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HEALTH CARE SYSTEMS & SOCIETAL LEVEL COMMUNITY BENEFIT

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A DISSERTATION

Submitted to the graduate faculty of the University of Alabama at Birmingham,
in partial fulfillment of the requirements for the degree of
Doctor of Science in Administration-Health Service

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HEALTH CARE SYSTEMS AND SOCIETAL LEVEL COMMUNITY BENEFIT

MEGHAN BLUEBERRY MCCARTHY

DOCTOR OF SCIENCE IN ADMINISTRATION-HEALTH SERVICES

ABSTRACT

In America, the amount spent on community benefit as tax exemption justification for not-for-profit health care is approaching 100 billion dollars annually. There are multiple categories for community benefit as defined by the Internal Revenue Service (IRS). The overwhelming majority of these funds are spent on individual financial assistance rather than societal level community health investments to address social determinates of health. Societal level community benefit is defined as the total spending on community health improvement, cash & in-kind donations to community groups and community building as reported on IRS form 990 Schedule H. These three combined itemized areas of community benefit spending represent the most accurate insights into contributions that are focused on assisting society rather than one individual.

Current research is lacking when it comes to indicating if health care systems executive leaders and state level policies influence the amount of societal level community benefit spending as a percentage of operating expense. This information could guide organizational decision making for achieving the fullest potential health for all citizens.

This study is a retrospective analysis using publicly available not-for-profit health system community benefit tax data that found no statistically significant association between chief executive leadership characteristics, state level policy and year-over-year societal level community benefit spending as a percentage of operating expense.

Keywords: community benefit, CEO characteristics, federal tax-exempt status, not-for-profit health care systems

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CHAPTER 1

BACKGROUND AND SIGNIFICANCE

Statement of Problem

The not-for-profit health care system in America spends billions of dollars annually to improve the health of our communities. This is in part because not-for-profit status is conditional upon providing and proving community benefit to the Internal Revenue Service (IRS). There is increasing importance placed on community benefit tax reporting to justify tax exemption for not-for-profit health organizations.

In lieu of standardized community benefit performance metrics, dollar amount spent has served as an imperfect proxy to justify and quantify the value to communities and, therefore, the retention of not-for-profit tax exemption status for almost 4,000 hospitals in America. The amount of community benefit required is not set at parity to the corporate tax rate nor is any set minimum amount required by the IRS. Consequentially, the amount of community benefit provided varies greatly within not-for-profit health care systems. The IRS has estimated that 9% of hospitals provide 60% of community benefit spending. This variance weakens the overall argument to retain not-for-profit tax exemption for health care systems.

The Patient Protection and Affordable Care Act (ACA) reduced the uninsured population while also holding not-for-profit health care to a higher IRS reporting standard, creating an opportunity for a portion of the current community benefit spending

to be redirected from direct patient financial assistance into community level health investments while holding the overall health system contribution and tax exemption constant.

There is significant variation in the extent and method in which not-for-profit hospitals provide funding for community benefit. In 2016, the American Hospital Association found that more than 25% of the 5,534 United States hospitals did not have any community partnerships for collaboration on community health improvement (Kacik, 2018). The same survey also indicated that the second most common community benefit program were health fairs behind general community health education. These examples are in stark contrast to hospitals that serve as anchor institutions, investing in housing, food insecurity, economic development, education, public safety, health equity and community health collaboratives. A disproportionate focus among hospitals on external investments in communities also promotes inefficiencies from the lack of collaboration within the health care industry and further limits the ability to address the root systematic challenges around the social determinants of health.

Societal level community benefit is defined as the total spending on community health improvement, cash and in-kind donations to community groups and community building as reported on IRS form 990 Schedule H. These three combined itemized areas of community benefit spending represent the most accurate insights into contributions that are focused on assisting society rather than one individual.

Academics, the government and the general public question the reasons for the variation in contributions towards community benefit. Interestingly, some studies have shown that community benefit spending is explained by relatively few hospital and

market characteristics (Herring, 2018). Research in this area has shifted focus to the influence that hospital leadership can have. Chief executive officers (CEOs) are ultimately responsible for a health care system's performance and priorities. CEO influence and characteristics may outweigh environmental forces on driving community benefit spending.

The future of the American health care system, its tax policy and community benefit practices can be influenced by exploring the variance within the not-for-profit health care delivery of community benefit investments and the leaders that control the community benefit strategy. Specifically, greater understanding of the relationship between chief executive leadership characteristics, state level policy and specific categories of community benefit spending will guide organizational decision making for achieving the fullest potential health for all citizens.

Background

All hospitals in the United States began as charity for the those who could not afford to be treated privately in their homes. As medical science and technological needs evolved, the role of hospitals expanded to serve a broader section of the community. A few physicians formed independent hospitals that provided profit to the owner/operators, but otherwise all hospitals were not-for-profit organizations. In 1965 with the passing of Medicaid and Medicare legislation and guaranteed government payment for the health care of those enrolled in their programs, the first investor-owned hospitals opened. Growth of for-profit hospital systems has continued since. The number of for-profit health care systems doubled in the 1980s and currently, there are 1,034 for-profit

hospitals in the United States compared to 2,848 for-profit hospitals (American Hospital Association Hospital Statistics, 2017).

Today, if we omit the approximately 1,000 government-affiliated hospitals, there are two major structures of health care delivery systems: for-profit and not-for-profit. The Center for Disease Control (CDC) reported in 2015 that 80% of the total non-government hospital beds in the U.S. were in not-for-profit hospitals (Center for Disease Control, 2015). Further, according to *Health Affairs,* seven out of the ten most profitable hospitals are not-for-profit (Meyer, 2016). The major difference between these two categories is the fiscal responsibility to either shareholders or to the government for relief of the burden of care for people who could not otherwise pay.

Not-for-profit health care systems have traditionally been faith-based and tied to a religious mission. Further, many hospitals were established and managed by female religious orders. Today, the three largest not-for-profit health care systems are Accession, Catholic Health Initiatives and Trinity. Together, these health care systems represent around 300 hospitals out of the almost 3,000 not-for-profits hospitals in operation, which represents approximately 62% of all hospitals in the United States. Delaware, Rhode Island and Vermont have only not-for-profit hospitals (Kaiser Family Foundation, 2017).

The three largest systems in the for-profit category include Health Corporations of America (HCA), Tenet and Community Health Systems, which together lead roughly 400 hospitals or 40% of the total for-profit hospitals (Kaiser Family Foundation, 2017). Becker's Hospital Review reports that five states—California, Texas, Tennessee, Georgia and Florida–contain 58% of for-profit hospitals (Ellison, 2015).

Out of the total 6,210 hospitals in the Unites States, 3,494 are part of a health care system. The American Hospital Association (AHA) defines a system as two or more hospitals (American Hospital Association, 2019).

History of Community Benefit

Federal income tax statutes began in 1913 and established that organizations operated for charitable purposes are exempt from taxation. Section 501(c)(3) requirements outline approval by category (educational, religious) or by meeting the general definition of charitable as either broad based public benefit or alleviation of poverty. Health care was not outlined specifically in these regulations, but hospitals at the time were primarily providing free care to the poor, which therefore fits into the alleviation of poverty category. Ongoing regulations issued by the Treasury in 1923 and 1939 reaffirmed not-for-profit status for “corporations organized and operated exclusively for charitable purposes comprise, in general, organizations for the relief of the poor” (Fox, 1991).

In 1956, the IRS adjusted this qualification into a financial-ability standard, which required hospitals to provide health care to those who would otherwise be unable to afford it to the extent financially possible. The ruling states that a hospital is charitable if it “operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those able and expected to pay,” and it defined the charity provided by not-for-profit hospitals as the provision of benefits to the community as a whole (Principe, 2012).

In 1969, the IRS determined the promotion of health to be a charitable purpose and established the "community benefit standard" as the criteria for qualifying for tax

exemption status. No requirements were placed on the provision of charity care as a subset of community benefit. The community-benefit standard was based on the promotion of health for the benefit of the community. To be granted tax exemptions, not-for-profit hospitals generally had to meet the following criteria:

1. Operate an emergency department that cares for anyone, regardless of ability to pay (In 1983, the IRS determined that hospitals without emergency departments could be considered tax-exempt and would make determinations on a case-by-case basis)
2. Provide non-emergency department care for anyone who can pay
3. Participate in Medicare and Medicaid
4. Create a governing board that represents the community
5. Allow any qualified professional who applies to receive medical-staff privileges
6. Reinvest surplus funds, rather than disseminate them as dividends

In 2010, the Patient Protection and Affordable Care Act (ACA), the comprehensive health reform law, added Section 501(r). This law conditions hospitals' eligibility for tax-exempt status on their ability to meet four basic requirements: (a) complete a community health needs assessment (CHNA) every three years and develop an implementation strategy to address identified needs; (b) establish and publicize a written financial assistance policy (FAP) and emergency medical care policy that meet certain statutory requirements; (c) limit amounts charged for emergency and other medically necessary care provided to individuals eligible for assistance under the hospital's financial assistance policy to no more than amounts generally billed to insured individuals; and (d) make reasonable efforts to determine whether an individual is

eligible for the hospital's financial assistance policy before engaging in extraordinary collection actions.

