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Hospital Community Benefit

Existing Hospital Programs and Requirements

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Introduction

In spring 2023, the Department of Health Care Policy & Financing (HCPF) contracted with the Colorado Health Institute (CHI) to conduct research and provide community-informed recommendations about hospital community investments.

This work was driven by a renewed focus on nonprofit hospital practices. Some state and federal policymakers have recently expressed concerns that hospitals are interpreting their community benefit requirements inconsistently and may not always provide community investments adequate to justify their tax-exempt status.[1] Hospitals, in turn, cite narrow margins and regulatory burdens as barriers to addressing community needs.

To help guide the debate over hospital community benefits, CHI has compiled current hospital programs and requirements overseen by HCPF, other state agencies, and the federal government. This report highlights the breadth of hospital programs and requirements and explores how those programs and requirements do or do not complement each other.

This report outlines hospital programs and requirements within the following categories:

- Conducting community engagement for needs assessments and community benefit implementation plans
- Reporting on profits, expenses, and community spending
- Meeting access, affordability, and health outcome indicators
- Providing financial assistance and discounted care

It also covers other supplemental payments hospitals can receive, as well as any requirements to receive those payments.

Key Takeaways

- For many programs, hospitals must report on community engagement, spending, and profits. Hospital representatives feel that these reports can be duplicative, but HCPF and the subject matter experts it works with actively use all these reports.
- Hospitals receive many payment opportunities, including value-based payments and supplemental payments, but these payments often require hospitals to meet community engagement, reporting, and quality improvement deadlines.
- Many programs and requirements exist on totally independent timelines, and one way to reduce burden without reducing hospital accountability may be to align these timelines.

Community Engagement Requirements

HCPF, the federal government, and the Colorado Department of Public Health & Environment (CDPHE) all require hospitals or their community partners to conduct regular

community engagements. These are used to inform needs assessments, community benefit spending, and community implementation plans.

As outlined in Table 1 (see Appendix), specific program requirements that either directly or indirectly impact hospitals' community engagement activities include:

- The Community and Health Neighborhood Engagement (CHNE) required by the Hospital Transformation Program (HTP)
- Engagement to inform community benefit spending as required by Colorado House Bill (HB) 23-1243
- Community health needs assessments (CHNAs) required by the Affordable Care Act (ACA)
- Local public health agency community health assessments (CHAs) required by CDPHE

Under CHNE requirements, hospitals must hold at least five community engagement sessions spaced throughout each year. These include a mix of public meetings, community advisory meetings, and key stakeholder engagements. CHNE engagements can be incorporated into existing meetings if they are their own agenda item within the meeting. Additionally, reporting on CHNE is combined with other HTP reporting across a program year running from October to September (see Figure 1). These reports require hospitals to list the organizations in attendance and the HTP topics discussed each quarter, as well as to provide an overview of the feedback received and plans to act on that feedback.

Figure 1. HTP Reporting Schedule by Program Year

Report	Purpose	Q1	Q2	Q3	Q4
Ongoing CHNE Reporting	Report on key stakeholder, community advisory, and public engagements	X	X	X	X
Interim Activity Reporting	Report on activities in support of completing upcoming milestones	X		X	
Milestone Reporting	Documentation of whether Implementation Plan milestones have been met		X		X

Under HB23-1243, hospitals will be required to hold an annual public meeting to report on their community benefit spending over the previous year and their proposed implementation plan for community benefit spending over the next year.

Finally, the ACA requires hospitals to host community engagement sessions to complete a CHNA every three years.

HCPF has stated that hospitals can use one meeting to discuss CHNE requirements, community benefit spending, and community health needs assessments, so long as each is a separate agenda item meriting its own discussion. This is intended to reduce any administrative burden of these requirements. These community engagement requirements, although focused on different goals, are all related, so it may make sense for hospitals to fulfill their community engagement for several programs within one meeting. While hospital representatives appreciate this, some feel that, even when they combine meetings, the strict requirements for what they need to cover make community engagement less authentic.

