“Wisconsin Hospitals: Connecting with our Communities”

A Report of the

WHA Task Force on Community Benefits

November 2005

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A. INTRODUCTION/BACKGROUND

Wisconsin's hospitals were developed by communities and religious orders to meet community need for healthcare and health. This is a proud tradition that continues today. But what hospitals have not been good at is telling our story. As a result, non-profit hospitals are under attack nationally for a variety of issues, including billing and collection practices. Additionally, members of Congress, state legislatures and local community leaders are questioning historic tax-exempt status. Tough questions are being asked that are predicated on the belief that not-for-profit community hospitals are little different than for-profit businesses when it comes to attitude, practice and operation.

A number of national organizations, including the American Hospital Association (AHA), the Catholic Health Association (CHA) and VHA, Inc., have closely examined the difficult environment. They have determined that measuring and reporting community benefits provided by not-for-profit community hospitals is a proactive means to address ongoing questions raised by policymakers. Those organizations argue that today, perhaps in contrast to years past, the community benefit role of not-for-profit health care organizations is not well understood, even by persons within our institutions and organizations. These national organizations are beginning to embrace the notion that a standardized approach to measuring and reporting community benefits that uses a uniform methodology is necessary and desirable.

In Wisconsin, many of the same circumstances are being observed. Lawsuits are being filed which allege that non-profit hospitals are inappropriately billing the uninsured, and some are saying that non-profit hospitals appear to be behaving much like for-profit organizations. The WHA Board, after reviewing the State and national environment, established a Task Force on Community Benefits and charged it to review these issues and determine if a WHA-led Wisconsin initiative on Community Benefits is necessary or appropriate.

This document summarizes the activities of the Task Force, and outlines the strategies it recommends to address the public perception problems outlined above.

B. ENVIRONMENTAL FACTORS

1. Tax/Legal Background

<u>Income Tax Exemption</u> – A number of benefits accrue to organizations as a result of having 501(c)(3) tax-exempt status. First, obviously, is exemption from federal income tax. Wisconsin hospitals totaled over $800 million in profits in 2004. If that amount were subject to taxation on that income, hospitals would have had to pay almost $300 million in Federal taxes. In addition, Wisconsin's corporate income tax would have been an additional $68 million.

Other financial benefits are available to non-profit organizations as well. Tax exempt contributions can be made to these entities, and tax exempt financing is also available, making borrowing less expensive than that available in the for profit arena.

Criteria for Federal tax exemption – In order for an organization to be granted tax-exempt status, it must be organized and operated for charitable purposes. The assets must be for limited purposes, i.e., dedicated for not-for-profit purposes only, and not used for the benefit of any individual.

In addition, not-for-profit hospitals must meet what the IRS calls a "community benefit standard". The meaning of community benefits is spelled out in the IRS Revenue Ruling 69-545. In that ruling, the IRS provided a definition and gave a number of criteria that help clarify the meaning. IRS 69-545 defines community benefits as: "The promotion of the health of a class of persons is deemed a 501(c)(3) charitable purpose that is beneficial to the community provided that the class is not so small that its relief is not of benefit to the community. " The criteria enumerated include:

- An emergency room open to all without regard for ability to pay
- Governance by a board representing the community
- An open medical staff
- Non-discrimination toward Medicare and Medicaid beneficiaries
- Any surplus would be used for additional services or facilities for the community
- Have in place charity care policies directed at those in need

2. Perceptions of the Public and Policymakers

Billing the Uninsured – Over the past several years, lawsuits have been filed against 70 health systems in 32 states by the Scruggs law firm of Mississippi. Allegations include: Charging their uninsured patients significantly more than those who have Insurance, Medicare or Medicaid; pursuing the poor or uninsured relentlessly by aggressive and humiliating collection techniques; and rampantly violating federal and state prohibition against profiteering by "private interests". Wisconsin has seen its own lawsuits, not sponsored by the Scruggs firm, but making the same allegations.

Thus far there have been no settlements, and many of these suits are being thrown out. But the fallout in terms of damaged public perception of not-for-profit hospitals continues to linger.

Congressional Hearings – A number of Committees of Congress have been holding hearings on tax exemption in general, and not-for-profit hospitals in particular. For example, the House Energy and Commerce Oversight and Investigations Subcommittee held hearings on hospital billing practices and collections pertaining to the uninsured. The House Ways and Means Oversight Subcommittee examined hospital pricing practices. And the Senate Finance Committee will be holding hearings on whether not-for-profit hospitals are earning their tax-exempt status.

