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Hospital Community Benefits after the ACA: Community Building and the Root Causes of Poor Health

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Introduction

The Hilltop Institute's Hospital Community Benefit Program is a central, objective resource for state and local decision makers who seek to ensure that tax-exempt hospital community benefit activities are responsive to pressing community health needs. This brief is part of a series funded by the Robert Wood Johnson Foundation (RWJF) and the Kresge Foundation.

In previous briefs, the program addressed the new requirements for nonprofit hospitals established by §9007 of the Affordable Care Act (ACA),¹ explored federal and state approaches to community benefit regulation, and identified community-engaged collaborations centered on community needs assessment, priority setting, strategic planning, and the implementation of programs and initiatives to improve population health.

This brief focuses on hospital community building activities and their importance in addressing the root causes of poor health and disability. These activities go beyond the provision of health care services to focus on “upstream” social, economic, and environmental factors—education, employment, income, housing, community design, family and social support, community safety, and the environment—that are major contributors to population health. Internal Revenue Service (IRS) Form 990, Schedule H is the vehicle hospitals use to report their community benefit activities.

Schedule H and Hospital Community Benefit—Opportunities and Challenges for the States (Barnett & Somerville, 2012) discusses key federal community benefit reporting requirements of Schedule H² and its value both as a reporting framework and as an informational resource. The program is pub-

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lishing it simultaneously with this brief to afford the reader a more complete perspective of the evolving federal reporting treatment of hospitals' community building activ-

ities, along with the opportunities and challenges it presents to state officials and policymakers.

Overview

Section 9007 of the ACA clarifies nonprofit hospitals' responsibilities to provide benefits to the communities they serve and requires standardized reporting of these benefits as a condition of federal tax exemption. Traditionally, most community benefits provided by nonprofit hospitals have consisted of free and reduced-cost care for those who cannot afford it, along with activities such as health screenings and health education. Access to quality health care services contributes substantially to community health. Nevertheless, the United States, with the highest medical care costs (both per capita and as a percentage of gross domestic product), ranks poorly among industrialized countries in life expectancy, infant mortality, and other indicators of healthy life (Organisation for Economic Co-operation and Development [OECD], 2011, 2012). Within the United States, health status varies dramatically among states, communities, and socioeconomic groups.

Clearly, factors other than medical care play important roles in community health. Many significant risk factors (e.g., obesity and tobacco use) are ultimately under the control of individuals. Yet these risk factors themselves are influenced by circumstances that are outside the health care domain (Institute of Medicine [IOM], 2011).

Healthy People 2020, which sets forth health-related goals and objectives for the decade, is one of many national and international sources recognizing that nonbiological factors unrelated to medical care—such as socioeconomic status, housing, educational attainment, social norms and attitudes, language, literacy, and culture—can be determinants of population health. These factors are often termed the “social” or “social and economic” determinants of health. Healthy People 2020 highlights the importance of addressing health determinants in its four overarching goals for the decade (U.S. Department of Health and Human Services [HHS], 2011a):³

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and healthy behaviors across all life stages.

The World Health Organization (WHO) provides the most comprehensive description, stating that the social determinants of health “are the conditions in which people are born, grow, live, work and age...” (WHO, 2008).

Community Benefit, Community Building, and the IRS

The federal community benefit reporting requirements implemented by IRS Form 990, Schedule H provide the public detailed information about the charitable practices of tax-exempt hospitals. Community building activities are a form of hospital charitable practices that are generally understood to benefit population health but not involve the provision of medical care. These activities address the root causes of poor health in areas such as education, employment, income, housing, community design, family and social support, community safety, and the environment (HHS, 2011a; IOM, 2011). Community building activities are proactive strategic investments in prevention to reduce the need for costly medical intervention by addressing the “upstream” causes of poor health status and premature death. Such activities are fully aligned with the prevention-based cost containment goals of national health reform. Schedule H lists in Part I categories of activities that may be reported as community benefits. In this respect, Schedule H is consistent with the community benefit reporting framework developed by the Catholic Health Association of the United States (CHA) (CHA, 2006), with one exception: unlike CHA’s *Guidelines*, Part I of Schedule H includes no “community building” category. Instead, the schedule features a separate part

(II) for reporting community building activities. These include:

- Physical improvements and housing
- Economic development
- Community support (e.g., child care, mentoring, and violence prevention)
- Environmental improvements
- Leadership development for community members
- Coalition building
- Community health improvement advocacy
- Workforce development
- Other

Until recently, separate reporting of community building activities led to a not uncommon inference among hospitals that the IRS would not consider community building costs when assessing whether a hospital’s charitable activities adequately support the organization’s federal tax exemption. However, changes in the 2011 Schedule H Instructions appear to indicate otherwise. Issues surrounding the reporting of community building activities are discussed in detail in a later section of this brief, *Reporting Community Building Activities: IRS Form 990, Schedule H*.

