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Hospital Community Benefits after the ACA: *Present Posture, Future Challenges*

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Introduction

This is the eighth issue brief in a series, *Hospital Community Benefits after the ACA*, published by The Hilltop Institute's Hospital Community Benefit Program with the generous support of the Robert Wood Johnson Foundation and the Kresge Foundation. The series began in January 2011 with *The Emerging Federal Framework* and has addressed important policy issues surrounding hospital community benefit. This brief focuses on updating significant points concerning community health needs assessment (CHNA) and other aspects of community benefit discussed in the earlier briefs, as well as on identifying and exploring more recent developments and emerging issues. Specifically, this brief discusses the Internal Revenue Service's (IRS's) 2013 proposed rules, "Community Health Needs Assessments for Charitable Hospitals," and their potential impact on nonprofit hospital needs assessment, community benefit planning, and collaborative approaches to community health improvement.

The Federal Framework

Section 9007(a) of the Affordable Care Act (ACA),[1] codified as Internal Revenue Code (I.R.C.§501(r)), established four "additional requirements for charitable hospitals" concerning:

- CHNA and implementation strategy
- Financial assistance policies
- Limitations on charges
- Billing and collections practices

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Since the ACA's enactment in March 2010, the Department of the Treasury and the IRS have interpreted these ACA requirements, providing clarification and specificity to the terms of the statute. The IRS has issued two requests for comments (IRS, 2010; IRS, 2011) and two Notices of Proposed Rulemaking (NPRM) (IRS, 2012; IRS, 2013).

Federal requirements relating to hospitals' financial assistance policies and those that constrain hospital charges, billing, and collection practices have been ably examined elsewhere.[2] Issues relating to community health needs assessment and the collaborative approach to population health that the proposed rule inspires will likely have far-reaching implications for population health improvement, health system transformation, and health equity.

Community Health Needs Assessment

The term "community health needs assessment" (or "CHNA") is used in the ACA and by the IRS to describe a systematic process employed by a tax-exempt hospital, in consultation with its community, to identify the community's health-related needs, the significance and relative priority of the needs identified, relevant resources available in the community to address these needs, and potential actions the hospital may take to meet these needs. At least every three years a hospital organization[3] must conduct a CHNA for each hospital facility it operates. The CHNA must (I.R.C.§501(r)(3)):

> *(i) [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, and*
>
> *(ii) [Be] made widely available to the public.*

As the agency responsible for implementing, enforcing, and monitoring hospitals' compliance with the ACA's community benefit provisions, it is the IRS's responsibility to interpret IRC §501(r) and to flesh out the bare bones of the statute's requirements. The IRS first issued an informal guidance, Notice 2011-52, to elicit stakeholder comments on provisions that the agency intended to include in future regulations (IRS, 2011). In April 2013, the IRS issued an NPRM that addressed comments received in response to Notice 2011-52 and proposed formal regulations that would specify the parameters of acceptable CHNA practice. The content of the proposed rule exemplifies a regulatory approach that, although on some points prescriptive, generally affords hospitals substantial flexibility in the design and focus of their CHNAs, as well as in their assessment of the significance of the community needs identified and priority setting for community benefit implementation.

The proposed rule would require that a tax-exempt hospital organization conduct a CHNA at least every three years for each hospital facility it operates, and that an authorized body of the hospital facility adopt an implementation strategy to meet the CHNA-identified needs by the end of the same tax year in which its CHNA is conducted (§1.501(r)-3(a)). A hospital facility would be expected to complete five steps (§1.501(r)-3(b)):

- Define the community it serves
- Assess the community's health needs
- Take into account input from persons who represent the broad interests of the community, including those with special knowledge of or expertise in public health

- Document the CHNA in a written report (CHNA report) that is adopted for the hospital facility by an authorized body of the hospital facility
- Make the CHNA report widely available to the public

Defining the Community Served—§1.501(r)-3(b)(1)(i) & (b)(3)

A threshold issue for CHNA is how to define "the community served by the hospital facility."[4] Initially, many assumed that in this context a hospital's "community" meant its service area—a geographically-defined area in which a hospital's patients reside. The proposed rule appears to regard service area as a minimally adequate community definition, but it indicates that a hospital "may take into account" other relevant factors and circumstances as well (IRS, 2011, 2013 [NPRM preamble], p. 20540). In this way, the proposed rule acknowledges hospital best practices and public health literature recommending a community definition that embraces "areas of the greatest need" (e.g., CHA, 2008, p. 67), such as federally designated medically underserved areas, medically underserved populations, and health professional shortage areas (e.g., Barnett, 2012). The proposed rule makes clear that a hospital's definition of the community it serves would not need to mirror its service area but might include "populations and geographic areas outside of those in which its patient populations reside." In defining its community, a hospital might focus on populations the hospital has historically served or targeted (for example, a pediatric hospital's CHNA might focus on children); or on those that need particular specialty services provided by the hospital as its "principal function" (for example, a psychiatric hospital's CHNA might focus on individuals in need of intensive mental health therapies) (§1.501(r)-3(b)(3)).

The IRS's regulatory approach to community definition, which otherwise emphasizes hospital flexibility, includes an important caveat: although a hospital might "take into account all the relevant facts and circumstances" in defining its community, it could *not* adopt a definition that excludes minority, low-income, or broadly defined[5] medically underserved populations who reside in the hospitals' service area, are part of its patient populations, or who otherwise should be included by evenhanded application of the hospital's chosen method of defining its community (§1.501(r)-3(b)(3)). Beyond protecting vulnerable and underserved populations from exclusion, the proposed rule would legitimize approaches to community definition that are purposefully designed to advance health equity.

