Improving Community Health through Hospital Community Benefit Spending: Charting a Path to Reform

Funded by the Kresge Foundation and the Robert Wood Johnson Foundation

Sara Rosenbaum

Maureen Byrnes

Sara Rothenberg

Rachel Gunsalus

Milken Institute School of Public Health

The George Washington University

December 2016

Contents

Acknowledgments i

Executive Summary ii

Introduction 1

Background 2

The Origin of Community Benefit 2

The Public Interest in Community Benefit 4

How the IRS Defines Community Benefit 8

The IRS Community Benefit Definitions 10

Community Building versus Community Benefit: Ambiguity and Overlap 13

The Growing Role of Hospitals as Community Health Actors 16

Social Determinants as a Prioritized Health Need in Current Hospital CHNAs 17

Policy Opportunities: Strengthening Hospitals' Role in Improving Community Health 20

Appendix 27

Acknowledgments

We are grateful to the Kresge Foundation and to the Robert Wood Johnson Foundation for their support of this project and for their many related activities that will result in improving community health.

In preparing this report, we have benefitted greatly from the guidance of the following individuals:

Kevin Barnett, Public Health Institute

Stuart Butler, The Brookings Institution

Bechara Choucair, Trinity Health

Guy Collier, McDermott Will & Emery

Jessica Curtis, Community Catalyst

David M. Frankford, Rutgers Law School

Feygele Jacobs, RCHN Community Health Foundation

Robert Louthian, McDermott Will & Emery

Gene Matthews, University of North Carolina Gillings School of Global Public Health

Glen Mays, University of Kentucky College of Public Health

Martha Somerville, Somerville Consulting

Julie Trocchio, Catholic Health Association

Paul Stange, Consultant

Cynthia H. Woodcock, The Hilltop Institute

Gary Young, Northeastern University

Executive Summary

The Origin and Evolution of Community Benefit

For nearly half a century, nonprofit hospitals that seek tax-exempt status have been required by law to meet a "community benefit" test. Over time, the community benefit test has become a significant aspect of U.S. health policy, providing a means by which the public can measure how nonprofit hospitals give back to their communities in exchange for the tax benefits they receive.

Tax-exempt hospital policy began in 1956, when the Internal Revenue Service (IRS) ruled that hospitals could qualify for a charitable tax exemption if they furnished charity care. In 1969, the IRS used its broad legal authority to replace the charity care test with a "community benefit" standard. This standard made charitable care optional for tax-exempt hospitals and recognized a broader range of expenditures that could qualify hospitals for charitable tax-exempt status. Charitable activities added under the ruling included operating an emergency room open to all, participation in health insurance, professional education and training, and research.

Beginning in 2009, the IRS introduced a new reporting system, known as Schedule H, which accompanies Form 990, filed annually by tax-exempt hospital organizations. Schedule H contains an array of information on hospital activities, including their community benefit expenditures in accordance with IRS-designated categories. However, hospital organizations that operate multiple facilities and report their facilities under a single tax number also report their community benefit spending in an aggregated, rather than facility-specific, fashion.

Community Building versus Community Benefit

Community benefit expenditures are reported in Part I of Schedule H. Part I defines community benefit to include financial assistance to patients, shortfalls attributable to participation in Medicaid and other means-tested government insurance programs, subsidized health services to the entire community such as trauma units, research, health professions education and training, and "community health improvement services."

By "community health improvement services," the IRS means hospital-subsidized activities and programs "carried out or supported for the express purpose of improving community health" and that "do not generate inpatient or outpatient revenue [other than nominal fees]." Because this definition refers to hospital revenues, the implication is that the term "community health improvement" focuses on free or reduced-cost clinical care and support to individual patients.

In addition to Part I, the IRS also recognizes a separate category of spending in Part II of Schedule H, known as "community building." These community building expenditures are defined as activities that "promote" the health and wellbeing of communities as a whole, well beyond the realm of clinical care and individual patient supports. The recognized categories of community building expenditures include physical improvements and housing, economic development, community support, environmental improvements, and other

activities. The IRS permits hospitals to report Part II community building activities as Part I community benefits related to community health improvement. But, the agency has failed to publish guidance on either the circumstances under which such crossover reporting is permissible or the categories of community building expenditure for which Part I reporting is a permissible option. Hospital community benefit expenditures "not reportable" as community benefit spending remain separate from the Part I community benefit definition. Because federal and state regulators, researchers – and most importantly perhaps, the public – look to Part I in determining how hospitals support their communities, the ambiguity and uncertainties created by the IRS policy regarding community building may diminish hospitals' willingness to spend on activities that promote health on a community-wide basis while encouraging them to focus their efforts on expenditures devoted to specific patient care.

Social Determinants of Health as a Prioritized Health Need

The ambiguities and uncertainties surrounding IRS community benefit policy come at a time of growing recognition of the degree to which the social conditions in which Americans grow, live, work, and age can affect overall health. This policy also comes at a time of elevated hospital interest in developing interventions that can promote health and wellness. Hospitals increasingly are looking to broaden their missions to include partnerships and initiatives designed to promote health and speed recovery.

This changing relationship between hospitals and communities was reinforced

Key Terms in Schedule H (Form 990)

Community Health Improvement Services (Part I):

"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 revenue."

Community Benefit Operations (Part I):

"Activities associated with conducting community health needs assessments, community benefit program administration, and the organization's activities associated with fundraising or grant-writing for community benefit programs. [These activities] seek to achieve a community benefit objective, including improving access to health services, enhancing public health, advancing increased general knowledge, and relief of a government burden to improve health."

Community Building Activities (Part II):

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.

2015 Schedule H (Form 990) Instructions, p. 16-18; 2016 Schedule H (Form 990), p. 2

by Affordable Care Act (ACA) amendments to the Internal Revenue Code that expand the obligations of tax-exempt hospitals and elevate their role beyond patient care and into the realm of community-wide health actors. The ACA reforms made provision of community benefit a basic obligation of tax -exempt hospitals and made other changes to reduce the burden on indigent patients. Additionally, the ACA reforms now require tax-exempt hospitals to conduct periodic community health needs assessments (CHNAs) and to link their assessments to annual implementation strategies that indicate how hospitals will respond to high priority needs. The CHNA amendments thus assign hospitals a formal role in measuring, prioritizing, and responding to broader community health needs, and implementing IRS regulations identify the social conditions of health as falling within the scope of the assessment process.

Numerous hospitals are beginning to take steps to reallocate a portion of their community benefit spending toward activities that more broadly promote community-wide health. Our analysis of hospitals' most recently available CHNAs reveals that the great majority have identified environmental conditions, education, and physical activity as the most significant challenges facing their communities and driving health outcomes. Seventy-two (72) percent of hospitals identified obesity, 68 percent identified mental health, and 62 percent identified diabetes as the most prevalent health conditions in their communities. In addition, just under half of all hospitals studied identified substance abuse, chronic disease, cancer, heart disease, and tobacco use as prominent health conditions affecting their communities as a whole. The community health needs assessment process thus has become a vehicle by which hospitals can position themselves to become community health anchors.

