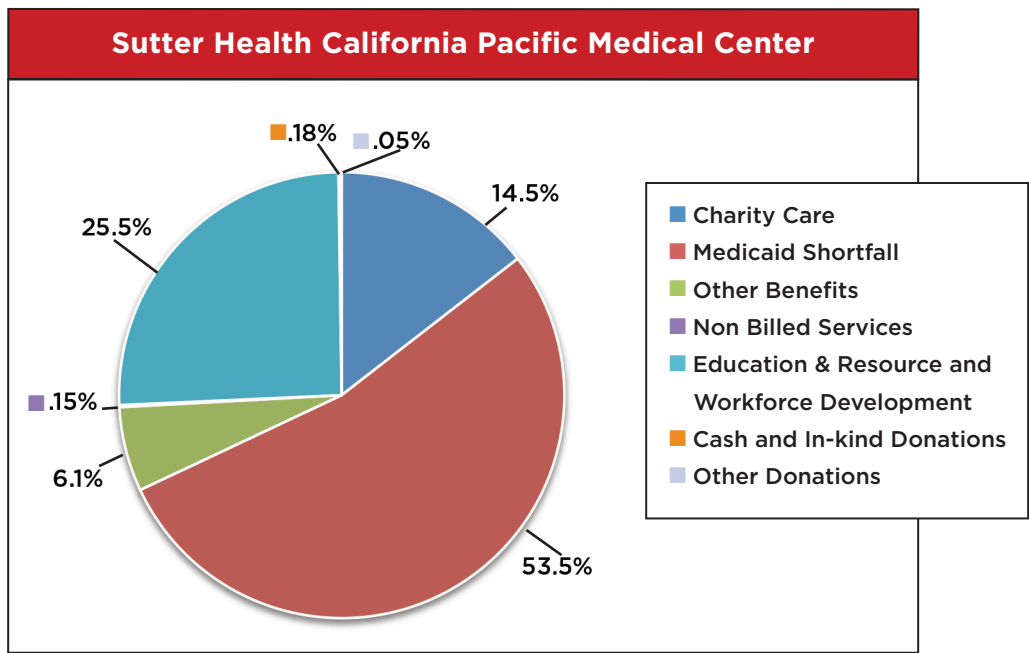
### Dignity Health St. Mary's Medical Center

The Dignity Health St. Mary's Medical Center (SMMC) "2013 Community Benefit Report, 2014 Community Benefit Implementation Plan" claims a total of \$51,179,654 as community benefit.<sup>25</sup> The largest portion, 69 percent, went to the under-reimbursed cost of care for patients in Medi-Cal and Medicare. At the federal level hospitals are not allowed to count the under-reimbursed rate of providing services for Medicare because studies have shown that this reimbursement amount is adequate to cover costs.<sup>26</sup> California still allows hospitals to claim the Medicare shortfall as community benefit. The report describes some key programs, but not all of these descriptions list the total financial contribution or the total number of people served. It is also unclear to what degree, if any, the programs described addressed upstream health investments. Of the total community benefit reported, St. Mary's awarded \$106,000 to community-based organizations through grants. The community benefit report broke down expenses as shown below, but definitions of categories and activities are unclear or missing. For example, Dignity never explains what activities fall under "Community Health Improvement" as opposed to "Financial and In-Kind Contributions."



### Sutter Health California Pacific Medical Center

The Sutter Health California Pacific Medical Center (CPMC) claims \$167,371,000 in community benefit contributions through its five campuses in San Francisco in 2013.<sup>27</sup> The community benefit financial breakdown as reported online is shown below.<sup>28</sup> The implementation plan includes descriptions of activities that align with the CHNA-identified health priorities, but gives no consistent financial reporting of resources committed to each activity. In addition to the implementation plan, CPMC also produces a separate “Report to the Community” with more details on the populations served through key programs. Although it contains a financial breakdown, the document is unclear regarding which activities fall under which categories. Outside of the community benefit expenditures listed below, Sutter also claims, “In 2013 CPMC spent \$20.9 million in its commitment to the City and County of San Francisco in support of affordable housing, increased access to health care, workforce training, and transit and pedestrian safety improvements.”<sup>29</sup> While this commitment seems like a positive upstream investment in ensuring healthy and safe living environments, it is unclear why this amount is not counted as community benefit expenditures. This appears to represent money given to the city when CPMC faced much community and political opposition<sup>30</sup> to the building of a new hospital. Public documents show that CPMC committed \$20.9 million to the San Francisco Municipal Transportation Agency (SFMTA) to address the increased traffic congestion associated with the new hospital.<sup>31</sup>



