

# CHA's Community Benefit Evolution Reaps Health Care Results

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It was April 1988, my second week on the job and first board meeting. Policy expert Larry Lewin (may he rest in peace), was leading the Catholic Health Association board through recent attacks on hospital tax-exemption.

A large nonprofit health system in Utah was being asked to pay state taxes for the first time. In Vermont, Burlington Mayor Bernie Sanders sent a local hospital a \$2.9 million tax bill. Rep. Pete Stark, chair of the House Ways and Means Subcommittee on Health, was instrumental in taking away federal tax-exemption of nonprofit health plans.

The powerful chair of the House Ways and Means Committee, Dan Rostenkowski (may he also rest in peace), was questioning why nonprofit hospitals were not taxed. Fueling his concerns, a Harvard Business School professor had just published an article claiming that there was little difference in the amount of uncompensated care provided by for-profit and nonprofit hospitals.

What is the difference between for-profit and nonprofit hospitals?

In 1987, *Health Progress* reported on the testimony of then-CHA board secretary-treasurer Sr. Bernice Coreil, DC, before the House Ways and Means Oversight Committee on the difference between these sectors. Her testimony noted, "The fundamental distinction between the not-for-profit and for-profit healthcare sectors is their essential purpose, their mission ... The purpose of the not-for-profit sector is *for* healing, *for* community service, and *for* medical education and research ..."

When Lewin talked to the CHA board, he questioned the findings of the Harvard study. Regina Hertzlinger, the researcher, was wrong in many ways, said Lewin. First, uncompensated care was not a proper measure because it combined bad debt and charity care. Bad debt is an expense borne by businesses, but charity care is financial assistance granted to low-income patients unable to pay some or all of their bills. But more importantly, he said, the Harvard study neglected to look at the key differences between the two sectors: their involvement in health professional education and research, how they subsidize needed services and their activities that improve the health of communities.

Lewin had been invited to the CHA board meeting because he and others had just published their views in *The New England Journal of Medicine* article, "Setting the Record Straight." A *Health Progress* story summarized his remarks to CHA's board. "The threats to tax status are real," he said. "... In the game of defending tax-exempt status, winning is not enough. The best thing is to avoid having to come on the field in the first place, by taking a proactive stance to avoid attack."

The board accepted the challenge to be proactive and asked Lewin to help quantify the differences he had outlined in *The New England Journal of Medicine* article.

So, in my second week at CHA, I found my job description: work with a board committee, chaired by Sr. Coreil and Lewin's organization to explore what distinguishes Catholic and other not-for-profit health care from the emerging for-profit hospital industry and find a way to document the difference.

We visited hospitals and health systems throughout the country and recorded what they did to serve their communities, how they did it and how they kept track. We found wonderful and creative examples of how Catholic health care organizations were responding to needs in their communities, especially the need of low-income and vulnerable people. We also found examples of how systems were making these activities possible:

- The Daughters of Charity Health System had an accounting system to document how its organizations were serving people living in poverty.

- Catholic Healthcare West was using strategic planning to plan community services.

- Sr. Linda Werthman, RSM, from the Mercy System in Farmington Hills, Mich., was using census and other public data to assess community need.

Sr. Coreil's committee reviewed our findings and started to shape CHA's policy and activities. They had lively discussions. This is what I remember:

- One member said that if his large family gave only the money to favorite charities that was left after paying its bills and day-to-day costs, the family would never be able to make contributions. Instead, he had to put those modest expenses in the family budget. That is what our hospitals must do, he said, budget for charity care and other services.

- Another member added that hospitals' budgets were perhaps their most significant religious document, because they revealed value commitments and a practical sense of mission.

- Committee members were concerned that Medicare was changing its reimbursement system for hospitals, moving from a cost basis to paying per diagnosis. This would make hospitals

more cost-conscious than ever. They asked: Will this mean community services will be the first to go? We shouldn't let this happen.

- What if we help hospitals meet needs of the poorest in our communities, will it put "band-aids" on structured problems and let the government shun its responsibility?

The result of the staff and committee work was the *Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint*. This document categorized the community services provided by

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nonprofit hospitals and described a process for how to plan, track and report these services. Perhaps most importantly, the *Social Accountability Budget* included a financial accounting system that enabled hospitals to both budget and track expenses.

As the book went through the CHA review process, it was sharpened and designed to be readable. This was important because one reviewer said, "This is very good but dry, it reads like an IRS manual." (The second half of this remark would prove to be forward-looking as the story goes on.)

In announcing the book in *Health Progress*, Virginia Pearson and I wrote that its purpose was not just to protect tax status but to help Catholic health care facilities carry out their tradition of serving those most in need, despite increasing financial constraints. (Pearson was then directing communications for the Sisters of the Sorrowful Mother (SSM) Ministry Corp. in Wisconsin.) To the amazement of CHA's publication department, the *Social Accountability Budget* became an instant success. Orders came in from all over the country, from Catholic and other nonprofit hospi-

tals. The Healthcare Association of New York State ordered 400 copies.