Unfortunately, there is no requirement that hospitals expressly draw a link between community benefit spending policy and the CHNA process. Nor do the reforms expressly address the distinction between Part I community benefit spending and Part II community building activities. But, clearly Congress intended that hospitals broadly engage with their communities, and implementing IRS rules reflect this intent. Current law and the IRS's own implementing rules thus call into question the continued desirability of distinguishing between community benefit and community building activities, as well as ambiguous and conflicting IRS policies embedded in the Schedule H reporting instructions stating that certain community building activities are "not reportable" as community benefit spending. Moreover, while certain community building activities may be "reportable," Schedule H lacks instructions to guide hospitals.

The Policy Opportunities

Given its broad grant of regulatory powers under the Internal Revenue Code and its authority to define the concept of community benefit, the IRS could take action to align community benefit policy with this larger vision of community-wide health improvement, a concept now widely accepted as essential to health system transformation by both public and private payers. Such a shift in policy would be supported by a wealth of literature documenting the relationship between health and the social conditions of health. Were the IRS to pursue this policy, its actions could further encourage community benefit spending whose aim is to improve health on a community-wide basis. Such reforms would clearly signal to hospitals

the importance of reallocating community benefit expenditures toward activities and partnerships that take place outside the hospital door and that help create the conditions to improve the health of community residents, regardless of whether or not they are patients.

These policy opportunities have two overarching goals. The first goal is to move to a definition of community health improvement for purposes of community benefit spending that fully embraces both patient-specific clinical care and activities that promote the health of entire communities. The second goal is to develop the range of policies and guidelines that actively encourage tax-exempt hospitals to contribute to and participate in community-wide efforts that emerge through the community health needs assessment process and that lift the health of communities as a whole.

Policy Opportunity 1. Broaden the definition of community health improvement

The IRS could eliminate the distinction between community benefit and community building by moving Part II community building activities clearly into Part I community benefit, thereby broadening the definition of community health improvement to clearly encompass activities described in Part II, which improve the health of communities as a whole. In doing so, the IRS would recognize the expanding vision of hospitals and the value of hospital involvement in community-wide health improvement. Such a shift could help promote the growth of partnering relationships with schools, churches, nutrition assistance programs, social service agencies and organizations, housing authorities, community and economic development programs, and other local entities that seek to integrate health, social, educational, environmental, and other spending in order to support community-wide solutions to health.

To further encourage hospitals to contribute to, and participate in, activities that promote community-wide health, the IRS could exempt from being counted as offsetting revenues restricted grants and funds that hospitals receive from corporate endowments or other sources and that are dedicated to support community-building endeavors such as housing, reducing environmental threats, improvements to the physical environment, early childhood development, community-wide nutrition efforts, and other activities such as tobacco and obesity reduction efforts that promote the health of all community residents, even those who are not patients.

Policy Opportunity 2. Bring greater transparency to community benefit reporting

The IRS could consider revising the definition of community benefit contained in Part I of Schedule H to add a specific new category of community benefit spending that is linked to hospital CHNA activities, including their implementation strategies. Although many sources of information may help hospitals prioritize community health need, the CHNA process is designed to encourage community-wide input and thus its result may merit special attention. In this spending category, hospitals could report on the percentage of their community benefit spending allocated to community health improvement activities (both patient care and community building) that have been identified as health need priorities through the CHNA process. In addition, the IRS could require hospitals to make their community benefit spending allocations, along with their CHNA implementation strategies, widely available to the public, as is the case with

the CHNAs themselves. The IRS could further require hospital systems that aggregate their community benefit spending across all of their individual hospital facilities and report community benefit spending in the aggregate to also report, as part of each facility's CHNA and implementation strategy, the amount of organizational community benefit spending allocated to the community served by that facility. These reforms would bring greater community-specific transparency to community benefit spending.

Policy Opportunity 3. Establish community-wide health improvement guidance, along with goals and metrics for reallocating community benefit spending toward a broader set of community health improvement activities

The IRS could consider partnering with federal agencies that specialize in programs and activities that help promote community health in order to develop broad guidance for hospitals regarding community building efforts that promote community-wide health. This guidance, disseminated by the agency under its statutory oversight role, could bring broad public health expertise to bear in identifying interventions that show reasonable evidence of effectiveness, are associated with successful outcomes, are feasible, and have the potential to contribute to health improvement. Working with experts drawn from public health and health services research, the IRS also could develop suggested goals and metrics for reallocating community benefit spending toward community-wide activities that promote health, and that may be useful to hospitals that experience a decline in the need for charity care and whose uncompensated care burdens begin to decline in the face of expanded insurance coverage.

In order to provide the expertise it needs to develop such guidance and reallocation metrics, the IRS could create an interagency task force of experts in the social conditions of health to work closely with the agency on policy development. Experts could be drawn from the Departments of Agriculture, Health and Human Services, Education, Labor, Housing and Urban Development, Transportation, Commerce, Veterans Affairs, and other agencies whose missions and areas of focus relate to the social determinants of health. The National Prevention Council, created under the ACA, offers the IRS an important source of cross-Agency expertise. Also critical to this task are experts in the Treasury Department and the Federal Reserve who have developed broad community development policies that have the overall health of communities at their core.

The financial stake in policy reforms that use tax law to more effectively advance health policy is considerable: in 2011 hospitals reported more than $62.4 billion in community benefit spending. From a tax -expenditure perspective, the stake in such policy revision is also considerable. In 2011, taxpayers invested almost $25 billion nationwide to support tax-exempt hospitals. Through a more comprehensive definition of community benefit spending that emphasizes community-wide health improvement, and through policy guidance developed with the help of experts in the field of community health, the IRS could align tax policy with twenty-first century health policy goals.

Introduction

For nearly half a century, nonprofit hospitals that seek tax-exempt status have been required to meet a "community benefit" test. Over time, this test, and the broader policy goals it reflects, has become a significant aspect of U.S. health policy. Today, community benefit reporting by tax-exempt hospitals represents a means by which the public can measure how hospitals give back to their communities in exchange for the tax benefits they receive.

The policy landscape continues to evolve under health reform. As policymaking increasingly focuses on addressing the underlying social determinants of health as an indispensable dimension of health system transformation,[1] a key question becomes how to more effectively use longstanding community benefit policy to spur a more significant role for hospitals as partners in community health. Some hospital leaders already are moving in this direction, linking their community benefit spending to activities that can help improve overall community health.