Several comments made at the House Ways and Means Oversight Committee are noteworthy. The General Accountability Office, for example, stated that the differences between the nonprofit and for-profit groups were often small; that uncompensated care costs were not evenly distributed among hospitals; and that other benefits hospitals reported are hard to distinguish and impossible to compare among non-profit and for-profit hospitals.

Another comment reflects the opinions of many policy makers: *"Lack of reporting information and transparency makes it difficult to answer how much community benefit hospitals provide. Most nonprofits do not earn the value of their tax-exemptions with charity care."* Nancy Kane, Professor of Health Policy and Management at the Harvard School of Public Health.

The Senate Finance Committee will be holding hearings in early 2006, and in preparation for them, Chairman Grassley has sent a list of questions to 12 large health systems. The questions illustrate some skepticism regarding adherence to the requirements for tax exemption:

- How does your organization define charity care?
- What types of activities or programs does your organization include in its definition or determination of charity care?
- Which of these activities or programs would your organization not incur, at all or to the same extent, if you were organized and operated as a for-profit hospital?
- Does your organization maintain a charity policy? If so, please describe the policy or provide a copy of it. Does it require certain types and amounts of charity care be provided?

In summary, it is safe to say that many in the public arena are questioning whether not-for-profit hospitals are in fact conforming to the requirements for tax-exempt status. Legal and legislative challenges appear to be continuing and even intensifying.

C. A COMMUNITY BENEFIT REPORTING INITIATIVE FOR WISCONSIN

The Task Force assessed the environment facing Wisconsin's not-for-profit hospitals, and determined that WHA should initiate a voluntary reporting system of community benefits.

In designing the system, the Task Force had to answer a number of questions:

- How do we arrive at a standard definition for community benefits?
- What messages do we want to convey?
  - How often?
  - By what methods?
  - Who are our audiences?
- How do we gather the information?

1. DEFINING COMMUNITY BENEFITS

In order for us to effectively communicate regarding our community benefit activities, we first must agree on what we mean by the term. The concept of community benefits has evolved over time, with the most commonly accepted definition coming from the joint effort of the Catholic Health Association (CHA) and the Voluntary Hospital Association (VHA). Their publication, "Community Benefit Reporting: Guidelines and Standard Definitions for the Community Benefit Inventory for Social Accountability" (Guidelines), has been used by the not-for-profit hospital industry as the standard source for defining and calculating community benefits activities.

The Task Force elected to use the CHA/VHA definitions in its design for a reporting system.

The CHA/VHA define community benefits as: "*A community benefit is a planned, managed, organized, and measured approach to a health care organization's participation in meeting identified community health needs. It implies collaboration with a "community" to "benefit" its residents—particularly the poor, minorities, and other underserved groups—by improving health status and quality of life*." They further elaborate by saying: "*Community benefits respond to an identified community need and meet at least one of the following criteria:*

- *It generates a low or negative margin*
- *It responds to needs of special populations, such as minorities, frail elderly, poor persons with disabilities, the chronically mentally ill, and persons with AIDS*
- *It provides services or programs that would likely be discontinued if the decision were made on a purely financial basis*"

Generally, Community benefits are categorized into two main areas: charity care and government program underfunding; and the five specific activities outlined below:

- **Community Health Education and Prevention Services**
    - Community Health Education
    - Community-Based Clinical Services
    - Health Care Support Services

- **Health Professions Education**
    - Physicians/Medical Students
    - Scholarships/Funding for Professional Education
    - Nurses/Nursing Students
    - Technicians
    - Other Health Professional Education

- **Subsidized Health Services**
    - Emergency and Trauma Services
    - Neonatal Intensive Care
    - Hospital Outpatient Services
    - Burn Unit
    - Women's and Children's Services
    - Renal Dialysis Services
    - Hospice/Home Care/Adult Day Care
    - Behavioral Health Services

- **Research**
    - Clinical Research
    - Community Health

- **Financial Contributions**
    - Cash Donations
    - Grants

- In-Kind Donations
- Cost of Fund-Raising for Community Programs

Relative to charity care and government program underfunding, the Task Force decided on the following:

> **Charity Care** is defined as free or discounted health and health-related services provided to persons who cannot afford to pay, and from which no payment is expected. Charity care will be calculated using costs, and not charges, as has been customary in Wisconsin.
>
> **Government Program Underfunding** will be confined to the Medicaid program, and to the dollar shortfall between payment and the costs of providing services to the recipients of the program. The Task Force discussed whether to also include the Medicare program shortfalls, and determined that, since essentially all hospitals, including for-profit hospitals, provide care to Medicare patients, that Medicare shortfalls would not be counted as community benefits.

