

Panel 5: Stakeholder Roles and Contributions

Okay, we are starting our last panel of the morning and I should say last but certainly not least given the two individuals who will be presenting. But absolutely not the least. In looking at this community health improvement cycle, a key dimension of that was that we knew we had to consider was how do we do this work in the context of health reform?

What are the issues that we need to consider and how do we -- how do we accommodate some very different institutions in our examination of that?

We have two long-time friends and colleagues with -- with between them an absolutely unassailable level of volume of research and engagement in the field on these issues. Paul Hattis is a professor at Tufts University School of Medicine and has been a long-time colleague in community benefit work going back to originally the Hospital Community Benefit Standards Program that he helped lead under the leadership of Bob Sigmund. Brad Gray, Senior Fellow at The Urban Institute and also editor of the Milbank Quarterly, has what I believe to be the largest volume of published research as it relates to hospitals and community benefit programming. I'm going to turn it over -- turn it over to Paul first.

Thank you, Kevin. It's both a delight to be here to join all of you and honored to be on a panel with Brad Gray. I think our goal is to try to jump into a few brief comments that we want to say to you and then really engage you, we hope we will, in a set of questions although I would be remiss if I didn't call out as it's already been called out my mentor in this field, Bob Sigmund, who I was just sitting with in the back of the room, and the interesting thing is when -- when Bob and I and Tony Covner, and a very distinguished panel of advisors started the Hospital Community Benefit Standards Program back in 1989, the issues we were struggling with, which is helping institutions figure out who their community is or how they involve physicians in aligning them to think about community health, public health and the like, and working on the issue, which we had no success then; but today perhaps we might at reducing the growth of community healthcare costs. It's just fascinating to me that the issues really haven't changed and we're sort of still stuck on working on all this stuff today. I also see in the audience my two colleagues from Boston who will keep me honest because I do want to add a little bit of a Massachusetts perspective, but Joan Quinlan, we've already heard from from the MGH, I think I saw Laurie Cammisa here, too, from Children's Hospital, so they'll -- they'll correct everything I have to say.

Okay, so what I want to focus -- I'm going to move away this way -- on, because Kevin has asked me, is a little bit some of the megatrends tied to what's going on sort of broadly affecting hospitals and their incentives and how it intersects and/or aligns or doesn't align with some of the -- the direction of the community benefits stuff. This is a busy slide. I'm going to focus in in a moment, but the ACA has different components of it, and I want to mention some of them. One is the Affordable Care Act creates the opportunity to create some demonstration projects including Medicare ACOs. I won't go in detail exactly all the rules and regulations as they've been published now about accountable care organizations. But the whole notion of focusing on accountable care organizations is, what I'm going to get to is, there's some alignment opportunity in terms of the incentives about changing the incentives of how providers are paid that could well line up more in a public health sense. And briefly, whether it's a Medicare ACO or ACO more generally, the notion of moving away from this notion that we pay for piecemeal in this country, that the way we get care done is to pay a doctor or hospital for, you know, a single event or a visit or a hospitalization when people are sick, in terms of moving towards a global payment or capitation.

Obviously not a completely new concept although the -- the use of capitation in some ways flowing in to provider systems or ACOs is something that met some resistance when we tried to move more significantly towards that in the 1990s. The key determinant, though, and I think this still is a challenge even in some of the early ACOs we're beginning to see form, is how you pay providers underneath that sort of risk adjusted capitation coming in in terms of getting rid of modal fee for service payment and whether you pay global

Panel 5: Stakeholder Roles and Contributions

payment or whether you pay salaries to people, whether you pay them some kind of capitation, I think it does fundamentally matter; and I think that is still being worked out so that you align providers from wanting to do quality care efficient, and thinking about the stream of public health. And I put the notion of patient centered medical home here because if you're going to be successful from a provider system perspective where there's a fixed amount of resources going in and having the right incentives with your providers is you incentivize them to pay it out, the whole notion is you have a strong incentive to keep people healthier because whether it's, you know, not just not getting paid for readmissions but as people get sicker or have complications; again, if you're receiving a fixed amount of payment there aren't necessarily more dollars for you.

So I think there's alignment there in concept with this whole notion of public health and community benefits that if that kind of model takes off as we're talking about now in Massachusetts, not only for Medicare patients but more broadly than that as we're discussing some health care costs legislation. Let me focus the moment on, although Jessica did a great job on the -- on the ACA, the thing I want to say, you know, these are the community benefit requirements about the needs assessments and implementation plans and the like. The key one I want to focus on from my little list here is that for years, we saw this back from 1989 even when we started the Community Benefits Standards Program, hospitals and health systems have been good, often better than one would expect at trying to look at data and say something about what's happening, although they've done it usually more from a problem perspective than from an assets perspective. But even true in our state when our State Attorney General came in and required hospitals to do community benefits reporting, what they tended to fail to do, and there's a new tweak in our own law -- our own voluntary guidelines to get them better at this, is really a focus on planning. Accountable kind of planning. Where you say ahead of the time, hopefully engaged with community organizations and people and everybody else you need to engage with to say here's what we want to accomplish next year for purposes of improving overall health and well being or addressing iniquities or whatever else it is that you're working on, and we're saying up front what we're trying to accomplish. At the end of the year, we'll write a report that evaluates what we did based on what we said we were going to do. That's new for hospitals. Not only in Massachusetts for the most part, but in the country I would add, that, you know, we're fearful. I know when I meet with my boss, do my annual review, you know, with the dean, you know, I want to talk about all my accomplishments of the last year but for me to commit what I'm going to accomplish the next year is something I probably prefer not to do.