Assuring that hospital community benefit policy aligns with this growing emphasis on community-wide health improvement represents a critical reform opportunity, especially as hospitals begin to experience the financial effects associated with the expansion of health insurance coverage and a corresponding decline in the level of uncompensated care. This shift will not happen quickly, but the public interest is enormous, in light of the magnitude of community benefit spending and taxpayer support for hospitals that operate as tax-exempt charities.

To be sure, millions of Americans will continue to need the financial assistance that nonprofit tax-exempt hospitals provide. At the same time, even a relatively modest realignment of community benefit expenditures could have a significant impact on the level of resources available to communities to meet broader health needs. Indeed, the Internal Revenue Code amendments to the Affordable Care Act (ACA), make this Congressional expectation clear.

Community benefit policy falls within the purview of the Internal Revenue Service (IRS) and the Treasury Department, which have broad authority to interpret and apply policies governing tax-exempt charitable organizations. Since 1956, the IRS has focused specifically on the application of tax-exempt policy to hospitals,[2] and in recent years the agency has done much to clarify and refine the meaning of community benefit in a hospital context.

Building on a wealth of research pointing to the value of expenditures that improve the underlying social conditions of health, such as housing supports, nutrition, child development, employment, and community development,[3] this report

[1] Jack Homer et al., Combined Regional Investments Could Substantially Enhance Health System Performance and Be Financially Affordable, *Health Affairs* 35:8 (August 2016) pp. 1435 – 1443. http://content.healthaffairs.org/content/35/8/1435.abstract (Accessed August 15, 2016)

[2] Sara Rosenbaum and David Frankford, Sylvia Law, Rand Rosenblatt, *Law and the American Health Care System* (Foundation Press, 2012; 2012-2016 Update)

[3] Rachel Thornton et al., Evaluating Strategies For Reducing Health Disparities By Addressing The Social Determinants Of Health, *Health Affairs* 35:8 (August 2016) pp. 1416-1423. http://content.healthaffairs.org/content/35/8/1416.abstract (Accessed August 15, 2016)

describes opportunities to strengthen the role of hospitals in community-wide health improvement efforts. The opportunities described in this report do not require additional legislation; the IRS has broad authority to implement such actions. Over time, these policy reforms could encourage greater hospital involvement in addressing the social conditions in which individuals and families live and work and that, in turn, exert such a major influence on their health as well as the health of the larger community as a whole in which they reside. These opportunities also build on the direction in which hospitals' community benefit policies and practices are beginning to move.

These policy opportunities have two overarching goals. The first goal is to move to a definition of community health improvement for purposes of community benefit spending that fully embraces both patient-specific clinical care health supports, and activities that promote the health of communities as a whole. The second goal is to develop policies and guidelines that actively encourage tax-exempt hospitals to contribute to and participate in transparent, community-wide efforts that emerge through the community health needs assessment (CHNA) process and that lift the health of communities as a whole.

Following a background summary examining the evolution of community benefit policy, this report assesses the current status of community benefit policy and presents evidence of growing hospital emphasis on population health needs as part of the CHNA process. The report concludes with a discussion of policy opportunities for expanding hospitals' role as community health actors and partners.

Background

The Origin and Evolution of Community Benefit

How community benefit is defined is a matter of tax policy. It is also a matter of great consequence to health policy, given the extent to which hospital spending policies and practices can affect health and health care.

Beginning with the enactment of the income tax in 1913, federal law has contained special rules for entities organized and operated for charitable purposes, and since 1917, contributions to charitable organizations have been tax-deductible.[4] Where hospitals are concerned, their relationship to tax-exempt policy for charitable organizations has been

[4] Daniel M. Fox and Daniel Schaffer, Tax Administration as Health Policy: Hospitals, the Internal Revenue Service, and the Courts. *Journal of Health Politics, Policy and Law* 16:2 (1991) pp. 251 – 279. http://jhppl.dukejournals.org/content/16/2/251.full.pdf (Accessed August 15, 2016)

an evolutionary one. The provision of medical care does not constitute an independent basis for qualifying as a tax-exempt organization. In 1956, when health insurance reached only a limited portion of the population, the IRS ruled[5] that hospitals could qualify as tax-exempt charities under § 501(c)(3) of the Internal Revenue Code if they furnished charity care to people unable to pay.

In 1969, four years after the enactment of Medicare and Medicaid and as employer-sponsored coverage reached its zenith, the IRS used its broad legal authority to modify its earlier policy.[6] Under the agency's modified policy, hospitals could qualify as tax-exempt organizations, even if they did not provide charity care, as long as they offered what the IRS termed a "community benefit." The agency defined the concept of community benefit broadly to encompass various types of hospital activities that benefit communities as a whole, such as operating an emergency room open to everyone (not just those already established patients of the medical staff), participation in health insurance,[7] participation in professional education and training, and research. An additional tax ruling in 1983 made emergency care optional for hospitals to the extent that state or local health planning determined that services were not needed or would duplicate other care.[8]

Beginning in 2009, the IRS clarified the meaning of community benefit by defining the term in greater detail and embedding the definition in a special, detailed reporting instrument that tax-exempt hospitals file annually along with their tax returns on Form 990. This special instrument, appended to Form 990, is known as Schedule H. Schedule H, which has its origins in certain hospitals' own informal reporting systems,[9] does not establish minimum community benefit spending requirements, nor does the Internal Revenue Code do so. However, Schedule H requires hospitals to report with some particularity about the types of community benefit spending in which they engage. The definitions used by the IRS to classify community benefit spending under Schedule H are essentially an outgrowth of the 1969 IRS revenue ruling.

The ACA, signed into law a year after the IRS reporting reforms, did not establish a legislative definition of community benefit, nor did it specify minimum community benefit spending requirements. However, recognizing the considerable importance of the tax-exemption to overall health policy, Congress included provisions in the ACA that, as a matter of formal legislative policy, established certain minimum standards applicable to all hospitals operating as § 501(c)(3) organizations.

Codified in § 501(r) of the Internal Revenue Code, the ACA amendments set forth certain additional requirements that tax-exempt hospitals must meet. Under tax law, as amended, in order to be considered charitable organizations, hospitals must: (i) provide financial assistance in accordance with written policies (thereby echoing the

[5] Rev. Rul. 56-185, 1956-1 C.B. 202, *modified by* Rev. Rul. 69-545, 1969-2 C.B. 117. See generally, Joint Committee on Taxation, Present Law and Background Relating to the Tax-Exempt Status of Charitable Hospitals (2006), available at http://www.jct.gov/x-40-06.pdf (Accessed August 8, 2016)

[6] Rev. Rul. 69-545, 1969-2 C.B. 117.

[7] Initially IRS policy was ambiguous as to whether Medicaid participation was an expectation. "Tax Administration as Health Policy," op. cit.

[8] Rev. Rul. 83-157, 1983-2 C.B. 94.