Hospitals are required to submit separate reports to HCPF for each community engagement requirement. CHNE goals focus on hospital initiatives to improve health outcomes, reduce avoidable hospital visits, and improve operational efficiencies, while the CHNAs and community benefit spending address community health needs. However, many hospital representatives maintain that, despite the distinct goals, these separate reports are often duplicative, and they would like to see reporting on these separate initiatives reduced and combined.

Additionally, some hospital representatives cite duplication of efforts in community engagements to create needs assessments by both hospitals and local public health agencies. According to hospitals, these assessments contain similar information on community health priorities and require community engagement with the same community partners but occur on different timelines — every three years for hospitals, every five for public health.

The state notes that these needs assessments have distinct goals: one is focused on hospital implementation planning and the other on the work of public health agencies. In practice, however, many of the same stakeholders participate in hospital CHNAs and public health CHAs, and there is a significant misalignment between the timelines of these requirements. While the CHNA timeline is federally established, CHA timelines are established by state statute and could be revisited with CDPHE.

Hospital representatives also say that the timelines for CHNE and for community benefit implementation plan reporting differ from each other and from the timelines for needs assessments. They say these conflicting timelines create a burden, noting that while the information is interconnected, they must lead stakeholder engagement on three different timelines and participate in CHAs created by local public health agencies that occur on a fourth timeline.

HCPF notes that community benefit implementation engagement can happen any time during the year, as can the engagement for needs assessments, but reporting for both

must be submitted by July 1. CHNE reporting happens at the end of each quarter, but hospitals have flexibility on when they hold different engagements and can choose to align with needs assessment and community benefit meetings. However, reports are due one month later for CHNE (July 31 instead of July 1).

Options for streamlining community engagement requirements may include:

- Changing the timeline of public health CHAs to align with hospital CHNAs
- Quantifying the administrative burden hospitals face to better understand the true impact of these requirements
- Ensuring that hospitals have an accurate understanding of their reporting requirements for these various community engagements
- Changing the quarterly reporting deadline for CHNE to July 1 to match timelines for community benefit implementation and needs assessments reports

Profit and Expense Reporting Requirements

Both the federal and state government require hospitals to report on revenue and spending. Nonprofit hospitals have additional reporting requirements, particularly when it comes to community benefit activities.

Table 2 outlines reporting requirements from both the state and federal governments, including:

- State community benefit reporting for nonprofit hospitals through HB19-1320 and HB23-1243
- State reporting on revenues and expenses through hospital transparency reporting required by HB19-1001 and HB23-1226
- Federal community benefit reporting for nonprofit hospitals to the Internal Revenue Service (IRS) through the Form 990
- Federal cost reporting to the Centers for Medicare & Medicaid Services (CMS) through the Medicare Cost Reports
- Recovery Audit Contractor (RAC) audits when required by CMS

Over the past five years, Colorado lawmakers have implemented new reporting requirements to supplement federal reports, which subject matter experts say are often insufficient to ensure accountability or evaluate policy impacts. HB19-1320 and HB23-1243 reporting requirements focus on community benefit activities, while HB19-1001 and HB23-1226 focus on hospital transparency more broadly, particularly around their expenses and profits.

These state reports are intended to expand the breadth of information available, rather than duplicate federal requirements. For instance, nonprofit hospitals that report on their community benefit to the state may submit their most recent Form 990 instead; similarly,

as part of annual reports to HCPF on costs and expenses, hospitals include certain cost reports also sent to CMS.

Yet some hospital representatives feel that these reports are still burdensome. They say that federal reporting on profits, expenses, and community benefit spending should provide the state with any information it needs. HCPF staff and subject matter experts say they are unable to find all the information they want in existing federal reports and that these state reports provide a fuller picture of hospitals' finances. This friction may be particularly true for nonprofit hospitals, which submit annual reports on income and community benefit spending to both the federal and state governments (required by the IRS and HB23-1243) while also submitting separate but related federal and state reports on general profits and expenses (required by the IRS, CMS, and HB23-1226). The former is only required of nonprofit hospitals, while the latter is required of all hospitals.

Hospitals that do not meet deadlines and requirements for reporting may be penalized by either the state or federal government. Penalties can include fines, audits, and the withholding of Medicare payments.