## San Francisco Community Benefit

As shown in the charts above, these hospitals provided differing levels of detail on their specific community benefit expenditures. Each hospital provided short descriptions of key programs aligned with the CHNA identified priorities, but it is difficult to assess how much funding they provided to upstream programming activities and what population benefited. Publicly available information fails to make clear how community benefit spending aligns with needs of the most vulnerable populations. In addition, the wide variations in reporting between hospitals render it difficult to compare their community benefit programs to each other. From the information available, it appears that upstream programming grants given to local community-based organizations represent a negligible percentage of total contributions.

The California State Auditor's 2012 report on not-for-profit hospitals found that there is no statutory standard or methodology for hospitals to follow when calculating benefits.<sup>32</sup> Therefore, one hospital might associate a price with a community benefit activity that differs from the cost another hospital assigns to the same activity. If hospitals are going to be held accountable, they must provide clear and consistent data on their community benefit contributions.

	Total Community Benefit	Medi-Cal Shortfall	Community Grants Reported	Percent Spent on Vulnerable Population*	Percent of Hospital Operating Revenue Spent on Community Benefit
<b>Sutter CPMC</b>	\$167,371,000 <sup>33</sup>	89,533,000 <sup>34</sup>	Not reported	74%	Not reported
<b>Dignity SMMC</b>	\$51,179,654 <sup>35</sup>	13,336,807 <sup>36</sup>	106,000 <sup>37</sup>	41%	13.2% <sup>38</sup>
<b>Kaiser SF</b>	\$24,300,000 <sup>39</sup>	Not reported	568,000**	Not reported	Not reported

## Unclear and Inaccessible Reporting

As shown above, it is unclear how community benefit activities align with funds claimed as community benefit and how hospitals calculate the financial benefits they claim to give. Although the law stipulates that community benefit reports and implementation plans should be made “widely available,” they tend to be buried on hospital and government websites — in spots where they are unlikely to be found except by those searching diligently.

Along with their Form 990, hospitals are required to file a Schedule H, which asks for specific details on community benefit activities.<sup>40</sup> Although hospitals claim<sup>41</sup> this creates transparency, since Form 990s are public information, in practice these filings can be difficult to access and hard for the average person to understand.<sup>42</sup> Not-for-profit hospitals are typically large systems with many hospital facilities. On a Form 990 and Schedule H, the parent corporation can combine the information from across all their individual hospital facilities,<sup>43</sup> making it impossible to understand how an individual hospital conducts its community benefit activities.


\*Calculated as the total amount spent on “Services to the Poor and Underserved” divided by the “Grand Total”

\*\*This number was calculated by adding up all the grant awards listed in “Supporting San Francisco Communities: Kaiser Permanente 2013 Community Investment Report.”

## Systematic Problems

The health care system is largely unregulated when it comes to setting charges. Hospitals are their own “chargemasters,” meaning they can set any price for their services without any incentives to keep costs low, and the public has little understanding of how hospital costs are related to charges. People in need of care don’t (and often can’t) shop around for the best prices. The charge for a typical lipid panel blood test can range from \$10 to \$10,000 in the U.S.<sup>44</sup> According to the chargemaster list for Sutter’s California Pacific Medical Center (CPMC) one pill of 325 mg. acetaminophen (generic Tylenol) costs \$0.98<sup>45</sup> while the same pill at Kaiser Foundation Hospital in San Francisco cost \$19.00.<sup>46</sup> For up to an hour of chemotherapy using an infusion technique costs \$1,405.00 at CPMC, while the same treatment at Kaiser will cost \$715.00.\* Although hospitals aren’t allowed to claim the full charge as community benefit, only the costs, there is little public transparency or understanding of what constitutes a hospital cost.