[9] Natalie Dean and Julie Trocchio, Community Benefit: What It Is and Isn't, *Health Progress* (July-August 2005) pp. 22-26.

IRS' 1956 revenue ruling, which established charitable care as a basic requirement of all tax-exempt hospitals); (ii) comply with limits on charges in the case of patients eligible for financial assistance, along with limits on the types of billing and collection practices they may use; (iii) comply with federal law governing provision of emergency care at hospitals with emergency departments (EMTALA), and (iv) conduct triennial community health needs assessments that are accompanied by annual "implementation strategies" to advance priorities identified through the CHNA process.[10] Extensive regulations issued by the IRS in 2014 formally interpret these requirements in detail.[11]

Although the ACA amendments set a statutory minimum standard for § 501(c)(3) hospitals, the IRS retains broad authority to define the full range of hospital expenditures that qualify as community benefit spending. As noted, the IRS sets forth this definition as part of its annual tax reporting requirements, and the agency regularly updates its reporting forms and policies. Nearly 2,900 private tax-exempt hospitals operate as § 501(c)(3) organizations subject to the law's community benefit requirements, including the reporting requirements.[12]

The Public Interest in Community Benefit

For several reasons, the public interest in how community benefit is defined is considerable, as is the public interest in the community benefit choices hospitals make.

The first reason is the sheer magnitude of hospital community benefit spending. According to a 2015 IRS Report to Congress,[13] in 2011, hospital community

Community Health Needs Assessment (CHNA): Key Elements

- Must be carried out on a recurring basis every three years
- Must solicit and "take into account input from persons who represent the broad interests of the community served by the hospital facility"
- Must include people with "special knowledge or expertise in public health"
- Must be made "widely available" to the public
- Hospital must also adopt "an implementation strategy to meet the community health needs identified through such assessment"

26 U.S.C. § 501(r), added by Affordable Care Act § 9007

[10] Internal Revenue Code § 501(r)(1)(A)-(D)
[11] 79 Fed. Reg. 78954 (December 31, 2014)
[12] Gary Young et al., Provision of Community Benefits by Tax-Exempt U.S. Hospitals, *New England Jour. Medicine* , 368:16 (April 18, 2013), pp. 1519-1527. http://www.nejm.org/doi/full/10.1056/NEJMsa1210239 (Accessed August 15, 2016)
[13] Internal Revenue Service, Report to Congress on Private Tax-Exempt, Taxable, and Government-Owned Hospitals (January 2015), available at https://www.vha.com/AboutVHA/PublicPolicy/CommunityBenefit/Documents/Report_to_Congress_on_Hospitals_Jan_2015.pdf (Accessed August 9, 2016)

benefit spending surpassed $62.4 billion – more than 9.6 percent of hospitals' total operational spending that year. This figure represents ten times the entire Centers for Disease Control and Prevention (CDC) Fiscal Year 2011 budget[14] and nearly equaled total federal, state, and local public health spending that year.[15]

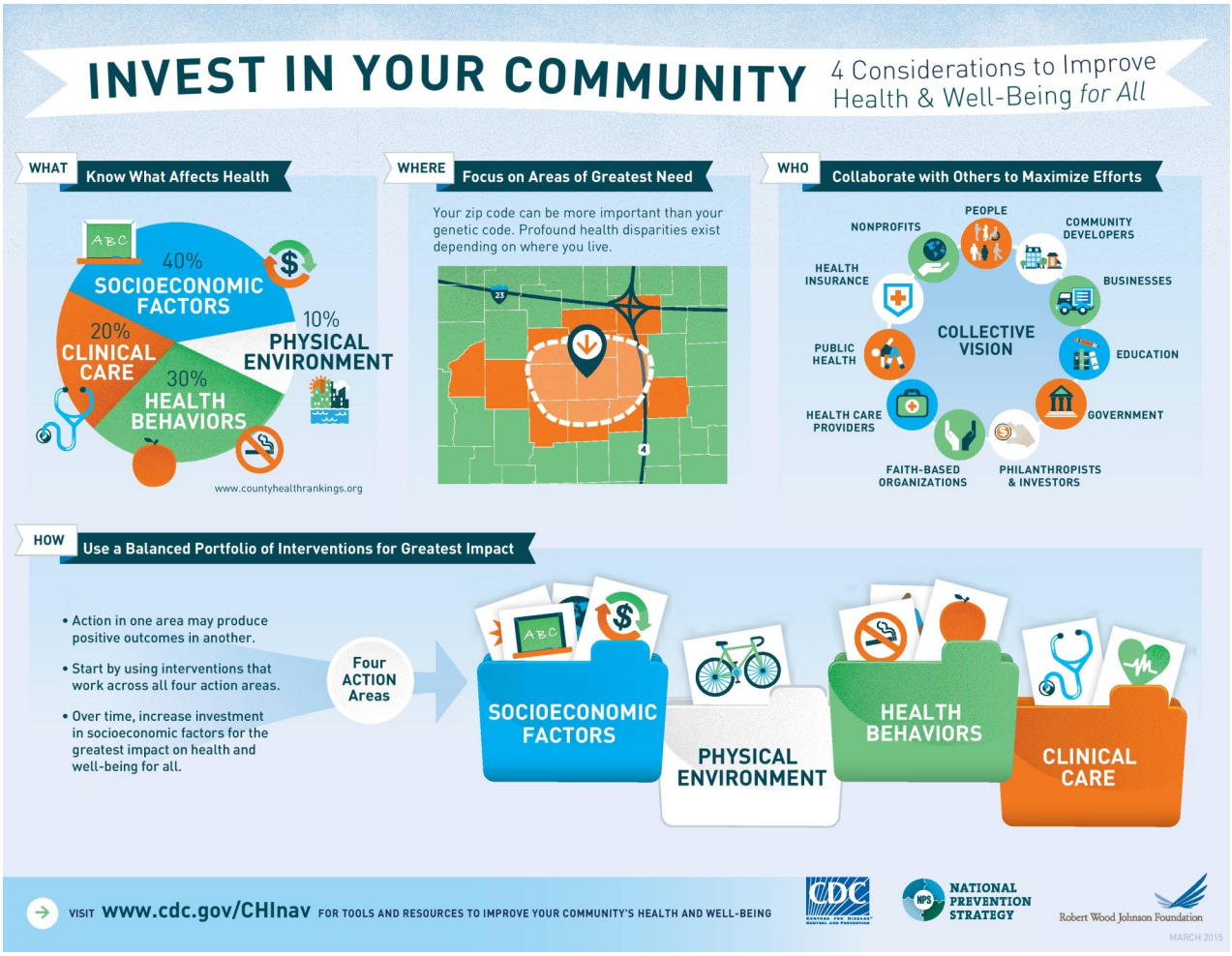
The second reason why the definition of community benefit is important is the size of the public investment in tax-exempt hospitals. Because they are tax-exempt, these hospitals not only qualify for tax-deductible contributions but also derive considerable support as a result of their exemption from the federal, state, and local taxes they otherwise would owe, as well as their ability to offer tax- exempt bond financing. (States typically tie their own tax policies to the federal tax system.)[16] In 2011, the total estimated national value of this tax exemption reached $24.6 billion, about double the amount from the previous decade.[17]