Approaches to streamline reporting may include:

- Confirming which reports stakeholders would like to see on a more standard timeline
- Assessing reports for any duplicative information that could be removed
- Quantifying the administrative burden hospitals face to better understand the true impact of these requirements

Access, Affordability, and Outcomes Indicators

Both private and public insurers increasingly leverage value-based payment approaches, and several of HCPF's current value-based payment efforts impact hospitals.

Table 3 outlines HCPF payment programs that require hospitals to work on certain access, affordability, or other outcomes indicators, including:

- Hospital Transformation Program (HTP)
- Hospital Quality Incentive Payment Program (HQIP)

HTP, which runs until 2026, is currently HCPF's primary value-based payment program for hospitals. Beginning in 2023, hospitals will need to make measurable progress on metrics they have already chosen within the following areas:

- Reducing avoidable hospital utilization
- Core populations
- Behavioral health and substance use disorder

- Clinical and operational efficiencies
- Population health and total cost of care

The specific metrics can be found in this framework.

Like HTP, HQIP is an alternative payment for hospitals. These programs are intended to complement one another. While HTP focuses on connecting hospitals with the larger delivery system, HQIP is focused on the following areas within the hospital setting:

- Maternal and child health
- Patient safety
- Patient experience

Specific metrics and measures for the HQIP are listed in this document.

A few metrics overlap between the two programs. HCPF intentionally focused HTP on broader service delivery, such as metrics around social needs screenings, length of hospital stay, and referrals to other care. HQIP, on the other hand, focuses more directly on services provided within the hospital. These two programs encourage hospitals to make progress or sustain their work in a range of areas.

Hospitals and HCPF agree that these are important measures for progress. However, some hospital representatives feel that they are being asked to focus simultaneously on too many different payment programs, especially because private insurers can often have related but separate value-based payment programs.

Approaches to reduce the work associated with these programs may include:

- Ensuring that metrics between these programs and any additional value-based payment programs, including those not run by HCPF, are as complementary as possible
- Exploring whether it would be more or less burdensome to consolidate reporting for HQIP and HTP onto the same timeline

Financial Assistance and Discounted Care Programs

When asked about their community benefit work, many hospital representatives cite discounted care and financial assistance provided to patients who cannot pay for services. This financial assistance can be cited as a community benefit by nonprofit hospitals on their Forms 990, so the programs outlined in this section do affect other hospital community benefit spending.

Table 4 describes three financial assistance programs or guidelines:

- The Colorado Indigent Care Program (CICP)

- Hospital discounted care requirements established through HB21-1198
- Federal requirements for financial assistance through Section 501(r)

CICP is a state program that covers some hospital care for people who do not qualify for Medicaid and cannot afford private health insurance. Hospitals choosing to participate in CICP receive state funding through Disproportionate Share Hospital (DSH) payments.

Unlike CICP, the state hospital discounted care requirements are mandatory. HB21-1198 sets minimum standards for the financial assistance programs available in general and acute care hospitals across the state. These include requirements on how qualifies for financial assistance, payment amounts, and payment plan and collection activities.

CICP and the hospital discounted care requirements are the two main hospital financial assistance initiatives in Colorado. The state has worked hard to align these efforts: they share one screening and application form, hospitals can report on them together to HCPF, and both are considered charity care for tax purposes.

However, some hospital representatives report that the administrative burden for the CICP program and hospital discounted care requirements are large: the application process can be time consuming, as can be the processes of setting up a payment plan and reporting to HCPF. Because of the administrative burden, some hospitals choose to forgive the entire bill instead of setting up a payment plan.

Additionally, CICP and the hospital discounted care requirements have slightly different criteria for the services covered (hospital discounted care has more expansive obligations), copayment rates (CICP's are lower), and application procedures (hospital discounted care must often be provided without a Medicaid denial). Therefore, hospitals that provide CICP can sometimes struggle to decide when to apply CICP rules and when to apply the criteria required by hospital discounted care.

Given some of these administrative burdens, HCPF and hospitals have discussed eliminating CICP entirely, as has the CICP Advisory Council, which published this report. The elimination of CICP would not impact patients' ability to get discounted care required by hospital discounted care.

Therefore, one recommendation to reduce the administrative burden associated with financial assistance is the elimination of CICP.