What Is Community Building?

Although it may be generally understood that hospital initiatives addressing the underlying social and economic determinants of community health are “community building” activities (Trocchio, 2011), there is no precise, universally accepted definition of the term.

The concept arose, however, well in advance of the introduction of the federal community benefit reporting framework for 2008 (IRS, 2007a). The CHA recognized that “social problems that negatively affect the well-being of the community ... such as a lack of

education, employment, or transportation, or higher rates of violence” should be included in a hospital community service plan’s statement of needs (CHA, 1995, p. 64). In his 1997 monograph, *The Future of Public Health Programming*, Kevin Barnett introduced an expanded community benefit model that included “community building activities,” described as community benefit activities “that address the root causes of health problems and tend to focus in low income communities with disproportionate unmet health needs” (p. 50). More recently, CHA has defined “community building” as programs that address the root causes of poor health, including poverty, homelessness, and environmental risks (CHA, 2008a). Several state hospital associations have adopted this definition or define community building similarly (e.g., Iowa Hospital Association, 2011; Minnesota Hospital Association, 2011).

Some state agencies responsible for monitoring nonprofit hospitals’ community benefit contributions explicitly or implicitly recognize community building as community benefit. In Maryland, for example, reporting guidelines include community building activities, described as “cash, in-kind donations, and budgeted expenditures for the develop-

ment of community health programs and partnerships” reportable as community benefit (Maryland Health Services Cost Review Commission, 2012, p. 19). Although California does not specifically define community building, its community benefit law appears to contemplate these activities by stating that community benefits include, for example, “home delivered meals to the homebound” and “sponsorship of free food, shelter, and clothing to the homeless” (CA Health & Safety Code §127340(d), 2012).

What these definitions and descriptions have in common is a recognition that community benefit includes activities that promote population health by addressing its underlying causes—and that community benefit is not limited to the provision of medical care and other health care services. Whether the lack of a uniformly accepted definition of community building presents a disincentive for hospitals to allocate community benefit resources to community building activities is unclear; because some states’ reporting structures include community building costs as a distinct community benefit category⁴ and others do not, the level of community building activities that nonprofit hospitals currently conduct is also unclear.

Investing in Prevention

Investing in health promotion and prevention activities should be recognized as an effective, proactive approach to creating healthier communities (IOM, 2012). Children grow up healthier when their housing is decent and their neighborhoods “walkable” (Sandel & Frank, 2011; Chiqui, Taber, Slater, Turner, Lowrey, & Chaloupka, 2012). Workplace and community wellness programs increase productivity and reduce health care spending (Trust for America’s Health, 2011). When workplaces provide healthy food choices and

encourage employees to exercise, a healthier workforce can result; a healthier workforce can be more productive and generate lower health insurance costs for employers. Communities with healthy, productive workforces are attractive places for businesses to locate and for families to live, which increases communities’ ability to attract and retain employers and achieve economic growth (Partnership for Prevention, 2001; Florida, 2012). The prevention of avoidable disease and inju-

ries is key to improving America's physical and economic health (IOM, 2011).

At the federal level, there is broad-based appreciation of the imperative to prevent illness and injuries before they arise. There is also appreciation for the proposition that "upstream" investments in prevention can be an effective means to promote both individual and community health (IOM, 2011). The ACA includes numerous provisions that focus on prevention and population wellness. For example, ACA §4001 created a National Prevention, Health Promotion and Public Health Council (National Prevention Council) chaired by the Surgeon General with a membership composed of cabinet secretaries and directors of 17 federal departments and agencies. In 2011, the Council released a National Prevention Strategy (NPS) that identifies strategic, foundational directions for the nation's health prevention efforts (National Prevention Council, 2011). Upon its release, HHS Secretary Kathleen Sebelius affirmed that prevention helps people live long and productive lives and can help combat rising health care costs (HHS, 2011b).