A third reason underscoring the importance of hospital community benefit policy is the fundamental repositioning of tax-exempt hospitals as actors and partners in community-wide health improvement efforts. This repositioning has happened as a result of the ACA's CHNA amendment, which itself reflects the increased attention paid to the health impact of social conditions and the importance of reforms that seek to better align health and social spending.[18] Hospitals are essential to their communities and occupy a social presence that extends well beyond the specific services they offer. To be sure, the central mission of hospitals is to care for individual patients. At the same time, however, hospitals have the potential to serve as what leading policy figures have termed "hubs," with the capacity to influence not only the accessibility and quality of health care, but also the overall health of communities through activities that address the "upstream" factors that influence health.[19] As such, hospitals have a significant role to play in improving community health.

IRS rules implementing the CHNA provisions reinforce the role of hospitals as essential community health actors. The rules define the relationship between hospitals and their surroundings in community and geographic terms rather than in relation to the much narrower population of patients served. Under the rules, hospitals maintain discretion to define their communities, but federal law also prohibits definitions that exclude medically underserved populations.[20] This policy to encourage hospitals to use a broader lens when assessing community need extends to the concept of community health need itself; the IRS rules define

[14] Trust for America's Health, Investing in America's Health: A State-by-State Look at Public Health Funding and Key Facts (April 2016), available at http://healthyamericans.org/assets/files/TFAH-2016-InvestInAmericaRpt-FINAL.pdf (Accessed August 9, 2016)
[15] Sara Rosenbaum et al., The Value of the Nonprofit Hospital Tax Exemption Was $24.6 Billion in 2011, (July 2015) *Health Affairs* 34:7 (pp. 1225-1233. http://content.healthaffairs.org/content/early/2015/06/18/hlthaff.2014.1424.full (Accessed August 15, 2016)
[16] Gayle D. Nelson et al., Hospital Community Benefits After the ACA: Policy Implications of the State Law Landscape (Hilltop Institute, 2013) http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-PolicyImplicationsIssueBrief7-Sept2013.pdf (Accessed August 15, 2016)
[17] The Value of the Nonprofit Hospital Tax Exemption Was $24.6 Billion in 2011, op. cit.
[18] Lauren A. Taylor et al., Leveraging the Social Determinants of Health: What Works? (June 2015) http://bluecrossfoundation.org/publication/leveraging-social-determinants-health-what-works (Accessed online, August 15, 2016)
[19] Stuart Butler et al., Hospitals as Hubs to Create Healthy Communities: Lessons from Washington Adventist Hospital (Brookings Institution, 2015), available at https://www.brookings.edu/wp-content/uploads/2016/07/Hospitals-as-Hubs-to-Create-Health-Communities.pdf (Accessed August 9, 2016)
[20] 26 C.F.R. 1-501(r)-3(b)(3)

Figure 1. CDC's Community Health Investment Infographic



"community health needs" to include the "requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities)."[21]

Furthermore, in offering examples of the types of needs a CHNA is intended to capture, the rules point to the importance of addressing not only "financial and other barriers to accessing care," but also barriers to actions that "prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community."[22] The breadth of the needs identified in CHNAs is expected to represent a broad public health vision of the type that the CDC uses in policies that guide community health improvement, shown in **Figure 1**, and that identify the relative role in health played by factors other than health care. In effect, the IRS CHNA rules define the duties of tax-exempt hospitals as encompassing efforts to understand and respond to the imperative of population health improvement.

The factors that encourage hospitals to adopt broader health assessment frameworks go beyond the public health considerations that underlie the CHNA

[21] 26 C.F.R. 1-501(r)-3(b)(4)
[22] Id.

process. Hospitals have a business reason for looking outward to matters of community health. Payment reforms incentivize hospitals to think beyond their doors and to focus on maintaining the health of discharged patients in order to reduce unnecessary readmissions.[23] Payment reform strategies aimed at bringing greater efficiency to health care through bundled and global payments make hospitals more sensitive to the complexity of patients' health and to underlying factors that may contribute to severity. For these strategies to not merely reduce hospital revenues –and therefore the amount of care available to those who need it—but to actually promote better health outcomes and greater efficiencies, achieving greater hospital engagement in the conditions that influence health gains importance.

The IRS, of course, is not alone in confronting this fundamental shift in health policies affecting hospitals; hospitals themselves are doing so. Furthermore, key government agencies increasingly are focused on how hospitals can work more strategically with other partners to address the social determinants of health, as defined in a considerable body of research.[24] These agencies span a wide range. They include the Treasury Department and the Federal Reserve, which both have longstanding interest in the health of communities as an element of community development and community reinvestment. They also include federal agencies whose purviews touch on health, such as Agriculture, Housing and Urban Development (HUD), Education, Transportation, and Health and Human Services (HHS). Within HHS, many agencies play a role in health, including the CDC, the Health Resources and Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Agency on Aging, the Administration for Children, Youth and Families, and the Centers for Medicare and Medicaid Services (CMS).

CMS' interest in communities focuses on Medicare policy reforms. Furthermore, along with state Medicaid programs, CMS is working to encourage new forms of health care delivery that can better bridge the divide between health care and social services through an organizational approach that produces health systems capable of operating in ways that encourage health and social interaction as well as simply delivering health care.[25] CMS has not only pursued the development of accountable care organizations that bring a broader orientation to health care but has also launched an "Accountable Health Communities" initiative to stimulate the development of health care entities able to bridge health and social services in order to increase efficiency while improving health.[26] Likewise, the CDC has fully embraced the CHNA process and has built a range of tools to aid hospitals in effective health planning[27] while simultaneously documenting the value of interventions that can have a significant impact on overall community health.[28]

[23] Melinda Abrams et al., The Affordable Care Act's Payment and Delivery System Reforms: A Progress Report at Five years (Commonwealth Fund, 2015), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1816_abrams_aca_reforms_delivery_payment_rb.pdf (Accessed August 15, 2016)

[24] Erika Rogan and Elizabeth Bradley, Investing in Social Services for States' Health: Identifying and Overcoming the Barriers (Milbank Fund, 2016) http://www.milbank.org/uploads/documents/Bradley-Rogan%20Investing%20in%20Social%20Services%20Report.pdf