Discussion of Current Community Benefit

Not-for-profit health care systems must file 990 tax forms that demonstrate that they are spending the funds that would have been paid to the government in corporate taxes on providing benefit to the communities in which they operate. Community benefit is the commonly used term for this category of requirements for not-for-profit health care organizations. As defined by IRS instruction, the purpose of Schedule H for hospital organizations on Form 990 is "to provide information on the activities and policies of, and community benefit provided by, its hospital facilities and other non-hospital health care facilities that it operated during the tax year" (Internal Revenue Service, 2019).

Community benefit consists of programs or activities that provide treatment or promote health and healing as a response to identified community need. Community benefit programs have a special focus on disadvantaged populations and must be available to the broad community. According to the IRS, to count as a community benefit, a program or activity must respond to a demonstrated health-related community need and seek to achieve at least one community benefit objective: increase access to health services, enhance public health, advance knowledge through education or research and relieve or reduce the government's burden to improve health (Internal Revenue Service, 2019).

There are several criteria hospitals can meet to satisfy the IRS's requirement for community benefit. The lion's share of community benefit spending is reported as financial assistance for uncompensated care, formerly titled "charity care," which

accounts for the medical treatment of patients without the ability to pay and the differential between the cost of the medical care provided and the dollar amount reimbursed to the health care system through means tested government programs. The "other" includes non-direct patient benefits, such as medical professional education, health education and health promotion activities (Internal Revenue Service, 2019).

The overwhelming majority of community benefit dollars are for direct patient financial assistance, the total of the uncompensated care and the governmental payor reimbursement differential. The volume of the patient population in need of financial assistance is largely out of the control of the hospital system, as it is directly impacted by the percentage of the population that is insured and the reimbursement model of the governmental payor. Despite the implementation of the ACA, including Medicaid Expansion, 27 million people remain uninsured (Kaiser Family Foundation, 2017). The ACA requires all not-for-profit hospitals to have publicly-posted financial assistance policies but allows the hospital to determine its details, including which patients qualify, percent discount and what charges should be waived (Valdovinos, 2015). Accordingly, health systems have developed varied financial assistance policies to outline a process for people to qualify for free and discounted care. Qualifications are usually set as a percentage of the Federal Poverty Line (FPL), an income measurement that is updated annually by the Department of Health and Human Services (DHHS) and used for qualification for Medicaid and the Child Health Insurance Program (CHIP). For example, as posted on their respective websites, Cedar-Sinai Medical Center in California will provide full financial assistance to those at or below 200% of the FPL and partial financial assistance between 201% and 450% of FLP. Northwestern Memorial Hospital

provides free care up to 250% of FPL and a discount up to 600% of FLP. The discount must be made from "generally billed" charges. This can be defined by the Medicare reimbursement rate, an average of three negotiated private insurance rates or other stated calculation rather than the "charge master" cost, which is non-negotiated and frequently inflated many times greater than Medicare reimbursement rates. The hospital or health care system's chief executive is responsible for the overall financial policy, which determines what percentage of the FPL qualifies for financial assistance and the terms for calculation of discounts.

The non-direct patient financial assistance category aggregates a wide range of community benefit spending categories in which leadership can organize strategies around investments in community health promotion that aim to focus on the social determinates of health. The World Health Organization (WHO) defines social determinates of health (SDoH) as, "The conditions in which people are born, grow, live, work and age" (World Health Organization, 2019).

The first portion of Schedule H comprises of the direct financial assistance cost of uncompensated patient care. Section (a) is for reporting financial assistance at cost, which includes the cost of care to uninsured patients or patients without the ability to pay. Section (b) accounts for the differential in the cost of care and the reimbursement by Medicaid. Section (c) is similar, but it is for all other means tested government programs. Categories a, b and c total as section (d). The remaining sections are identified as "Other" and are five classifications for broader community health spending. Section (e) contains community health improvement services and community benefit operations. Section (f) represents health professional education. Sections (g) lists subsidized health

services. Section (h) identifies research. and (i) is cash and in-kind contributions for community benefit.

Table 1

IRS 990 Schedule H Categories

Category	Title	Example
A	Financial Assistance	Free services for those unable to pay
B & C	Medicaid & Costs of Other Means Tested Government Programs	The shortfall between cost of care and reimbursement by the government
D	Totals of A, B & C	All individual patient financial assistance and means-tested government programs
E	Community Health Improvement Services & Community Benefit Operations	Hospital staff dedicated to community benefit
F	Health Professional Education	Costs of residents or interns
G	Subsidized Health Services	Negative margin health service lines
H	Research	Production of generalizable knowledge for the health field
I	Cash & In-Kind Donations	Space allocated to other not-for-profit health service agencies
J	Total E through I	Other sections of community benefit combined
K	Total of line D and J	Total community benefit
Part II	Community Building Activities	Economic development initiatives

The first grouping of sections (a), (b) and (c) account for the majority of community benefit spending. However, sections (e) and (i) represent the social determinates of health directed community benefit spending, stated in many not-for-profit

health care systems missions. These goals include promoting, restoring and maintaining the health of the communities they serve.

Part II of Schedule H is the IRS subcategories for spending on community building. Spending on initiatives in this section currently does not contribute to the overall total spending for community benefit. However, it includes a well described list of important areas for community enhancement that have been included for reporting. The section for community building represents:

- physical improvements and housing, including vulnerable populations upon inpatient discharge and seniors
- removing harmful building materials, neighborhood improvement and revitalization
- parks and playgrounds to improve physical activities
- economic development activities such as assisting in small business development and creating employment opportunities in areas with high joblessness rates
- community supports such as childcare, mentoring programs, neighborhood support groups and violence prevention
- disaster readiness and public health emergency preparedness
- community disease surveillance "beyond what is required by accrediting bodies or government entities"
- environmental improvements to address "environmental hazards that affect community health such as alleviation of water or air pollution," the safe removal or treatment of garbage and waste products and other activities to protect the community from environmental hazards

- leadership development and training for community members such as training in conflict resolution, civil, cultural, or language skills and medical interpreter skills
- coalition building such as community coalitions to address health and safety issues
- community health improvement advocacy such as efforts to support policies and programs to safeguard or improve public health, access to health care services, housing, the environment and transportation
- workforce development, including recruiting physicians and other health professionals to underserved areas, and other activities, such as community building activities that protect or improve the community's health or safety that are not described in the categories above (IRS).

In 2013, the New England Journal of Medicine published a study that examined community benefit expenditures by hospitals with tax exempt status for tax year 2009. The study found that 85% of community benefit spending involved financial assistance, and of the remaining portion, only .05% was devoted to spending on community health improvement activities (Young, 2013). This specific imbalance in composition of the community benefit expenditures is significant and misaligned with the stated goals of the ACA to contribute to preventative and population health needs of communities (Graves, 2017).

Community Benefit Spending as Health Care's Corporate Social Responsibility

For-profit management research outside the health care industry has studied Corporate Social Responsibility (CSR). CSR is a self-regulating business model and defined by the International Organization for Standardization (ISO) as "the responsibility

of an organization for the impacts of its decisions and activities on society and the environment, resulting in ethical behavior and transparency which contributes to sustainable development, including the health and well-being of society; takes into account the expectations of stakeholders; complies with current laws and is consistent with international standards of behavior; and is integrated throughout the organization and implemented in its relations" (International Organization for Standardization [ISO], 2019). A firm that embraces CSR goes beyond complying with regulatory requirements and attempts to achieve broad social outcomes beyond those that are required by law. Multiple authors (Dalaba-Roohi, Groves & LaRocca, Ibrahim, Liket) have attempted to provide a greater understanding of the relationship between CSR deliverables and leadership. CSR research has no universal success metric and varies in the specific desired outcomes. The significant body of research on CSR has focused on the characteristics that influence the amount of philanthropic spending and the return on investment for financial business impact.

The value of not-for-profit health care tax exemption was roughly $24.6 billion dollars in 2011 (Herring, 2018). Comparatively, in 2013, corporate philanthropy in the United States was estimated at $16.7 billion dollars (Liket, 2015). CSR can develop organizational branding, serve as a substitution for marketing spending and strengthen overall strategy and market position. A positive community perception may enhance recruiting efforts and employee engagement for both private corporations and the health care industry. Public relations departments for all industries have used philanthropy to counterbalance negative public opinion. CSR has been shown to have a beneficial impact on employee motivation, morale and retention (Groves, 2011). In summary, there is

research evidence that CSR is a benefit to the organization and to society (Waldman, 2006). The parallel can be drawn that societal level community benefit spending is the health care industry's equivalent of corporate social responsibility.

As with community benefit in the health care industry, success of CSR has traditionally been measured by dollar amount rather than a more dynamic and more challenging achievement of desired outcomes. For both societal level community benefit spending and CSR, specific outcome measurement is lacking. There is a much greater stream of research on CSR than studies specific to community benefit spending, and many conceptual correlates can be made from the robust research on CSR.