So there is discomfort around that, but it's absolutely the way to go. And -- and so I think it's one important evolution that you're seeing. Now for some reason it's a little bit more off line than I thought here because of the -- because I thought you'd be able to see it. I think I might be able to move towards it. But the state Health Department have a role here, too. They're the bottom quarter of this screen. Because obviously they do their own community needs assessments, they're involved in public health and community benefit sort of work as their charged mission; and if you talk to the provider systems in Massachusetts or insurers, what they say the biggest threat to public health is really the underfunding of governmental public health.

So I think there really is a leadership recognition that's sort of the core, you know, even though you might have ACOs and the incentives that providers have there, you have the accountability from these new community benefit requirements to, you know, identify work on public health. You also still remember even after the ACA fully kicks in nationally, it's thought we're going to still have 20 million people uninsured so I Eileen Barsi's kind of work, which says how do you care for the uninsured, especially important in geographic parts of the country where undocumented people are not going to be -- their situation is not going to be improved by the ACA. But there's still an incentive to keep people healthy to avoid the costs of caring for the uninsured.

Panel 5: Stakeholder Roles and Contributions

So I want to move to hospitals for a moment. I'm sorry this is cutting off at the screen but I'll do my best here, which is to talk about what are the community benefits, sort of expectations we place on hospitals?

Now the first item here, care for the uninsured, has historically been, you know, the cornerstone of how the IRS viewed what tax exemption was all about. We used to have a free care standard. Even though we created a community benefit standard, quite frankly I think when it's the field, if you ask most hospital CEOs what community benefits is about or you ask the service, the IRS, it's still some definition that ties in for the uninsured. But it really, and this goes back to the work we tried to do at NYU some 20 years ago, was broaden that notion to include the kinds of things you see on this list here, enhanced investments and primary care and prevention, and that's not just individual prevention, that's community prevention. Focus on health inequities or disparities. We used to call it care for vulnerable populations when we did our work back 20 years ago. For a teaching hospital, because Kevin asked me to address this, there's an educational mission. And then -- and then, you know, I think also as we've come to learn, we weren't aware of this back in '89 as much, I think, in our focus, but the humane billing and collection practice and how you deal with people around hospital billing, while it ties to all patients, you can also have a community view of that. I know there's some organizations, a very few hospitals who've actually delegated the responsibility for figuring out whether it's eligibility for the uninsured or how to in some ways create better, fairer systems around the financial aspects of billing and collection practices to some consumer groups. They've actually delegated that outside the institution because they felt that that was a fairer way in some ways, you know, to deal with those kinds of things.

Employees and how they're treated, obviously is important, and we had a reference to community based participatory research by our Duke colleague. I put in bold, though, even though this was back in our 1990 or '89 standards of the NYU program, and hardly anybody wanted to focus on it; I can tell you in Massachusetts right now, and whether we connect this to the community benefits label or not, the issue du jour is reducing healthcare costs. And I mean the total ball of wax, whether it's -- you call it -- you know, the premiums in the marketplace, the total medical expenditures. We have successfully gotten down to about 2% uninsured in our state, and although the press nationally writes it wrong and says the reason that Massachusetts healthcare is so unaffordable is because of our law, which is fundamentally not true. We were already per capita before our law went into effect the most expensive healthcare system in the country. Our premium is about 25% or so higher than the national average. Those trends were well in our marketplace for a variety of reasons, that we can maybe talk a little bit more about in the question-and-answer session, long before our 2006 law went into place, but the reality is, we can't afford it. Okay, I've got five minutes. I'll be done.

We absolutely cannot afford the system we have in Massachusetts. I don't just mean from the governmental side, which, you know, is not only forcing government at a state level or local level to crowd out all other kinds of investments, but, you know, in a marketplace where a family premium is \$20,000 to \$21,000 a year, whatever percentage the employer pays of that, increasingly less, it has a drag effect on jobs; and obviously unaffordable for what we're pulling out of, you know, really, I would argue, is really ultimately wage workers' money because if money is going to the benefits side, then there's less money to pay them pay raises. Now we talked about way back in NYU days the notion of measurement and assessment, that's been a tough issue to get the hospital field to do that in an accountable way. And again, as Bob Sigmund will point out to me always when we chat about this, the institutions need to think about that from a community perspective and not only a patient perspective or population perspective. Let me say a few things about HPEIs. That's a picture of Harvard Medical School. I couldn't find one picture on Tufts readily off the internet last night, so here you are. But HPEIs, or Health Professional Educational Institutions, actually they define their tax exemption not under the charitable notion like hospitals, but under education.