Lewin's team and I hit the road to promote the book to Catholic health systems. Concepts related to planning and tracking community services were well received. However, reporting what we in Catholic health care do was less popular. "It does not seem right to brag about what we do for the poor," we were told repeatedly. In fact, at one system meeting where we were presenting the framework for reporting community benefit, the program began with a reading from Matthew's Gospel about not letting the left hand know what the right is doing and hiding your light under a bushel.

Keeping the policy pressures in mind, we needed to explain that reporting community benefit was not bragging, rather it was about being accountable to the government entities that grant tax-exemption, to volunteers, to board members and their communities.

Over the next months and years, the steps in the social accountability process became standard practice in many Catholic and other nonprofit health care organizations. These hospitals developed infrastructures for sustaining their efforts, assessed community health needs, planned to meet those needs, tracked activities and their

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— SR. BERNICE COREIL, DC

expense, and reported what they accomplished.

When a sister in Toledo, Ohio, learned the accounting system was not available electronically she asked a local computer company, Lyon Software, to develop a program to track expenses. A few years later, CHA formed a partnership with Lyon Software and VHA, Inc., (now Vizient) to sponsor the software, *Community Benefit Inventory for Social Accountability*, known as CBISA. CHA also partnered with the American Associa-



tion of Homes and Services for the Aging (now LeadingAge) to develop a version of the *Social Accountability Budget* for nonprofit long-term care organizations.

*Health Progress* continued to follow the issues. The theme of the January/February 1992 issue was, "In the Line of Fire, The Battle over Tax-exempt Status Continues." In that issue, David

Seay from the United Hospital Fund of New York put the IRS community benefit standard in a historic context:

"U.S. hospitals were exempt from taxation even before the establishment of an income tax or the Internal Revenue Code. The notion of community benefit — the current legal standard by which federal tax-exemption is accorded to not-for-profit hospitals — is itself quite old. The idea dates back to the early seventeenth century, when laws regulating the charitable use of property were first enacted in England. Later in 1891, in a restatement of the English law of charity (which has long been recognized as a leading authority in the United States), Lord MacNaghten clearly delineated community benefit as a separate and distinct category of activity that is deemed charitable: 'Charity in its legal sense comprises four principal divisions: trusts for the relief of poverty; trusts for the advancement of education; trusts for the advancement of religion; and trusts for other purposes beneficial to the community, not falling under any of the preceding heads.'"

In the same issue, Sr. Coreil, who chaired CHA's Community Benefit Committee wrote, "Few issues are more important to the leaders of Catholic healthcare facilities than our tradition of service to our communities." In that same issue, health leader Emily Friedman wrote an essay saying tax-exemption was a metaphor for public trust in hospitals.

The book was periodically revised to keep up

with public health advances and practices in our hospitals and systems, and in 2008 the revised book was renamed to *A Guide for Planning and Reporting Community Benefit* to be consistent with the language used in our organizations.

### **Tax exemption becomes an issue again but CHA makes mission the focus**

In November 1992, while the Clinton health reform bill, the Health Security Act, was being debated, a *Health Progress* policy column explored what tax exemption would mean in a reformed health system. In “A Systematic Method of Accountability,” professors at Saint Louis University and a finance officer at Mercy Health discussed how charity care and the service to low-income people would remain a priority. They said. “... charity care policies can reinforce implementation of the organizational mission, guide the assessment of the community’s needs, and ensure a consistent message of mission effectiveness in reporting to the community.”

While the Health Security Act did not pass, CHA’s attention to providing community benefit and *Health Progress’s* coverage continued with an emphasis on mission and social justice.

In 2005, the theme of a *Health Progress* issue was *The Theology of Community Benefit*. It led with an article by CHA’s then-vice president, mission services, Sr. Patricia Talone, RSM, PhD, who said, “Precisely because of the church’s commitment to the common good, promotion of community benefit (and the tracking of community benefit data) arises within Catholic health care from concern neither for not-for-profit status nor public perception, but rather from a deep and abiding sense of its identity as a healing ministry of the church. Community benefit is a viable expression of the church’s recognition that society as a whole is responsible for allowing each and every member to pursue life’s goods.”

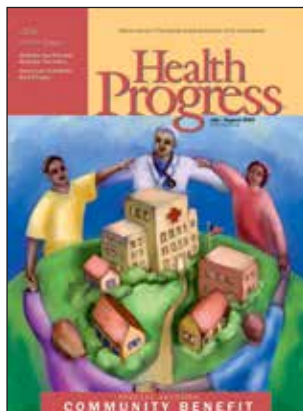
In 2006, the tax-exemption of hospitals again became a policy issue. Sen. Chuck Grassley, chair of the U.S. Senate Finance Committee, began asking the same question Rostenkowski had asked in the 1980s, “Why do not-for-profit hospitals de-

serve tax-exemption?” He also questioned why hospitals were not asked to account for whether they met the Internal Revenue Services Community Benefit Standard, the basis of federal tax-exemption. (Rev. Rul. 69 -545.) What is community benefit anyway, he added.