[25] Deborah Bachrach et al., Medicaid Coverage of Social Interventions: A Road Map for States (Milbank Fund, 2016) http://www.milbank.org/publications/milbank-issue-briefs/538-medicaid-coverage-of-social-interventions-a-road-map-for-states (Accessed August 15, 2016)

[26] Accountable Health Communities Model, Centers for Medicare & Medicaid Services, https://innovation.cms.gov/initiatives/AHCM (Accessed August 11, 2016)

[27] CDC Community Health Assessment & Health Improvement Planning, http://www.cdc.gov/stltpublichealth/cha/ (Accessed August 11, 2016)

[28] See, e.g., hi5 http://www.cdc.gov/policy/hst/hi5/interventions/index.html (Accessed August 11, 2016) and The Guide to Community Preventive Services, http://www.thecommunityguide.org/ (Accessed August 15, 2016)

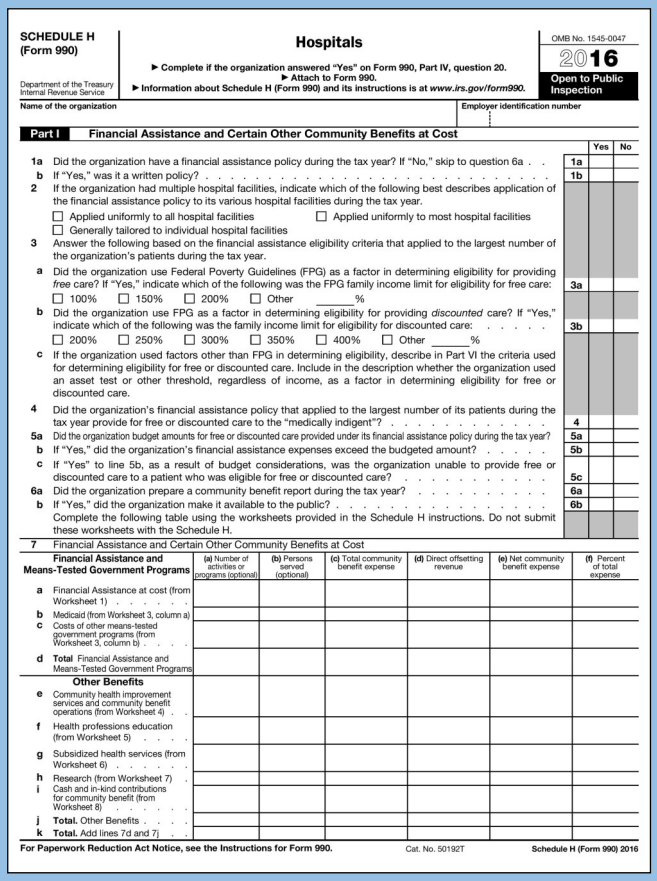
How the IRS Defines Community Benefit

The IRS definition of community benefit is found in the instructions for Schedule H which accompanies the Form 990 that hospitals operating under § 501(c)(3) must file with the IRS annually. As noted, Schedule H has undergone steady evolution as the IRS has refined its policies regarding the obligations of nonprofit hospitals. Activities that the IRS defines as community benefit spending are listed in Part I of Schedule H, and the meaning of the terms as set forth in Schedule H can be found in the accompanying instructions.[29]

Part I of Schedule H (**Figure 2**) creates a series of community benefit categories under which hospitals report their expenditures. Within each category, hospitals must report the total cost of their community benefit spending, as well as any "direct offsetting revenue" received in support of community benefit expenditures. Direct offsetting revenue is defined as "any revenue generated by the activity or program," also including restricted research grants or contributions, but does not include unrestricted grants or contributions. Based on these figures, hospitals then report their net community benefit spending, as well as their community benefit spending as a percentage of total hospital spending.

Table 1 displays reported hospital community benefit spending allocations by category, as defined in the Schedule H instructions, for 2011, the most recent data according to a 2015 IRS report.

Figure 2. IRS Schedule H (Form 990), Part I: Community Benefit



SCHEDULE H (Form 990) — Hospitals — OMB No. 1545-0047 — 2016

Department of the Treasury, Internal Revenue Service

► Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
► Attach to Form 990.
► Information about Schedule H (Form 990) and its instructions is at *www.irs.gov/form990*.

Open to Public Inspection

Name of the organization | Employer identification number

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a		
b	If "Yes," was it a written policy?	1b		
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☐ 200% ☐ Other _____%	3a		
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☐ 400% ☐ Other _____%	3b		
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4		
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a		
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		
6a	Did the organization prepare a community benefit report during the tax year?	6a		
b	If "Yes," did the organization make it available to the public?	6b		

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

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

For Paperwork Reduction Act Notice, see the Instructions for Form 990. Cat. No. 50192T Schedule H (Form 990) 2016

[29] Schedule H (Form 990) from the 2016 tax year can be found at https://www.irs.gov/pub/irs-pdf/f990.pdf (Accessed November 10, 2016)

Table 1: Charity Care and Certain Other Community Benefits at Cost for Tax Year 2011: Number and Selected Financial Data by Type of Community Benefit*

Type of Community Benefit	Number of activities or programs	Number of persons served	Total community benefit expense	Direct offsetting revenue	Net community benefit expense	Percent of total expense[x]
Total Community Benefits[†]	(1)	(2)	(3)	(4)	(5)	(6)
	553,999	**82,710,801**	**$149,281,744**	**$86,927,818**	**$62,463,371**	**9.67**
Total charity care and means-tested government programs[±]	**399,099**	**15 ,747,656**	**104,046,778**	**69,186,996**	**35,054,051**	**5.42**
Charity care at cost	25,575	3,159,408	17,415,426	2,500,841	15,011,379	2.32
Unreimbursed Medicaid	372,742	11,758,070	82,406,170	63,769,821	18,736,792	2.90
Unreimbursed costs—other means-tested government programs	782	830,178	4,225,182	2,916,334	1,305,880	0.20
Total other benefits[v]	**154,900**	**66,963,145**	**45,234,966**	**7,740,822**	**27,409,320**	**4.24**
Community health improvement services and community benefit operations	131,187	53,208,425	3,029,646	369,626	2,659,025	0.41
Health professions education	9,804	1,465,110	13,621,372	4,389,163	9,232,250	1.43
Subsidized health services	2,497	5,577,800	17,113,507	11,916,218	5,113,403	0.79
Research	1,405	130,351	9,435,570	1,022,817	8,412,686	1.30
Cash and in-kind contributions to community groups	10,007	6,581,459	2,034,871	42,998	1,991,957	0.31
Note: Money amounts are in thousands of dollars. Detail may not add to totals due to rounding.						

