Flex Monitoring Team
STATE DATA REPORT
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Community Impact & Benefit Activities of CAHs, Other Rural, and Urban Hospitals, 2014

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KEY FINDINGS:

- In general, CAHs were less likely than other rural and urban hospitals to provide certain community benefit and essential services (e.g., health screenings, community outreach, enrollment assistance, substance abuse, psychiatric, obstetrical, dental, palliative, and hospice services) reflected in the core service and financial community benefit indicators we examined.
- CAHs were more likely than other rural and urban hospitals to offer long term care, ambulance, and adult day care services.
- CAHs reported lower rates of charity care and greater rates of non-Medicare and non-reimbursable Medicare bad debt than other rural and urban hospitals.

INTRODUCTION

Non-profit and publicly-owned hospitals, including Critical Access Hospitals (CAHs), have obligations to address the health needs of their communities. Non-profit hospitals are required to report their community benefit activities to the Internal Revenue Service using Form 990, Schedule H. Community benefit activities are programs and services that provide treatment and/or promote health in response to identified community needs. Publicly-owned hospitals are held accountable to the needs of their communities through the oversight of their governing boards and local governments. In order to monitor the community impact and benefit activities of CAHs and understand whether and how their community impact and benefit profiles differ from those of other hospitals, we compared CAHs to other rural and urban hospitals using a set of indicators developed by the Flex Monitoring Team (FMT). We have prepared a series of tables to allow State Flex Program and CAH administrators to compare the community impact and benefit profiles of CAHs nationally (Tables 1 and 2) to the performance of CAHs in their state (see links to state-specific tables on page 5). Table 1 provides data for select measures of community impact and benefit activity as well as the provision of essential health care services that are typically difficult to access in many rural communities. Table 2 provides data on hospital charity care, bad debt, and uncompensated care activities.

APPROACH

This report uses data from the American Hospital Association (AHA) Annual Survey Database and Worksheet S-10 cost report data from the Center for Medicare and Medicaid Services (Form CMS-2552-10) for fiscal year 2014 to examine the community benefit profiles of CAHs with those of other hospitals. We linked the AHA Survey data with the Flex Monitoring Team's list of CAHs (as of April 6, 2016) to identify CAHs in the dataset and with the 2013 Rural Urban Continuum Codes (RUCCs) to classify the remaining hospitals as either rural (RUCCs 4 through 9) or urban (RUCCs 1 through 3). This resulting dataset was then linked to Worksheet S-10 cost report data retrieved

from the Center for Medicare and Medicaid Services website. The 2014 AHA database contains self-reported data on 1,324 CAHs, 852 other rural general medical and surgical hospitals, and 2,309 urban general medical and surgical hospitals. Cost report data were not available for all AHA survey respondents. Hospitals located in Puerto Rico, the Marshall Islands, Guam, American Samoa, the Virgin Islands, and the Northern Mariana Islands were excluded from the analysis.

The FMT developed "core" and "financial" indicators of community benefit activity. The core indicators show the provision of community benefit and essential health services directly by hospitals or through participation in a health system or joint venture. The financial indicators compare the levels of charity care, bad debt, total uncompensated care, and unreimbursed costs of serving patients covered by means-tested government programs (i.e., Medicaid, State Children's Health Insurance Programs (SCHIP), and other state and local indigent care programs) across all hospital types (i.e. CAH, other rural, and urban). The calculation of charity care and bad debt performance as a percentage of adjusted revenue allows for comparison across hospitals regardless of differences in volume, service mix, and charge rates.

RESULTS

Services Offered by Hospitals

We compared CAH involvement in the provision of community impact and benefit services, including essential community services, to the performance of other rural and urban hospitals (Table 1, page 4). CAHs were less likely than other rural and urban hospitals to offer traditional community benefit services and programs such as health screenings, enrollment assistance, health fairs, community health education, health screenings, and research. They were also less likely to offer certain essential services such as substance use treatment, dental care, hemodialysis, hospice care, obstetrical care, psychiatric services, and palliative care or be designated as a certified trauma center.