CHA knew the answer to his last question. Since 1969, tax-exempt hospitals have had to meet the IRS “community benefit standard” but that term was not well defined in the revenue ruling. Our process defined and measured it. While the IRS’ revenue ruling did not specifically define what was meant by community benefit, CHA’s materials itemized and defined categories of community benefit. These included charity care, means-tested program shortfalls (such as Medicaid), community improvement services, health profession education and research, subsidized services, cash and in-kind donations and community-building activities.

Representatives from CHA, led by Sr. Carol Keehan, DC, met with Sen. Grassley and his staff to show them our definitions of community benefit and the accounting system for budgeting and tracking community benefit. In response, Sen. Grassley asked the U.S. Treasury Department and the IRS to look at CHA’s categories and accounting system. The IRS revised its Form 990, the reporting form for all tax-exempt organizations, adding a Schedule H for hospital reporting. The new Schedule H mirrored most of CHA’s original accounting framework.

Five years later, the Senate Finance and House Ways and Means Committee again looked at hospital tax-exemption in the context of health reform. Legislators, again led by Sen. Grassley, said the Affordable Care Act (ACA) should require nonprofit hospitals to demonstrate that they deserve special tax status. CHA joined other hospital organizations in advocating that hospitals should show that they understand their communities’ health needs, work with public health and community members to identify those needs and have plans to make their communities healthier. As passed, the ACA required that tax-exempt hospitals conduct community health needs assessments with public health agencies and their communities and





develop implementation strategies for addressing needs.

Again, CHA was ready. All of the editions of our community benefit books included guidelines for assessing community health needs and planning to address those needs. CHA expanded these guidelines into a new document, *Assessing and Addressing Community Health Needs*. This book was used (along with other input) by Treasury Department staff writing the IRS rules to implement the Affordable Care Act.

In 2012, *Health Progress* previewed CHA's assessment book. The article traced Catholic health care's community health needs assessment to the sisters who established our ministries. I wrote, "The sisters who founded our ministries came to this new nation looking for what needed to be done to care for the sick, old and orphaned and to help the poor. With courage and creativity, they assessed the needs of their new communities and acted in response."

When the final rules were published, they included a requirement on evaluating impact of community benefit activities. CHA updated *Assessing and Addressing Community Health Needs* and produced a new document, *Evaluating Your Community Benefit Impact*.

In 2015, *Health Progress* focused on community partnerships and in 2018 "Taking Our Care Outside the Walls." This issue included an article by Dr. Rod Hochman, president of Renton, Wash.-based Providence St. Joseph Health and Sr. Donna Markham, OP, president and chief executive officer of Catholic Charities USA, on how Catholic health care and charities agencies can work together to address needs of low-income people. They said, "For people who are poor and vulnerable, attending to the social determinants of health is foundational to their overall health. There are no better resources to address those social determinants of health than these two faith-driven organizations working in tandem."

As *Health Progress* has reported, CHA's advocacy and resources have paved the way for the high-quality community benefit programs we have today — both within Catholic health care

and in other nonprofit health care organizations.

How did this happen? It happened because the CHA board was prophetic in identifying a key issue for our ministry and seized the opportunity to advocate for tax-exempt health care and to be a leader in community benefit. Through the years, the board has renewed its commitment to community benefit, even in the absence of congressional and federal activity.

Community benefit is at the heart of our ministry. It carries on the tradition of our founding sisters and other leaders who saw needs in their communities and sacrificed to address those needs. It puts the preferential option for the poor into action, demonstrating respect for the lives of all in our communities, especially our most vulnerable neighbors. It is a concrete expression of our commitment to the common good and our ethic of life.

As I write this, it has been 31 years since that board meeting when I first learned about the importance in distinguishing our hospitals as charitable organizations and the need to tell that story. It has been an honor to staff this work and to help implement the vision of CHA's executive and board leaders.

Throughout the years, *Health Progress* (and before that, *Hospital Progress*) has covered community benefit and tax-exemption issues. Some editions focused specifically on

these issues and others on related topics, such as poverty, immigration, social needs and violence. In reviewing the history of our journal's coverage of community benefit and tax exemption, not only has *Health Progress* presented a historical record of these issues, which indeed it has, but has been a vehicle for thoughtful reflection of what it means to be a community-oriented, mission-driven, nonprofit health care organization. It has tapped legal, tax and public health experts as well as some of the best health care thinkers of the day. It has issued warnings, challenges and congratulations.

Happy Birthday, *Health Progress*. You have made a remarkable contribution to community benefit.

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