Variation in Community Benefit Spending

Not-for-profit health systems are exempt from federal, state and local taxes, including property taxes, which added up to an estimated 25 billion dollars annually in 2011 (Rosenbaum, 2015). In addition, not-for-profit hospitals can receive non-taxed charitable donations and issue tax-exempt bonds. The amount of community benefit spending required by the IRS is not set at parity to the corporate tax rate, nor is there a set minimum amount. As a result, the amount of community benefit spending varies greatly between health care systems. Young et al. found that in 2009, not-for-profit hospitals spent an average of 7.5% of their operating revenue on community benefit expenditures (Young, 2013). The IRS has estimated that 9% of hospitals provide 60% of the community benefit contributions.

This disproportionate burden promotes inefficiencies of collaboration within the health care industry to solve root systematic challenges around the social determinates of health. If all not-for-profit health care systems provided a relative amount of societal

level community benefit funding, the total amount in collective community investment would increase and allow for improved outcome tracking. For example, if four large health care systems in a region are each individually funding ten safety-net, free clinics at various and fluctuating amounts, each health care system could contribute equally to a fund that could distribute a consistent amount of funding annually based on patient utilization metrics. Technical assistance and standardized reporting to the health care system funders could be added without additional administration time for any of the recipient organizations and promote sharing of access to care data. In addition, the disparity in the spending amount and reporting detail of societal level community benefit expenditures across not-for-profit health care systems inhibits the direct comparison with for-profit health care systems around community health investments and financial assistance.

Influence of State Level Policy

In 1991, federal legislators unsuccessfully attempted to make not-for-profit tax exemption status guidelines stricter with a set level of required financial assistance. Hence, states began passing legislation to achieve the same goal. In 1993, Texas required not-for-profit hospitals to conduct an annual community needs assessment and established four alternative, quantitative standards of which not-for-profit hospitals must meet at least one to qualify for tax exemption status. The Texas "reasonableness standard" required that either the value of financial assistance is commensurate with the level of unmet need in the community, as determined by the community needs assessment, or financial assistance must equal at least 4% of net patient revenues or 100% of tax-exempt benefits or government sponsored indigent care plus other spending

on community benefit programs must equal at least 5% of net patient revenue (Texas Hospital Trustees 1993).

In 1994, California also required hospitals to complete a community needs assessment and develop a publicly available "community benefits plan" (Burda 1994). California continued to add regulations and is the only state that requires both for-profit and not-for-profit hospitals to report uncompensated care. In addition, under these state regulations, three state legislatures have heard significant legal challenges to the property tax exemption status of not-for-profit hospitals on the grounds of inadequate community benefit: Utah v. Intermountain; Illinois v. Provena; City of Pittsburgh v. University of Pittsburgh Medical Center (Colombo, 1992).

CEO Leadership

The increasing number of hospital mergers means the consolidation of the number of leaders who are making decisions for billions of dollars in community benefit spending. More understanding is needed about which leaders will most effectively invest community benefit funds for the future health of all Americans. Future policy and practice can be positively influenced by knowing which leaders incentivize and increase investments in the narrowing gap between clinical and community services. Almost nothing is known about the characteristics of chief executive officers of health care systems and community benefit spending.

Gray and Schlesinger quantitatively and qualitatively studied Maryland's hospital progressive community benefit spending. The authors found that community benefit expenditures reported by Maryland hospitals in 2007 ranged from 1.3% to 13.5% of operating expenses, with an average of 7.4%. One of the ten dimensions explored was

the inclusion of community benefit in strategic planning. An example cited was CEO direction to all department heads to include community benefit activities in opportunity statements that were submitted for the strategic planning process. Overall, 71% of CEOs reported including community benefit in some way in their strategic plan (Gray, 2009).

The research did not include assessment of the profile of the CEOs who most valued community benefit. To my knowledge, this is the only study that examines the relationship between CEO leadership and community benefit spending. More research in this area is needed as community benefit contributions have the potential to fund significant positive impact on health outcomes. For health equity improvement, alignment of community benefit policies and strategies among health care leaders could provide enhanced collective action.

This study will contribute to the body of research that aligns CEO leadership and societal level community benefit spending within not-for-profit health care.

Research Question

Within American not-for-profit health care systems who filed IRS documents in aggregate for 2015, what is the association between CEO characteristics, state level policies and societal level community benefit contribution as a percent of operating expense?

Chapter 2

REVIEW OF THE LITERATURE

CEO Influence on Corporate Social Responsibility

Corporate Social Responsibility (CSR) has been researched within five major dimensions—natural environment, community, product, employee relations and diversity—but there appears to be little research on the role that CEO leadership plays in the level of community benefit spending (Walden & Siegal, 2008). Walden and Siegal contend that omission of the leadership lens from any analysis of corporate social responsibility is problematic and leads to imprecise conclusions. The community engagement dimension of CSR refers to charitable giving, supporting educational and residential development, volunteer programs and non-evasive tax behavior (Hess, 2002). Community engagement is largely an externally focused aspect of CSR strategy. CEOs who have more output experience understand the potential relational benefits that accrue from community CSR (Porter & Kramer 1999). CEOs with more experience in output functions can be expected to emphasize community engagement in formulating CSR strategy.

In their CSR research, Walden and Siegal further argue that using upper echelon theory adds predictive power to scholarship and could be used to improve the selection and development of executives. Upper echelon theory describes CEO characteristics as useful for inferring the stimuli in which they are most sensitive, the opportunities they recognize, the interpretations they bring to task related discussions

and the stakeholders they prioritize. Dominant functional experiences condition beliefs (Hambrick & Mason, 1984). Functional experiences can be divided into output and throughput orientations. Output orientation is market-focused and includes experiences in functions such as marketing, sales, research and development. Throughput orientation is organization-focused and includes experiences in functions such as production, process engineering, accounting finance and administration. In the case of healthcare, a clinical background would be considered a stakeholder function that aligns with a market focus and output orientation.

Manner studied 650 American firms to determine if there was a correlation between CEO characteristics and CSR performance and found that observable CEO characteristics predicted differences in CSP between firms, even when firm and industry characteristics are controlled for. Specifically, CSR performance was found to be positively associated with the CEO having a degree in the humanities, having a breadth of career experience and being female (Manner, 2010). In addition, the research contends that CEOs have more discretion in influencing strong social performance than impacting poor corporate social performance. This data provides a strong indication that CEO characteristics underpin CSR patterns (Heyden, 2017).

Community Orientation

Foundational research prior to the Patient Protection and Affordable Care Act (ACA) has explored "Community Orientation" of hospitals and the relationship to environmental and organizational factors. Proenca defines community orientation as "organization wide generation, dissemination and use of community intelligence to address present and future community health needs" (Proenca, 1998). Many authors

used the thirteen questions in the American Hospital Association (AHA) Survey that related to indicators of community orientation. Jennings et al. found positive correlation between community orientation and financial performance (Jennings, 2017). The authors also suggest future consideration of the role of the chief executive officer and his or her inclination towards social responsibility. Changes in both the AHA survey questions in 2010, IRS regulations and the overall health care environment due to the passing of the ACA invited new research to explore the connection between community orientation and community benefit spending.

In 2009, Alexander et al. used the community orientation questions on the AHA Annual Survey to construct a community engagement scale as the sum of nine dichotomous items to measure a hospital's generation and dissemination of community intelligence to address community health needs in order to understand the variance of community activities between independent hospital and system affiliated hospitals. Hospital system affiliation was positively associated with community engagement, indicating that hospitals affiliated with systems engage in more community engagement activities than independent hospitals (Alexander, 2009).

Gender

Gender in leadership has been an important research topic in management for decades and has increased with the heightened focus on corporate culture and equality. It is well documented and observationally obvious that the health care workforce is primarily female, averaging over 80 percent female according to the Bureau of Labor Statistics (Bureau of Labor, 2019). The United States Department of Labor reports that women make most health care decisions for their families and themselves as the major

customers of health care (Department of Labor, 2020). This influence is not reflected in health care senior leadership. According to Modern Healthcare, the estimates vary depending on the definition of the executive suite but range from 11 to 28 percent female (Castellucci, 2017).

One significant study in 2014 by Ho, Li, Tam and Zhange investigates the relationship between a leader's risk aversion and ethical sensitivity as moderated by gender. Accounting issues, such as conservatism in financial accounting, were used as evidence of leadership and decision-making ability. The authors cited that "females are frequently described as being less assertive, less aggressive, less overconfident, more anxious, more risk averse and more ethical, all of which are qualities that suggest a conservative mind-set and a low propensity to commit fraud" (Ho, 2014). The paper argues that female CEOs contribute to better internal control environments. The paper also provides data of a positive association between female leadership and accounting conservativism. Previously, in 2009, Francis et al. conducted a similar study and found that female CFOs were more conservative in financial reporting. In addition, accounting conservativism is aligned with improved contracting efficiency, which leads to a lower cost of capital and impacts overall firm value (Francis, 2009). Above all, this study demonstrates that gender may be a factor for consideration in making senior leadership decisions within the health care industry as the controversial debate of defending not-for-profit tax exemption status intensifies.

Harvard Business School researchers found that between 1996 and 2006, Fortune 500 companies with more women board directors and corporate officers had greater philanthropic giving than peer companies with fewer or no women in senior roles

(Marquis, 2012). The authors highlight that, "During the period of our sample, the number of female Fortune 500 CEOs grew from zero in 1996 to nine in 2006 to 14 in 2010. This number was too small to permit statistical tests in this study, but we strongly believe that future research should investigate the implications of CEO gender, whether through statistical or qualitative methods." Additional studies have shown that women leaders enhance a company's commitment to CSR, increase levels of charitable giving and are more likely to lead companies to develop higher-quality CSR initiatives.