Assessing the Health Needs of the Community—§1.501(r)--3(b)(1)(ii) & (b)(4)

The proposed rule would require hospitals to "identify significant health needs of the community, prioritize those health needs, and identify potential measures and resources (such as programs, organizations, and facilities in the community) available to address the health needs" (§1.501(r)-3(b)(4)). In response to concerns raised by "a few commenters," the IRS added the modifier "significant" to the predecessor of proposed §1.501(r)-3(b)(4) as stated in Notice 2011-52. Presumably, these commenters argued that it would be unworkable and burdensome to require hospitals to report and prioritize *all* community health needs identified by CHNA, inasmuch as the needs listed would "likely [be] extensive" (IRS, 2013 [NPRM preamble], p. 20529). Consequently, the proposed rule indicates that a hospital might determine whether a need is significant "based on all the facts and circumstances present in the community;" in assigning priorities to CHNA-identified needs, a hospital might "use any criteria" it chooses (§1.501(r)-3(b)(4). (Issues relating to determining the significance and priority of CHNA-identified health needs are discussed below, in connection with CHNA documentation.)

Proposed §1.501(r)-3(b)(4) sheds additional light on what scope and focus of a CHNA is appropriate by clarifying that the health needs of a community would include "the requisites for health status in both the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities)."

Taking into Account Community and Expert Input—§1.501(r)-3(b)(1)(iii) & (b)(5)

Mirroring the requirement articulated in ACA §9007(a) (I.R.C. §501(r)(3)(B)(i)), proposed rule §1.501(r)-3(b)(1)(iii) would require that a hospital facility:

> *In assessing the health needs of the community, take into account input from persons who represent the broad interests of that community, including those with special knowledge of or expertise in public health*

A tax-exempt hospital's responsibility to provide benefits to its community in addition to fully reimbursed medical services arises from the public foregoing tax revenues that a charitable institution would otherwise owe (Somerville, 2012). The ACA recognizes communities' stake in hospitals' community benefit investments by requiring a CHNA process that "takes into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise in public health" and is made "widely available to the public" (I.R.C. §501(r)(3)(B)). The statute's requirements appear intended to ensure that hospitals actively engage their communities in inclusive dialogue and that hospitals are accountable for the CHNA findings they report.

In addition to sources of community input that would be expressly required for CHNA (discussed below), the proposed rule provides that a hospital *may* take into account input from "a broad range of persons located in or serving its community," such as health care consumers, consumer advocates, community-based organizations, academic experts, and representatives of multiple other sectors in the community (§1.501(r)-3(b)(5).

Sources of community input that a hospital facility must "take into account"

The proposed rule specifies three sources from which a hospital would have to seek input in conducting its CHNA and provides that input from these sources should include "input on any financial and other barriers to access to care in the community" (§1.501(r)-3(b)(5)).

(i) Health Departments

Section 501(r)(3)(B)(i) of the Internal Revenue Code (ACA §9007) requires hospital facilities to take into account input from "those with special knowledge of or expertise in public health." The 2013 NPRM builds on and refines the agency's previous guidance in Notice 2011-52 by expressly identifying the kinds of public health experts whose consultation would satisfy this CHNA requirement. Specifically, the 2013 NPRM would require hospitals to take into account input from (§1.501(r)-3(b)(5)(i)) (emphasis added)):

> *At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of that community*

Public comments submitted in response to the 2013 NPRM indicated some dissatisfaction that consultation with a hospital's *local* health department is not specifically required, noting local

health departments' important role in coordinating CHNA efforts at the local level: providing expertise with respect to identification of local data sources, community-level population health planning, and community outreach, as well as their familiarity with local conditions, needs, and resources (e.g., National Association of County and City Health Officials (NACCHO), 2013; APHA et al., 2012). The IRS response to similar comments received in connection with Notice 2011-52 appears in the 2013 NPRM's preamble: not every jurisdiction has a local health department, and the proposed rule would allow hospital facilities flexibility to determine which jurisdictional level of public health agency input is most appropriate for its CHNA (IRS, 2013 [NPRM preamble], p. 20530). The IRS makes clear, however, that a hospital's consultation with a *federal* public health agency would not fulfill the just-quoted requirement that it has proposed (IRS, 2013 [NPRM preamble], p. 20530)). The NPRM's preamble also indicates that compliance with proposed §1.501(r)-3(b)(3)(i) would satisfy the ACA's requirement for CHNA input from "those with special knowledge of or expertise in public health" (IRS, 2013 [NPRM preamble], p. 20530).

A hospitals' consultation with governmental public health departments can support its CHNA by providing a source of technical expertise for data collection and analysis, community engagement and outreach, and community health planning. Assessment of community health needs has been widely recognized as a "core" function of public health (Corso, Wiesner, Halverson, & Brown, 2000; NACCHO, 2005; Centers for Disease Control and Prevention (CDC), 2011; American Public Health Association, n.d.). Needs assessment partnerships of hospitals and local health departments can leverage public and private resources in the community, reduce duplication of community health services, and align hospitals' private community benefit activities with public health priorities and initiatives.

Hospital-health department CHNA partnerships can also benefit their communities with their potential for advancing health department accreditation as a strategy for strengthening the public health infrastructure and system capacity (IOM, 2002; CDC, 2010). In its 1988 *The Future of Public Health,* the Institute of Medicine (IOM) recommended that governmental public health agencies "regularly and systematically" collect, analyze, and disseminate information on community health status, health needs, and studies of community health problems (p.7). That recommendation is reflected in subsequent national health department benchmarks, performance standards, and accreditation standards, including NACCHO's Operational Definition of a Functional Local Health Department (2005), National Public Health Performance Standards (CDC, 2013) and the Public Health Accreditation Board (PHAB) Standards and Measures (PHAB, 2011). Accreditation standards and measures adopted by the national Public Health Accreditation Board (PHAB)[6] are designed to advance population health by improving the quality and performance of state, local, tribal, and territorial health departments (PHAB, 2013a; Lenaway, Corso, & Bailey, 2007; CDC, 2010). Health department performance has been shown to affect community health status (Kanarek, Stanley, & Bialek, 2006). The PHAB voluntary accreditation process requires a health department to document its capacity to deliver the "three core functions" of public health and the "ten essential public health services"[7] (PHAB, n.d.b.).