The Guidelines also provide methods for calculating the cost of community benefits and capturing other pertinent information.

2. COMMUNICATIONS PLAN

The key elements of any communications plan are: defining the communication goals; identifying the audiences; and developing the appropriate communication materials and vehicles. Our effort has four main goals. They include:

- Proactively informing key audiences of the strengths and contributions of Wisconsin hospitals (i.e. community benefit reporting).
- Promoting the idea of quality and compassionate health care through consistent messages from Wisconsin hospitals.
- Utilizing recommended themes and messages derived from work groups that WHA recommends be convened during the summer of 2005.
- Demonstrating that the community benefit purpose is being fulfilled.

The key audiences for our plan include both internal and external audiences that include hospital staff and governance, local and statewide publics, and policymakers at all levels. Ideally, each hospital will need to tailor their key audiences based on their individual situation, but it is likely that the list will include most of the following:

<u>Internal Audiences</u>
Board of Trustees
Community Advisory Committees
Hospital staff at all levels
Volunteers
Physicians
Patients

External Audiences
Community leaders and partners
General Public
News media
Policy Makers

The key messages will include the primary message that hospitals throughout Wisconsin annually provide community benefits, and those activities show that our hospitals:

- Care about the health of our communities.
- Are committed to access for all.
- Go beyond facility walls: are committed to community partnerships and collaboration.
- Have a commitment to quality.
- Are caring and compassionate.

What will make the communication of these themes more effective will be the combining of data with real life stories. In other words, in addition to providing facts and figures about what the activities were, we need to show how those community benefits impacted the lives of those served. So the format of our communications will include:

- Tell real life stories
- Provide data in tables and charts that are easy to understand
- Provide examples of activities that hospitals have carried out in the community
- Show how hospitals have collaborated with other stakeholders in the community
- Provide testimonials from those who have benefited

Communication vehicles should be tied to the audience. The chart below lists the possible communication vehicle and target audience:

Table 1. COMMUNICATION VEHICLES AND AUDIENCES

Internal	Brochure	Web Site	Print Ads	Letters	News releases	Posters	Valued Voice articles	Presen-tations
Board of Directors	X	X				X	X	X
Hospital Leadership	X	X				X	X	X
Department heads	X	X				X	X	X
Employees	X	X		X		X	X	X
Volunteers	X	X		X		X	X	

Physicians	X	X		X				X
Patients & Residents	X	X				X	X	
External								
Community leaders	X	X		X				
General public	X	X						
Policy makers	X	X		X	X			X
Newspaper		X	X					
Magazines		X	X					
Trade press		X	X					
Television		X						
Radio	X			X				

3. Gathering Data

To develop a plan for gathering the data, the Task Force assigned a Data Work Group. The Work Group looked first at the standard definitions for community benefits, because these are the data elements – numbers of services and dollars expended – that will comprise the statistical part of our communications. The Work Group then evaluated currently available data and the processes used to gather that data.

Currently, all Wisconsin hospitals are required to submit bad debt and charity care information to the State of Wisconsin. The Work Group felt that this mandated report would serve our needs for the charity care portion of community benefits.

To understand to what extent hospitals are reporting on the other community benefits, the Work Group conducted a survey and found that over 70% of all Wisconsin hospitals provide and accumulate information on community benefits. Furthermore, over 60% use the CHA definitions. So information is being generated, and mainly in the format that we would need. However, no centralized data base exists for these community benefits. Hospitals are reporting to their individual communities, or to their sponsors, but nothing exists on a statewide basis.

The Work Group evaluated a number of alternatives, concentrating on either creating a survey instrument or licensing an existing one. After investigating the alternatives, the Work Group recommended to the Task Force that we license the survey instrument used by the Michigan Hospital Association. The Work Group recommended the MHA instrument because:

- It is an online tool, providing ease of data entry
- It follows a modified version of CHA definitions, ensuring uniformity

- WHA could supplement the survey with data sources already available, including the uncompensated care survey and fiscal survey
- It is already in use in paper form in Michigan, so it has been tested
- There would be no need for WHA development
- Licensing, training, and implementation could be accomplished by end of the first quarter 2006, which would be responsive to our timetable to have reports by the middle of 2006

Training would include both data entry onto the survey instrument as well as accumulation of data on community benefit activities prior to entering information into the survey.

