State of Community Benefit Spending in Texas

Key Insights from Non-Profit Hospital Tax Filings

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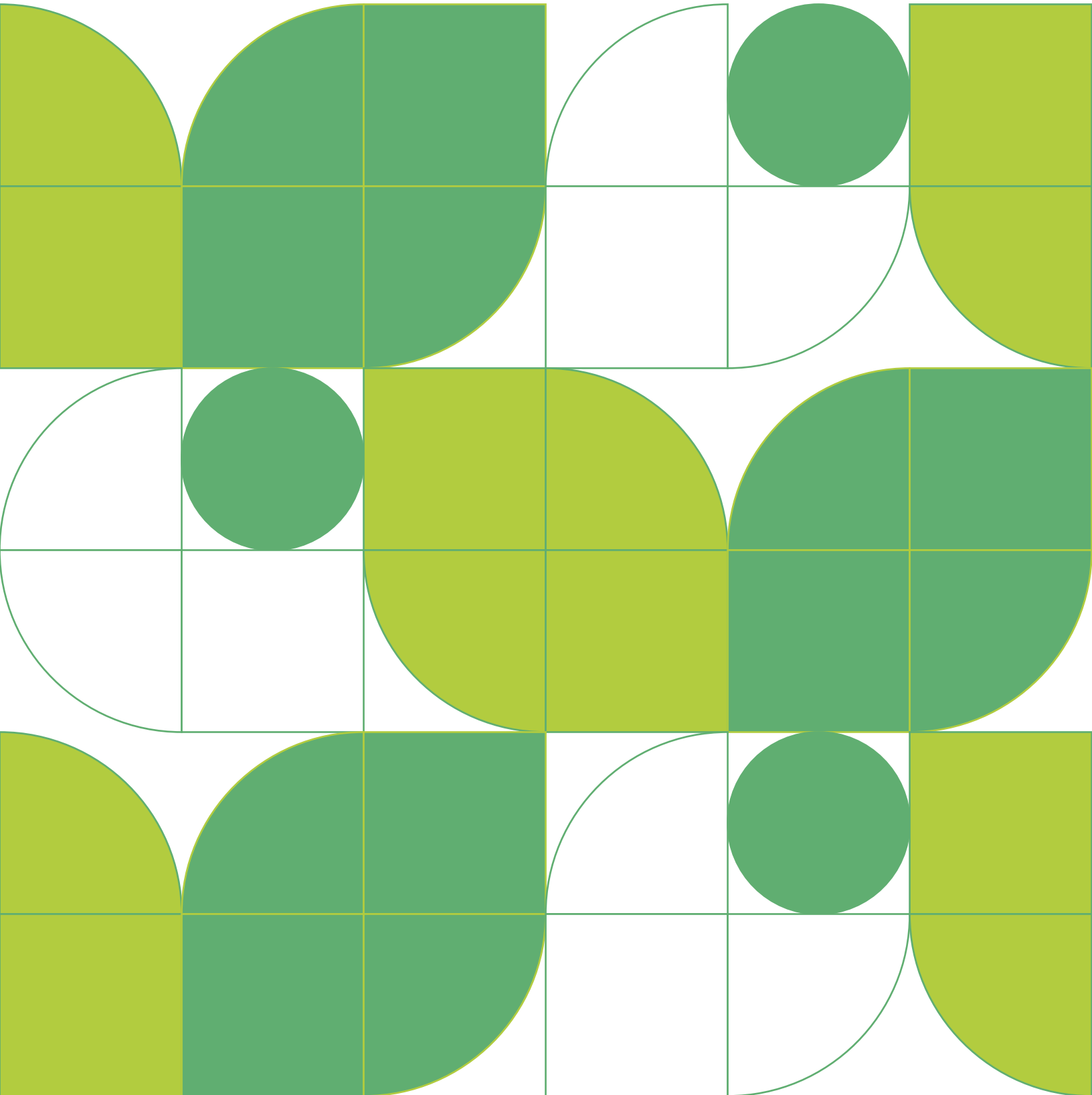


Key Takeaways

- **Texas is one of the few states that maintains a community benefit spending floor**. Texas-based hospital systems or facilities are required to spend more than the value of their tax exemption on community benefits. Additionally, hospitals are required to spend 5% of their patient service revenue on charitable care.