A CHNA conducted collaboratively by a hospital and health department can address both the hospital's ACA assessment responsibility and PHAB Domain 1 accreditation standards[8] and can enhance the impact, effectiveness, and value of hospitals' community benefit activities and investments (Somerville, Mueller, Boddie-Willis, Folkemer, & Grossman, 2012).

(ii) Medically underserved, low-income, and minority populations

Another category of input that the IRS proposes a hospital must take into account in conducting its CHNA is that of (§1.501(r)-3(b)(5)(ii) (emphasis added)):

> *Members of medically underserved, low-income, and minority populations in the community served by the hospital facility, or individuals or organizations serving or representing the interests of such populations....*

The proposed rule's definition of "medically underserved" encompasses populations that experience health disparities or are at risk for inadequate care due to any of a variety of reasons, including being uninsured or underinsured, financial inability to pay for care, language barriers, and geographical barriers such as distance to care and lack of transportation (§1.501(r)-3(b)(3)). Although the proposed rule (in contrast to Notice 2011-52) would not expressly require hospitals to consider the input of chronic disease populations, the NPRM's preamble indicates that it considers persons with chronic illness to be included in the "medically underserved populations" category of input that a hospital would have to take into account. Hospitals might engage members of minority, low-income, and medically underserved populations either directly (e.g., public meetings, focus groups, or surveys) or secure input from organizations that represent their interests (IRS, 2013 [NPRM preamble], p. 20530). Ideally, hospitals will seek broad-based input from medically underserved populations in the community in order to ensure that the input they "take into account" accurately reflects the needs and priorities of these populations as a whole.

(iii) Written comments on CHNA & Implementation Strategy

In assessing the health needs of its community, hospitals would also have to take into account (§1.501(r)-3(b)(5)(iii) (emphasis added)):

> *Written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy.*

A hospital's obligation to consider written public comments on its last CHNA and implementation strategy would arise up to three years after it completes the CHNA and implementation strategy on which the written comments are made. The IRS considers the time lag before a hospital must consider such comments useful as a "continuous feedback" mechanism (IRS, 2013 [NPRM preamble], pp. 20529-30). It seems likely that the utility of this mechanism for community input may be diminished by the delay between the public's comments and the hospital's response. Moreover, the feedback mechanism's utility could be further diminished by the degree of difficulty the public could face in accessing a hospital's implementation strategy. (See "Implementation Strategy" section, below.)

CHNA Report: Documenting the Community's CHNA-Identified Health Needs—§1.501(r)-3(b)(1)(iv) & (b)(7)

The proposed rule would require a hospital facility to document its CHNA in a report adopted by an authorized body of the hospital facility for the hospital facility (§1.501(r)-3(b)((1)(iv). The CHNA report would have to include (§1.501(r)-3(b)(7)):

- A definition of the community served and a description of how the community was identified

- A description of CHNA processes and methods (including how data and information were collected, analyzed, and used, and an identification of CHNA collaborators and contractors)
- A description of how the hospital secured input from persons who represent the broad interests of the community
- A prioritized description of significant health needs of the community and a description of the process and criteria used to determine identified needs' significance and priorities

In prioritizing the community's significant health needs (including "requisites for the improvement or maintenance of health status in both the community at large and in particular parts of the community"), a hospital might "use any criteria," including, but not limited to, the burden, scope, severity or urgency associated with a particular need; the feasibility and effectiveness of addressing it; the health disparities associated with it; and "the importance the community places on addressing the need" (§1.501(r)-3(b)(4)). On its face, the just-quoted provision seems to indicate that a hospital need not consider the *community's* expressed priorities as it ranks CHNA-identified community health needs *for its CHNA report*, in effect permitting the hospital to ignore community input that it would be required to "take into account" *when conducting its CHNA*.

It could be interpreted that the IRS intended to require hospitals to take community and expert input into account for *identifying* the community's significant health needs but not for *prioritizing* them. Yet, such an interpretation seems inconsistent with the proposed rule's treatment of needs prioritization as part of the CHNA process (§1.501(r)-3(b)) and seems inconsistent, as well, with the ACA's emphasis on community engagement as an essential element of CHNA (ACA §9007, I.R.C. §501(r)(3)(B)(i)). Moreover, under the proposed rule, a hospital's CHNA report also would have to include a description of the process and criteria used by the hospital to determine which needs were significant and how they were prioritized (§1.501(r)-3(b)(1)(D)). By mandating the disclosure of a hospital's process and criteria for determining the significance and priority of identified community health needs, the proposed rule would ensure that a hospital's approach to determining significance and priority is transparent. Although such transparency may expose a hospital to its community's disapprobation if the approach used is unreasonable or unresponsive to the public weal, it falls short of ensuring that a hospital's determination of community needs' significance and priority will be consistent with the community input it has received.

Making the CHNA Widely Available to the Public—§1.501-3(b)(1)(v) & (b)(8)

The proposed rule would afford a hospital facility two options for compliance with the requirement to make its CHNA report "widely available to the public." The hospital might post its CHNA report on its website[9] at least until after it posts its two subsequent CHNA reports. Alternatively, the hospital might make a paper copy of the report available for public inspection without charge until it makes paper copies of its two subsequent CHNA reports available without charge (§1.501(r)-3(b)(8)(i)).

As discussed below, the proposed rule would require an authorized body of the hospital facility to adopt an implementation strategy during the tax year in which it makes its finalized CHNA report "widely available to the public" (§1.501(r)-3(c)(5)).