### Differences in charges for the same services at different hospitals based on hospital chargemaster list.

	325 mg Acetaminophen (Generic Tylenol)	0-60 minutes Infusion Chemotherapy
<b>Kaiser San Francisco</b>	 \$19	 \$715
<b>Sutter CPMC</b>	\$0.98	\$1,405

Source: Office of Statewide Health Planning and Development

...if the three hospitals systems studied were for-profit, in 2010 they would all rank in the Fortune 500 list.

On average, California hospitals bill \$451 for every \$100 of costs — third highest in the nation for how much charges exceed costs.<sup>47</sup> Ironically, there is a great deal of money to be made by being a not-for-profit hospital. To put this into perspective, if the three hospitals systems studied were for-profit, in 2010 they would all rank in the Fortune 500 list.<sup>48</sup>

These costs present significant limitations to community benefit. The largest portion of community benefit is given through discounted or free care known as “charity care.” A study from the Hilltop Institute examining 500 hospitals found that on average 85 percent of community benefit spending went towards subsidized or in-kind health care services.<sup>49</sup> This also includes the un- or under-reimbursed costs of providing medical care through Medicaid/Medi-Cal and other government programs. The study also showed that only 5.3 percent of community benefit went towards community health improvement. Each hospital facility individually writes off millions of dollars in charity care, but serve very few people. If hospitals invested in more community health improvement outside of their walls, their dollars could go so much farther towards preventing people from ending up in the hospital in the first place.

\*These prices come from the chargemaster lists that each hospital is required to make public in California.

## Low Rate of Medicaid Reimbursement

Medicaid/Medi-Cal payments generally do not cover the full costs of providing service. The unreimbursed rate of Medicaid or “Medicaid shortfall” is often the largest portion of community benefit claims. California’s Medi-Cal has one of the lowest reimbursement rates for Medicaid, ranking 47th out of the states.<sup>50</sup> The ACA has expanded coverage for millions of Californians, but in California only 62 percent of physicians accept new Medi-Cal patients because of this low reimbursement rate.<sup>51</sup> The Hilltop Institute predicts that full implementation of ACA would result in fewer uninsured people and likely diminish the need for discounted and charity care, potentially freeing up community benefit funds to address upstream determinants of health.<sup>52</sup> The spokesperson from the Hospital Council of Northern California disagreed with this view, countering that while the need for charity care will go down, Medi-Cal will expand under the new law, increasing the Medi-Cal shortfall hospitals claim as community benefit.<sup>53</sup> In this current climate, it seems unlikely that hospitals will decrease costs or increase the amount of funds given to upstream community benefit programs.

## Stakeholder Perspective

Stakeholder interviews identified key themes that highlighted the limitations of not-for-profit hospital community benefit, as well as potential avenues for improvement.

### Community Benefit Limitations

Generally, the public is not aware that major hospitals like Kaiser and Sutter are not-for-profits or is unfamiliar with not-for-profit hospital community benefit programs. One stakeholder whose organization receives funds from community benefit grants commented, “Generally the public doesn’t know about community benefit or charity care... People have a right to know where community benefit funds are going because it’s their community and their dollars.”<sup>54</sup> None of the other stakeholders interviewed, who represented vulnerable community groups, were familiar with community benefit requirements. These groups that represent Asian Pacific Islander, Latino, African American, LGBTQ, and homeless populations have a lot to gain by becoming familiar with hospital community benefit requirements, since their communities are often the target of community benefit programming. Hospitals need to be open and transparent with community members on how community benefit dollars are being spent, so the public can hold them accountable.