Supplemental Payments to Hospitals

Many of the previous sections discuss requirements hospitals must meet to participate in payment programs or maintain their nonprofit status. HCPF also provides substantial supplemental payment programs to help complete the requirements. Many of these support Essential Access hospitals (those with 25 or fewer beds that are also critical care

and/or serve rural communities), rural hospitals, and other hospitals with lower profit margins.

Table 5 describes the main sources of these supplemental payments, though a full list includes:

- HTP Rural Support Supplemental Payment
- HTP Supplemental Medicaid Payment
    - Inpatient Supplemental Payment
    - Outpatient Supplemental Payment
    - Essential Access Supplemental Payment
- DSH Payment
- Hospital Quality Incentive Supplemental Payment Program (HQIP)
- High Volume Inpatient Payment
- University of Colorado School of Medicine Payment
- Public Emergency Medical Services Payment
- Denver Health Ambulance Payment
- Family Medicine Residency Payment
- State University Teaching Hospital Payment
- Pediatric Major Teaching Hospital Payment
- Physician Supplemental Payment

The most significant of these supplemental payments (HTP, DSH, and HQIP) are administered by the Colorado Health Insurance Affordability Enterprise. The Enterprise and HCPF and sought and received approval to draw enhanced federal matching funds on these payments to help fund hospitals' work. Many of these payments are intended to support smaller or less profitable hospitals that often struggle to meet their HTP requirements due to limited funding.

While these programs do not require hospitals to meet specific metrics, hospitals can only receive the Essential Access, Inpatient, and Outpatient Supplemental Payments if they meet all HTP deadlines. This makes the HTP program and its requirements particularly important for hospital finances.

The HTP Rural Support Supplemental Payment, which was designed to ensure rural hospitals have the infrastructure to be successful in HTP, is contingent both on hospitals meeting their HTP deadlines and on hospitals submitting updates on how they are using this supplemental funding.

Conclusion

Hospitals participate in or are subject to many government programs or requirements, particularly at the state level. According to many subject matter experts, these programs and requirements ensure that hospitals, particularly nonprofit hospitals, are being held

accountable and that they are providing the benefits to communities that they are expected to provide. However, while both hospitals and HCPF agree on the need to provide benefits to the community, they disagree about some specifics in the necessity and burden of some of these requirements.

This report outlines a broad list of both the requirements and payments that are connected to hospitals' community benefit work and provides specific points on which HCPF and hospitals disagree and might be able to compromise on certain requirements, including timelines. One disagreement that this report does not dive into is the question of how much information and reporting policymakers need to hold hospitals accountable; answering that question may help clarify where these requirements and programs either need to be made more robust or need to be streamlined. However, because many of these requirements are written into state law, they may be outside the scope of this project.

We appreciate the opportunity to partner on this work. If you have questions about this report, please reach out to Emily Johnson at JohnsonE@coloradohealthinstitute.org or Kendra Neumann at NeumannK@coloradohealthinstitute.org.

Appendix: Tables

Icons indicate whether each initiative is federal, state, or both.

Table 1: Community Engagement Initiatives

Requirement	Timeline	Topic	Community Engagement Reporting	Enforcement & Eligibility
Community and Health Neighborhood Engagements (Hospital Transformation Program) 	Annually conduct: Two community advisory meetings. One public meeting. Two other key stakeholder engagements.	Provide updates on HTP initiative progress. Seek feedback on that progress and on needed course correction.	As part of quarterly HTP reports, hospitals must report on CHNE work, including interim activities and milestone progress.	General acute care and pediatric hospitals participate in HTP. Certain supplemental payments can be withheld if hospitals do not complete their requirements.
Community Benefit Requirements and Implementation Plans (HB23-1243) 	Annual meeting.	Report on previous year's community benefit spending. Share and seek feedback on coming year's implementation plan.	Must submit a finalized Implementation Plan. Must report on meeting minutes, content, and attendees.	Required of all nonprofit hospitals. HCPF can fine hospitals for noncompliance.
Hospital Community Health Needs Assessments (Affordable Care Act) 	Every three years.	Used to identify community needs and priorities. This should inform community benefit implementation plans.	Must submit a new CHNA every three years.	Required of all nonprofit hospitals. Noncompliance can result in loss of nonprofit status or $50,000 fine.