Implementation Strategy

A term of art specific to the ACA and federally tax-exempt hospitals, an "implementation strategy" is a written document—adopted by an authorized body of the hospital facility—describing the hospital's plans to provide specified community benefits to address community health needs identified through its CHNA process. Under the proposed rule, with respect to each significant health need identified by the CHNA that the hospital intends to address, the implementation strategy would have to include (§1.501(r)-3(c)(2):

- A description of actions the hospital will take to address the need and these actions' anticipated impact
- A plan to evaluate such impact
- An identification of the programs and resources the hospital will commit toward addressing the need
- A description of its plans to collaborate with other facilities or organizations to address the need

The 2013 NPRM proposes—for the first time—a requirement that hospitals develop plans to evaluate the effect of their community benefit initiatives on community health. Significantly, it appears to signal IRS recognition that the value of community benefits depends on their effectiveness to improve community health. Inclusion of the proposed evaluation requirement in the final rule should ultimately advance the development of a robust evidence base that can inform hospital and community development of innovative public health initiatives for which effectiveness has been demonstrated.[10]

For each significant need a hospital does not intend to address, its implementation strategy would have to include a brief explanation of why the hospital does not plan on addressing that need. The proposed rule provides examples of acceptable explanations, including (§1.501(r)-3(c)(3):

- Resource constraints
- That the need is being addressed by another community organization
- That the hospital lacks the necessary expertise to effectively address the need
- That the need is relatively low priority, or
- That no effective interventions have been identified to address the need

For each hospital facility it operates, a hospital organization must either attach a copy of the facility's implementation strategy to the organization's annual Form 990 informational return or provide the URL of the web page on which the implementation strategy has been made widely available to the public (proposed §1.6033-2(a)(2)(ii)(I)(2)).

Although in principle hospitals' Form 990s are public information, in practice locating and gaining access to hospitals' Form 990 filings can be quite difficult (Noveck & Goroff, 2013). By not *requiring* that hospitals' implementation strategies be made widely available to the public, the IRS has missed an important opportunity to ensure the same degree of transparency for implementation strategies that it has demanded for hospitals' CHNA reports.

CHNA Report & Implementation Strategy—Community Review & Input

The IRS's proposed rule would require hospitals to complete their implementation strategies within the same tax year as when they make their CHNAs "widely available to the public" (§1.501(r)-3(c)(5)), but it clarifies that a hospital's issuance of a draft CHNA report for public review and comment would not trigger this implementation strategy due date. Rather, the proposed rule would permit a hospital to disseminate a draft CHNA report (clearly designated as such) for public comment without committing the hospital to developing its implementation strategy within the same tax year (§1.501(r)-3(b)(8)(ii)). The proposed rule would thus facilitate (but not require) hospital development of CHNA reports through an iterative process that would incorporate community input at this critical stage of community benefit planning (IRS, 2013 [NPRM preamble], pp. 20530-31).

Collaborative CHNA & Implementation Strategies: Multiple Hospital Facilities

Multi-sector collaboration can bring together and leverage public and private resources, diverse perspectives and experience, and external expertise in conducting needs assessment, planning community health improvement programs and activities, and implementing initiatives to improve community health. The ACA requires a hospital system ("organizations operating more than one hospital facility") to fulfill CHNA requirements separately with respect to each facility it operates (I.R.C. §501(r)(2)(B)(1)). The IRS has interpreted this requirement in a way that would permit multiple hospital facilities (regardless of whether or not they are related entities) to conduct collaborative CHNAs.

The proposed rule provides that, generally, each collaborating hospital would have to develop its own facility-specific CHNA report and implementation strategy (§501(r)-3(b)(7)(iv) and (c)). However, "if appropriate under the facts and circumstances," portions of a facility-specific CHNA report may be "substantively identical" to portions of the CHNA report of another collaborating hospital or of another organization conducting a CHNA (§501(r)-3(b)(7)(iv). The proposed rule provides two examples of the kind of "portions" of CHNA reports that might be substantively identical: a description of a survey and its findings, and an inventory of community health improvement resources conducted by a local health department (§501(r)-3(b)(7)(iv)). As discussed above, a hospital facility generally would be expected to detail the facility's intention to address CHNA-identified significant needs in a written plan tailored specifically to that facility, taking into account its own programs and resources (§501(r)-3(c)(4)).

Under certain circumstances, however, collaborating hospitals would qualify to develop a joint CHNA report and joint implementation strategy that would satisfy these proposed requirements if (§501(r)-3(b)(7)(v)):

- All of the collaborating hospital facilities adopt an identical community definition
- An authorized body of each collaborating hospital facility adopts the joint CHNA report for its own hospital facility
- The joint CHNA report clearly indicates that it applies to the hospital facility

If a hospital facility adopts a joint CHNA report, it may also adopt a joint implementation strategy that clearly identifies its application to the hospital facility and (§501(r)-3(c)(4)):

- Describes how the collaborating hospital facilities plan to address (or explains why they will not address) each significant need identified in the joint CHNA report
- Clearly identifies the hospital facility's role in carrying out the joint implementation strategy, including programs and resources it will commit to the effort
- Includes a tool (e.g., a summary) to help the reader locate the portions of the joint implementation strategy that apply to the hospital facility

Encouraging multiple hospitals to conduct CHNA collaboratively lays the groundwork for more efficiently conducted CHNAs encompassing geographic areas beyond a hospital's service area. By combining and aligning their expertise and assessment resources, collaborating hospitals can leverage resources to identify community needs, avoid duplicated efforts (particularly in the case of hospitals with overlapping service areas), and engage effectively—rather than consecutively and redundantly—with local leaders and community-based organizations. Moreover, CHNA collaboration facilitates hospitals' collective community benefit investment and can be focused on populations of greatest need across cities, counties, or regions.

As described in the box below, the Western North Carolina (WNC) Healthy Impact collaborative represents a multi-sector collaborative alliance that fully embraces a broad-based strategy for conducting comprehensive CHNA across the region. Participants include health departments, hospitals and hospital systems, community-based providers, and other community-based organizations.