The ACA also created the Prevention and Public Health Fund (ACA §4002), a funding

stream dedicated to public health and prevention activities (Johnson, 2012). The Community Transformation Grants program, also established by the ACA, supports state- and community-level interventions to address the root causes of poor health. Grant funding must be directed toward improving where Americans live, work, play, and go to school so that they can lead healthier, more productive lives (Centers for Disease Control and Prevention [CDC], 2012a).

National health reform will present nonprofit hospitals with unique opportunities to enhance their upstream investments in health—investments that create conditions that enhance health and wellbeing before illness occurs. According to the Congressional Budget Office (CBO) (2012), 14 million currently uninsured Americans are expected to gain access to health coverage in 2014.⁵ As a result, it is likely that the demand for free care will lessen, presenting nonprofit hospitals with the opportunity to shift a portion of their community benefit investments from the provision of free and discounted care to activities that address the root causes of poor health.

Addressing the Social and Economic Determinants of Health: Nonprofit Hospital Community Building

The causative relationship between various health determinants and population health outcomes are complex and can be difficult to isolate for separate analysis. The following discussion focuses on selected social and economic determinants of health and presents examples of how nonprofit hospitals are addressing them through community building-type activities and programs.⁶

Education and Economic Factors. A substantial body of evidence links educational

attainment to health, even when other factors are taken into account (RWJF, 2011a). Better educated individuals and their children are more likely to live longer and healthier; babies born to mothers who have not finished high school are nearly twice as likely to die before their first birthdays as babies born to college graduates (Mathews & MacDorman, 2007). Higher educated populations are also more likely to engage in health-promoting behaviors such as physical exercise, seeking

regular preventive care, and living a tobacco-free lifestyle (Braveman & Egerter, 2008).

A strong relationship has similarly been observed between income/wealth and health. Economic factors can impact families' ability to live in safer homes and neighborhoods, have better access to educational opportunities, eat healthier foods, engage in physically active leisure activities, and perhaps even have lower, less harmful levels of stress. Children in families with low incomes are about seven times more likely to be in fair or poor health than children in families with incomes at or above 400 percent of the federal poverty level (RWJF, 2011b). Among adults aged 25, those in the highest-income group are likely to live more than six years longer than those in low-income groups (RWJF, 2011b).

Hospital Activities to Improve Educational Attainment and Earning Capacity. A number of hospitals across the country are engaged in activities to improve the educational attainment and earning capacity of individuals in their catchment areas, as well as to improve population health. Two examples follow.

In collaboration with community partners, the metropolitan Detroit-based *Henry Ford Hospital System* operates "Henry Ford Early College," a competitive, technology-integrated program designed to prepare students for futures in the allied health professions. Beginning in the ninth grade, students simultaneously complete high school, earn college credits, and receive allied health professional certification ("First Class to Graduate," 2012).

Every year since 2007, six nonprofit hospitals⁷ and the Baltimore City Public School System have partnered to provide 60 rising high school seniors a six-week paid career-

building work experience in a hospital setting. Sponsored by the *Baltimore Alliance for Careers in Healthcare* (BACH), this initiative is designed to help allied health students focus their careers and plan a path to college or the workplace. In 2012, BACH expanded this work-based experience to a year-round activity (National Fund for Workforce Solutions, 2012).

Both of these programs are designed to enhance educational opportunities for participating students, making it more likely that they will secure higher-paid skilled employment and greater earning capacity. At the same time, these programs address workforce shortages in the health care industry.

Housing and Neighborhoods. For most Americans, home—where they and their families eat, sleep, relax, and interact—is central to their daily lives. Safe housing that is free of physical hazards supports good health. Conversely, poor-quality and inadequate housing increases the risks of health problems such as infectious and chronic diseases, as well as developmental issues in children (Shaw, 2004). Living in deteriorating homes built before 1978 can expose children to lead-based paint and lead-contaminated water, both of which are potentially damaging to children's nervous systems and, consequently, to their learning and earning capacity. Despite vigorous public health efforts, an estimated 121,000 children aged five years or younger nationwide have elevated blood lead levels (CDC, 2010).

Neighborhood characteristics also contribute to health status. Neighborhoods with safe places for children to play and for adults to exercise support health; those with high crime rates and pollution do not. Communities with access to fresh produce and other healthy food choices, good employment opportunities, and convenient transportation

options support good health; those without these options may not (RWJF, 2011c).