Local Public Health Community Health Assessments 	Every five years.	Used by LPHAs to identify community needs and priorities. Hospitals are usually involved in this work.	No reporting requirements for hospitals.	No enforcement for hospitals; not a hospital requirement.

Table 2: Profit and Expense Reporting Requirements

Requirement	Timeline	Topic of Report	Enforcement & Eligibility
Community Benefit, Costs, Shortfalls Reporting (HB 19-1320 and HB23-1243) 	Annual report.	Hospitals must report on and submit: • Community investment amounts and types • Total expenses • Net revenue • Previous Form 990 copies	HCPF can fine hospitals for noncompliance. This is required for all nonprofit hospitals.
Transparency and Expenditure Reporting (HB19-1001 and HB23-1226) 	Annual report.	Hospitals must submit: • Copy of hospital cost report provided to CMS • Audited financial statements • Summary of transfers of cash, equity, and assets • Statement of cash flow • Summary of major planned and completed projects Hospitals must also report on: • Available beds and patient statistics • Charges by payer group • Bad debt and charity write offs • Operating revenue, gross revenue, net profit, profit margin • Balance sheet with assets • Affiliations • Some salary data	HCPF can create corrective action plans tied to HTP funding in cases of noncompliance. HCPF can fine hospitals for egregious noncompliance. This is required for all hospitals.
Forms 990 (Internal Revenue Service) 	Annual tax reporting.	Among other provisions, hospitals must report on: • Total community investment • Total unreimbursed costs	Tax reporting is required of all hospitals. Reporting on community investment is required for nonprofit hospitals.

			The IRS can fine or audit hospitals that do not submit.
Hospital Medicare Cost Report (Centers for Medicare & Medicaid Services) 	Annual report.	Hospitals that are Medicare-certified must report on: • Facility characteristics • Utilization data • Cost and charges by cost center • Medicare settlement data • Financial statement data	Required of all hospitals that work with Medicare. CMS can withhold Medicare payments or fine hospitals for noncompliance.
Recovery Audit Contractor Audits 	By request, hospitals must submit records to federal and state governments.	Hospitals must keep records on: • Services provided • Claims submitted	Required of all hospitals. Claims that are not submitted are deemed overpayments by the government.

Table 3: Access, Affordability, and Outcomes Programs

Program & Timeline	Requirements	Metrics	Reporting	Eligibility	Enforcement
Hospital Transformation Program 5 year program (2021-2026) Quarterly reporting on milestones and community engagement. Annual reporting on outcomes in January.	Hospitals must report/meet milestones on a number of metrics (the specific number depends on hospital size). Milestones are concrete activities and deliverables to meet set goals. Hospitals submit a deliverable/documentation for each milestone. Milestones continue all five years but are a focus of years 1-3. In years 3-5, hospitals must make progress on outcomes for their chosen metrics.	For years 3-5, hospitals must choose from specific measures in these areas to make progress on: • Reducing avoidable hospital utilization • Core populations • Behavioral health/substance use disorder (SUD) • Clinical and operational efficiencies • Population health/ total cost of care	Hospitals must report quarterly on milestones and interim activities to reach milestones. Hospitals must report quarterly on their chosen performance measures in the second phase.	All hospitals serving Medicaid patients are eligible.	HCPF can withhold funds if milestones aren't completed (Years 1-3). HCPF can withhold funds if hospitals don't meet chosen evaluation measures (Years 3-5).

Hospital Quality Incentive Supplemental Payment  Annual payment and reporting in May.	Hospitals that opt in have a series of metrics on which they are scored each year. Many metrics are process-based, but some are outcome-based.	Hospitals are measured and scored on metrics in these categories: • Maternal and child health • Patient safety • Patient experience HCPF could change metrics year-to-year but has not.	Hospitals must report on metrics that HCPF does not otherwise collect.	Psychiatric hospitals are not eligible. Most other hospitals serving Medicaid patients are eligible.	Hospitals are scored, and the amount of payment depends on composite score.