WNC Healthy Impact
A Regional Approach to Community Health Assessment

WNC Healthy Impact is a collaborative initiative of hospitals and health departments in 16 of North Carolina's mountainous, predominantly rural westernmost counties, working to improve community health. Local health departments in North Carolina had been conducting community health assessments for years in connection with state mandatory local health department accreditation. The 2010 enactment of the ACA, with its CHNA and other hospital community benefit requirements, provided an opportunity to enhance hospital involvement in these collaborative assessments. Building on a rich history of regional collaboration, it was also an opportunity to consider expanding collaborative CHNA in western North Carolina (H. Gates interview, August 28, 2013).

First convened in November 2011, the WNC Healthy Impact steering committee is composed of hospital and health department leaders from the region and representatives of regional partners, including WNC Health Network, the Western North Carolina Partnership for Public Health, the North Carolina Center for Health and Wellness (UNC Asheville), and the Western Carolina Medical Society. The steering committee; five task-related work groups; staff from health departments, hospitals, and regional partners; a data consulting team; a data collection vendor; and a regional coordinator are working together to implement sequential steps of the community health improvement process. These steps are: regional data collection (Summer 2012), local-level health assessment (2012-2013), community health improvement planning (Summer 2013), and an action and evaluation phase (2013-2015) (WNC Healthy Impact, 2013a). Backbone support for this regional initiative is provided by WNC Health Network.[11]

WNC Healthy Impact collected a core data set (primary and secondary data) at the regional level[12] and reported it out at both the regional and local (county) levels for use by hospitals and health departments. As an important component of this data set, a data collection vendor conducted telephone interviews of 3,300 adult residents in the region, stratified by county, using a survey instrument that addressed "general health status, access to health care, dental and behavioral health services, primary care relationships, tobacco and alcohol use, the prevalence of chronic disease, nutrition, physical fitness, activity limitations, and quality of life as perceived by the interviewee" (Professional Research Consultants, n.d.).

Collected data are included in WNC Healthy Impacts' regional- and county-level data reports and are used by both hospitals and county health departments as they conduct CHNAs to satisfy both ACA and state accreditation requirements, respectively. Hospital implementation strategies are developed by each individual hospital facility but are aligned with a larger community-wide plan and approach to addressing priority health needs in the community (H. Gates[13] interview, August 28, 2013).

For example, county-level and regional data from WNC Healthy Impact was used by Mission Hospital, Buncombe County Department of Health, and the Madison County Health Department to compare county- and regional-level data. A comprehensive community health assessment for the two-county area (which Mission Hospital defines as its geographic service area) was completed in December 2012. Health priorities for Buncombe County included women's preconception health, healthy living and healthy weight, early child development and children's health, and access to primary and mental health care. Priority areas identified for Madison County were chronic disease preventive care and treatment, child health, and access to mental health care. Poverty and access to care were woven into all of Madison County's three priority areas (Frankel, 2012).

Assessing and Addressing the Social Determinants of Health

As discussed in one of Hilltop's earlier briefs, *Hospital Community Benefits after the ACA: Community Building and the Root Causes of Poor Health,* the social determinants of health are factors unrelated to medical care or genetics that affect health outcomes. Examples include economic status, healthy food access, housing, education, language, literacy, environment, and culture (Somerville, Nelson, Mueller, Boddie-Willis, & Folkemer, 2012).

Community Health Rankings and Roadmaps measure and rank population health in places—counties and county equivalents within states—with the goal of raising awareness about the factors that influence population health (University of Wisconsin Population Health Institute (UWPHI), 2013a). These rankings are based on a population health model that emphasizes health determinants (factors) that are subject to improvement—i.e., can be changed—to make communities healthier (UWPHI, 2013b). To develop its rankings model, UWPHI compiled county-level measures from national and state data sources, standardized them, and combined them using scientifically informed weights (UWPHI, 2013c; Booske, 2010). The model incorporates health outcomes and health factors; the latter consist of four *changeable* factors that affect health: health behaviors, clinical care, social and economic factors, and physical environment. Genetic factors are not included because they cannot be changed (UWPHI, 2013d). UWPHI's model assigns 20 percent of the responsibility for population health outcomes to clinical care, 30 percent to health behaviors, 40 percent to social and economic factors, and 10 percent to the physical environment (UWPHI, 2013b). (See Figure 1, below.)

As described below, "Healthy Hartford" in Connecticut represents an approach to CHNA and community health improvement planning designed to identify and address the "requisites for the improvement or maintenance of health status in both the community at large and in [those] particular parts of the community" with the greatest needs (IRS, 2013 [NPRM preamble], p. 20529).

Healthy Hartford
A Health Department-Led City-Wide Needs Assessment with a Focus on the Social Determinants of Population Health

The population of Hartford, Connecticut, numbering around 125,000, is proportionately younger than the state of Connecticut and the rest of the country. It is also one of the nation's most racially, ethnically, and culturally diverse populations. Although *metropolitan* Hartford has the sixth lowest poverty rate of all Metropolitan Statistical Areas, the city itself is one of the poorest in the nation. This extreme economic disparity is perceived by Hartford's Department of Health and Human Services (HHS) as "highly associated with the health inequities many of the city's residents face daily" (Hartford HHS, 2013).

In early 2010, HHS combined efforts with local hospitals[14] to plan a city-wide CHNA. The overarching shared goal of this "Community Health Needs Assessment Consortium" (Consortium) was to maximize available resources in the community to conduct a high-quality assessment and develop a comprehensive strategic planning document for use by HHS, city agencies, community planners, and the community at large (Hartford HHS, 2012, 2013). Other drivers of action were the ACA's enactment (specifically its CHNA requirement) and HHS's intention to pursue accreditation when the PHAB launched the following year (M. Stuart[15] interview, August 27, 2013).

A threshold challenge for the Consortium was a scarcity of public health resources; this was navigated by participating hospitals covering most CHNA expenses, while HHS provided leadership, expertise, and staffing (M. Stuart interview, August 27, 2013). From HHS's perspective, shifting hospitals' focus from individual clinical care to population health was an initial challenge that was overcome during the needs assessment process (R. Pino[16] interview, August 27, 2013). From a hospital perspective, when the Consortium met to consider provider and resident survey findings, community health needs relating to social health determinants "rose to the top" (M. Stuart interview, August 27, 2013).