Panel 5: Stakeholder Roles and Contributions

They don't technically have a community benefits requirement, although I think there are some of us who would like to read that in for them, including those of us who work at private, nonprofit 501(c)(3) Universities; but they have a role here in terms of enhanced investments in training and primary care. I know that we're trying to make a focus at our medical school of really increasing the number of students who graduate and go into primary care training. What will solve that, of course, is getting rid of the huge disparity in income as well as the debt burdens that students face, they can make primary care a meaningful choice. We are teaching about public health and the socioecologic model, probably not enough to all students, but I help run a program that involves MDMPH students and they're certainly getting a good chunk of it. We're giving them a focus on diversity and cultural competent. Health professionals as cultural respect as somebody has corrected me. You know, and Kevin and I did some work with Jeff Oxendine and others from UC Berkeley that that just isn't only about who you teach, but it's also about who your faculty are, what their backgrounds are, who you accept in your student body, and really emphasizing people from journeyed backgrounds, both economically and racially and ethnically. And there's a relationship between those teaching hospitals and health professional organizations. In Boston right now, for example, both of them are subject to a new requirement from our municipal government of a payment in lieu of tax so we're going to figure out what the assessed tax is on their buildings, take 25% of that, and say you owe that as your contribution less up to half of it what you do for community benefits.

So we not only have federal responsibilities under the IRS or state responsibilities of voluntary guidelines; but our universities and teaching hospitals and the other nonprofits now have to make, and I think it's appropriate given the amount of municipal services that we use, contributions towards that as well.

So, I'll leave you with this -- I'm going to stop here with the last slide, which goes back to honoring Bob Sigmund, my mentor; but we go back to what we did back at NYU and really where we tried to, for the first time, take an organized management approach to the notion of community benefit for hospitals, which really, in our minds, didn't have any focus at that time. We created four simple standards about what the organization commits to in an accountable way, about what kind of demonstrable activities it has to evidence, about the nature of and ways in which it can do community engagement, and how it turns on its own internal constituencies, physicians and others. I think those principles that we articulated 20 years ago are really the same ones that are valid today and the ones I think that we're all, really, you know, those of us who either are in the provider world or if you're in the public health world, figuring out what it is that the providers ought to be focusing on. I think those principles are as solid now as they were then. With that I want to let my colleague Brad Gray get us started. Well, good morning. I have to start out by saying how impressed I am with the work that the people who put this conference together in such a short time were able to do in bringing such a great group of people together and presentations. A lot of these presentations have been about rather concrete activities that people are engaged in in various parts of the country, and they've all been very impressive. I'm going to be taking a somewhat broader, and maybe a bit indirect route to this topic and I hope it -- I hope it proves useful. We'll see.

One of the -- I don't know, I was going to say a quirk -- one of the interesting parts of my work history is that I spent a few years as director of the Yale program on nonprofit organizations, which is -- was the first academic program that was really focused on doing research on the nonprofit sector broadly. And I mention this because even though most of my work over my career, in fact almost all of my work over my career, has been on health policy related issues. I became keenly aware that hospitals and healthcare organizations are part of a much larger nonprofit sector that something like a 1.5 million or more organizations are nonprofits, of which fewer than 3,000 are hospitals. And these -- this larger set of organizations rests not always terribly comfortably between government and business. It's been called a third sector. Seeing nonprofit healthcare organizations as part of a broader sector made me aware of a number of important points regarding public accountability, which I think is what we're talking about here. One of them is that nonprofit organizations are not properly understood as an arm of government. They're nonprofit organi -- they're nongovernmental

Panel 5: Stakeholder Roles and Contributions

organizations. They have their own governance structures, boards of trustees and the like. It's true that their revenues come substantially from governmental sources. That doesn't distinguish them from lots of other kinds of nonprofit organizations, however. And conditions can be attached to the funding -- the federal funding as with the requirement that hospitals provide emergency treatment to people who are in need of that, the EMTALA law. But those are conditions of participation in the Medicare program, not a condition of tax exemption.

So we need to think about what should be expected of hospitals because they're hospitals and not because they're nonprofit organizations, which has the peculiar effect -- peculiar in my opinion; I don't know how the IRS actually views it, but it has the peculiar effect of having the Internal Revenue Service becoming responsible for overseeing what's being done to improve the health of communities. That's a very strange thing. But it's because these conditions were attached to tax exempt status as opposed to, say, tax -- attached to Medicare participation or something else.

So that's just sort of the first point that I want to make. The second one is that the tax exemption of nonprofit organizations, whether we're talking about hospitals or nursing homes or art museums or universities or National Public Radio, are not predicated on a quid pro quo understanding. The history of federal tax exemption doesn't have anything to do with providing tax exemptions to nonprofit organizations in exchange for their doing something that is specified by the government for them to do. That's just not the logic of tax exemptions, which go all the way back to 1601 and the Elizabeth Poor Law and the relationship that was set up at that time between government and state -- government and religion. The church. And it was basically that there was an understanding that they each treated each other as a sovereign and they didn't interfere with each other's activities and that's sort of, you know, you roll it through British common law into the United States, that's the way it evolved. Having said that, however, clearly hospitals and other nonprofits are established under state laws for self-defined purposes and they can receive federal tax exemptions if they meet certain requirements regarding what's done with the income that they generate and if they're -- if they're formed for any of the purposes that are enumerated in 501(c)(3), or 501(c), really. And providing healthcare is actually not one of the enumerated purposes, as I'm sure everybody knows, but hospitals and other nonprofit healthcare organizations have always fallen under the charitable category ever since the federal income tax law was passed in 1913, and even in its predecessor legislation that was found unconstitutional.