- However, Texas-based non-profit hospitals spend half the amount on community benefits compared to national standards — **$236 per capita nationally versus $120 per capita in Texas.**

- **Less than 1%** of all community benefit spending **funds Social Determinants of Health programming and engagement** in Texas.

- Current **spending is not targeted towards socioeconomic need** with less funding going towards low-income populations and communities of color.

Introduction

Non-Profit hospitals are exempt from Federal, State, and Local taxes in exchange for providing care for all patients, regardless of ability to pay. Any excess funds must be reinvested into hospital facilities, staff, or satisfying an unmet health need in the community. This exemption is currently valued nationally at $28 Billion in 2020, with some estimates placing Texas hospitals receiving $1.7 Billion in annual exemptions. In return, non-profit hospitals spent more than $80 Billion in 2019 on medical services for low-income patients, building partnerships with local community organizations, and engaging in the social determinants of health (SDOH).

This report outlines the challenges to community benefit programming in Texas. Texans receive less than half the per capita spending than their national counterparts. Additionally, the little spent in the state is not targeted towards communities with the highest need. And finally, without Medicaid expansion, Texas hospitals are disproportionately spending on medical services and failing to address downstream drivers of health.

The Unique Regulatory Framework for Community Benefits in Texas

In the United States, non-profit hospitals are typically exempt from all taxes — including Federal, State, and Local taxes. Hospitals must meet certain criteria outlined by the Internal Revenue Service to maintain their Federal exemption. First, hospitals must be organized to promote health and benefit their community. Second, hospitals must meet the Patient Protection and Affordable Care Act requirements that mandate written financial assistance policies and regular community health needs assessments. And **finally, hospitals must demonstrate that they provide a community benefit by providing care to all patients regardless of ability to pay and reinvesting surplus funds into hospital facilities, patient care, or community health.**

Key Findings: Texas is one of a few states that mandates a community benefit spending minimum.

Hospitals are required to spend 5% of their patient revenue on CBS and more than the value of their tax exemption on care for low-income Texans.

The IRS requires hospitals to report these investments, along with financial assistance policies and results from community health needs assessments annually. While individual hospital facilities or systems define community benefits differently, the IRS has broadly listed 17 categories of possible benefits that hospitals can report. These categories include Medicaid Shortfall and Other Government Programs, Medical Services for Low-Income Patients, Investments in Community Health and Partnerships, Research/Education Spending, and Social Determinants of Health Investments.

In Texas, hospitals are required to provide additional evidence and satisfy other regulations to be exempt from state taxes. Texas is one of the few states that maintains a community benefit spending minimum. Here, **hospitals are required to spend at least 5%** of the facility or system's **net patient revenue on charity care**. Per Texas State Code, hospital facilities or systems must also spend more on charity care for low-income and socially vulnerable patients than the value of their tax exemption. Hospitals designated a *disproportionate share hospital* by the Centers for Medicare and Medicaid Services (i.e., hospitals that service a significantly higher proportion of low-income Medicare patients) do not need to comply with the community benefit spending floor.

Outside of submitting annual federal taxes, Texas-based hospitals or systems must report an **Annual Statement of Community Benefit Standards** (ASCBS). Each hospital ASCBS must outline the facility or system's uncompensated care programming and net patient revenue, among other details. These reports are filed electronically to the Texas Department of State Health Services.

Texas has a comparably different regulatory framework for implementing non-profit hospital community benefit programming. Unlike other states, Texas regulatory authorities dictate that hospitals must comply with a minimum spending floor. This threshold is calculated based on the individual facility or system's tax exemption value. Hospitals must spend more than the total value of the exemption on care for low-income Texans. These standards may influence overall hospital community benefit spending behaviors. Instead of spending on non-medical drivers of health, including the social determinants or deepening community partnerships, non-profit hospitals must spend more on undercompensated medical services.