The Consortium engaged a health research consulting firm to conduct an analysis of secondary data and perform telephonic key informant interviews of local health care providers to elicit information concerning (among other things) access to care barriers and underserved populations. Key informants were also asked to identify the five most significant health issues in the community and to identify improvements that might address them. A local faith-based nonprofit, the Urban Alliance, conducted a resident survey focused on barriers to care and human service needs (e.g., affordable housing, financial supports, food assistance, employment assistance, child care, and transportation) (Hartford HHS, 2012). Another important component of the Consortium's analysis was a Health Equity Index developed by the Connecticut Association of Directors of Health (CADH). This electronic mapping tool focuses on community-specific social determinants of health and health outcomes, and provides direction for additional qualitative data collection from community residents who have experienced or witnessed health inequities (CADH, 2013). Finally, a grant from the federal Health Resources and Services Administration (HRSA) provided funding that enabled the Consortium to convene community focus groups, thereby enhancing the scope of qualitative data collected for the assessment and providing a stronger "community voice" (M. Stuart interview, August 27, 2013).

As a result of the Consortium's efforts, HHS published *A Community Health Needs Assessment* in March 2012. The report systematically reviews the data collected and contextualizes it in categories consisting of demographics, social determinants, health indicators (life expectancy and disease prevalence), and barriers to accessing health services. As part of its summary of key findings, the report notes that key informants had most often mentioned poverty, job opportunities, quality of housing, neighborhood safety, and education as factors that most negatively impact the quality of life in the community. The report concludes (Hartford HHS, 2012, p. 41) (emphasis added):

[*T]rends in health outcomes are determined not just by individual-level factors such as genetic make-up or access to medical services.... [I]t has become clear that the disproportionate rates of morbidity and mortality borne by the city's marginalized communities result from far more than access to medical services.... [They also result from] cumulative social and environmental conditions in which Hartford's low-income residents are born, grow up, live and work. Hartford stakeholders can no longer afford to ignore evidence linking social determinants of health with health outcomes. By building on the analysis in this report and partnerships throughout the city, Hartford will take significant steps to build the capacity to understand and address the conditions contributing to the compromised health of our most vulnerable neighborhoods.*

Hartford's individual hospitals and systems participating in the Consortium used the HHS document to inform their own federally required CHNA reports and implementation strategies (M. Stuart interview, August 27, 2013).

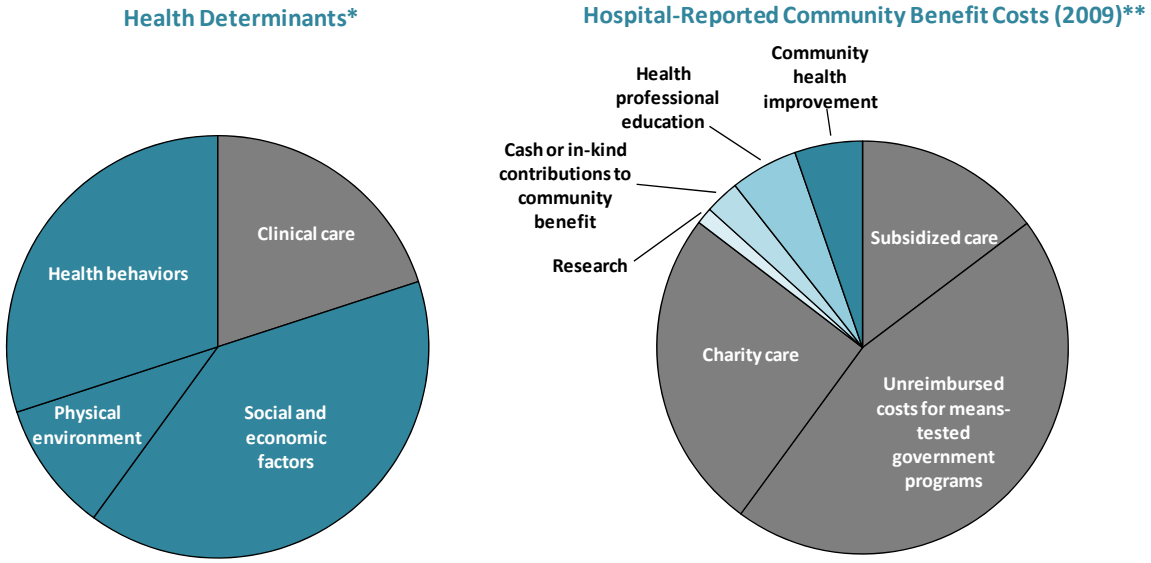
Community Benefits for Community Health Improvement

The IRS recognizes categories of activities, investments, and expenditures for which hospitals may report their associated costs as providing as community benefits to their communities (IRS, n.d.a. – n.d.k.):

- Financial Assistance at cost
- Unreimbursed costs of providing Medicaid services and other means-tested government programs
- Community health improvement services[17] and community benefit operations
- Health professions education
- Subsidized health services
- Research
- Cash and in-kind contributions for community health

A recent study at Northeastern University (Young, 2013) used tax year 2009 Schedule H data reported by over 1800 tax-exempt hospitals (about two-thirds of Schedule H filers) to measure the proportion of community benefit expenses hospitals allocated to each reporting category. In Figure 1, the study's findings are compared with the relative effect of four categories of improvement-sensitive health determinants identified by UWPHI. As shown by the pie chart on the right side in Figure 1, over 85 percent of hospital community benefits were reported as unreimbursed costs associated with medical care, while only 5.3 percent were directed to community health improvement activities and investments (i.e., to the community benefit category in which hospitals report costs associated with initiatives and investments to address social (including economic and environmental) health determinants).