Within the health care industry, outcomes can be accessed with a wide scope of metrics including financial, patient safety, patient experiences scores and many more. This broadness has contributed to limitations on establishing the relationship between female leadership, when present, and measures of success. Community benefit accounting on IRS-required tax documents for not-for-profit health care organizations provides a concise measurement for research. However, there is no literature addressing community benefit spending as a proxy for community health improvement outcomes and the relationship of CEO gender.

Empathy

Empathy as a leadership skill is based in transformational leadership theory and highlighted in Goleman's model of emotional intelligence. Empathy has been long studied within the psychology field and is modernly described as the ability to sense, perceive, or conceptualize how another person experiences the world (Frankel, 2017).

One author articulates the difference between sympathy and empathy as follows: "Sympathy is a strong feeling of care for someone in need. Empathy is the ability to understand why that person is in need in the first place" (Duff, 2017). This explanation

fits perfectly with health care's expressed desire to focus on social determinates of health. This is a stark contrast to the traditional medical model's focus on treatment of disease-specific condition. This summarizes why CEOs with high empathy would be more effective at providing higher levels of societal level community benefit spending.

Eagly conducted a meta-analysis of 45 studies to establish that females exceed males in transformational leadership style and that women emerge as social leaders more frequently (Eagly, 2003). Transformational leadership style has been found to be the most closely correlated to outcome achievement and the female gender when compared to transactional and laissez-faire style as originally described by Burns in 1978 (Bass, Avolio, & Atwater, 1996; Applebaum, 2002).

Empathy, like other personality traits, can be placed along a spectrum with the extreme low end of the continuum representing narcissistic behaviors or more generally, detachment. The high end of the empathy spectrum would be high pro-social behavior. Baren-Cohen (2011) describe the empathy bell curve as following normal distribution among the general population.

Outside of specific empathy research, some studies have examined more generally if CEOs are more likely to demonstrate higher narcissistic or pro-social behavior. Ingersoll (2017) found women CEOs are less likely to be narcissistic than men CEOs and that gender moderates the relationship between CEO narcissism and risky behavior and questionable business practices.

Boddy (2010) describes leaders with low empathy and high narcissism as corporate psychopaths. The author's research shows highly significant and negative influence of corporate psychopaths on measures of corporate social responsibly.

Samay-Tsoory (2018) reviewed the complicated neuroscience research of empathy as determined by a combination of genes, neurophysiology and environment. Studies outline two types of empathy: affective empathy, or the emotional response, and cognitive empathy, or the conscious and rational response to understanding another person's perspective or mental state.

Neither type of empathy is perceived as mandatory to be a leader. However, both are significant in effectiveness for leading people. As health care is at its core a service industry, empathy to the customer and caregivers is valuable for long-term success. Donaldson (2008) states that empathy allows for positive interaction with a wide variety of stakeholders. This affinity for diversity is also particularly relevant within not-for-profit health care, as CEOs are responsible to a board of directors in addition to the communities they serve.

Researchers acknowledge that leader characteristics alone are not enough to explain effective leadership but that understanding traits like empathy can provide insights on leadership behavior and the decisions related to concern for people and production. There is evidence that women are more likely to be empathetic and therefore more likely to select organizations with a culture that values that skill and allows for focus on applying empathy to the community as a social mission.

Diversity Influence

Lee reviews the connection between diversity and empathy in a legal review of Supreme Court rulings (2011). She examines the role of leadership in implementing the diversity rationale affirmed by the U.S. Supreme Court in Grutter v. Bollinger and Regents of University of California v. Bakke. The Court acknowledged the

interdependent relationship between diversity and leadership but did not describe the specific skills needed to lead in diverse environments, nor did it attempt to describe how such skills may be developed. Lee contends that organizational leaders ought to develop their capacity for empathy in order to effectively lead in diverse settings and that to support a culture of core diversity and substantive equality, the act of leading must include an empathetic aspect.

According to Henderson, we are more likely to empathize with people like ourselves, and therefore, individuals with exposure to and backgrounds with greater diversity allow for a wider range of receivers of empathy (Henderson, 1987).

Clinical Experience

Empathy in doctor-patient relationships has been well studied, but it is inconclusive if empathy increases or decreases with medical training and practice. In a meta literature review of 109 studies of all types of clinical education, the most common methods used to measure empathy relied heavily on self-report and cognition divorced from action (Sulzer, 2017). However, the development of empathy in professional conduct is an explicit goal of both the American Association of Medical Colleges and the Accreditation Council for Graduate Medical Education (Hojat, 2009). Overall, very little is known about the relationship between medical care providers as administrators and the role of empathy.

Education

One study examined the educational background of CEOs from large U.S. firms and found links between CEO education and firm performance (Jabert, 2011). Within health care research, Galstian found that higher levels of CEO education are not

significantly or specifically associated with patient experience scores as a measurement of performance (Galstian, 2018).

This study will explore if each of these individual CEO characteristics are positively associated with higher levels of societal level community benefit spending as a percentage of operating expense. Additionally, it will determine if there is a correlation between female gender, clinical and educational backgrounds.

Health system leadership must function under the state level policies that regulate the health care industry. Many not-for-profit health care systems operate in multiple states with varying state governance policies. To explore the influence of state level policy on societal level community benefit as a percentage of operating expense, two state level policies were investigated.

The first state level policy is Medicaid expansion. Medicaid expansion states were able to increase health insurance coverage eligibility to lower the number the uninsured citizens in their states. If not-for-profit health care systems in these states were able to reduce their community benefit spending on financial assistance as a percentage of operating expense, they could then increase spending on societal level community benefit as a percentage of operating expense. This research strives to yield initial findings around the influence of Medicaid expansion on societal level community benefit spending as a percentage of operating expense.

The second state level policy is states that have legislatively passed additional state regulations for community benefit reporting. Community benefit legislation is an ongoing process and many states have passed community benefit guidance over the past two decades. The national standards for community benefit reporting changed with the

ACA which may have standardized state reporting, therefor decreasing the impact of additional state level reporting.

Each of these two state level policies may influence societal level community benefit spending as a percentage of operating expense for not-for-profit health care systems and this research will provide beginning insights into understanding if there is any relationship.

Theoretical and Conceptual Framework

Upper Echelon Theory.

Upper echelon theory (UET) was first described by Hambrick and Mason in 1984. The central premise is that executives' experiences, values and personalities influence decision-making. The seminal work developed 21 propositions characterizing UET's dependent variables that correlate with the independent variables related to age, functional track, peripheral function experience, career experience, formal education, socio-economic background, financial position and group heterogeneity (Hambrick & Mason, 1984). Research literature has used UET to link key characteristics of the CEO to important organizational strategies and outcomes. Multiple surveys have identified the company CEO as the central figure in the establishment of a firm's giving policies (Siegfried, McElroy, & Biernot-Fawkes, 1983; Useem & Kutner 1986).

UET advocates argue that strategic decisions are largely influenced by the personality traits and the specific characteristics of the key decision makers. Decision makers often bring their personal beliefs into the equation when making organizational decisions, and their prior experiences and practices largely influence their decisions (Giberson, 2009).

UET considers physiological traits and cognitive values, socioeconomic class, demographic variables and career related variables. To enhance understanding of what influences executives' decision making, researchers have used demographical variables as proxies for the subjective beliefs and values of the executives to study the effects of these characteristics on corporate strategies and outcomes (Al-Shammari, 2017). This body of research has explored the differences in various areas of strategic decisions, including innovation, diversification, acquisition, capital intensity and corporate social responsibly strategies.

Institutional Theory.

While understanding CEO influences are important, the external environment such as health policy and market environment can impact the extent to which an organization supports societal level community benefit. Institutional theory can guide our understanding of the role of external environment in general, and state health policy specifically.

Institutional theory views an institution's environment as strongly influencing an organization. Environmental pressures guide organizations towards isomorphism. Isomorphism is the similarity in the processes or structure between organizations. Institutional theory grounds us in the foundation that isomorphic forces will drive organizational decision-making processes (Scott, 1995).

Multiple types of external forces contribute to the pressure on an organization. They can be categorized into three groups: Normative, mimetic and coercive (DiMaggio and Powell, 1983). Normative pressures include morals and accreditation, while mimetic pressures are culturally supported peer pressures. Coercive isomorphism results from

pressures that are exerted either formally or informally by other organizations upon which one is dependent. Formal, dominant and powerful pressure on an organization from the government comes in the form of rules, laws and regulations at both the federal and state level.

The American health care system has a high level of regulation and institutional constraint. Health care industry research has extensively used the institutional theory framework to study the impact of those regulations in guiding hospital strategy (Covaleski, 1993). William Scott wrote in his 2000 text, "Institutional change and healthcare organizations: from professional dominance to managed care" that in order to survive, organizations must conform to the rules prevailing in the environment.
The ACA, Medicaid expansion and the ongoing legislative discussion of changes for state level community benefit regulations form the context in which health care systems adapt and function. Larger multi-state health care systems must balance a greater number of varying coercive pressures from each state in which they operate in conjunction with federal guidelines.