Texas Spending on Community Benefits by Category

In annual reporting to the U.S. IRS, hospitals are required to describe spending across 17 categories that can be broadly categorized into Medical Services, Community Health & Partnerships, and Social Determinants of Health. **Texans receive nearly half the overall community benefit spending compared to national standards. Nationally, hospitals spend $236 per person. However, Texas-based non-profit hospitals spend only $120 per person on community benefits.** This spending disparity varies significantly by community benefit category.

Medical Services

The largest category of community benefit spending is subsidizing medical services for low-income patients. Here, medical services spending can be broken into four categories: Medicaid Shortfall, Shortfall from Other Government Programs, Means-Tested Financial Assistance, and Non-Means-Tested Financial Assistance. **Texas communities receive fewer medical service subsidies across all categories ($89.80 per person in Texas versus $183 per person Nationally).**

Key Findings: Texas Communities received nearly a tenth of national Medicaid shortfall spending compared to national standards.

However, the implementation of financial assistance minimum meant Texas communities received more money for medical subsidies for patients under 200% FPL.

The most significant disparity between national standards and Texas-based community benefit spending is in Medicaid Shortfall. This spending category represents the total amount hospitals lose on participating in Medicaid, the state-administered health insurance for low-income individuals.

Here, Texans received nearly a tenth of national uncompensated Medicaid spending at $11 per person versus $100 per person. This could be explained as Texas is one of fifteen states where Medicaid reimbursement exceeds cost. Additionally, Texas is one of the final states that has not expanded Medicaid. This has important implications for the administration of non-profit hospital community benefits. In a national analysis, Medicaid expansion shifted community benefit expenses from other financial assistance categories to Medicaid shortfall.

As previously discussed, Texas mandates that non-profit hospitals spend more than the value of the facility or system's tax exemption on means-tested financial assistance for patients under the 200% federal poverty line. In short, this creates a minimum of community benefit spending based exclusively on providing care for low-income Texans who do not qualify for Medicaid. **The Texas spending minimum has proven relatively effective in driving financial subsidies for low-income non-Medicaid-eligible Texans compared to national spending ($63.4 versus $42.6 per person).** However, this could lead to lower spending in other medical service categories. For example, Texas communities only receive $7.32 per person for non-means-tested financial assistance, while nationally, communities receive $35.4 per person.

Community Health and Partnerships

The next largest category of community benefit spending is on community health and partnerships. This composite category includes community health improvement services, defined by the IRS as costs for

conducting community health needs assessments, improving access to health services, or improving public health efforts. Additionally, this category includes all cash and in-kind contributions for community benefit programming. This includes financial donations or in-kind support (i.e., staff hours or donation of goods) to community groups for providing medical services, public health efforts, or social determinants of health initiatives. **Overall, Texas remains close to the national average in hospital spending on community health and partnerships ($13.60 per person in Texas versus $15.20 per person Nationally)**.

However, Texas might be outsourcing community benefit obligations to other parties. **For example, Texas hospitals outspent the national average on cash and in-kind contributions for community benefit programming ($8.19 per person versus $6.63 per person)**. However, in previous analyses of annual hospital surveys, we found that Texas hospitals maintained fewer community partnerships. On a positive note, while Texas hospitals tend to have 15% fewer partnerships than the national average, Texas hospitals might be engaging deeper with those partners, as indicated by outspending the national cohort on cash/in-kind contributions for CBS. However, this could also mean Texas hospitals outsource their community benefit obligations to other organizations. Additional qualitative work is required to understand how and with whom hospitals are partnering for community benefit programming.

Social Determinants of Health

The final category of community benefit spending includes investments in the social determinants of health. Broadly, the IRS captures direct SDOH programming such as workforce development, physical infrastructure improvements, or economic development and indirect SDOH efforts like coalition building for health issues or other community improvement activities. **This is the smallest line item on community benefit balance sheets, and Texas lags nationally. In Texas, non-profit hospitals invest less than $0.55 per person in SDOH initiatives, while nationally, hospitals fund around $1.32 per person.**

Key Findings: Texas hospitals spend less than 1% of community benefit budgets on investments in the social determinants of health.

Overall, Texas communities receive less than $0.55 per person on related initiatives.