Figure 1: Comparison of health impacts of social, economic, and environmental health determinants and 2009 tax-exempt hospital community benefit investment



*Based on University of Wisconsin Public Health Institute, County Health Rankings and Roadmaps Ranking Methods (2013). Retrieved from http://www.countyhealthrankings.org/ranking-methods
** Based on Young, G., et al. (2013). Provision of community benefit by tax-exempt U.S. Hospitals. N Engl J Med, 368, 16.

Even though (as shown in Figure 1) population health depends most dramatically on nonmedical health factors, by far the lion's share of hospitals' community benefit investments go to providing free, discounted, and under-reimbursed medical care. Thus, current community benefit investment patterns are not aligned with addressing the conditions that contribute most to population health nor, necessarily, with community input obtained through the CHNA process.

Full implementation of the ACA's coverage provisions is expected to result in fewer uninsured individuals (see, e.g., Nardin, Zallman, McCormick, Woolhandler, & Himmelstein, 2013). Although there will continue to be a need for free and discounted hospital care, that need will likely diminish in a post-ACA environment, thereby freeing up a portion of hospitals' community benefit resources[18] for potential redirection to investments that address the nonmedical health determinants that so profoundly affect community health. Viewed on a grand scale, negative health determinants such as poverty, substandard housing, food insecurity, environmental hazards, poor educational opportunities, crime, and unemployment may be problems that are simply too extensive for nonprofit hospitals—or indeed for any single sector of the community—to tackle on its own. These factors, however, might be addressed through inclusive, cross-sector partnerships of government (notably health departments), nonprofit hospitals, and individuals and organizations representing multiple sectors in the community.

Conclusion

In America's era of health reform, nonprofit hospitals face significant challenges as they adapt to new care delivery models, new payment structures, and heightened expectations of quality, efficiency, and accountability in their delivery of health care services. At the same time, federal community benefit standards, including regulations proposed by the IRS in 2012 and 2013, can act as an impetus for fresh consideration of tax-exempt hospitals' "charitable" roles in and responsibilities to the communities they serve. These challenges bring with them opportunities, both to improve the nation's health care delivery system and to improve the nation's health.

As interpreted by the IRS, the ACA's community benefit provisions can be used as levers to encourage participation by tax-exempt hospitals in community-based multi-sector partnerships for population health improvement across communities to improve the health of their most vulnerable populations. The IRS's 2013 NPRM would mandate more focused hospital consideration and, ideally, greater responsiveness to their communities' health needs. Hospitals' approaches to their community benefit responsibilities will be more transparent to their communities, and their decisions as to the kinds and extent of their community benefit investments will be more fully subject to public scrutiny. Greater transparency of nonprofit hospitals' community benefit decision-making may afford community representatives a stronger voice and greater ability to influence such decision-making and, ultimately, the scope and direction of hospitals' community benefit investments.

Tax-exempt hospitals will face a series of decision points as they enter the post-health reform environment. These decision points may arise in the context of a hospital's definition of its community to include or avoid geographic areas beyond its traditional service area in order to target or steer clear of medically underserved, low-income, and minority populations. Another telling decision point might be whether or not a hospital chooses to participate (or how actively and substantively it participates) in collaborative CHNA, and to what extent its community benefit planning and implementation strategy development accurately reflects community priorities. How seriously will the hospital pursue community engagement? How deeply will it involve community representatives in developing and carrying out its implementation strategy?

Will it seek real-time feedback on its CHNA report by seeking public input on draft CHNA reports? Will it simply *take* community input, or will it *act* on the community's views as to which of its identified health needs are "significant" and how to prioritize its hospital community benefit investments?

As full ACA implementation begins, unresolved issues and policy gaps persist and new ones emerge. How might structural changes in the delivery of hospital services, new reimbursement models, and current trends toward industry consolidation affect nonprofit hospitals as they navigate their community benefit responsibilities? As hospitals join with other providers to take on global responsibility for coordinated patient care, can federal and state governments craft policies that support their joint endeavors to improve community health, or that support initiatives to address nonmedical health factors that disproportionately affect community health? Will federal and state community benefit policies turn to encouraging improvements in community health that are unrelated to medical care (housing, urban planning, transportation, etc.)? As hospital engagement in community health improvement evolves and expands, how can government policy best support broad-based, effective initiatives to improve community health?

Additional issues arise in connection with the ACA's transformation of the health care landscape. To what extent will the Medicaid coverage expansion—along with improved access to private health insurance coverage—substantially reduce the demand for unreimbursed health care services? Will hospital collaborations in joint needs assessment and joint community benefit planning lead to regional CHNAs and implementation strategies that target medically underserved areas and populations? While on-the-ground cross-sector coalition building around shared community goals has received substantial attention and investment, broad strategies for using public policy and law to incentivize hospital investment in community health improvement initiatives are still emerging.

Tax-exempt hospital alignment with multiple-sector community partnerships can support CHNA, community benefit planning, and the development of CHNA reports and implementation strategies that are more responsive to community-identified health needs and priorities. Each partnering organization, as well as the community at large, has a considerable stake in the outcome of efforts to improve population health in their communities.

Endnotes

[1] The Patient Protection and Affordable Care Act, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, 124 Stat. 1028 (2010). These consolidated Acts are referenced herein as the Affordable Care Act (ACA).

[2] Analyses of the ACA and IRS requirements concerning consumers' financial protection (ACA §9007(a), codified as I.R.C. §501(r)(4)-(6); IRS, 2012) can be found in Somerville, Nelson, & Mueller, 2013 and Nelson, Somerville, Mueller, & Boddie-Willis, 2013. Excellent analyses can also be found in materials developed by Community Catalyst's Hospital Accountability Project (e.g., Community Catalyst, 2012a, 2012b), and by Health Reform GPS (e.g., Rosenbaum, S., 2013).