So this raises the important question of what does it mean for an organization to be charitable. And -- what?

I -- I -- hmm.

Somehow my -- what's -- what -- what number is that, can you see?

Two is on the bottom?

Okay. All right, well, I'm not sure how I got to this one quite yet, but anyway, I'll stay with this. First is -- so the question that I was raising with this slide is why do we focus on hospitals separately?

As I said, 3,000 out of a 1.5 million, and I think these are the reasons. One is that they are very prominent, you know, even though they are a small number, they account for a rather large share, close to 50%, of the revenues of the whole nonprofit sector.

So that's a pretty important reason. Another is their commerciality. They, they are -- nonprofits exist on a continuum between organizations that generate their revenues from the sale of services and those that get it from donations. Hospitals are at the commercial end, and that means that they behave a lot like business.

Panel 5: Stakeholder Roles and Contributions

They're expected to raise money for capital needs through borrowing. They have to operate in a way that the debt market will respect. They're even required by Medicare to make efforts to collect bad debts.

So in many ways they're pushed to be commercial. They also have for-profit counterparts, which has led to a lot of questions about are they really different than for-profits. I've done a lot of work on that. And finally, they're -- we have a big focus on them because their charitability is a health policy issue as well as a tax policy issue, and I think that a lot of things come into that.

So the question of what it means to be charitable is really important for hospitals. We had the 1956 revenue ruling that said that they should operate -- offer free or discounted care to those who need it to the extent of their financial ability. I don't think the IRS ever got around to figuring out how you figure out what the extent of the financial responsibility, or ability, was; but by 1969 we had the Community Benefits Standard, which went largely undefined for about 30 years before Schedule H came along. I would say, by the way, I think that Community Benefit was the right -- is the right criteria for tax exemption, and I think that even the reasoning that the IRS used at that time was good reasoning. And it went back again to the history, all the way back to Elizabethan times. But -- and Schedule H is really valuable, I think, for clarifying what it means. I would echo everybody else that says they made a mistake in the way that community building activities were hired -- were handled. But in that, I think that Schedule H was really a very positive thing for accountability. Just about that thing, just three points about it very quickly. One is it's hard to imagine that an organization that is exempt -- expected to provide community benefit that community building isn't a criteria for tax exemption. The second one is the point that we've all made so many times about the social determinants.

And the third is by leaving it in the denominator, it actually -- it actually reduces the reported percentage of hospital community benefit expenditures that go to -- that are reported, so it -- it's really quite perverse. Having said all that about the community building, in the aggregate these expenditures are fairly modest although there are some important exceptions to that. I'm actually going to shift to some research I did in Maryland. Maryland was useful because they've had a community benefit reporting requirement since 2004. That's not as early as California and some of the other states, but their 2004 requirements are very similar to the Schedule H. They're also based on the Catholic Health Association VHA standards. And I studied the filings of the hospitals in Maryland. There's 45 nonprofits and I did interviews at 20. There's articles in Health Affairs and Inquiry I'd be happy to send you if you haven't seen them about this. I'm going to just tell a little bit about -- this provides some perspective on what's going on. Maryland is not a typical state. No state is typical. Maryland has a little lower uninsured rate than most of the other -- than the average. I think it's 13.8 versus 15, but it's, you know, it's not terribly low. It also has a hospital rate setting program in which hospitals are actually reimbursed for their uncompensated care.

So they have no disincentive to provide charity care. This is -- 7% is about the average of the community benefit expenditures in Maryland. When Modern Health Care looked at Schedule H filings for 20 systems in the country, theirs was a little higher, 8%, but Schedule H allows some accounting of some things that were not counted in Maryland such as Medicaid shortfalls for example.

So 7% or 8% is probably about the amount that is provided. It's mostly charity care, health professional education and what they call subsidized. In Maryland they call it mission driven services. Each of those accounted for just a little less than a third of the charity care -- of the community benefit expense. The variation among hospitals was huge. From 1.3% to 13.5% in 2007. And it was mostly due to charity care and health professional education expenses. The 13.5% is University of Maryland Hospital in Baltimore and the 1.3%, I forget but it's in a relatively prosperous county. At the county level, poverty in Maryland varies from 5% of families to 20% of families, so just in one state you have a four-fold range of poverty which, as we

Panel 5: Stakeholder Roles and Contributions

know, is important for the things that we're talking about. Community benefit building expenses were less than 2% of the community benefit expenditures in Maryland.

So that's not 2% of expenditures, that's 2% of community benefit expenditures, so it wasn't a big deal in Maryland. The thing that I think is -- one of the things that I think is really important about the -- the reporting requirement, it's not that the hospitals got any feedback from anybody. They almost got no feedback from the state, from anybody. They didn't get praise for doing what they were doing. But it did affect their thinking about community benefit because for the first time they -- the leadership could see how much was being spent. They had never pulled this information together before. That had a big impact. I made a distinction in the article, and similar I think -- I think Paul maybe yesterday was talking about, or maybe it was somebody else, about a reporting approach to this topic or a -- or a strategic approach. Those are my terms. A different term was used yesterday. But this is what I -- this is what I -- these are the elements that I use, there's 10 of them here that I ask in my interviews do you do this, so these are hospitals' reports in an interview situation, face to face. But these are -- these are dimensions of a managerial approach, and you can see the third column -- the first column of numbers is the total out of 20 that said that they had done this. I had split them for the analysis between managerial and accounting approaches. That doesn't really matter for the purpose of this table. You can see which ones are the most common. But the 10 were, Have they undertaken a community benefit and have they undertaken things that they actually called initiatives?