Even the affordability of housing has health implications: lack of affordable housing⁸ constrains choices about where to live; therefore, families with low incomes may have to live in substandard, unsafe housing in crowded neighborhoods. Individuals living in unaffordable housing face financial burdens that often cause a diversion of scarce resources from other basic needs, such as heating, eating nutritious foods, and health care (RWJF, 2011d).

Social environment affects health as well. Neighborhoods where residents trust each other and are willing to intervene on each other's behalf are associated with lower homicide rates (Sampson, Raudenbush, & Earls, 1997). In contrast, neighborhoods where residents are more isolated and experience more crime and social disorder⁹ have been associated with anxiety and depression (Ross, 2000; Elliott, 2000).

Hospital Activity to Promote Healthier Neighborhoods. Two hospitals in Ohio demonstrate how hospitals can work in their communities to improve neighborhood conditions that affect health.

Over the last 30 years, the downtown Columbus, Ohio neighborhood of *Nationwide Children's Hospital* has experienced job losses, an increase in crime, and deteriorating schools. In 2008, the hospital launched Healthy Neighborhoods, Healthy Families (HNHF), now a public-private partnership of the hospital and local community-based organizations. The program targets affordable housing, education, safe and accessible neighborhoods, and workforce and economic development. HNHF has (Nationwide Children's Hospital, 2010):

- Renovated or repaired neighborhood homes to increase the availability of quality affordable housing
- Made grants to homeowners for exterior upgrades to their homes
- Initiated farmers' markets to improve access to fresh foods
- Facilitated the mentoring of local elementary school students by hospital volunteers

The Community Health Initiative (CHI), a program of the *Cincinnati Children's Hospital Medical Center*, includes work with non-traditional community partners to support community organizing and address asthma, prematurity, accidental injuries, and poor nutrition in the community. For example, using geocoding technology to identify hotspots (areas of greatest need) by mapping of residences associated with hospital admissions, the program identified clusters of re-admitted asthma patients who all lived in substandard housing units owned by the same landlord. CHI partnered with the Legal Aid Society of Greater Cincinnati, which helped tenants form an association compel the property owner to make repairs. CHI also makes referrals to Legal Aid for patients who need help with Medicaid benefits or require other legal assistance. CHI has developed specific health metrics with which it evaluates the effectiveness of its programs and shares these data with local community organizations and CHI's community partners (Cincinnati Children's Hospital Medical Center, 2011).

Social and Economic Determinants and Race. Race, ethnicity, and socioeconomic conditions all have important implications for health. Minorities experience significant differences in health status, health outcomes, and longevity. The largest, most persistent

health inequalities are generally observed between Black and White Americans (RWJF, 2011e). Hispanics and some Asian subgroups are also less healthy when compared with Whites. For example, non-Hispanic Blacks have a higher risk of hypertension and its related complications (stroke, diabetes, and chronic kidney disease) than non-Hispanic Whites (CDC, 2011). Adult Hispanics, Asians, and Blacks have higher rates of diabetes than adult Whites (RWJF, 2011e).

A number of factors interact to play important roles in racial and ethnic health disparities. Higher incomes and higher levels of educational attainment are associated with better health (Braveman & Egerter, 2008). CDC researchers have estimated that as much

as 38 percent of excess mortality among Black relative to White adults is related to differences in income (Otten, Teutsch, Williamson, & Marks, 1990). Neighborhood characteristics are also important: Black and Hispanic adolescents with low incomes tend to live in more disadvantaged neighborhoods than their White counterparts (Braveman, Cubbin, & Egerter, 2005). Differences in access to quality medical care also play a significant role in health inequalities (Agency for Healthcare Research and Quality, 2011). Higher levels of stress (regardless of their association with race-related negative experiences or adverse social or economic determinants) are also thought to contribute to racial and ethnic health disparities (Hertzman & Power, 2003; McEwen, 1998).

Community Building Resources

Much remains to be learned about how race and social and economic determinants affect health. Nevertheless, resources such as the CDC's [Guide to Community Preventive Services](#) (the Community Guide) detail interventions, programs, and projects that have proven to be useful in addressing social determinants and improving population health. For example, based on its determination that sufficient evidence supports an association between adequate housing and reductions in exposures to crime and social disorder, the Community Guide recommends tenant-based rental assistance—through vouchers or direct cash assistance—to increase poor families' housing options. The Community Guide also recommends comprehensive, center-based early childhood development programs for children of families with low income, based on strong evidence of improved cognitive development and academic achievement (CDC, 2012b).