Hospitals need to invest in the social determinants of health in substantial amounts. **Some estimates put the total investment in SDOH-related activities by non-profit Texas hospitals at just over $20.5 million a year. Compared to the $4.1 billion per year in total community benefit spending, investments in SDOH are minuscule.**

Community Allocation of Benefit Spending

Beyond understanding the amount of dollars invested in non-profit hospitals' community benefits, we also sought to understand what types of communities received more funding. To answer this question, we distributed hospital-level spending to Texas communities using Medicare inpatient discharges. We assigned dollars by calculating the number of discharges of patients from a zip code at each Texas hospital. We then applied this proportion to the total amount of hospital spending to estimate the number of dollars spent by hospitals in that zip code. These results illustrate that Community Benefit Spending in Texas is highly concentrated to some metropolitan regions and potentially inappropriately allocated to communities with lower levels of social need.

Allocation by Metropolitan Area

Community Benefit Spending varies significantly across metropolitan areas. Figure 1. illustrates per capita total community benefit spending by zip code. These results have been scaled to showcase where each zip code ranks against the national sample. In overall community benefit programming, spending is concentrated in Houston, Austin, and the surrounding area of Corpus Christi. Notable, San Antonio's per capita allocation—where the median household income is $12,000 less than Texas overall— is among the bottom quarter of national spending.

Figure 1. Total Community Benefit Spending Per Capita by Zip-Code, National Percentile