### CHNA Transparency

Outside of the reporting requirements, we also found a lack of transparency in how San Francisco hospitals conducted their CHNA. Most of the community stakeholders interviewed who took part in the CHNA were not familiar with not-for-profit hospital community benefit requirements. One stakeholder, who represented the LGBTQ community in the task force, said, “I like things to be very concrete and clear, so that you can create accountability around it, and I did not feel like we got enough of that in this process.”<sup>55</sup> The CHNA conducted jointly with the San Francisco Department of Public Health had many different objectives and groups involved, leaving it unclear to stakeholders that the countywide community health assessment would inform community benefit decisions hospitals made. Of the seven stakeholders interviewed who work for community-based organizations representing vulnerable populations, five were unaware that hospitals were using the information from the HCSMP task force to inform hospital community benefit priorities and funding decisions. One stakeholder who works with the Latino community was not fully aware that hospitals were using the information from the needs assessment to make these decisions, and said that if they had been aware, the “questions and discussions would have been different.”<sup>56</sup> When community stakeholders are asked to sit at the table and represent the needs of their communities, they need to be fully aware of how their input will be used.



Because the updated IRS guidelines require hospitals to take into account input from public health departments during the CHNA process,<sup>57</sup> more hospitals in other regions will likely conduct joint CHNAs. Collaboration with a public health department has great potential for

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hospitals to leverage the expertise and outreach capabilities of the department;<sup>58</sup> however, it should be made clear to community leaders and members involved in the process how the information will be used. One member of the San Francisco Health Improvement Partnership commented, “There is a role for advocacy and community based organizations to first be informed about how their communities are being talked about through the health needs assessment and implementation plan and then holding those hospitals accountable.”<sup>59</sup>

## Improving Community Benefit to Address Health Equity

### Need for Formal Regulations

#### Standardizing Reporting

Not-for-profit hospitals are required to comply with both state and federal community benefit requirements.<sup>60</sup> Currently in California, state and IRS requirements under the Affordable

Care Act conflict,<sup>61</sup> which makes reporting more difficult. The ACA’s community benefit language disallowed claims for bad debt and Medicare shortfall as community benefit spending. However, California still allows such claims. Regulations should be put in place to better align federal and state rules. The Hospital Council spokesperson agreed, stating, “[What] would be helpful is to make the review, regulation and transparency part of community benefit as stable and clear and consistent as possible. Hospitals spend a lot of time doing the reporting and if definitions at the local, state, and federal levels are more consistent it would make things a whole lot easier.”<sup>62</sup>

#### Clarifying Definitions

Definitions of what counts as community benefit and who counts as a vulnerable population need clarification. One stakeholder mentioned that the wide variety of reporting has to do with how the person doing the report interprets the regulations.<sup>63</sup> A hospital administrator agreed, saying, “What you give, depends on how you define it.”<sup>64</sup> If community benefit is meant to ensure those with the greatest health needs are being served, regulations need to specify how hospitals define and count community benefit. As shown in the San Francisco community benefit summary charts, hospitals take great liberty with how they categorize their community benefit dollars and what numbers they decide to make public.

#### Enforcement

Although the IRS has updated federal regulations on community benefit, it is still unclear how it will enforce these new requirements. At the state level, OSHPD is responsible for collecting the CHNA and implementation plan, but lacks authority to enforce the existing policies or audit the hospital reports.<sup>65</sup> A member of SFHIP commented, “What would really be game-changing for community benefit would be if hospitals knew that there is going to be strict enforcement around it.”<sup>66</sup> Strict enforcement or a system that graded hospitals on the quality of their community benefit could have a positive impact on service to communities in need.

## Need for Meaningful Community Engagement

Many community stakeholders interviewed felt there could be more meaningful community engagement in the CHNA and community benefit process. The ACA requirements emphasize community input as an essential element of the CHNA.<sup>67</sup> However in practice the avenues for community input are limited. The CHNA provides the only opportunity for community stakeholders to directly engage with community benefit processes, but this engagement is severely limited.

As mentioned previously, not all stakeholder community representatives realized that hospitals used the countywide CHNA to inform community benefit funding. This represents a missed opportunity. One community stakeholder stated, “As an advocate, I’m often at the table with these people [hospitals] and able to give my point of view, but it is not directly linked to their process or critiquing their plans or outcomes.”<sup>68</sup> Another commented, “You can have a lot of people in the room, but did they really participate? Did we open up the opportunity for influence?”<sup>69</sup> This comment echoed many stakeholders who felt that although their input was listened to, it wasn’t necessarily represented in the final developed priorities. Many community stakeholders felt that power players and private interests drove the process, making it difficult to push for the community voice. One stakeholder felt that the task force wanted to keep the priorities very general and all-encompassing and mentioned that it was hard to make demands on the system with big hospitals and big government institutions leading the process.<sup>70</sup> Many community stakeholders felt that the final priorities were kept too vague, when they would have preferred more specific priorities focused on populations and neighborhoods in need.