[What Works for Health](#) is an online searchable menu of policies and programs to improve health that is organized by the multiple factors that affect health, including health behaviors, clinical care, social and economic factors, and the physical environment. Developed by the University of Wisconsin Population Health Institute (UWPHI) in collaboration with RWJF as part of *County Health Rankings & Roadmaps*, What Works for Health provides an evidence rating for each policy and program to indicate the relative strength of the evidence supporting the strategy, and links users directly to the available evidence for the program or policy (UWPHI, 2012b).¹⁰

[Community Commons](#), a web-based resource for exploring promising approaches to promote community health and development, is another useful online resource that features an interactive map linked to detailed descrip-

tions of programs and interventions in communities across the country (Community Commons, 2012a). Additionally, Community Commons' Community Toolbox links to more than 15 databases of illustrative best

practices and more than 30 categorical web-based resources for promising approaches to addressing particular issues (Community Commons, 2012b).¹¹

Reporting Community Building Activities: IRS Form 990, Schedule H

Form 990 is an informational return that most tax-exempt organizations are required to file annually. In 2007, Form 990 was redesigned and a new **Schedule H** was introduced. Specifically for tax-exempt hospitals, this new schedule was intended to increase transparency and objectively quantify nonprofit hospitals' community benefit activities (IRS, 2007). Otherwise generally adapted from CHA's community benefit reporting model (CHA, 2006), a discussion draft of the 2008 Schedule H eliminated the model's community building category of community benefit (IRS, 2007). In response to stakeholders' urging, the IRS added Part II, "Community Building Activities," to the final version (American Hospital Association, 2008). Viewed as a compromise, the addition of Part II to the 2008 Schedule H facilitated the IRS's collection of additional information on charitable activities considered "controversial" without acknowledging their qualification as community benefit (Salinsky, 2009). The IRS had taken no definite position on whether some, all, or none of the activities reportable as "community building" would be credited as community benefit. Rather, it would collect data to inform its consideration of the issue (Flex Monitoring Team, 2009).

In 2008, Ron Schultz, then senior technical advisor in the IRS's Tax Exempt and Government Entities Division, explained the IRS's rationale. Acknowledging that "almost the entire not-for-profit hospital sector ... believed [community building] should count" as community benefit, the IRS perceived "a

much less direct connection" between hospital expenditures for community building activities and the promotion of community health (CHA, 2008b, pp. 48-49). In the IRS's view, that made it "inappropriate" to treat community building as community benefit "at this time" (CHA, 2008b, pp. 48-49). Instead, by collecting information about community building activities separately in Part II of the schedule, the IRS would be in a better position to assess whether initiatives such as supporting affordable housing, economic development, and environmental improvements meet the established standard that community benefit activities support the promotion of health (CHA, 2008b, pp. 48-49).

Since its inception and to date, Schedule H has included among the Part I categories reportable as community benefit "community health improvement services and community benefit operations" (line 7e). There have been no substantive changes in either the schedule itself or in the **Instructions'** relevant worksheet since Schedule H was first introduced for 2008. The Instructions for Part I, line 7e include the following definition (2008-2011 Schedule H Instructions):

Community health improvement services" means activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health. Such services do not generate inpatient or outpatient bills, although there may be a nominal patient

fee or sliding scale fee for these services.

Part II of Schedule H (2008-2011), accommodates the separate reporting of community building activities; Part II reporters are directed to include in Part VI (“Supplemental Information”) a description of how the organization’s community building activities reported in Part II promote the health of the community the organization serves. Schedule H (2008-2011) lists nine categories of activities reportable as community building: physical improvements and housing, economic development, community support, environmental improvements, leadership development and training for community members, coalition building, community health improvement advocacy, workforce development, and “other.” The 2011 Instructions explain that “community building activities... [are] the organization’s activities that it engaged in during the tax year to protect or improve the community’s health or safety, and that are not reportable in Part I” (p. 4).