[3] A *hospital organization* is an entity that operates one or more *hospital facilities* during the relevant tax year. A *hospital facility* is a facility that "is required by a State to be licensed, registered, or similarly recognized as a hospital" (I.R.C. §501(r)(2)(A)). *Hospital organizations* that operate more than one *hospital facility* are required to submit an annual information return (Form 990, including Schedule H) to

the I.R.S., and to "meet the requirements of [I.R.C. §501(r)] separately with respect to each such facility" (I.R.C. §501(r)(2)(A); IRS, 2013: proposed 26 CFR §1.501(r)-1; IRS, n.d.j.).

[4] A CHNA that satisfies the statute's requirements "(i) takes 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, and (ii) is made widely available to the public" (I.R.C. §501(r)(3)(B), emphasis added).

[5] The proposed rule defines "medically underserved populations" to include those "experiencing health disparities or at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers" (IRS, 2013: §1.501(r)-3(b)(6)).

[6] The PHAB, initiated and sponsored by the CDC and the Robert Wood Johnson Foundation, was established as an independent nonprofit body in 2007. Accreditation process and standards were developed, tested, vetted, revised, and a final version adopted in July 2011. National public health department accreditation launched in September 2011 (PHAB, n.d.a.). As of August 21, 2013, 19 health departments had been awarded full PHAB accreditation, with hundreds more preparing to seek PHAB accreditation (PHAB, 2013b).

[7] The "ten essential public health services" align with the three "core public health functions" (assessment, policy development, and assurance) as follows:

Assessment: (1) Monitor community health status to identify problems, (2) Diagnose and investigate health problems and health hazards in the community;
Policy development: (3) Inform, educate, and empower people about health issues, (4) Mobilize community partnerships to identify and solve health problems, (5) Develop policies and plans that support individual and community health efforts, (6) Enforce laws and regulations that protect health and ensure safety;
Assurance: (7) Link people to needed health services and assure the provision of health care when otherwise unavailable, (8) Assure a competent public health and personal health care workforce, (9) Evaluate effectiveness, accessibility, and quality of personal and population-based health services, (10) Conduct research for new insights and innovative solutions to health problems (CDC, 2011; American Public Health Association, n.d.).

[8] PHAB Standards 1.1—1.4 require health departments seeking accreditation to conduct or participate in "a collaborative process resulting in a comprehensive community health assessment," including the collection and analysis of health data, identification of trends in health problems, environmental hazards, and social and economic factors affecting health, and the development of recommendations on public health policy, processes, programs, or interventions (PHAB, 2011, p. 9).

[9] The proposed rule defines making a hospital facility's CHNA "widely available" on a website as conspicuously posting a complete and current version of its CHNA that can be accessed and printed without fee and without special hardware or software, with the hospital facility providing the URL to individuals who ask. The CHNA would have to be posted either on the hospital facility's website, or, if none, on the hospital organization's website, or on the website of another entity if the hospital facility's or organization's website conspicuously links to the page of the other entity's webpage on which its CHNA is displayed, along with instructions for accessing it through the third-party website (proposed 1.501(r)-1(4)).

[10] Resources useful for hospitals' development of community benefit evaluation plans are available, for example, from the Catholic Health Association and Kaiser Permanente (CHA, 2013; Kaiser Permanente, 2013).

[11] The WNC Health Network, an alliance of 51 hospitals and health systems in North Carolina, South Carolina, Virginia, Tennessee, Pennsylvania and Kentucky, facilitates collaboration among its member organizations to reduce costs (e.g., through group purchasing), improve quality, and share best practices (WNC Health Network, 2013). For the WNC Healthy Impact collaborative, it functions as a "backbone organization" in the sense of the "collective impact" collaboration model that was introduced by FSG (a nonprofit consulting firm) in 2011 (Kania & Kramer, 2011). Thereafter, the collective impact model has

become an important and ubiquitous subject of discussion in the context of multi-sector partnerships for population health improvement. A four-part series of posts in the Stanford Social Innovation Review blog reviews and evaluates the value of backbone organizations to collective impact initiatives (Turner, Merchant, Kania, & Martin, 2012). FSG has identified five conditions for successful collective impact: participants sharing a common agenda; shared measurement (consistent data collection and measurement); mutually reinforcing activities; continuous communication; and a separate backbone organization "with staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies" (FSG, 2013).

[12] WNC Healthy Impact Regional Reports were completed in 2012 and are linked from WNC Healthy Impact's website (WNC Healthy Impact, 2013b.)

[13] Heather Gates is the Director of WNC Programs at the WNC Health Network. In this role she serves as the regional coordinator of WNC Healthy Impact.

[14] Hospitals participating in the Hartford, Connecticut Community Health Needs Assessment Consortium included Connecticut Children's Medical Center, Hartford Hospital, Saint Francis Hospital and Medical Center, and the University of Connecticut Health Center.

[15] Mary Stuart directs the Center for Health Equity at Saint Francis Hospital, is responsible for the hospital's community benefit program, and leads the Saint Francis Diversity Collaborative Team.

[16] Dr. Raul Pino directs the City of Hartford, Connecticut's Department of Health & Human Services.

[17] For an analysis of hospitals' "community building" activities and related reporting issues, see Hilltop's issue briefs titled and *Hospital Community Benefits after the ACA: Community Building and the Root Causes of Poor Health* (Somerville et al., 2012) and *Hospital Community Benefits after the ACA: Schedule H and Hospital Community Benefit—Opportunities and Challenges for the States* (Barnett & Somerville, 2012).

[18] An expected increase in demand for Medicaid-reimbursed hospital services following full ACA implementation would also generate higher "Medicaid shortfall" costs reportable as community benefit. It seems reasonable, however, to assume that hospitals' increased Medicaid shortfall costs will be more than offset by the savings expected from a diminished demand for free and discounted care. Medicaid coverage and premium subsidies for purchasing private insurance through Health Benefit Exchanges should increase overall levels of hospital reimbursement for providing services to populations that are currently uninsured. For updated estimates of post-ACA implementation levels of insurance coverage, see Holahan, Buettgens, Carroll & Dorn, 2012 and Congressional Budget Office, 2013.

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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 a 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, hospitals, and community-based organizations to use 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).

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