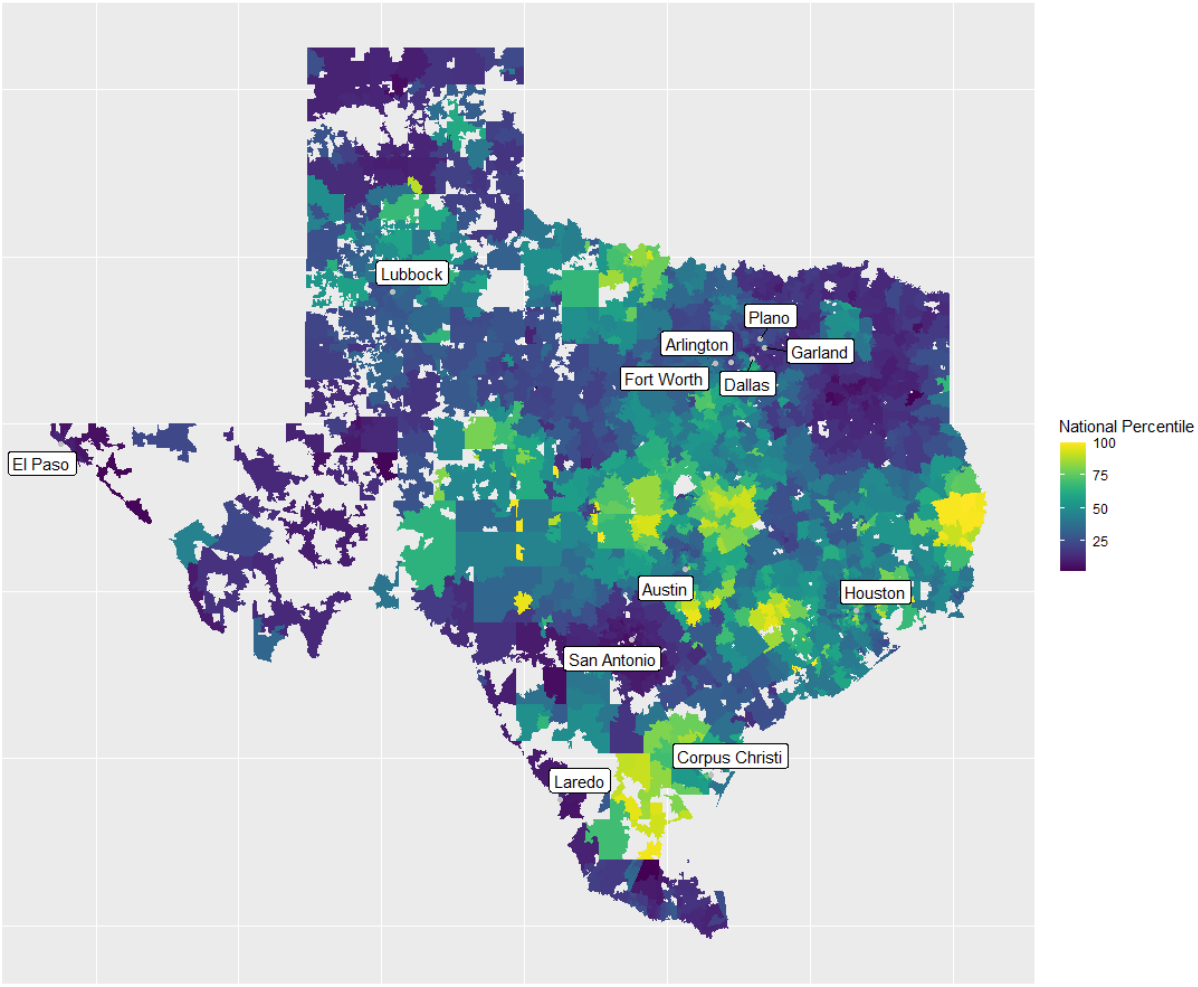
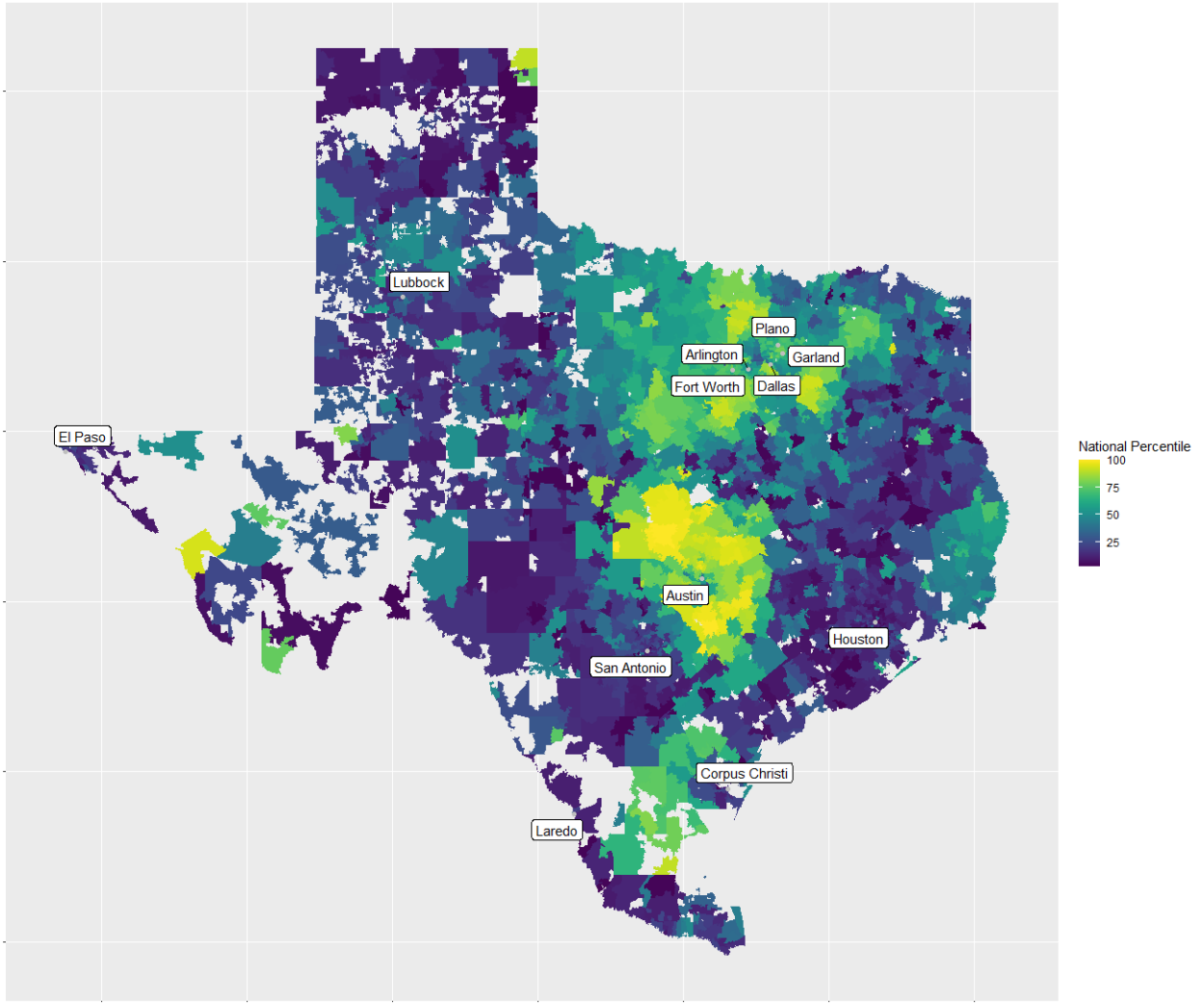