The separate reporting format for community health improvement services (Schedule H, Part I) and community building activities (Schedule H, Part II) has been the source of considerable confusion, inasmuch as many activities considered community building (e.g., environmental improvements that abate public health hazards) would seem to satisfy either of the two definitions. The difference between the Schedule H definitions of “community health improvement services” and “community building activities” is both elusive and question-begging: Both describe activities that improve community health, but those considered “community building” should be reported in Part II if they “are not reportable in Part I” (Schedule H Instructions, p. 4). The IRS provided only limited clarification by adding in the 2011 Schedule

H Instructions that “some community building activities may also meet the definition of community benefit” and restating that community building activities reported in Part I should not be reported in Part II.¹² Perhaps this change in the 2011 Schedule H Instructions indicates the IRS’s better appreciation in 2012 (compared with its 2008 perspective) that activities such as promoting safe housing, economic development, and environmental improvements can be shown to improve community health—and thereby satisfy the traditional community benefit standard.

CHA, a longtime proponent of hospital involvement in community building activities, has developed a guidance document addressing whether activities should be reported as community benefit or community building. As that document states, “an activity that might otherwise fit in one of the categories of community building ... could be reported as community health improvement when the activity meets all of the IRS criteria for community health improvement” (CHA, 2012a, p. 2).¹³ The guidance recommends a range of respected public health resources that can be used to provide evidence that an activity meets a community benefit objective and can be reported as a community health improvement. These resources include, among others, the NPS (National Prevention Council, 2011), Healthy People 2020 (HHS, 2011a), and the CDC Guide to Community Preventive Services: What Works to Promote Health? (CHA, 2012a).

The Advisory Group on Prevention, Health Promotion and Integrative and Public Health (Advisory Group) has urged the IRS to provide clarification regarding hospital reporting of community building activities, recommending “that any evidence-based activities that fall within the four strategic directions of

the NPS will be recognized as a true community benefit for which the hospital will receive community benefit credit” (Advisory Group, 2012, p. 2). The NPS’s four Strategic Directions include:

- Clinical and community preventive services
- Healthy and safe community environments
- Empowered people
- Elimination of health disparities

These goals are fully consistent with the ultimate goals of community building activities. As the Advisory Group (2012) noted, the NPS “identifies evidence-based strategies and actions, together with indicators, for each of these Strategic Directions. In addition to the NPS, the Guide to Community Preventive Services [(CDC, 2012b)]..., Healthy People 2020 [(HHS, 2011a)]..., and the Cochrane Collaboration [(Cochrane, 2012)], among others, can serve as a guide for hospitals in assuring the IRS that the approaches they take have been proven effective” (p. 2).

This recommendation recognizes hospitals’ need for certainty as to whether a proposed community building activity will be reportable as community benefit. During the course of a convening sponsored by the Trust for America’s Health,¹⁴ it was suggested that the IRS should recognize specific, available resources—such as UWPHI’s *What Works for Health* and those (later) cited by the Advisory Group—as sources for identifying evidence-based community building strategies reportable as community benefit because these sources all catalogue demonstrably evidence-based health improvement initiatives. Hospitals would be assured that their replication of community building activities described in such sources would unquestionably “count” toward discharging their com-

munity benefit obligations. This “safe harbor” approach to reporting community building activities as community benefit could encourage hospitals to engage in these activities knowing they would “count” as community benefit. A potential drawback of this approach should be noted, however. The IRS’s recognition as community benefit of any finite set of community building activities could lead to an unintended consequence. That is, would it discourage hospitals from undertaking community building activities lacking express IRS recognition? Might it reduce hospital incentives and flexibility to initiate new, innovative, and potentially valuable community building activities *not* within the “safe harbor”?

The language of the 2011 Schedule H Instructions suggests another approach to determining whether a hospital’s activity or program should be reported as community health improvement (Part I, Community Benefit, line 7e) or as a community building (Part II) activity. It is important to recognize that, for *any* activity to qualify as a “community health improvement service” that may be reported in Part I, the activity must (Schedule H Instructions, Worksheet 4, pp. 13-15):

- Be carried out or supported for the purpose of improving community health or safety
- Be subsidized by the organization
- Not generate an inpatient or outpatient bill
- Not be provided primarily for marketing purposes
- Not be more beneficial to the organization than to the community
- Not be required for licensure or accreditation
- Not be restricted to individuals affiliated with the organization

- Meet at least one community benefit objective (e.g., improving health services access, public health enhancement, advancing general knowledge, and relief of a government burden relating to health improvement)
- Respond to a demonstrated community need

The IRS has indicated in the 2008-2011 Schedule H Instructions that the foregoing criteria define community health improvement services properly reported in Part I as community benefit. The 2011 Instructions expressly state that “some community building activities may also meet the definition of

community benefit.” Considering both these expressions of IRS intent, it appears that any community building activity that a hospital can report—simply by following the Schedule H Instructions—as a community health improvement service must qualify as community benefit. Formal regulations or a clearer statement by the IRS to this effect would be consistent with the recommendations of the Advisory Group (as well as those of CHA and others), and might lead to the expansion of nonprofit hospitals’ commitment to community benefit activities that promote population health by addressing its underlying causes.