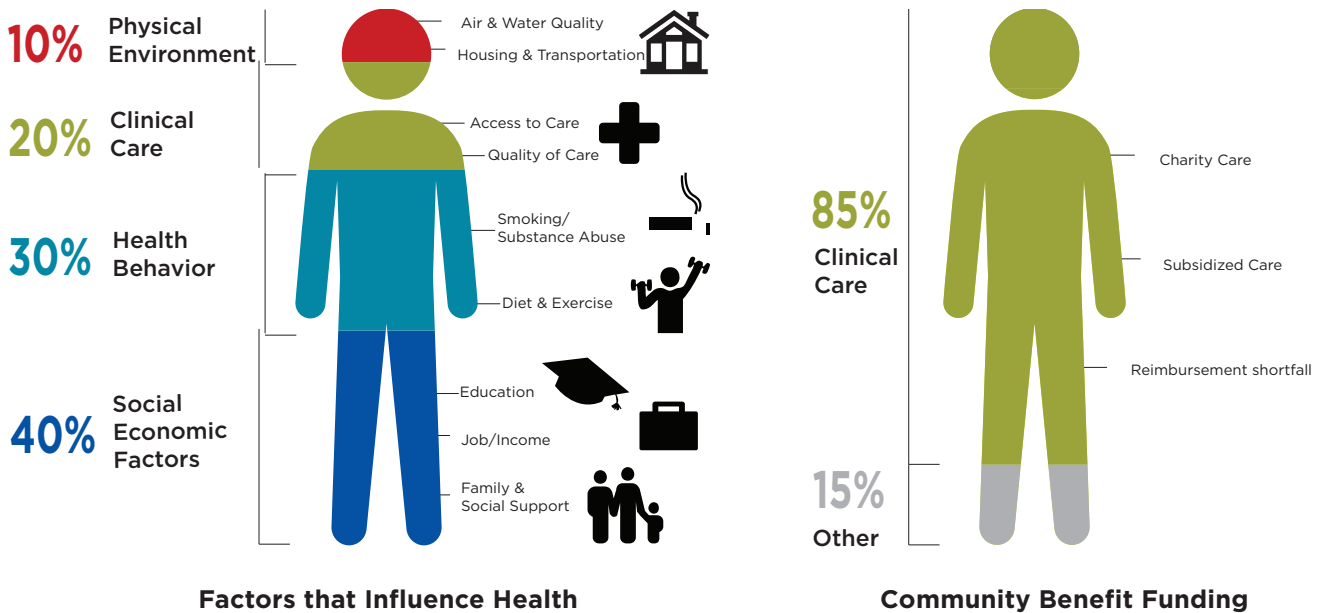
While hospitals are required to have community input on the CHNA, they do not have to take this input into account when determining priorities for their community benefit programs. The IRS allows hospitals to “use any criteria” for determining priorities to focus on,<sup>71</sup> and these priorities do not have to align with the needs identified in the CHNA. When asked about how community members could comment on a hospital CHNA document or implementation plans, the Hospital Council spokesperson commented, “There should be a ‘contact us’ link on the webpage.” When asked about what kind of messages they received and how they responded, the spokesperson referenced her previous experience working at a hospital and said, “We didn’t get responses. People didn’t line up and send us notes.”<sup>72</sup> If hospitals want to take community benefit seriously, they need to open opportunities for conversations beyond the CHNA. Even the Hospital Council spokesperson noted, “The best way to get input is through a conversation [and] community meetings. Email doesn’t allow for same richness of conversation for someone to express an opinion.”<sup>73</sup>

Community stakeholders, government institutions, and hospitals all recognize that community engagement is important, but it is not yet happening effectively. Typical formats used by large institutions to solicit community input generally contain structures or processes that can impede innovation and creative ideas. It’s commendable that San Francisco’s CHNA included 41 members in its task force, representing a broad and diverse range of interests, but the communication loop seems to have been one-sided. The process should facilitate two-way communication between hospitals and community stakeholders. One stakeholder commented, “You are not always going to get what you need, but it should feel like a partnership, that they want to invest in the health of our community.”<sup>74</sup> With greater transparency and community engagement, community representatives may have a stronger voice and ability to influence decisions affecting the scope, and direction of community benefit.