Okay. Think I'm doing fine. Did they have community benefit in the hospital strategic plan?

13 of the 20 did at that point in Maryland. Had they done a needs assessment?

13 said they had. In some cases they worked with local health departments, some had done their own surveys. There was -- some had had focus groups. It was a variety of things that they had done, but they had done various things. A number of them said that they didn't have any -- there was not information available from the local health department that would be helpful for them. You remember this is a sort of a scattered -- all of our states have a lot of rural areas. This one -- this one does, too, despite being concentrated between Baltimore and Washington and Annapolis. Hospital has goals. 13 said they did. Nine, there was actually somebody responsible for community benefit. Also the same number had an organized program. Those two things are probably related to each other. Nine also had a budget for community benefit, and sometimes that went down to the departmental level. Again, nine involved the board in community benefit. There was a working group in six, and four of the 20 had done evaluations, so evaluation is still -- and by the way, the evaluations were mostly the pencil and paper of people that had attended a session, was this useful to you, you may be -- get one of those at this one by the time it's over.

So that's sort of what the picture was of -- the one thing I was going to mention on the previous -- when I did just the examples of what the subsidized services were, they were cardiac rehabilitation, hospice, homecare services, outpatient mental health programs, and then a whole variety of programs that were targeted to homeless, seniors, immigrants, women, adolescents and substance abusers.

So those -- that was sort of the picture of what the subsidized services were.

So, we're in the post-PPACA -- as one of my colleagues calls it -- world. I was -- it was refreshing yesterday to hear somebody call it the Patient Protection Act, because everybody else has been referring to it as the Affordable Care Act as though it doesn't have anything to do with patients; but assuming it's implemented as passed, the need for charity care and subsidized care will decline, but it's not going to disappear. It will be -- it will be dropped a little more than half, I think the best estimates are. There will be a very big growth in

Panel 5: Stakeholder Roles and Contributions

Medicaid, so they'll be a big growth in subsidized services because Medicaid programs are probably not going to be any better payers in the future than they have been in the past, for reasons that we understand.

So the patterns of community benefit will be changing. There will be reduced resources for hospital charity care, at least DISH payments. The Affordable Care Act has incentives that should reduce hospital use, but -- I wrote BUT in capital letters -- but at least the initial proposed regulations have not met with favor by organizations that one might expect to be interested in creating ACOs, and nobody really knows if ACOs will work; and there is a lot of people, my colleague Bob Berenson at The Urban Institute, one of them, worries that basically hospitals will have more economic leverage with regard to insurance companies and -- and it may not -- higher prices may defeat whatever reduced hospital use, at least in terms of cost. The Triple Aim logic has come to CMS. Don Berwick continues to talk about Triple Aim. I think he has a different term, Triple Purpose, Triple something. Anyway, he's changed the terminology. But I asked him at a conference a month or so ago, you know, he was talking about, Triple Aim is patient satisfaction, quality and reduced overall costs -- community cost. Where -- where is the reduced cost component in what you're doing?

And he pointed to the parts of the Affordable Care Act that provide compensation for preventive services for seniors.

So I was a little, you know, Don, at least in that public forum, wasn't going out with some sort of an ambitious thing about we're going to reduce community costs, it was going to be we're going to reduce some expenditures through prevention. Concluding points, as everybody else has said, IRS should recognize a link between community building and population health. Better evidence is needed. There is some reference to better -- some evidence here. It would be worth, probably, pulling that together and providing it to the service because they will probably be -- like to have better evidence of that. Schedule H and needs assessment provisions of the law will push hospitals toward a managerial approach. I think that that's just inevitable, and I don't think we need to expect it to happen next year or the year after; but I just think that -- I mean we've heard a lot of presentations from California at this meeting with hospitals and systems doing great things. They've had a reporting requirement since 1994. I think you can see the effect of a reporting requirement when you look at those kinds of things from California.

So I think that this is really pushing things in the right direction and I hope that Congress and our friend from Iowa will give it time to play itself out. There will continue to be a temptation to use tax policy to produce health policy goals. I think that that should be approached with caution. It's -- I think I probably said enough about that earlier. Hospitals are important community resources. Clearly it's important -- it's actually essential that they be engaged in any of the sorts of things that we've been talking about because of the kinds of expertise and data, commitment and so forth that we've already heard about. But hospitals and communities vary in important way -- in ways that are important to community benefit. We've heard also a lot about that at this meeting, and particularly we've heard about small rural hospitals -- critical access hospitals and those sorts of things. But we also need to remember that we have hospitals that are tax exempt that are specialty hospitals of various sorts that are -- whether they be psychiatric hospitals. I'm thinking about a project I did in New York, I was in New York for a few years, it involved looking at utilization patterns by geographic area, and it turns out that Sloan-Kettering, you know Sloan-Kettering is located in a very wealthy part of New York. I guess people know. And if you looked at the health -- unmet health needs in the area surrounding Sloan-Kettering, it wouldn't be much; but their patients come from all over, all over the Northeast, all over the world.