Conclusions and Policy Implications

Two important themes of the ACA—expanded coverage for uninsured persons and a mandate for greater attention to community benefits—can increase the prospect of hospitals supporting activities that address the root causes of poor health in their communities. In 2014, an estimated 14 million now-uninsured Americans will secure health care coverage (CBO, 2012). The current level of demand for free and discounted care should diminish commensurately. This will present opportunities for nonprofit hospitals to shift a portion of their community benefit investments from the provision of free and discounted care to community building activities.

The underlying determinants of health are well-established; they include education, employment, income, housing, community design, family and social support, community safety, and the environment. To the extent that states and localities reexamine existing policies and regulatory structures, and develop new ones to respond to the post-health reform environment, they might consider

how hospitals’ investments in upstream prevention activities can create long-term improvement in population health status, while reducing the societal burden of ever-increasing health care expenditures.

States and localities may want to ask:

- Are nonprofit hospitals made aware of and encouraged to recognize social and economic problems in the context of assessing their community’s health needs?
- Does state community benefit policy recognize nonprofit hospitals’ community building activities—activities to address the root causes of poor health—as community benefit?
- Do state community benefit reporting structures facilitate nonprofit hospital reporting of community building activities?

At the federal level, a lack of clarity regarding the reporting status of community building activities may have discouraged hospitals from undertaking initiatives that address the root causes of poor health. The IRS’s change (or clarification) in the 2011 Schedule H In-

structions may reduce that uncertainty somewhat. This could prompt some nonprofit hospitals that had previously hesitated to undertake community building activities to begin to allocate community benefit investments to upstream, prevention-directed initiatives. The IRS's adoption of a "safe harbor" approach for identifying community building activities that unequivocally "count" as community benefit might provide further encouragement in this direction.

On the other hand, if the IRS were to expressly identify certain community building programs and initiatives (e.g., those referenced in specifically identified publications) as community benefits, it should make clear that this recognition is non-exclusive, and that the legitimacy of reporting other community building initiatives as community benefit would be unaffected.

Perhaps the better approach would be to assess the reporting status of community building activities no differently than other community health improvement activities, consistent with the principles and criteria set out in the Schedule H Instructions. In view of the 2011 Instructions' recognition that "some community building activities may also meet the definition of community benefit" (p. 4), perhaps the IRS should take the next logical steps: revise Schedule H to eliminate Part II

(Community Building) altogether and instruct tax-exempt hospitals to enter in Part I, line 7e *all* activities and programs (whether or not they are considered "community building") that, consistent with the Instructions, qualify as "community health improvement services." Hospitals could then determine whether their community building initiatives qualify as community benefits by reference to the nine criteria (summarized above) that accompany Worksheet 4 of the Schedule H Instructions (pp. 13-15). If a hospital's community building initiative does not satisfy all of these criteria, it could be entered in Part VI, line 6 as "other information important to describing how the organization ... [furthers] its exempt purpose by promoting the health of the community."

The discussion in this brief has outlined various approaches to hospital reporting and IRS evaluation of community building initiatives. It does not intend to imply that the IRS's issuance of new forms and instructions for community benefit reporting is a preferred regulatory practice. To the contrary, it seems likely that the uncertainties surrounding the reporting status of community building activities will persist, at least to some degree, until the IRS promulgates regulations that establish clear reporting criteria for all aspects of community benefit.

The information in this brief is provided for informational purposes only and is not intended as legal advice. The Hilltop Institute does not enter into attorney-client relationships.

Endnotes

¹ The Patient Protection and Affordable Care Act, P.L. 111-148 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152. These consolidated Acts are referred to herein as the Affordable Care Act (ACA).

² Unless otherwise noted, references in this brief to [Schedule H](#) and [Schedule H Instructions](#) refer to those applicable to hospitals' 2011 tax year.

³ *County Health Rankings & Roadmaps*' What Works for Health, developed by the University of Wisconsin Population Health Institute (UWPHI), similarly identifies health determinants as education, employment, income, family and social support, community safety, environmental quality, built environment, and access to quality health care (UWPHI, 2012a).