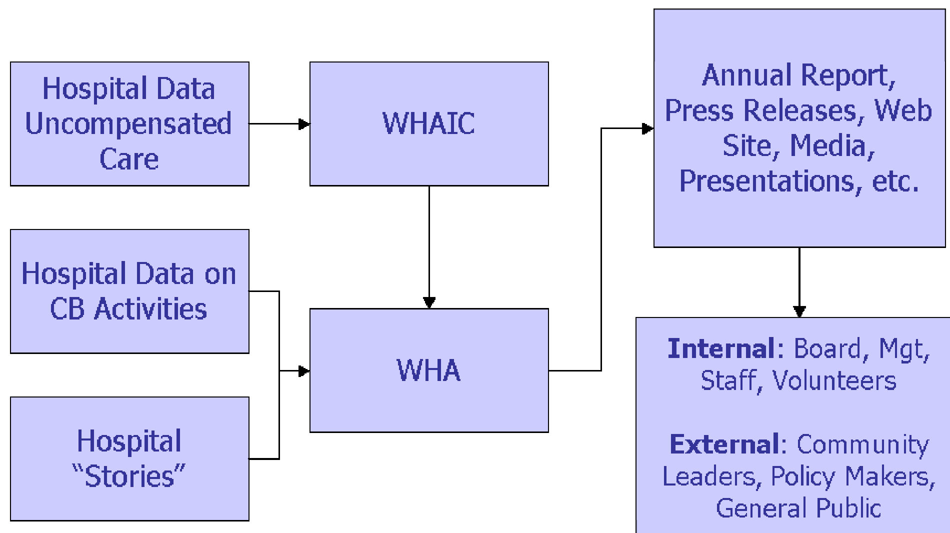
4. GATHERING STORIES

As stated above, stories – or the narrative – will put "flesh and bones" on the data, and provide a more compelling case than data alone about what hospitals are doing for their communities. A Communications Work Group was assigned to develop a plan and process for gathering stories from hospitals. The nature of the information is such that a survey instrument would not be as useful as it would be for data only, so the Work Group suggested the following:

- Identify "Story Ideas"
  - Follow State Health Plan 11 Health Priorities
  - "Real People Stories" that set us apart from other industries that deliver benefits in the community
- Collect Stories
  - Provide Template
  - Provide sample stories
  - Collect from all employees, but put some one in charge
- Report and Publish:
  - Publish in Newsletter on a monthly basis, one health priority each month with stories submitted by the hospitals
  - Statewide Annual Report on Community Benefit
  - At the statewide and local news conferences or editorial board meetings
  - With legislators, taxing authorities, civic organizations
  - Joint news opportunities would present with hospitals and public health departments (also with WHA and DHFS/State Health Dept.)
- Develop Wisconsin Hospitals' Community Benefit Web site to Report Results
- The process will be continuous for collecting and publishing
- Conduct training on how to collect stories
- Role of hospital CEOs:
  - Encourage submission of stories, and reward it
  - Present at civic organizations and employee meetings
  - Tell the local news media what you're doing
  - Release a "Report to the Community"

The communications work group would continue in existence to aid in the accumulation of stories and the development of ongoing themes.

The following chart illustrates the conceptual design of our data/story gathering and reporting system.



5. TIMETABLE AND RESPONSIBILITIES

Our goal is to deliver a statewide report by the middle of 2006. In order to meet that timetable, a number of processes need to be in place, and data/story gathering needs to be underway. The following table outlines the tasks, responsibilities and timing.

Table 2. Suggested Timetable and Responsibilities

Task	Responsible	Due Date	Status
Develop data gathering methodology	Data Work Group	October 2005	Completed
Identify working themes and develop story templates	Communications Work Group	October 2005	Completed
Board approval	Board, WHA staff	December 2005	
Packets of materials delivered to members	WHA staff	January 2006	
Training on survey	Members/WHA staff	First quarter 2006	
Begin gathering data	Members/WHA staff	First quarter 2006	
Begin gathering stories	Members/WHA staff	First quarter 2006	
Draft report, press releases, talking points, etc	WHA staff	Mid 2006	