So I don't -- it will be interesting to see how they define their community, and, you know, I think that organizations shouldn't be penalized for not being general acute care hospitals located in medium-size cities. And finally, I think that IRS policy should focus on reporting, not substantive requirements. You know,

Panel 5: Stakeholder Roles and Contributions

there was a lot of pressure in Congress to set a 5% spending limit for charity care. You know, those kinds of -- those kinds of substantive requirements, set requirements, whatever, just -- just can't take account of the variations that exist between hospitals, their resources, what they're good at, the difference in communities and the needs of communities.

So I think that -- I had a list of questions for the future and maybe I have a minute left to do them, so I will -- I will just -- these are questions -- Kevin sort of said talk about what might be research questions for the future. I think these are research questions. The question is, will reduced focus on charity care increase the focus of community benefit on outcomes?

There have been advocates for outcomes orientation for many years. We've heard some good examples of that today. I think that if hospitals can't show that they're providing a lot of charity care, it's going to become increasingly important that they say we've made this kind of a difference. Outcomes are going to be more important. The question is will hospitals adopt more -- a more managerial approach or strategic approach to community benefit?

I implied that I believe that it will. I think it's worth studying and seeing how that happens. Will the logic of community benefit reporting extend beyond hospitals?

It's not obvious to me why hospitals, out of all of the nonprofits in the world, are expected to provide community benefit and we want to see what they're doing in that regard. Why is -- why is this something that's limited to hospitals?

Or even limited to healthcare?

Will the logic of addressing unmet community needs lead to more collaborative efforts?

I think we've heard some good examples. I think that's promising. Worth studying. Can hospitals be successfully pushed to a community health improvement as their mission when the incentives continue to reward admissions?

And here at the ACO maybe we'll help as Paul was pointing out for the reasons that he stated; but right now we sort of have conflicting incentives, or conflicting pressures with hospitals under pressure to be community health improvement oriented and not being rewarded for that. And then finally, can we be thoughtful about using the tools of tax policy to pursue health policy goals?

And I'm back to my questioning of there's certain things that should, perhaps, be required of all hospitals, because they're hospitals and not nonprofit hospitals because they happen to be nonprofit and you have the lever of the tax exemption to use. And then finally needing to recognize the variations in missions and resources is part of being thoughtful about policy in this area.

Thanks very much.

Thank you, Brad.

Thank you, Paul. I'm going to do a little differently my own questions, I'm going to do what I've asked the audience to do which is I'm going to give the panel a set of questions and let you pick and choose among them. First question is, Paul, we did some work together as it related to the Sullivan Commission on the issue of diversity on the role of academic health centers in actually bringing health profession education institutions to the table. You might comment on that. Both Brad and Paul, on this issue of the role of

Panel 5: Stakeholder Roles and Contributions

teaching hospitals as it relates to the training of health professionals, I have an anecdotal -- we have one very large urban hospital that will go unnamed who claimed that there was another safety net hospital in town and their role -- their community benefit role was training the next generation of health care providers, in essence excluding themselves from the larger safety net role. There are some -- in your Maryland study, Brad, you noted that roughly a third of what is reported as community benefit is in the realm of health professions education and research. Had discussions with Paul and others in recent years about the degree to which there may be effective accounting in fact of potential inclusion of Medicare indirect rather than offsetting to those dollars in the reporting.

And also more recently, the IRS seclusion allowing teaching hospitals to count the research dollars that they bring in from the outside as their own charitable contributions; and I've already heard from a couple of hospitals such as Mass General and Children's Hospital Boston that say we're not counting those dollars. But the concern that some have is that in fact if we do count those dollars, it begins to skew the degree to which we are invested in charitable purposes, so please. Let me start with that latter point, and actually I think Mass General's and Children's Hospital's position on that is responsible because, you know, if we're in this accounting game, and I have my own challenge around why is it in community benefits, you know, we count how much hospitals do where they don't get paid for it; but you know, in quality improvement when we look at what people do we don't ask how much is the hospital spending on quality, we focus on -- on its outcomes. But I think Mass General and Children's Hospital have a right in saying that gee when they get research grants with overhead dollars, they ought not to count that as community benefit expense. Let me address two other parts of teaching hospitals which Kevin alluded to. I'll ask Brad about, too, which is in Maryland -- University of Maryland, my guess is that they're so high on the charts because their IME, the Indirect Medical Education part of Medicare which is rolled into their rates, is not, you know, and it's rolled there historically because Congress said well, gee, teaching hospitals have more complicated, complex patients, and sometimes they've said that; and sometimes they've said well, it's a teaching hospital, you need to give them a little bit more money; but because it isn't directly focused -- or it's rolled into the rate, it's not actually counted as its own separate flow of dollars that would offset their -- their -- their expenses in medical education, so probably that's an overstatement, really, of what their community benefit expense is. Let me -- and may I say one more thing about teaching hospitals. There are some teaching hospitals, and I'll point to Children's Hospital in Boston, who while they have this, you know, statewide, even, you know, regional, even national referral mission for which they take patients, they still, and they do things from a community health perspective that touches upon a broader geographic area, they also have a focused community mission measurable in some neighborhoods of Boston.