Institutional theory can be applied to understand how state level policy differences have contributed coercive pressures on the external health care environment as well as to understand how those pressures have impacted societal level community benefit spending.

My conceptual framework is designed to explore the relationship between CEO characteristics, state level policy and societal level community benefit spending as a percentage of operating expense within not-for-profit health care systems as guided by upper echelon and institutional theories.

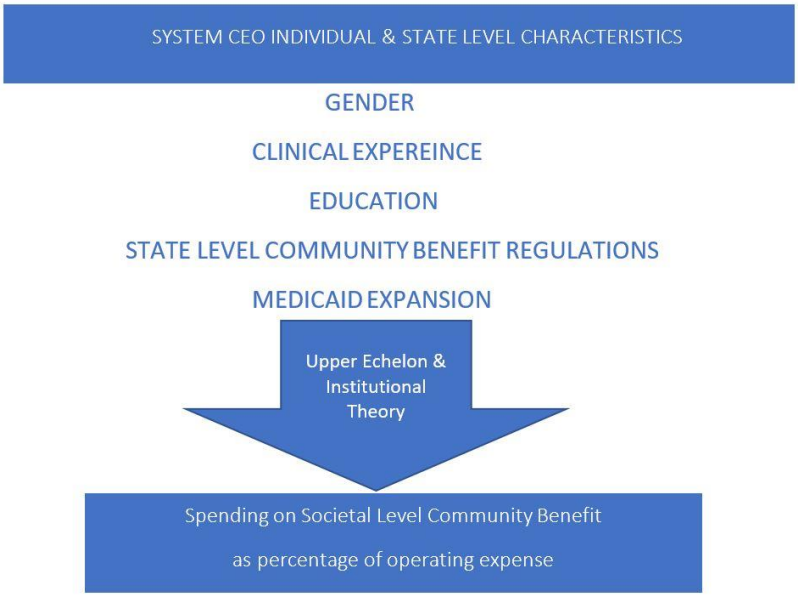

Figure 1. System CEO Individual & State Level Characteristics

CHAPTER 3

METHODS

The overarching goal of this research is to understand the determinants of societal level community benefit spending as a percentage of operating expense. Findings will have the potential to identify reasons for differences in societal level community benefit spending and possibly informing policy and programmatic changes. Specifically, this quantitative analysis was designed to investigate if there is a relationship between CEO leadership characteristics, state level policy and societal level community benefit spending as a percentage of operating expense. In addition, the study investigates whether there is a change in societal level community benefit spending as a percentage of operating expense between tax years 2015 and 2016.

Data Sources

Data will be retrospective IRS data. Not-for-profit organizations are required to disclose the information provided on Form 990 to the public. There are multiple websites that make not-for-profit tax form data searchable. The Community Benefits Insight (CBI) data warehouse is a clearinghouse of data on how hospitals meet the federal community benefit requirements (Community Benefit Insights, 2020). CBI provides free data resources for publicly available tax documents and focuses on the Schedule H section of the 990s form for health care not-for-profits, making it the best fit for this study. The CBI tool was developed by RTI International and the Milken Institute School of Public Health at The George Washington University through the support of the

Robert Wood Johnson Foundation to increase transparency in discovering how hospitals support to improve health and wellness in their communities. The CBI tool provided relatively easy access to historical IRS data that had already been validated. Community Benefit Insight provides the community benefit expenditures as reported by 501(c)(3) tax-exempt hospitals on tax form, IRS 990 Schedule H from both government and hospital sources and itemizes spending into community benefit categories. The CBI tools match the tax documentation with additional confirmatory content from the Centers for Medicare and Medicaid Service (CMS) and the American Hospital Association (AHA). It is available online at www.communitybenefitinsight.org.

The primary data source for the CBI tool is IRS Form 990. Additional data sources are used to confirm not-for-profit hospital status and provide contextual information about each hospital or health system. This supplemental information also allows for hospital comparisons. Additional confirmatory data sources include CMS Cost Report, CMS Providers of Service, AHA hospital data, Kaiser Family Foundation for ACA Medicaid expansion and Catholic Health Association for state level community benefits reporting requirement indicator.

The CBI tool follows a multiple step process for acquiring and matching relevant hospital data. Electronic IRS Form 990 data is extracted, by employer identification number or tax ID (EIN), from the Amazon Web Services (AWS) hosting site. Broad selection criteria are used to capture not-for-profit hospital EINs. Name and address information is extracted from Form 990 Schedule H and not-for-profit CCNs. Form 990 Schedule H data are matched to CCNs by name and standardized address. The results create the EIN-to-CCN crosswalk to build the CBI database. Community Benefit Insight

provides an Application Programming Interface (API), which allows retrieval of hospital data for use in research. The API returns data formatted in JSON - JavaScript Object Notation.

The CBI tool identifies each individual hospital and designates if that hospital files within a larger parent organization. With a customizable query function all the multi-facility organizations or health care systems that filed taxes in aggregate for 2015 were identified and exported as a JSON file. The JSON file was converted to Excel.

The study sample was 114 not-for-profit health care systems nationwide that made the strategic decision to file IRS tax reports in aggregate for tax year 2015. These not-for-profit health care systems do not report community benefit expenditures for each hospital independently but as cumulative totals of each of the hospitals within the health care system. The total amount of community benefit spending is divided by total operating expenses to provide an average for the health care system. Individual hospital community benefit spending may vary based on the level of that specific community's need, but health care systems have the advantage of distributing community benefits spending within the communities they operate based on an overall community health strategy. The criteria for the definition of health system was operating at minimum three hospitals.

For each of these not-for-profit health care systems, the percent of community benefit spending that was spent on societal level community benefit was calculated by combining the values spent on community health improvement, in-kind and cash donations to community organizations and community building. All community benefit spending amounts are listed by category on the publicly available IRS Schedule H form.

To adjust for size, these amounts are expressed as percentages of operating expenses. The three combined itemized areas of community benefit spending represent the most accurate insights into contributions that are focused on assisting society rather than one individual, and I refer to this as society level community benefit.

Next, additional research was manually compiled on each not-for-profit health system's CEO from each health care system's website. Every health care system CEO was profiled by gender, past clinical experience and advanced education.

Variables

This analysis includes one dependent variable, multiple independent variables and two organizational characteristic control variables. The dependent variable was created by manually calculating a new variable of societal level community benefit spending. *Societal Level Community Benefit Spending (total of all hospitals within a system) divided by Operating Expense (total of all hospitals with a system) is equal is to societal level community benefit spending as percentage of operating expense for each not-for-profit health care system.*

Using the health systems website leadership profile data, the CEO characteristic variables were assigned categorical values. The gender variable was 1 for female and 2 for male. Clinical experience or an advanced education was recorded as 0 for no and 1 for yes.

For not-for-profit health care systems with operations within a state with either voluntary or mandatory additional community benefit spending regulations, a dummy variable of 1 for yes and 0 for no was used. In 2010, the Catholic Health Association reported that 14 states had mandatory state level community benefit regulations, 20 states

had voluntary state level community benefit regulations and 10 states had both, with 7 states remaining with no additional state level community benefit regulations.

If the not-for-profit health care system operated in no states that expanded Medicaid it was assigned a 0 and not-for-profit health care systems that operated in states that expanded Medicaid were assigned a 1. States that operated in a combination of both states that did expand Medicaid and states that did not expand Medicaid were assigned a 1. The Kaiser Family Foundation accounted for the 13 states that had not expanded Medicaid at the time period corresponding to tax year 2015 (KFF, 2020),

Faith-based not-for-profit health care systems were assigned religious designation of a 1 and 0 for not-for-profit health care systems with no religious affiliation. The Community Benefit Insight tool confirmed religious affiliation with the search term, "church affiliation" with American Hospital Association data. The number of hospitals within the health care system was also confirmed by the CBI tool and was listed as a continuous variable. All variables and data sources are outlined in Table 2.

Table 2

Variables

Dependent Variable	**Data Source**	**Data Type**
Total societal level community benefit spending as a percent of operating expense	2015 IRS 990 Schedule H	Continuous
Independent Variables		
CEO Gender	Hospital Website Leadership Profiles	Categorical Male = 0 Female = 1
CEO Clinical Experience	Hospital Website Leadership Profiles	Categorical No = 0 Yes = 1
CEO Education	Hospital Website Leadership Profiles	Categorical No = 0 Yes = 1
Additional State Community Benefit Regulations	Catholic Health Association	Categorical No = 0 Yes = 1
Medicaid Expansion	Kaiser Family Foundation	Categorical No =0 Yes = 1
Organizational Level Controls		
Number of Hospitals in Health System	Community Benefit Insight Data Warehouse	Continuous
Religious Affiliation	American Hospital Association	Categorical None = 0 Faith Based =1

Data Analysis

This study selected data techniques to determine if there is an association between the societal level community benefit spending as a percentage of operating expense, characteristics of the CEO and state level policy.

- Aim 1: Demonstrate that not-for-profit health system CEO characteristics are associated with societal level community benefit spending as a percentage of operating expense.
- Aim 2: Demonstrate that state level policies are associated with societal level community benefit spending as a percentage of operating expense.