## Need for Upstream Investments

Community stakeholders as well as the Hospital Council representative agreed that more should be done to invest in addressing the social determinants of health. One stakeholder representing the African American community cited a need to be “thinking about health holistically and thinking about institutional inequities.”<sup>75</sup> Many stakeholders commented on the barriers not only to accessing health care for people of color and low-income communities, but also in maintaining a healthy lifestyle. One stakeholder stated, “When people are in crisis, their ability to overcome barriers is impacted.”<sup>76</sup> Another commented, “Even with insurance, people don’t have all the knowledge of how and when to access care.”<sup>77</sup> Research from the County Health Rankings and Roadmaps shows that clinical care accounts for only 20 percent of a person’s overall health outcomes, while other factors account for the other 80 percent (see below), with social and economic factors responsible for 40 percent of a person’s health.<sup>78</sup> Because of the astronomical cost of health care services in the U.S., research consistently shows that money invested in addressing the social determinants of health generates a higher return on investment than spending on health care.<sup>79</sup> But the system consistently fails to act upon this knowledge. Research from the Hilltop Institute on community benefit shows that on average hospitals spend 85 percent of their community benefit dollars on health care services, with only 5.3 percent directed to community health improvement.<sup>80</sup>

## Health Factors and Community Benefit Funding



## Collaborative Models

San Francisco represents an interesting model for collaboration opportunities. The information gathered from the joint CHNA informed a countywide implementation strategy, the San Francisco Community Health Improvement Plan (CHIP). The CHIP is an action plan for addressing community health needs. Community stakeholders, UC San Francisco, not-for-profit hospitals, and the public health department came together to form the San Francisco Health Improvement Partnership (SFHIP), which manages the implementation of CHIP.<sup>81</sup> The SFHIP uses a collective impact approach that brings people from different sectors together to address a common problem and think of innovative ways to address the problem of how to improve overall community health.<sup>82</sup> Some members on SFHIP's steering committee recognize that community benefit can be used as a tool to advance community health, not just as individual hospitals, but also as a collective pulling together diverse resources.<sup>83</sup>

Members of the SFHIP were interviewed regarding the effort's current challenges and potential. A member of the public health department commented that the "group has some growing pains. ...The group has some good ideas but doesn't have any real resources."<sup>84</sup> One member agreed that SFHIP has great potential but questioned, "How does cash trickle down to community based organizations?"<sup>85</sup> Another noted, "The actual execution of the collective impact approach is more conceptual than it is actual." They described the collective impact approach as a poker match where right now everyone at the table is hiding their cards, when it should be more like a potluck with everyone bringing their resources to the table.<sup>86</sup> One member would like to see the group think through "not just a hospital care plan, but a community care plan."<sup>87</sup>

While SFHIP is in its early stages, it has great potential to leverage private and public resources for the benefit of the entire community. The creation of this group with a diverse range of perspectives — representing public, private, and community interests — that meets beyond the community health needs assessment can keep the dialogue for collaboration open year-round. SFHIP can potentially be a model for other cities or regions to utilize community benefit to address community health holistically.

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## RECOMMENDATIONS

### For Legislators and Regulators

- **Legislation should be enacted to create a standard definition of community benefit.** The definition should focus on addressing health disparities by making sure hospitals maximize the amount they give to improve health outcomes for vulnerable populations. It should include community-building activities, allowing hospitals to invest in broader social determinants of health such as housing, transportation, and economic development. The definition should exclude funding of marketing and publicity activities.
- **California should enact legislation creating a standard that requires hospitals to report in detail how community benefit dollars are spent and whom they help.** Clear, standardized regulations will increase transparency around community benefit and hold hospitals accountable. At present, the public cannot determine how much funding goes to upstream programming and vulnerable populations. These rules should make it possible for community members to compare community benefit work between hospitals.