Table 4: Financial Assistance Programs

Program & Description	Screening & Application	Reporting	Discounted Services	Billing	Enforcement
Colorado Indigent Care Program (CICP)  Any hospital can choose to receive state funding through DSH payments to provide discounted care to qualifying Colorado residents.	CICP hospitals screen patients without insurance for CICP eligibility. CICP applicants must apply for and be denied Medicaid. Patients apply with a CICP provider to receive discounted care. This lasts for one year. Screening and application use the Universal Application.	Hospitals must submit data on charges, patients served, and total payments for an annual HCPF report. This can be combined with hospital discounted care reporting. HCPF conducts audits of one-third of CICP providers annually. CICP discounted care is reported as "charity care" for tax purposes.	Individual hospitals can set their own requirements for what care is discounted. They must prioritize emergency care, then urgent care, then other medically necessary care. Generally, the services are more limited than hospital discounted care services.	Copays for CICP are usually lower than for hospital discounted care. Patients are required to pay the CICP copay (or, if insured, they can choose to pay the leftover balance instead).	To receive this funding, providers or hospitals that opt in to CICP must complete screening and application processes.
Hospital discounted care requirements (HB21-1198)  Sets minimum requirements for general acute and critical access hospitals' financial	Hospitals must screen all uninsured patients or those who request screening for eligibility for the hospital discounted care program and Medicaid eligibility. Those who are eligible can choose whether to apply for hospital discounted	Hospitals must report hospital discounted care data, including screenings, to HCPF annually. This can be combined with CICP reporting. Financial assistance through hospital discounted care is reported as "charity	Hospital discounted care applies to emergency care, other medically necessary care, and other non-CICP services that patients seek in hospital settings.	Hospitals set up a payment plan that cannot charge patients more than 4% of their household income. After 36 months of payment, the remaining charges must be forgiven. Hospitals cannot send bills until the	HCPF can create a corrective action plan or fine hospitals for noncompliance regarding notifications. For improper screening or debt collection, hospitals may need to pay patients.

assistance plans for Colorado residents who qualify, including non-citizens, regardless of documentation status.	care. Patients can receive hospital discounted care even if they choose not to apply for Medicaid. This lasts for one year. Screening and application use the Universal Application.	care" for tax purposes.		application process is complete. They cannot send patients to collections until the third missed payment. Hospitals can choose to write off the full bill as charity care.	
501(r) Financial Assistance Requirements  For medically necessary services, all nonprofit hospitals must have a free or discounted care policy for those without insurance who qualify. They must also have plain language and translated descriptions of their programs.	Hospitals must determine whether patients are eligible for aid before sending them to collections.	Financial assistance is reported as "charity care" for tax purposes.	Hospitals must have a financial assistance policy for emergency care and other medically necessary care.	Those who qualify cannot be charged more than would be charged similar people with insurance (Medicaid or Medicare).	Hospitals that do not comply can lose their nonprofit status.

Table 5: Additional Supplemental Payment Programs

Program	Eligibility	Requirements
HTP Rural Support Supplemental Payment	Critical access and rural hospitals participating in HTP. Hospitals must be low revenue.	Hospitals must submit a specific planned use for funding.
Inpatient Supplemental Payment	Hospitals participating in HTP.	Hospitals that do not meet HTP timelines can have payments withheld.
Outpatient Supplemental Payment	Hospitals participating in HTP.	Hospitals that do not meet HTP timelines can have payments withheld.
Essential Access Supplemental Payment	Essential Access hospitals (hospitals with 25 or fewer beds that are also critical care and/or serve rural communities) participating in HTP.	Hospitals that do not meet HTP timelines can have payments withheld.
Disproportionate Share Hospital Supplemental Payment	CICP providers or hospitals with a high Medicaid Inpatient Utilization Rate with two obstetricians.	No additional requirements on hospitals.
Hospital Quality Incentive Supplemental Payment	Most hospitals serving Medicaid patients, excluding psychiatric hospitals.	Subject to the requirements discussed in Table 3.

[1] Lagasse J. Senators press Treasury, IRS on nonprofit hospitals' tax exemptions. (2023) Healthcare Finance. https://www.healthcarefinancenews.com/news/senators-press-treasury-irs-nonprofit-hospitals-tax-exemptions#:~:text=Four%20U.S.%20senators%2C%20led%20by,taking%20advantage%20of%20the%20broad