CAHs, on the other hand, were more likely than other rural and urban hospitals to offer essential services such as adult day care, ambulance services, and a range of long-term care services including skilled nursing, intermediate, and other long-term care (e.g., residential or elderly care) services.

CAHs were more likely than other rural hospitals, but less likely than urban hospitals, to operate indigent care and immunization programs. CAHs and urban hospitals were less likely than other rural hospitals to offer home health services.

Services Offered by Hospital Systems and Joint Ventures

Given that hospital involvement in health systems or joint ventures can expand the availability of services within communities, we examined the extent to which participation in a health system or a joint venture contributed to improvements in the level of community benefits and/or essential services by hospitals (Table 1, page 4). Generally speaking, involvement in a health system or joint venture expanded the overall level of services available in urban communities more than in rural communities but, with a few exceptions, did alter the overall patterns of community benefit and/or essential service provided by Critical Access, other rural, and urban hospitals. Health system or joint venture participation had the greatest impact on the availability of ambulance services, home health, hospice care, any psychiatric services, and dental services across all three hospital types.

Charity Care and Bad Debt Spending Patterns

The four financial indicators developed using the S-10 cost report data are expressed as a percentage of adjusted revenue and used to estimate the relative differences in uncompensated care (i.e., charity care and bad debt) spending patterns between CAHs and other hospitals (Table 2, page 5). When viewed as a percentage of adjusted revenues, urban hospitals provided greater rates of charity care than other rural hospitals and CAHs. In contrast, CAHs had higher rates of non-Medicare and non-reimbursable Medicare bad debt compared to other rural and urban hospitals respectively. Overall, CAHs provided slightly lower rates of uncompensated care than other rural hospitals, but higher rates than urban hospitals. Finally, the total unreimbursed costs for Medicaid, SCHIP and state and local indigent care programs (the difference between the cost of providing these services and the amount hospitals are

reimbursed by the programs) was relatively similar for all hospital types.

CONCLUSIONS

In general, CAHs were less likely than other rural and urban hospitals to provide certain community benefit and essential services (e.g., health screenings, community outreach, enrollment assistance, substance abuse, psychiatric, obstetrical, dental, palliative, and hospice services) reflected in the core service and financial community benefit indicators we examined. This may be attributable to their smaller size and more vulnerable financial status. However, CAHs were more likely than other rural and urban hospitals to offer long term care, ambulance, and adult day care services. Indicators on which CAHs outperform other hospitals may indicate areas where CAHs fill critical gaps in the local safety net. Participation in systems or joint ventures provides opportunities to develop and offer services that hospitals could not otherwise offer on their own. With regard to the financial community benefit indicators, CAHs reported lower rates of charity care and greater rates of non-Medicare and non-reimbursable Medicare bad debt than other rural and urban hospitals. Further research is needed to understand the factors driving variations in community benefit activity by CAHs and the resources and incentives needed to help CAHs refine and target their community benefit activity.

(Tables 1-2 begin on next page)