Led by OSHPD, a statewide group of leaders representing hospitals, community-based organizations, public health experts, and those researching community benefit should come together to develop reporting standards for all hospitals. This would allow stakeholders and hospitals to come to an agreement on what information is most valuable to the public, without asking hospitals to over-report.

- **Legislation should be passed establishing the Medicare reimbursement rate as the standard charge for services and supplies that can be claimed as charity care.** Present large differences in charges mean that two hospitals can claim vastly different amounts of charity care for the same services. Although hospitals are not allowed to claim the full charge as community benefit, only the cost, there is no transparency around the true costs for these services. Research shows that the reimbursement rate for Medicare patients approximates the true cost of service.<sup>88</sup>
- **Other regions should emulate the model established by the San Francisco Health Improvement Partnership (SFHIP), which has potential to utilize community benefit as a tool for improving overall community health, and San Francisco should develop this model further.** The diversity of perspectives and expertise on SFHIP should be used to guide hospitals to make community benefit decisions that reinforce overall community health needs. Rather than each hospital making individual priorities and plans, hospitals can coordinate their efforts to make deeper and more meaningful investments. SFHIP can benefit from an outside consultant with technical expertise in implementing a true collective impact approach.
- **The California Office of Statewide Health Planning and Development (OSHPD) should have the authority to analyze community benefit plans and rate hospitals based on how well their community benefit plans address community health needs.** This would highlight hospitals that do great work, while pushing those with low ratings to improve. Hospitals that consistently receive low ratings should have their nonprofit status revoked. This program could be modeled on existing rating systems, such as Community Reinvestment Act ratings of banks.

## For Hospitals

- **Hospitals must develop a process for meaningful community engagement in both the Community Health Needs Assessment (CHNA) process and the implementation plan in order to make the biggest impact with their community benefit dollars.** Community members should be included during all stages of hospital community benefit decision-making. This could happen through a community benefit committee that includes external members who represent vulnerable populations, which should have a voice in setting community benefit priorities and the allocation of funding. Opportunities for public comments on a CHNA and community benefit implementation plans must be robust and meaningful, not just a “contact us” link buried at the bottom of a website.
- **Hospitals should increase their funding allocations for upstream investments to further address the root causes of health inequity, including investing in education, housing, the environment, community development and overall wellness.** If hospitals invested more in prevention programs and community building activities, they could reduce the number of people who end up in the emergency room. Hospitals don’t need to be experts in this arena, but can strategically give funding to organizations that are; these investments can be made in coordination with other regulated entities, like banks and Community Development Financial Institutions in order to increase the scope of projects and programs, and the return on investment.

## For Community Advocates

- **Organizations working on community benefit should develop educational tools for the community and form a coalition to build awareness of community benefit.** Advocates should take the lead in informing the public on not-for-profit community benefit practices and build widespread support to hold hospitals accountable. If a big network comes together to push hospitals for more transparency, hospitals are more likely to pay attention and legislators are more likely to pass needed reforms.

## CONCLUSION

San Francisco has taken many steps that could lead to better alignment of hospital community benefit expenditures with pressing community health needs. These admirable efforts, however, are greatly hampered by incomplete and inconsistent reporting coupled with inadequate communication between hospitals, community advocates, and the public. Even a city that appears to be trying hard to do the right thing is presently falling short because of systemic limitations. Hospitals whose mission statements focus on “serving those most in need”<sup>89</sup> with “long-standing commitment to the communities”<sup>90</sup> need to go beyond just giving out charity care to make deep investments outside of the hospital walls.

The health inequities facing communities of color are not surmountable with small grants. The complication of our health care system and the prevalence of barriers creating poor health outcomes require deep, meaningful investments and collaboration between hospitals and the communities they serve. Community benefit is not the singular solution, but it can be better used as a tool to have a more meaningful impact on health inequity. The concrete reforms outlined in this report can help bring that about.

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