- Aim 3: Demonstrate that spending on societal level community benefit changed between tax years 2015 and 2016.

The data has been described statistically, including number of observations, mean and standard deviation. Correlation analysis was conducted for CEO characteristics. Aim 1 tested each CEO characteristic separately by conducting a series of bivariate analyses, Aim 2 tested with multivariate analysis and Aim 3 with a t-test. All statistical analysis was completed using Stata 15. Statistical significance was set at $p<.05$.

CHAPTER 4

RESULTS

Univariate Descriptive Analysis

The value of societal level community benefit spending as a percentage of operating expenses for every American not-for-profit health care system with aggregated tax filing for the 2015 and 2016 tax years was calculated. Of the 114 not-for-profit health care systems in the study sample, the range of the percentage of total operating expense that was spent on social level categories of community benefit was .01% to 87% in 2015 which translated to a mean of 2.25% with a standard deviation of 1.14%. The mean number of hospitals per health care system was 6.93 with a standard error of .549.

Table 3

Continuous Variables: Mean and Standard Deviation of Societal Level Community Benefit Spending, as Percentage of Operating Expenses

Year	Mean	Standard Deviation	Mean Number of Hospitals in System	Standard Error
2015	2.25%	1.13791%	6.93	.549

Of the not-for-profit health care system CEO's in the study sample, 11 were female, 18 had clinical experience and 19 had not obtained an advance educational degree.

Table 4

Categorical Descriptive Statistics for CEO Characteristics

Total Sample 114	Female Gender	Clinical Experience	Advanced Education
Frequency	11	18	19
Percentage	9.65%	15.79%	16.67%

A correlation matrix was run to show correlation coefficients between CEO variables of gender, clinical experience and advanced education. The results indicated no evidence of strong correlation between variables. However, the most significant correlation was between clinical experience and advanced education. For example, the combinations of a CEO with an RN and MBA or CEO with an MD and a MHA.

Table 5

CEO Variable Correlation Matrix

	Gender	Clinical Experience	Advanced Education
Gender	1.0		
Clinical Experience	-.1844	1.0	
Advanced Education	-.0664	-.5164	1.0

The study sample represented 38 states with not-for-profit health systems filing 2015 taxes in aggregate for more than 3 hospitals. The states not represented in the study criteria were Alaska, Connecticut, Idaho, Kanas, Maine, Maryland, Mississippi, Montana, Nevada, Rhode Island, Vermont, or Wyoming.

In the United States, only seven states do not have either voluntary or mandatory state level community benefit regulations. They include Arkansas, Arizona, Louisiana, Maine, South Dakota, Vermont and Wyoming. For the study sample there were 11 not-for-profit health care systems who filed aggregate 2015 tax data that operated in states without some level of additional non-federal community benefit regulation.

Corresponding to tax year 2015, 13 states had not expanded Medicaid. Those states were Alabama, Florida, Kanas, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin and Wyoming and the not-for-profit health care systems in these states represented 43.1% of the sample.

The study sample had 49 not-for-profit health systems who were religiously affiliated which represented 42.9%. The most common religious affiliation was Catholic, which aligns with national statistics.

Table 6

Descriptive Statistics for State Level Organizational Characteristics

Total Sample 114	Operating in Medicaid Expansion States	Operating in state with additional state level community benefit regulations	Religious Affiliation
Frequency	66	103	49
Percentage	57.9%	90.3%	42.9%

Bivariate Analysis

Aim 1

My first set of hypotheses were that CEO characteristics would be associated with greater spending on societal level community benefit as a percentage of operating expense.

- H1A: Female gender of CEO will be associated with greater spending on societal level community benefit as a percentage of operating expense.
- H1B: Clinical experience of CEO will be associated with greater spending on societal level community benefit as a percentage of operating expense.
- H1C: Advanced education of CEO will be associated with greater spending on societal level community benefit as a percentage of operating expense.

Using Stata 15, analysis was performed to determine if there was a relationship between each CEO characteristic and societal level community benefit spending as a percentage of operating expense by conducting a series of T-tests.

H1A: Gender

A t-test was performed to demonstrate the relationship between gender of health system CEO and social level of community benefit spending as a percentage of operating expense. There was no statistically significant result to indicate that gender was associated with societal level community benefit spending as a percentage of operating expense. There was no significant difference between male CEOs and female CEOs with societal level community benefit spending as a percentage of operating expense.

Table 7

Two Sample T-Test with Equal Variance: Gender and Societal Level Community Benefit Spending

Group	Observations	Mean	Standard Error	Standard Deviation	95% Confidence Interval
Female	11	.0043272	.0006889	.0022848	.0027923-.0058622
Male	103	.0244428	.0125849	.1277227	-.0005193-.0494049
Combined	114	.0225018	.0113791		-.0000422-.0450459
Difference		-.0201155	.0386637		-.0967227-.0564916

t = .6039

H1B: Clinical Experience

A t-test was conducted to demonstrate the relationship between clinical experience of health system CEO and societal level of community benefit spending as a percentage of operating expense. There was no statistically significant result to indicate

that clinical experience was associated with societal level community benefit spending as a percentage of operating expense. There was no significant difference between CEOs with clinical experience and CEOs without clinical experience and societal level community benefit spending as a percentage of operating expense.

Table 8

Two sample T-Test with Equal Variance: CEO Clinical and Societal Level Community Benefit

Group	Observations	Mean	Standard Error	Standard Deviation	95% Confidence Interval
No Clinical Experience	96	.025951	.0134939	.1322132	.0527399
Clinical Experience	18	.0041061	.0006866	.0029129	.0026576-.0055547
Combined	114	.0225018	.0113791	.1214954	-.0000422-.0450459
Difference		-.0218449	.0312771		-.0401267-.0838166

t = .4864

H1C: Advanced Education

A t-test was conducted to demonstrate the relationship between advanced education of not-for-profit health system CEO and societal level of community benefit spending as a percentage of operating expense. There was no statistically significant result to indicate that an advanced education was associated with societal level community benefit spending as a percentage of operating expense. There was no significant difference between CEOs with advanced education and CEOs without advanced education and societal level community benefit spending as a percentage of operating expense.

Table 9

Two sample T-Test with Equal Variance: CEO Education and Societal Level Community Benefit

Group	Observations	Mean	Standard Error	Standard Deviation	95% Confidence Interval
No Advanced Education	19	.0065637	.0018109	.0078934	.0027592-.0103682
Advanced Education	95	.0256895	.0136387	.1329331	-.0013904-.057693
Combined	114	.0225018	.0113791	.1214954	-.0000422-.0450459
Difference		-.0191258	.030616		-.0797875-.0415359

t =.5334

Aim 2

My second set of hypotheses were that greater societal level community benefit spending as a percentage of operating expense would be associated with state level policy.

- H2A: Health care systems operating in states with additional community benefit regulations will be associated with greater societal level community benefit spending as a percentage of operating expense.
- H2B: Health care systems operating in states that expanded Medicaid will be associated with greater societal level community benefit spending as a percentage of operating expense.

Using Stata 15, a bivariate analysis was performed to determine if the state level policies were associated with the level of societal level community benefit spending as a percentage of operating expense. The control variables were total number of hospitals and religious affiliation.

There was no statically significant relationship between presence of additional state level community benefit regulations and social level community benefit spending as a percentage of operating expense.

Table 10

Additional State Level Community Benefit Regulations and Societal Level Community Benefit Spending; Regression of Additional Community Benefit Regulation at State Level, Religious Affiliation and Number of Hospitals in Health Care System

Number of Observations	114
F (3,110)	.11
Probability > F	.9548
R Squared	.0030
Root MSE	.12296

Societal Level Community Benefit	Coefficient	Standard Error	T	P>|t|	95% Confidence Interval
State Level Addition Community Benefit Regulations	.0214155	.0391206	.55	.585	-.0561124-.0989433
Religious Affiliation	.0047862	.0233311	.21	.838	-.0414504-.0510229
Number of Hospital in System	.0000114	.0019728	.01	.995	-.0038983-.0039211
Constant	.0010168	.0416515	.02	.981	-.0815268-.0835603

Next, we tested if there was a relationship between Medicaid expansion and societal level community benefit spending as percentage of operating expense. There was no statistically significant relationship between Medicaid expansion states and the portion of societal level community benefit spending as a percentage of operating expense. An interesting finding was that the relationship between Medicaid expansion and societal level community benefit spending as a percentage of operating expense is

approaching significance with a p value of .06, meaning that states that expanded Medicaid may be more likely to have a higher societal level community benefit spending as a percentage of operating expense.

Table 11

Medicaid Expansion and Societal Level Community Benefit; Regression of Medicaid Expansion, Religious Affiliation and Number of Hospitals in Health Care System & Societal Level Community Benefit

Number of Observations			114		
F (3,110)			1.16		
Probability > F			.3284		
R Squared			.0307		
Root MSE			.12124		
Societal Level Community Benefit	Coefficient	Standard Error	T	P>|t|	95% Confidence Interval
Religious Affiliation	.0031771	.0229401	.14	.890	-.0422849-.0486391
Number of Hospital in System	.0006989	.0019814	.35	.725	-.0032278-.0046256
Medicaid Expansion States	-.0435386	.0234305	-1.86	.066	-.0899725-.0028956
Constant	.041494	.022998	1.80	.074	-.0040773-.0870761

These multivariate analyses established that state level policy is not statistically significantly related to societal level community benefit spending. For states that expanded Medicaid, F(3, 110) = 1.167, p = .3284 and explained .0307% of the variability. The regression equation for H2A was: Societal level community benefit spending = .0414 +- 0.043 x (State Regulation). For states with additional state level community benefit regulation, F(3, 110) = .11, p = .95 and additional regulations explained .00% of the variability. The H2B regression equation was predicted societal level community benefit spending= -2.135 + 0.044 x (Expansion).