TABLE SOURCE: Internal Revenue Service. (2015). *Report to Congress on Private Tax-Exempt, Taxable and Government-Owned Hospitals; Table 5* (identical replica). Retrieved from: https://www.vha.com/AboutVHA/PublicPolicy/CommunityBenefit/Documents/Report_to_Congress_on_Hospitals_Jan_2015.pdf. *Based on Schedule H, Part I, Line 7a-7k data from 2,469 hospital filers that are not "dual-status organizations." Dual-status organizations are government entities that have also been recognized as tax-exempt 501(c)(3) organizations. Fifty-two hospitals were removed from the original data file (Hospital Filer Population N=2,521) because they were identified as dual-status organizations. [x] This figure is calculated by taking the "Net community benefit expense" (Schedule H, Part I, Line 7, Column (e)) and dividing by the aggregate amount reported by the population on Form 990, Part IX, Line 25, Column (A), which is "Total functional expenses." [†] Sum of "Total charity care and means-tested government programs" and "Total other benefits." [±] Sum of "Charity care at cost," "Unreimbursed Medicaid," and "Unreimbursed costs—other means-tested government programs. [v] Sum of "Community health improvement services and community benefit operations," "Health professions education," "Subsidized health services," "Research," and "Cash and in-kind contributions to community group."

The IRS Community Benefit Definitions

Financial Assistance and Participation in Means-Tested Government Programs

Financial assistance at cost. The IRS defines "financial assistance at cost" as the gross patient charges written off to financial assistance, adjusted to reflect both the cost of financial assistance (as opposed to a hospital's full established rate for services furnished), as well as other offsetting revenues and costs in connection with the provision of uncompensated care. These offsetting revenues and costs would include provider taxes paid to state Medicaid programs and supplemental payments received under a state Medicaid disproportionate share hospital (DSH) program. In calculating the level of financial assistance provided, hospitals must separate out bad debt forgiveness, since writing off bad debt is not considered financial assistance to patients (that is, bad debt is not charity care) but instead is part of a hospital's basic business operations, as are its collection practices. The IRS has reported that in 2011, financial assistance accounted for 2.32 percent of total hospital spending that year.[30]

Medicaid and other means-tested government programs. Longstanding charitable law principles recognize participation in government programs as a form of charitable activity. The IRS classifies participation in Medicaid and other "means-tested" government programs (such as the Children's Health Insurance Program (CHIP) or other federal, state, or local health care programs) as a form of community benefit. However, the IRS does not classify Medicare participation as a community benefit.[31] Hospitals are permitted to treat as community benefits the difference between the cost of caring for beneficiaries and the actual Medicaid (and other means-tested programs) payments received in connection with such care. The IRS has reported that in 2011, the difference between revenues received from Medicaid and other means-tested programs and the cost of furnishing care was valued at 3.10 percent of total hospital spending that year.[32]

Taken together, as **Table 1** shows, hospital community benefit spending on financial assistance and participation in means-tested government programs stood at 5.42 percent of total hospital spending in 2011, or 56 percent of total hospital community benefit spending in 2011.

"Other" Community Benefits

In addition, consistent with longstanding policy, the IRS creates a series of "other" community benefit classifications that encompass hospital activities that go beyond the immediacy of patient care. In terms of total hospital spending on community benefits, spending for "other" community benefits totaled 4.24 percent of total hospital spending in 2011, or 44 percent of total hospital community benefit spending in 2011, according to the IRS.

These categories of "other" community benefit spending reflect long-standing expenditure classes first set forth in the IRS' 1969 revenue ruling that first established the community benefit standard.

[30] IRS Report to Congress, op. cit. Table 5.
[31] The IRS definition does not include hospital participation in qualified health plans sold in the health insurance Marketplace as participation in means tested governmental programs, even if patients insured through such plans receive advance premium tax credits or cost sharing subsidies.
[32] Id.

Community health improvement services and community benefit operations. The IRS defines the term "community health improvement" as "activities or programs, subsidized by the [hospital], carried out or supported for the express purpose of improving community health." The IRS further notes that "such services do not generate inpatient or outpatient revenue, although there may be a nominal patient fee or sliding scale fee for these services." The IRS definition of community health improvement services traditionally has been aimed at services that are directed at individuals, that can improve their health, and for which no expectation of payment exists. Examples would be screening mammography through a van that operates in the community or health education classes for people with diabetes.

The term "community health improvement" also encompasses expenditures incurred in connection with community benefit administration by the hospital, including costs connected to the development of the community health needs assessment, community benefit program operations, and activities in connection with fundraising for community benefit programs. (The IRS notes that "activities or programs cannot be reported [as community health improvement or community benefit operations] if they are provided primarily for marketing purposes or if they are more beneficial to the organization than to the community.") As **Table 1** shows, in 2011 hospitals reported spending 0.41 percent of their total reported expenditures for a combination of "community health improvement" and community benefit operations. This amount totaled 4.2 percent of total community benefit spending that year. Since the two activities are reported in a single line, it is not possible to know how much hospitals are spending to support community benefit operations versus the amount that goes toward community health improvement itself.

Health professions education. **Table 1** shows that in 2011, the IRS reported that hospitals allocated about 1.43 percent of total hospital spending (14.8 percent of community benefit spending) for community benefits consisting of health professions education, making this spending category the third largest that year. The size of this category of community benefit allocation is not surprising, since under the IRS definition the category includes not only programs that train degree and certificate health professions students but also continuing education programs necessary to retain licensure or certification. Programs operated exclusively for hospital employees cannot be counted, although intern and resident training programs can be counted.

Subsidized health services. Subsidized health services as a community benefit are distinguished from financial assistance at cost. Under the IRS definition, a subsidized health service means "clinical services provided despite a financial loss to the organization." The IRS considers services to be subsidized health services if they meet a community need and if, in the absence of the service, the community would lack it or have insufficient access to the service, or government would have to step in to finance the service. Examples would be health care services that are essential for all community residents regardless of their insurance status, such as neonatal intensive care, trauma care, and emergency care. Also covered by the definition are "satellite clinics designed to serve low income communities" and "home health programs." In other words,

subsidized health services can generate revenue for the hospital, but they nonetheless operate at a loss. In reporting expenditures in connection with subsidized health programs, hospitals must adjust their spending to remove other expenses reported as Medicaid, financial assistance, or bad debt. The IRS reports that in 2011 hospitals spent 0.79 percent of their total spending on subsidized health services, or 8.2 percent of total community benefit spending.

Research. The community benefit definition of research sets it aside from internal quality improvement studies that produce proprietary information for use by a hospital alone. Research, as defined by the IRS, reflects the definition found in federal research policy; that is, the research undertaking must have as its goal generating "increased generalizable knowledge made available to the public" and must be funded by a nonprofit organization or government entity. It is not necessary that the research undertaking in question be identified by communities as research that improves community health. According to the IRS, research as a reportable community benefit stood at 1.3 percent of total hospital spending in 2011 (13.4 percent of total community benefit spending that year), making it the fourth largest community benefit category.