Table 1. National Comparison of Service Indicators

Indicator	Hospital Provides Service[1]			System and/or Joint Venture Provides Service		
	% CAHs[2]	% Other Rural[2]	% Urban[2]	% CAHs[2]	% Other Rural[2]	% Urban[2]
Community outreach	65.1	74.0	86.1	69.7	77.0	90.9
Enrollment assistance services	48.8	57.8	77.1	56.1	67.2	88.3
Health fair	79.4	85.8	85.9	85.7	88.8	92.5
Community health education	79.2	85.2	89.5	84.2	87.6	94.0
Health screenings	83.1	88.2	89.8	86.3	90.5	94.3
Health research	1.9	9.3	45.0	9.6	15.5	60.6
Immunization program	46.0	39.4	50.8	54.4	44.6	64.2
Indigent care clinic	10.4	9.9	25.2	18.8	20.8	48.5
Adult day care	5.2	3.4	4.1	8.3	6.6	16.2
Any substance use services	5.6	11.8	26.0	15.0	19.6	47.3
Substance use inpatient care	3.0	6.7	13.2	7.7	11.9	30.6
Substance use outpatient care	3.4	9.0	22.3	11.5	16.1	43.8
Ambulance services	21.9	20.3	14.7	48.0	41.5	53.9
Certified trauma center[3]	42.0	44.0	46.6	45.7	46.7	58.9
Dental services	5.9	20.5	30.3	25.9	29.9	46.4
Hemodialysis	3.1	21.2	54.4	16.0	45.4	87.7
Home health services	26.9	41.3	26.9	51.7	63.1	68.1
Hospice program	18.3	23.9	27.0	60.0	58.5	74.2
Obstetrics care	36.1	79.6	78.4	42.8	81.3	86.7
Any psychiatric services	24.9	45.7	61.7	45.3	55.5	79.0
Psychiatric inpatient care	7.1	32.7	45.7	15.0	37.8	65.0
Psychiatric outpatient care	21.2	37.5	56.8	42.0	47.6	75.1
Palliative care program	17.3	28.1	59.5	31.3	39.0	73.5
Inpatient palliative care unit	4.3	7.6	17.2	11.3	12.1	28.1
Any long-term care	47.4	29.1	23.6	51.6	36.3	44.4
Skilled nursing care	42.1	26.0	19.1	46.6	32.7	39.2
Intermediate nursing care	15.4	7.2	7.1	19.4	11.5	20.7
Other long-term care	9.9	6.1	5.6	13.6	9.9	16.3

Source: 2014 American Hospital Association Annual Survey

[1]The United States Department of Agriculture's 2013 Rural Urban Continuum Codes (RUCCs) were used to classify non-Critical Access Hospitals as either "other rural" (RUCCs 4 through 9) or "urban" (RUCCs 1 through 3).

[2]N=1,324 CAHs, 852 other rural hospitals, and 2,309 urban hospitals.

[3]Because of the nature and wording of the AHA survey, hospital responses may not align with state and/or American College of Surgeons (ACS) lists of certified trauma centers.

Table 2. National Comparison of Uncompensated Care and Unreimbursed Cost of Means-Tested Government Programs

Indicator (expressed as a percentage of adjusted revenue)	% CAHs	% Other Rural	% Urban
Uncompensated care costs (total charity care and bad debt)	5.8	6.0	4.3
Charity care costs	1.6	1.9	2.1
Bad debt costs (Non-Medicare and non-reimbursable Medicare)	4.3	4.2	2.2
Unreimbursed cost of means-tested government programs (Medicaid, SCHIP, and state/local indigent care)	3.9	3.7	3.7

Source: 2014 Medicare Hospital Cost Reports, Form CMS-2552-10

Notes:

- Comparison hospitals include all general medical and surgical hospitals operating in the 45 states where CAHs operate. Due to refinements in the comparison group construction methodology and data cleaning process, data for other rural and urban hospitals in this report are not comparable to data for other rural and urban hospitals in earlier reports. CAH data is comparable across years.
- Cost report data were not available for all American Hospital Association survey respondents. Additionally, sample sizes vary across the four cost report indicators due to inconsistent reporting practices by the hospitals and are not reported.
- Cost report data include Worksheet S-10 line 19 (total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs); line 23, column 3 (cost of charity care), line 29 (cost of non-Medicare and non-reimbursable Medicare bad debt expense); and line 30 (cost of uncompensated care). Hospital revenue data is from Worksheet G-3 line 3 (net patient revenues).
- Six hospitals (one CAH, one other rural, and four urban) that reported one or more cost report indicator spending total that exceeded their adjusted revenue figure were removed from the cost report analyses.