Aim 3

- H3: Societal level community benefit spending as a percentage of operating expense will increase between tax years 2015 and 2016.

My third analysis was to compare 2016 tax data with 2015 tax data for change in levels of spending on societal level community benefit as a percentage of operating expense. My hypothesis was that societal level community benefit spending as a percentage of operating expense would increase with each year as focus on social determinants of health increases. The mean societal level community benefit spending as percentage of operating expense decreased between 2015 and 2016, while the mean of total spending on community benefit as a percentage of operating expense increased over the same time period. Although there is not a statistically significant relationship between societal level community benefit spending as a percentage of operating expense and tax years 2015 to 2016, it may be related to the relatively recent implementation of ACA guidelines. With more time for execution of regulations the relationship may become statistically significant.

Table 12

Year to Year Change of Community Benefit Spending

Variable as Percent of Operating Expense	Number of Observations	Mean	Standard Deviation	t	P
Total Community Benefit 2015	114	9.8886%	14.68762%	-.3353	.7377
Total Community Benefit 2016	107	10.63959%	18.49383%		

Societal Level Community Benefit 2015	114	2.25018%	12.14954%	.0340	.9729
Societal Level Community Benefit 2016	107	2.19533%	11.82306%		

All analyses found that there are no statistically significant relationships between social level community benefit as a percentage of operating expense and CEO characteristics, state level policies or year over year change between 2015 and 2016. Regression analysis was planned, however determined to be unnecessary based on the lack of association between independent and dependent variables.

CHAPTER 5

DISCUSSION

This study sought to understand whether individual characteristics of CEOs or state level policies were associated with the amount a not-for-profit health system contributed to societal level community benefits as a percentage of operating expense. A specific focus was on the role of gender, clinical background, advanced education and additional state level policies. The study was informed by a theoretical framework built on upper echelon and institutional theories.

The lack of statistically significant data points among health care system leadership characteristics is the most significant data point. The majority of health system CEO's continue to be traditional leaders who fit the profile of male, without clinical experience with an advanced educational degree. Although, the association of female CEO's and societal level community benefit spending as a percentage of operating expense was not statistically significant in this study of not-for-profit health systems with aggregated 2015 tax documents, the means of male spending levels and female were notably different. In future research with more female CEO's to provide a greater sample size, this association may be statistically significant.

The assumption that the ultimate strategic decision maker for societal level community benefit spending is the CEO may have been incorrect and at minimum an oversimplification. The health care strategic decision-making process is complex and may not be attributed to one individual. Specifically, the contribution of the

executive team and the chief financial officer, who likely has the largest influence on the overall financial assistance policy greatly influences the total amount of community benefit spending.

The fact that 114 not-for-profit health care systems elected to file the required IRS 990 tax forms in aggregate for 2015 is important. The filing of tax requirements as one system or as individual hospitals is a strategic decision made by senior leadership. Aggregate tax filing can provide resource savings of time and money, but it also reflects a coordinated system approach to operations verses a corporate structure who manages hospitals as holding company. As the trend of hospital mergers and acquisitions continues the number of independently operating hospitals will further decline. Not-for-profit health care systems have the advantageous ability to combine resources across multiple hospitals and redistribute community benefit spending proactively by need and opportunity verses the flexibility of responding to each hospital's immediate geographic needs. When attempting to address long standing systematic disparities such as social determinates of health, often a much larger investment is needed with sustainable resources to continue programs and initiatives over longer periods of time. Ideally this is accomplished with collaboration outside the health care system but budgeting internal health care system resources can create a collective giving model across different markets and allow for a more focused investment portfolio.

The 114 not-for-profit health care systems in the study sample represent 790 hospitals, almost one third of not-for-profit hospitals nationwide. For this study sample, the total spending for community benefit on societal level community health investments was one billion five hundred ten million dollars (1.51e9) in 2015. The mean spending on

societal level community benefit among not-for-profit health care systems filing 2015 taxes in aggregate was 2.25% of operating expenses with a standard deviation of 1.1%.

These findings are an important addition to the literature on community benefit spending, the understanding of societal level community investment and the specific contribution made by not-for-profit health care systems. For context, a study published in 2018 reviewed nationwide contributions of community benefit from 2014 and found the average of individual hospital spending was .7% of operating expenses with a standard deviation of 2.3% for societal level community benefit spending. This study used the term "community directed" expenditures to designate societal level expenditure but the same calculation was used to total the areas of spending on community health improvement, cash and in-kind donations to community organizations and community building (Chaiyachati, Qi, & Werner, 2018). Before the 2014 research, a 2009 assessment found less than 1% spending on societal level community benefit as a percentage of operating expense, demonstrating no change in investments of community benefit in this category over a five-year period, including the time period over ACA implementation. These data points together indicate that spending on societal level community benefit is increasing, at least among health systems who are filing taxes in aggregate.

The majority of community benefit spending research focuses on the total dollar amount of community benefit expenditures. This is an oversimplification that does not account for the quality or the impact of the spending. Within states that expanded Medicaid, the predicted budget shift within community benefit spending was a reduction of the total spending on free care to the uninsured. As well as a reciprocal increase of

number of individuals on Medicaid and therefore, a corresponding increase of the total amount of spending on the shortfall between the cost of care and the reimbursement payment from Medicaid. Overall, this shift was intended to lower the total spending on direct patient financial assistance and yield a greater percentage of the total spending on community benefit allocated on societal level spending post ACA. Correspondingly, it is common to hear CEOs discuss the importance of social determinates of health, which are addressed only by societal level community benefit spending.

The current state of not-for-profit health care system community benefit spending is overwhelmingly driven by financial assistance. The additional requirements for community benefits put in place by the Accountable Care Act have not been robust enough to incentivize a greater spending on the segments of community benefit that contribute to society level health. The power remains at the state level to pass additional community benefit guidelines in order to see an increase in societal level health improvements.

My analysis updates and calculates the value of societal level community benefit contributions from not-for-profit hospitals operating as part of a health care system and filing taxes in aggregate. The mean spending as percent of operating expenses on societal level community benefit among not-for-profit health care systems aggregately filing in 2015 is at 2.2%, more than double compared to the average spending of societal level community benefit as a percentage of operating expense by individual not-for-profit hospitals in 2014 (.7%) with the same criteria for societal level community benefit investments. This can be interpreted as an imbalance in which the larger hospital systems contribute more than the total of individual hospitals' share but I would suggest that it is a

more strategic approach taken by health care systems and their leaders. Not-for-profit health care systems have the advantage of combining the resources of all facilities and then redistributing the funds to the areas of greatest need or opportunity for positive health outcome change. An individual not-for-profit hospital operating in an area with higher health needs will have a higher demand for financial assistance and may not have the resources to appropriately meet the needs as determined by the ACA required community health needs assessment. That same hospital within a health system could benefit from support and resources of a health care system, including dedicated staff that provide expertise in public health investments and leveraging community collaboration. In addition, having community benefit staff allows for more accurate documentation of community benefit spending.

Limitations

The major weakness of the data was sample size. Specifically, the small number of female CEOs among not-for-profit health systems. Female leadership is still far below parity with male executive leadership levels. Health care industry efforts to develop more diverse leadership has not yet translated into gender of chief executive leadership among health care systems.

For not-for-profit health care systems that operated in a combination of at least one state that did not expand Medicaid and at least one state that did expand Medicaid, the mixed level state policy was categorized with a dummy variable of 1, representing positive presence of operations in a Medicaid expansion state. Only the states that operated solely outside of any state that expanded Medicaid were coded as 0 for non-Medicaid expansion state presence. Not-for profit health care systems operating in both

Medicaid expansion state and non-Medicaid expansion states would better be studied as a unique classification.

Similarly, in the classification of additional state level community benefit regulations both mandatory and voluntary state guidelines were coded as positive for the presence of state level additional policy. This follows the Catholic Health Associations view that the voluntary guidelines may be more accurate for community benefit reporting as there is no fear of legislative penalties as a barrier to transparency. By separating the health systems that operate in a mixture of voluntary and mandatory state level regulations there is a more specific understanding of the influence of the different types of state level guidance.

Hospital and health care systems have extensions for tax filing deadlines and, because of this delay, obtaining a comprehensive national dataset for current tax years is also challenging. For this study advancing the tax year toward the current calendar year increased the number of missing tax records and thus would have further lowered the sample size. The prolonged digitization schedule of third-party data providers like CBI advances the time distance between in tax year and current time.