⁴ Community benefit reporting requirements for nonprofit hospitals in Oregon, Minnesota, Maryland, and New Hampshire expressly include community building as a community benefit category (Rosenbaum, Byrnes, & Rieke, Draft 2012).

⁵ This CBO Report, issued following the decision of the U.S. Supreme Court in *National Federation of Independent Business v. Sebelius*, contemplates that some states will not expand their Medicaid programs at all or will not expand coverage to the full extent authorized by the ACA.

⁶ By including in the text descriptions of hospital community building activities, Hilltop does not intend to imply that these were reported by the hospitals involved as community benefit/community building activities in their respective Schedule H submissions. Hilltop did not explore how (or if) these initiatives were reported to IRS, and has no knowledge of specific hospitals' reporting practices.

⁷ The six partnering hospitals are Good Samaritan Hospital, Johns Hopkins Bay View, Johns Hopkins Hospital, Mercy Medical Center, Sinai Hospital, and the University of Maryland Medical Center.

⁸ Housing is generally considered "affordable" when its cost represents less than 30 percent of household income. Although the recent recession depressed household income, it did not reduce housing expenditures for many Americans. Between 2007 and 2010, the number of American households paying more than half of family income for housing rose by 2.3 million, bringing the total to 20.2 million (Joint Center for Housing Studies of Harvard University, 2012).

⁹ For an explanation of the term "social disorder" and its implications for community health, see Sampson and Raudenbush (2001).

¹⁰ For health outcomes, the UWPHI population health model assigns equal weight to length and quality of life. Four major health factors are weighted to reflect their relative contribution to health outcomes, as follows: social and economic factors (40 percent); health behaviors (30 percent); clinical health care (20 percent); and environmental factors (10 percent) (UWPHI, 2012b; Booske, Athens, Kindig, Park, & Remington, 2010).

¹¹ The Institute for Alternative Futures has developed a database of 176 initiatives undertaken by community health centers to address the social determinants of health, including family and social support, access to healthy foods, opportunities for physical activity and exercise, and community safety (Institute for Alternative Futures, 2012). Initiatives such as these may present community benefit opportunities for hospitals as well, either alone or in collaboration with community health centers. A related literature review provides illustrative examples of collaborative community prevention initiatives and their impact on community health (Clinical Directors Network, 2011).

¹² The 2010 Schedule H Instructions for Part II, Community Building Activities, provide the following: "Report in this part the costs of the organization's activities that it engaged in during the tax year to protect or improve the community's health or safety, and that are not reportable in Part I or III of this schedule. An organization that reports information in this part must describe in Part VI how its community building activities promote the health of the communities it serves. Do not include activities in this part that are reported on Part I, line 7" (p. 4). The 2011 Schedule H Instructions provide the following: "Report in this part the costs of the organization's activities

that it engaged in during the tax year to protect or improve the community's health or safety, and that are not reportable in Part I of this schedule. Some community building activities may also meet the definition community benefit. Do not report in Part II community building costs that are reported on Part I, line 7 as community benefit (costs of a community health improvement service reportable on Part I, line 7e). An organization that reports information in this Part II must describe in Part VI how its community building activities promote the health of the communities it serves" (p. 4).

¹³ CHA has also developed new (draft) guidelines for reporting environmental improvements (CHA, 2012b).

¹⁴ The Trust for America's Health convened a group of community benefit experts to discuss community benefit implementation strategies in Washington, D.C. on May 24, 2012.

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About The Hilltop Institute

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a non-partisan health research organization dedicated to improving the health and wellbeing of vulnerable populations. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations, and nonprofit organizations at the national, state, and local levels. Hilltop is committed to addressing complex issues through informed, objective, and innovative research and analysis. To learn more about The Hilltop Institute, please visit www.hilltopinstitute.org.

Hilltop's Hospital Community Benefit Program is the central resource created specifically for state and local policymakers who seek to ensure that tax-exempt hospital community benefit activities are responsive to pressing community health needs. The program provides tools to state and local health departments, hospital regulators, legislators, revenue collection and budgeting agencies, and hospitals, as these stakeholders develop approaches that will best suit their communities and work toward a more accessible, coordinated, and effective community health system. The program is funded for three years through the generous sponsorship of the Robert Wood Johnson Foundation (www.rwjf.org) and the Kresge Foundation (www.kresge.org).



The Hilltop Institute

analysis to advance the health of vulnerable populations

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