So it just proves to me that that right kind of thinking, you can have the -- the more focused community measurement notion because that is what I think in part why we give hospitals tax exemption while you're also doing your broader educational teaching, research or referral mission.

So let me stop there and see if Brad wants to jump in here. Yes, a couple of things. One is that I suppose a worry -- I don't think it's a very realistic worry, but one could worry that the great focus on community health improvement and trying to find out what the community thinks is important and all of that emphasis, could lead to devaluing health professional education and research because by and large I suspect that those are not things that the community values highly. I don't think organizations are going to abandon their research and teaching missions because of that, so I don't think it's a very realistic worry. With regard to this -- this including money for which the hospital is actually receiving support as a community benefit, I actually argued in favor of that based on the Maryland research that I did, but I wasn't thinking about research when I did that. I was thinking about what happens when a hospital identifies a need in the community and then goes out and is able to raise the money with which to create a health center or actually go to, in one of the cases that I visited the hospital basically did all the grant application work, everything that was necessary to get a community health center in a deprived neighborhood up and running. And it

Panel 5: Stakeholder Roles and Contributions

seemed to me sort of odd that if the hospital goes out and raises money to meet a community benefit type, to provide a community benefit service, that you shouldn't count it unless that you're somehow cross-subsidizing it out of patient revenue. If you don't have a source for it, then you can count it. If you have a source for it, you can't count it. That just seemed peculiar to me.

And Maryland had followed that peculiar practice, by the way, they said back it out, if you've received money to help you do this, back those dollars out, we only want to know what's being supported out of the -- out of the flow of patient dollars. On the other hand I think research is different from that, and I'm glad that there are some institutions that say, we're not going to put -- we're not going to put everything that we have that's grant supported in there. I do think that community benefit reports have to pass a straight face test, and I don't think they would if you started claiming credit for stuff that you're being paid -- that you're receiving research grants to do. In an earlier part of -- time in my life I was involved in an IOM study, I was the director of it, that compared for-profit and nonprofit healthcare. As a result of that, I got on a circuit for a few years with people like Tommy Frist, who at that time was the CEO of Hospital Corporation of America. And they would always get beat up, at that time, because at that time, this was the mid-80's, they didn't have any teaching hospitals. They weren't involved in teaching. And research institutes. They weren't doing research. And they would always get beat up. Bud Relman used to beat them up, you know, about this. And at some conference that we were at and Tommy and I were both speaking and he came up to me after and he said, Bradford, I just learned the most interesting thing about nonprofit hospitals and their research. You know they get grants with which they do that research. He was playing the dumb, you know, the dumb hick. And I said, yes, yes, I guess they do. And, you know, he said, well, you know, if -- maybe -- maybe that's what we should be doing so we don't get criticized for not doing research, it looks like it's pretty lucrative.

So there you are. I don't -- that's -- that's a long answer to an interesting question. I'm going to apologize to everybody given that we got a late start and we carried over a bit and we need to stop quickly. We're going to have a chance for one round of questions. We have two over here to get us started. Hi, this is Jean Nudelman from Kaiser Permanente, Northern California. I just wanted to follow up again a little bit on the issue of hospitals and hospital systems that provide both research and also teaching, and I'm wondering what your thoughts might be about how that could be reflected in a needs assessment because as you acknowledge it's unlikely, and in our experience it's unlikely, that issues, requirements related to the sustenance of the healthcare system get reflected in a local community health needs assessment and yet we think they're really vital to be able to provide.

Thank you. Great point. Next. Hi. I'm Laurie Cammisa from Boston Children's Hospital; so number one, Paul, thank you for saying nice things about us. We have come a long way since 1993 when we were on different sides of the table. And I can't speak for my colleague Joan at Mass General, but I just want to say, cause the IRS guy is sitting in front of me. We follow -- we follow the IRS guidelines when we file our Schedule H around how you count research and teaching. When we talk about it publicly, and when you go to our website, we count it differently. We only count what we subsidize for our research initiative and what we subsidize for teaching. We're allowed to count a much higher number from the IRS perspective.

So please, dear God, do not let me be the reason why Children's Hospital gets audited on Schedule H, Paul. Otherwise I'll be looking for jobs and I hope you all need a consultant. The second piece is I like, Bradford, I loved what you said about going from accounting to managerial approach to community benefits. In Massachusetts we've been doing this forever. I have one more year on Joan so I have filed 15 community benefit reports in Massachusetts. And we have gone, we were talking about it last night, from this just counting what we do and throwing in the kitchen sink to going to a managerial perspective. But it has taken us 15 years to feel like we have something that we can really be proud of. And I think your point about it will come, but I think it's a much more time consuming piece. I also -- Laurie, quick question. How many

Panel 5: Stakeholder Roles and Contributions

plan -- 15 reports, have many have you had perspective plans to say well we really got to accomplish this next?

Oh, Paul, do you really have to ask that question?

You know what, I wouldn't -- I can't tell you a year in which it changed. Okay. Because it really has been -- it has been iterative, and we have been doing community needs assessments since '94, '95; but the last time - the first time I wrote a plan plan, put it in an Excel spreadsheet, was for the AG. Okay.