Implications for Practice

Measuring total community benefit by dollar spent is not equivalent to using an outcomes-based model for determining success but assessment of the portion of the total amount spent on community benefit on proactive, societal level health promotion investments can yield a clearer indicator of value. Future research will help determine a balanced investment strategy between financial assistance and community health improvements. Ultimately, the study of a universal return on investment equation for

regulation of community benefit spending with value determined by improved health care outcomes is needed to provide a standardized formula for public and private policy makers to allocate resources more appropriately on the social determinants of health, which account for 90 percent of health outcomes (Lee & Paxman, 1997).

Specifically, not-for-profit health care systems that choose to file as a system represent a level of coordination and may have greater opportunities to apply strategy for community benefit spending. These not-for-profit health care system leaders represent thousands of hospitals and provide a nationwide sample of hospitals that cross over multiple states.

Continued research on the characteristics of not-for-profit health care system leaders is needed to further the policy and practice of community benefit. Further study over multi-year time periods, including the impact of leadership transitions, turnovers and mergers, would add more valuable context to this investigation. A more powerful conceptual apparatus is needed to understand causation of why there is there an emerging difference in community benefit spending categories when females lead. Female CEOs may be drawn to not-for-profit health care leadership for alignment of mission, values, culture and history of service to the community. Analysis and discussion will contribute to the under-researched area of female health care leadership in relation to community benefit spending.

Implications for Further Research

Future research and policy should include tax exemptions as an indirect form of government purchased health care. The concept of exempting not-for-profits from paying taxes is based on the belief that these organizations provide care for those

underinsured who would otherwise require the government to pay. Community benefit spending is a part of the United States health care safety net.

The ongoing trend of hospital mergers and acquisitions will continue to consolidate health care system governance resulting in fewer leaders with decision making power over the investments of community benefit dollars. A measurement for accountability is needed to connect leadership to community benefit spending, specifically for the initiatives aimed at improving the health of the community.

My hope is that this analysis is repeated in future years to demonstrate the evolution of the practice of community benefit. My study serves as a point in time assessment of community benefit spending at the societal level as a percentage of operating expense.

CHAPTER 6

CONCLUSION

The lack of statistically significant data points is the most significant data point of this study. The current state of not-for-profit health care system community benefit spending is overwhelmingly driven by financial assistance indicating that the additional federal requirements set by the Accountable Care Act have not been robust enough to incentivize a greater spending on the segment of community benefit that contributes to society level health enhancements. State level policies such as Medicaid expansion and the presence of additional community benefit regulations have also failed to differentiate societal level community benefit spending as a percentage of operating expense.

The current levels of societal level community benefit spending as a percentage of operating expense are not predicted by CEO characteristics nor state level policies for not-for-profit health care systems who file tax forms in aggregate. Continued research on the characteristics of not-for-profit health care system leaders is needed to further the policy and practice of community benefit.

The future of community benefit spending needs a more balanced investment strategy between financial assistance and societal level community health. Ultimately, a universal return on investment equation for regulation of community benefit spending with value determined by improved health care outcomes is needed to provide a standardized formula for policy makers to allocate resources more appropriately towards social determinants of health.

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APPENDIX A

IRS 990 SCHEDULE H

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
▶ Attach to Form 990.
▶ Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No. 1545-0047

2017

Open to Public Inspection

Name of the organization | **Employer identification number**

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a . .	1a		
b	If "Yes," was it a written policy?	1b		
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☐ 200% ☐ Other _____%	3a		
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: . . . . . ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☐ 400% ☐ Other _____%	3b		
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4		
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a		
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		
6a	Did the organization prepare a community benefit report during the tax year?	6a		
b	If "Yes," did the organization make it available to the public?	6b		
	Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.			

7 Financial Assistance and Certain Other Community Benefits at Cost

	Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a	Financial Assistance at cost (from Worksheet 1)						
b	Medicaid (from Worksheet 3, column a)						
c	Costs of other means-tested government programs (from Worksheet 3, column b)						
d	**Total** Financial Assistance and Means-Tested Government Programs						
	Other Benefits						
e	Community health improvement services and community benefit operations (from Worksheet 4) . .						
f	Health professions education (from Worksheet 5)						
g	Subsidized health services (from Worksheet 6)						
h	Research (from Worksheet 7) .						
i	Cash and in-kind contributions for community benefit (from Worksheet 8)						
j	**Total.** Other Benefits						
k	**Total.** Add lines 7d and 7j . .						

Part II **Community Building Activities** Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing						
2	Economic development						
3	Community support						
4	Environmental improvements						
5	Leadership development and training for community members						
6	Coalition building						
7	Community health improvement advocacy						
8	Workforce development						
9	Other						
10	Total						

Part III **Bad Debt, Medicare, & Collection Practices**

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5		
6	Enter Medicare allowable costs of care relating to payments on line 5	6		
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7		
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☐ Cost to charge ratio ☐ Other			

Section C. Collection Practices

9a	Did the organization have a written debt collection policy during the tax year?	9a		
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI . . .	9b		

Part IV **Management Companies and Joint Ventures** (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Part V Facility Information

Section A. Hospital Facilities

(list in order of size, from largest to smallest—see instructions)

How many hospital facilities did the organization operate during the tax year? _____

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER–24 hours	ER–other	Other (describe)	Facility reporting group
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

(complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or letter of facility reporting group _____

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): _____

			Yes	No
	Community Health Needs Assessment			
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3		
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	☐ A definition of the community served by the hospital facility			
b	☐ Demographics of the community			
c	☐ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☐ How data was obtained			
e	☐ The significant health needs of the community			
f	☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☐ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☐ The process for consulting with persons representing the community's interests			
i	☐ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20___			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5		
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a		
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b		
7	Did the hospital facility make its CHNA report widely available to the public?	7		
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	☐ Hospital facility's website (list url): _____			
b	☐ Other website (list url): _____			
c	☐ Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8		
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20___			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10		
a	If "Yes," (list url): _____			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group _____

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	**13**		
a	☐ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of __ __ __% and FPG family income limit for eligibility for discounted care of __ __ __%			
b	☐ Income level other than FPG (describe in Section C)			
c	☐ Asset level			
d	☐ Medical indigency			
e	☐ Insurance status			
f	☐ Underinsurance status			
g	☐ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	**14**		
15	Explained the method for applying for financial assistance?	**15**		
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	☐ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☐ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☐ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	**16**		
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	☐ The FAP was widely available on a website (list url): _____			
b	☐ The FAP application form was widely available on a website (list url): _____			
c	☐ A plain language summary of the FAP was widely available on a website (list url): _____			
d	☐ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☐ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☐ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☐ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	☐ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☐ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

Name of hospital facility or letter of facility reporting group _____

		Yes	No
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? **17**		
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a	☐ Reporting to credit agency(ies)		
b	☐ Selling an individual's debt to another party		
c	☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	☐ Actions that require a legal or judicial process		
e	☐ Other similar actions (describe in Section C)		
f	☐ None of these actions or other similar actions were permitted		
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? **19**		
	If "Yes," check all actions in which the hospital facility or a third party engaged:		
a	☐ Reporting to credit agency(ies)		
b	☐ Selling an individual's debt to another party		
c	☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	☐ Actions that require a legal or judicial process		
e	☐ Other similar actions (describe in Section C)		

20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):

- **a** ☐ Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs
- **b** ☐ Made a reasonable effort to orally notify individuals about the FAP and FAP application process
- **c** ☐ Processed incomplete and complete FAP applications
- **d** ☐ Made presumptive eligibility determinations
- **e** ☐ Other (describe in Section C)
- **f** ☐ None of these efforts were made

Policy Relating to Emergency Medical Care

		Yes	No
21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? **21**		
	If "No," indicate why:		
a	☐ The hospital facility did not provide care for any emergency medical conditions		
b	☐ The hospital facility's policy was not in writing		
c	☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)		
d	☐ Other (describe in Section C)		

Part V Facility Information *(continued)*

Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)

Name of hospital facility or letter of facility reporting group _____

			Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.			
a	☐	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b	☐	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
c	☐	The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
d	☐	The hospital facility used a prospective Medicare or Medicaid method		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care?	**23**		
	If "Yes," explain in Section C.			
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?	**24**		
	If "Yes," explain in Section C.			

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

Part V **Facility Information** *(continued)*

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility (list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? _____

Name and address	Type of Facility (describe)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

APPENDIX B

IRB APPROVAL FORM

THE UNIVERSITY OF ALABAMA AT BIRMINGHAM
Office of the Institutional Review Board for Human Use

470 Administration Building
701 20th Street South
Birmingham, AL 35294-0104
205.934.3789 | Fax 205.934.1301 | irb@uab.edu

NHSR DETERMINATION

TO: McCarthy, Meghan B

FROM: University of Alabama at Birmingham Institutional Review Board
Federalwide Assurance Number FWA00005960
IORG Registration # IRB00000196 (IRB 01)
IORG Registration # IRB00000726 (IRB 02)

DATE: 17-Apr-2019

RE: IRB-300003256
Health System Chief Executive Leadership and Community Benefit

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The Office of the IRB has reviewed your Application for Not Human Subjects Research Designation for the above referenced project.

The reviewer has determined this project is not subject to FDA regulations and is not Human Subjects Research. Note that any changes to the project should be resubmitted to the Office of the IRB for determination.

if you have questions or concerns, please contact the Office of the IRB at 205-934-3789.

Additional Comments:

Publicly available de-identified data