Figure 2. Social Determinants of Health Spending Per Capita by Zip-Code, National Percentile



T**he geographic concentration of community benefit spending becomes increasingly clear when you examine social determinants of health spending, as demonstrated in Figure 2**. Here, Texas non-profit hospital investment in SDOH programming, including programs to alleviate the burden of housing, joblessness, and food insecurity is highly concentrated in the metropolitan region of Austin. **Austin and the surrounding communities rank in the top quarter of national spending on SDOH. In contrast, the Houston metropolitan area, one of Texas' leaders in overall spending, receives some of the lowest per capita investment in social programming.**

The stark difference in SDOH investment in Austin and Houston illustrates an important detail to the allocation of community benefit spending. **Non-profit hospital engagement in social programming is largely not targeted toward social needs and is potentially structurally discriminatory towards socially vulnerable populations**. As illustrated in Figure 2., higher-income metropolitan areas — like Dallas/Fort Worth and Austin — received a disproportionate share of SDOH dollars. **Likewise, metropolitan areas with a higher proportion of the population identifying as Hispanic or Black received less funding**. The inequitable distribution of non-profit hospital SDOH spending in Texas may limit the effectiveness of community benefit programming.

Limitations

We would like to acknowledge a few key limitations to this analysis of Texas non-profit hospital community benefit spending. First, our study relies on publicly available non-profit hospital tax filings, specifically the Schedule H Series 990 form. While non-profit hospitals are required to report their spending, there is no uniform definition of community benefit. Hospitals maintain certain discretion on how they calculate spending and offsetting revenue. Recent reporting from the U.S. Department of Government Accountability Office has highlighted that hospitals are inconsistently filing their taxes. This heterogeneity in reporting might introduce some error in the distribution of community benefit spending.

Additionally, the flow of community benefit spending to Texas communities was estimated from the medical utilization. We assigned dollars to Texas zip codes by distributing spending proportionally by Medicare inpatient utilization from each hospital that treats patients in a zip code. While Medicare accounts for a plurality of inpatient hospitalizations, expanding our allocation method to include all payer types might improve the accuracy of the distribution.

Conclusion

Texas has established a unique strategy for regulating non-profit hospital community benefit spending. Unlike other states, Texas has a community benefit floor where hospitals must spend more than the inherent value of their tax exemption. However, this floor is limited to means-tested financial assistance to low-income Texans. While financial assistance is an important component of non-profit hospital access initiatives, Texas hospitals lag their national counterparts in other areas.

Overall, Texas communities receive half the **overall spending at $236 per capita nationally versus $120 per capita in Texas, with less than 1% of these funds going towards social determinants of health initiatives**. **Simply put, non-profit hospitals need to be spending more on non-biomedical determinants to justify their special tax status**. Further, current levels of funding are poorly distributed. In Texas, community benefit dollars are disproportionately distributed to higher-income and less-diverse communities. In this context, Texas non-profit hospitals must expand CBS programming to communities with higher needs and regulators should consider incentives to broaden investments.

Methods Note: This report is informed from publicly available data provided by the U.S. IRS on Non-Profit Hospital Tax Filings. We included the latest fiscal year for all hospitals available in the 2020 Data Release, typically including calendar years 2017 - 2020. Our dataset covers 87% of all non-profit hospitals in the U.S.