Community Benefit Issue Brief

Section 9007 of The Patient Protection and Affordable Care Act (ACA) revises the federal tax-exempt status requirements for nonprofit hospitals, in order to assure that hospitals' "community benefit" investments (a condition of their tax-exempt status) are transparent, concrete, measurable, and both responsive and accountable to identified community need. To this end, the ACA requires hospitals to conduct a "community health needs assessment" (CHNA) and to adopt an "Implementation Strategy."

Beginning with the first tax year on or after March 23, 2012, hospitals must "conduct" a CHNA in order to assess community need and must implement an Investment Strategy that flows from the assessment. Under the Code, as revised:

- The assessment and implementation strategy must be carried out triennially beginning with the first tax year after March, 2012.
- The assessment must "take into account" "input" from persons who "represent" the "broad interests" of the "community served by the hospital facility."
- The assessment must include "those" with "special knowledge or expertise in public health"
- The assessment must be made "widely available" to the "public."
- The hospital must "adopt[]" an "Implementation Strategy."

In July, 2011 and following an earlier request for information, the Internal Revenue Service and Department of Treasury (the federal agencies with oversight over this ACA provision) issued a Request for Comments (RFC) (IRS Policy 2011-52) which interprets and expands upon the legislative language of Section 9007. The comment period is closed and a final rule from the IRS is pending. Highlights of 2011-52 include:

- *Who must file*. The entities that must file CHNAs are hospital organizations operating state licensed hospital facilities or any other organization that Treasury determines has provision of hospital care as its principal function or purpose. The agencies seek comments on whether hospitals that are units of government should be covered. Organizations offering more than one hospital facility must "conduct a CHNA and adopt an implementation strategy for each hospital facility. . .". This requirement applies to hospital organizations regardless of whether they act alone or "collaborate with other organizations."

- *Form of CHNA*. The CHNA must be a written report that describes the community served by the facility, a description of the CHNA process, data, and methods used, any relevant information gaps, all collaborating organizations, third parties that have assisted in developing the CHNA, and how the hospital carried out its consultation responsibilities in relation to persons representing the "broad interests of the community served." The report also must "identify any individual providing input who has special knowledge of or expertise in public health" as well as persons considered "leader[s]" or "representative[s]" of the community.

- *Prioritization of need.* The CHNA must present a "prioritized description" of all of the community health needs as well as a "description of the process and criteria used in prioritizing such needs."

- *When conducted.* The CHNA will be considered "conducted" in the taxable year "that the written report of its findings is made "widely available" to the public.

- *Multi-facility CHNAs.* The agencies seek comment on whether they should permit "documenting CHNAs for multiple hospital facilities together in one written report" in order to improve their quality while ensuring "that information for each hospital facility is clearly presented."

- *Defining community.* The agencies propose to give hospitals the flexibility to use a "facts and circumstances" approach to defining the term "community" served by the facility. At the same time, the agencies indicate that they "expect that a hospital facility's community will be defined by geographic location" while also taking into account target populations if relevant. The agencies suggest that an approach (such as patient discharges) that "circumvents" the requirement to assess the needs of the broader community will not be acceptable. The agencies seek comments on whether the term "community" should be more defined from a geographic perspective (e.g., whether the term should be defined as an MSA or micropolitan statistical area or on a county basis).

- *Consultation with representatives.* The agencies define the concept of "persons who represent the broad interests of the community" to at a minimum consist of "(1) persons with special knowledge of or expertise in public health, (2) federal tribal, regional, state or local health or other departments or agencies with current data or other information relevant to the health needs of the community served by the hospital facility; and (3) leaders, representatives, or members of medically underserved, low income, and minority populations and populations with chronic disease needs, in the community served by the hospital facility."

- *Making the CHNA widely available.* The agencies indicate that "wide availability" means posting at the facility or organization website, websites of other entities, sending copies to requesters or a URL link, having downloadable or printed copies that are exact reproductions of the images, and free. (The guidance does not address questions of access with respect to community members whose primary language is not English or who face access barriers based on disability or low literacy).

- *Implementation Strategy.* The agencies require a separate Implementation Strategy for each hospital facility. The agencies define the strategy as a "written plan that addresses each of the community health needs identified through a CHNA for such facility." By "address," the agencies mean that Strategy describes how the "hospital facility plans to meet the health need" or "identifies the health need as one the hospital facility does not intend to meet and explains why. . ." The Strategy is expected to describe the programs and resources "that the hospital facility plans to commit to meeting the health need and

the anticipated impact of those programs and resources on the health need." The Strategy "could" also describe planned collaborations. The agencies consider the Strategy adopted when adopted by the organization governing body, and the Strategy must be adopted in the same year when the CHNA is conducted. The Strategy must be attached to the facility's report to the IRS, but there are no "widely available" requirements comparable to those applicable to the CHNA phase.

- *Measuring implementation*. The policy does not address the question of evaluation of CHNAs or Implementation Strategies.

- *Reporting*. Reporting takes place on the Schedule H form discussed below.

Schedule H

The agencies also have issued the latest Schedule H form as well as worksheets with accompanying instructions that both guide hospital reporting and contain critical definitions.

Part I of Schedule H defines "community benefit" as "financial assistance and other community benefits" and requires information by community benefit class and cost. The definition of community benefit encompasses:

- "financial assistance" (i.e., "charity care," see worksheet 1)
- "Medicaid"
- "costs of other means-tested government programs"
- "community health improvement services and community benefit operations"
- "health professions education"
- "research"
- "cash or in-kind contributions for community benefit," and
- "other benefits"

Part II lists "community building" activities that would fall outside the definition of community benefit. These are:

- "physical improvement 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 worksheet instructions give extensive definitions for each reporting line. All of the definitions are important, but of particular importance is the IRS worksheet definition for "community health improvement services and community benefit operations." The IRS defines these activities (Worksheet Four) as

> 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 nominal patient fee or sliding scale fee for these services. "Community benefit operations" means: activities associated with community health needs assessments; community planning and administration; the organization's activities associated with fundraising or grant-writing for community benefit programs.

Marketing and activities designed to attract paying customers cannot be classified as a community benefit. Worksheet Four goes on to state that

> Community benefit activities or programs also seek to achieve objectives including improving access to health services, enhancing public health, advancing increased general knowledge, and relief of a government burden to improve health this includes activities or programs that do the following: are available broadly to the public and serve low income consumers; reduce geographic, financial, or cultural barriers to accessing health services, and it [sic] ceased to exist would result in access problems (for example, longer wait times or increased travel distances); address federal, state, or local public health priorities such as eliminating disparities in health care among different populations; leverage or enhance public health department activities such as childhood immunization efforts; otherwise would become the responsibility of government or another tax-exempt organization; advance increased general knowledge through education or research that benefits the public.

Cash and in-kind activities can be included (Worksheet 8) if the award goes to organizations involved in activities defined as community benefit activities. Excluded from "community benefit" are "community building" activities, but the worksheets do not define these activities.