So that -- that's fairly recent. I liked the point about ACOs and the focus on both health outcomes and cost effectiveness. I do think that's, as Bluford said, you know, it's that sweet spot. But there was a comment yesterday about hospitals and how they define their community. And there was this little tension about oh hospitals are going to want to define it narrowly so they don't have to do as much. I think people might argue that we define our community quite narrowly because we look at neighborhoods within Boston; but the reason why we do that is because we're trying to demonstrate health outcomes, and if I do a broad and shallow approach to community benefits, I can't move the dial, but if I go narrow and deep in the neighborhood, I can make a difference and now I can show data with my program.

So I just don't want people feeling like hospitals are going narrow because they don't want to do anything. And the last piece about competitiveness and the earlier part, no Mass General and Children's don't compete over community benefits. But I would say where we probably do compete is on whether or not who has better practices because there's a level of pride that goes into this.

So rather than making it proscriptive and making it, you know, telling people what to do, it's bringing this best practice stuff up to the forefront that really helps us think differently about what we do and trying to get us to want to do more. Last quick question?

Go, Bob. Don't be shy, Bob. I just wanted to make a comment on Brad's excellent presentation because I think he said some things that, probably unintentionally, that might have confused some of you on the issue. I think he sounded like he said that in 1969 the IRS moved away from charity care to community benefit. And that's not at all what happened. Charity care was always the basic test for tax exemption for hospitals, and it still is. The -- the community benefit was added as a second form of charity over and above charity care because a lot of people thought that now that we have Medicare and Medicaid for the old people and the poor people, it would just be a few years before all the rest of the people would get the same and then there wouldn't be any more charity care so they invented out of some British history a new definition of charity, which did not involve doing things that you didn't get paid for. It involved doing things to improve the health of a community. Rich and poor, not necessarily alike because obviously the poor should get special attention; but there's no necessary connection in terms of the origins of the concept of community benefit being charity in the sense that you're doing something you're not paid for. The proportion of activity, even if it's measured in dollars, and I don't think that community benefit should be measured in dollars. We don't measure quality in dollars. We don't measure anything else in dollars. But it is measured in dollars, and it makes up a very small percentage -- I don't know, Brad, you probably have a figure on it. It has to be under 10% or 15%. Charity care?

What?

Charity care?

Say it again?

Panel 5: Stakeholder Roles and Contributions

Charity care?

Charity care is 2% to 3% of hospital expenses, and if you add in bad debt it can get up around 5% or 6%. Yes. But the proportion of money that goes for community benefit in relation to the money that goes for charity care, it's relatively insignificant, and -- Outside of Maryland, roughly 15% I think is the -- Yes.

So the notion that the IRS is primarily interested in community benefit just -- there's no basis for it other than that we're now back in a situation like we were in the 60s where everybody expects that somehow in the next few years there's not going to be any more charity care, which is -- I happen to be a strong supporter of the democratic position but I don't believe that there's any basis for thinking that charity care is going to disappear. And so I really believe that those of us that are interested in community benefit should be giving much more attention to charity care, and I think that the faster the community benefit departments take over the management of the charity care, which will give them millions of dollars to spend, the better. And so I -- I just wanted to clarify that. I assume that Brad's going to agree with me, but if he doesn't, he'll let you know right now. That's a great point, Bob, and I think -- Why would you assume that, Bob?

My reading of the 1969 revenue ruling that brought in the community benefits standard and wasn't a community benefits standard, said that community benefit was the criteria of exemption, it explicitly says that it's replacing the 1956 revenue ruling. It's explicit on that.

So, you read it differently than I do on that. I would just offer a friendly amendment to that. I'm not sure it's an and -- it's an or situation. I think the expansion is generally interpreted and practically applied as charity care being the primary component of a hospital's commitment to fulfill its charitable obligations. That may be an interpretation of commentators. I don't think that's -- I don't think that's the law. Read the appellate court decision Eastern Kentucky Welfare Rights Organization where they actually -- at least that one appellate judge, his interpretation was it's created an alternative standard so a hospital in theory could qualify either under the old '56 standard or the '69 community benefits standard. In practical application today, though, I think everybody just assumes it's the operative community benefits standard that -- that rules the day. But read that Eastern Kentucky Welfare Rights decision. I'll see what I can find. But I don't think anybody interprets community benefit as excluding charity care. Right. And if there was something that I said that implied that, I certainly didn't mean to do that. And even in the slide I had at the end I was saying that we're going to have a reduction in the need for charity care and uncompensated -- and Medicaid shortfalls -- charity care; but we're going to have more Medicaid shortfalls, and we're still going to have 8% of the population that's uninsured. Not to mention the undocumented. Well, they're probably included in that 8%.

So, we are -- we are at time, and I do want to just note in deference to Monica Lowell, who's already presented, and Laurie Cammisa, also from Massachusetts, Brad's reference to California being dominant, I want the folks who are -- who have presented or are going to present from Massachusetts, Wisconsin, Michigan, Texas, Illinois and Georgia, to please make sure that we know that you are very much at the table in demonstrating exemplary practices as well. With that, a couple quick directions to lunch. What I'd like to do is to remind you first that we have a tight timeline and we are going to reconvene at one o'clock, and the way you can get there, when you go to the restaurant please; and they've already been instructed to know that they're going to give you your check first so you can pay early in the process, and to get there go -- exit the room, go to the right upstairs center lobby, back downstairs to the restaurant and it's right there. Panel 05 Stakeholder Roles and Contributions 1