Cash and in-kind contributions for community benefit. The final category of "other" community benefit consists of cash and in-kind contributions defined as hospital contributions "to health care organizations and other community groups restricted, in writing, to one or more of . . . community benefit activities." In other words, the IRS considers it a community benefit for hospitals to give funds to outside health care or other community organizations in furtherance of activities that fall within the definition of community benefit. Payments made in the normal course of business and that involve a hospital business need, would not be considered a community benefit. The fundamental thrust of this category is payments made to further a shared community benefit mission. This category represents the smallest of all community benefit spending categories, amounting to 0.30 percent of total hospital spending in 2011, and 3.1 percent of total community benefit spending that year.

Schedule H (Form 990): Part I Categories

Financial Assistance and Means-Tested Government Programs

- Financial Assistance at Cost
- Medicaid
- Cost of Other Means-Tested Government Programs

Other Benefits

- Community Health Improvement Services and Community Benefit Operations
- Health Professions Education
- Subsidized Health Services
- Research
- Cash and In-Kind Contributions for Community Benefit

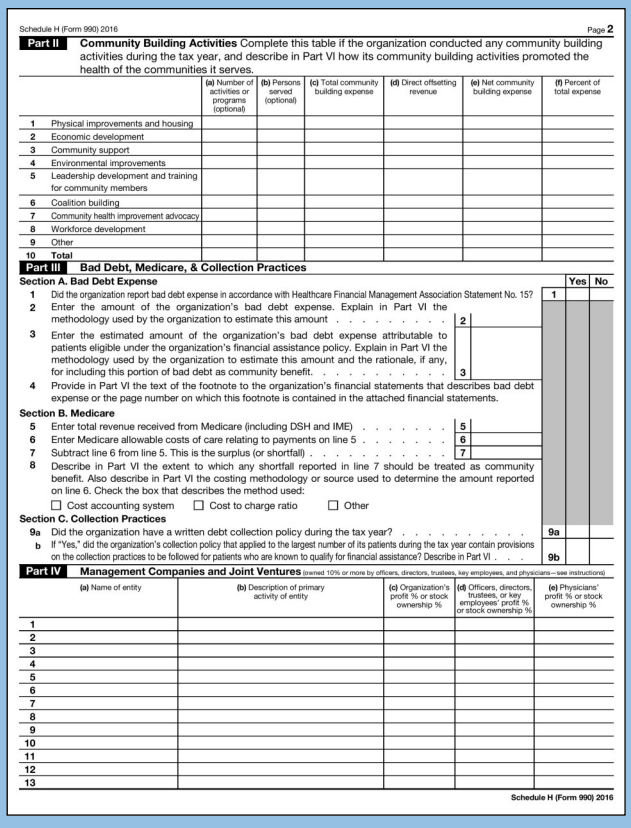
Community Building versus Community Benefit: Ambiguity and Overlap

In addition to Part I of Schedule H, which sets forth the definition of community benefit spending, the IRS also recognizes a separate category of spending, known as "community building." These community building activities are reported in a separate section of Schedule H (Part II, **Figure 3**) and are defined as activities to "protect or improve the community's health or safety."[33]

IRS policy on what constitutes "community health improvement" types of spending -- and thus are to be reported under Part I -- versus what amounts to "community building" activities and thus must be separately reported under Part II – is ambiguous. This ambiguity regarding what can be reported as a Part I community benefit expenditure is crucial, since federal and state regulators look to reporting as a means of measuring hospital compliance with federal tax law. Furthermore, researchers and the public look to community benefit spending as a measure of how hospitals give back to their communities.[34]

In its instructions for completing Part II of Schedule H (community building, shown in **Figure 3**), the IRS notes that certain community building expenditures "are not reportable" under Part I. (Community building activities reported under Part II rather than Part I (whatever they may be) are to be accompanied by a further hospital explanation under Part VI of Schedule H, which collects general information on a range of hospital activities.) At the same time, however, and in the same instruction, the agency states that "some community building activities may also meet the definition of community benefit,"[35] but offers no further explanation regarding what these "other" expenditures might be, from its perspective.

Figure 3. IRS Schedule H (Form 990), Part II: Community Building



Schedule H (Form 990) 2016 Page 2

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

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

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense — Yes / No

1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? 1

2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount . . . 2

3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit. . . . 3

4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME) . . . 5

6 Enter Medicare allowable costs of care relating to payments on line 5 . . . 6

7 Subtract line 6 from line 5. This is the surplus (or shortfall) . . . 7

8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:

☐ Cost accounting system ☐ Cost to charge ratio ☐ Other

Section C. Collection Practices

9a Did the organization have a written debt collection policy during the tax year? . . . 9a

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

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

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

Schedule H (Form 990) 2016

[33] 2015 Schedule H Instructions, p. 4, available at https://www.irs.gov/pub/irs-pdf/i990sh.pdf (Accessed August 15, 2016)
[34] Gary Young et al. (2013). Provision of Community Benefits by Tax-Exempt U.S. Hospitals. *New England Journal of Medicine*, 368 (16): 1519-1527. http://www.nejm.org/doi/full/10.1056/NEJMsa1210239#t=article (Accessed August 15, 2016)
[35] 2015 Schedule H Instructions, op. cit.

Given the understandable concern regarding being in compliance with IRS policy for tax-exempt organizations, and therefore, avoiding any conduct or practice that might be viewed as misrepresenting the magnitude of their community benefit activities, hospitals might be naturally inclined to limit community health improvement spending to those types of activities that clearly appear to constitute community health improvement. These would be the traditional patient-related activities that fall squarely within the IRS definition of community health improvement. The ambiguity of the IRS instructions, the lack of clarity regarding what constitutes "community health improvement" versus "community building", and the actual separation of Parts I and II of Schedule H, could suggest to hospitals that the safer course is to limit community health improvement to traditional activities associated with clinical care and patient supports rather than broader efforts to improve community health. Indeed, the existence of a distinction, for reporting purposes, between community benefit (Part I) and community building (Part II) creates a strong inference that community building somehow lies outside the scope of community benefit. This inference is further enforced by the fact that the IRS does not explain in any detail when community building can, in fact, be reported as community benefit. And yet, community building activities undertaken in response to clearly identified community need and that do not produce meaningful revenue for hospitals fit well within the definition of community health improvement.

In response to this ambiguity, leading hospital associations have provided guidance to members to clarify the types of "community building" interventions that might qualify as community health improvement given their impact on the underlying conditions of health.[36] The IRS also has, on occasion, attempted to shed further light on particular types of community-building activities that might satisfy the community health improvement test.[37] For example, in response to queries, the agency has confirmed that "some housing improvements and other spending on social determinants of health that meet a documented community need may qualify as community benefit for the purposes of meeting the community benefit standard."[38] But occasional agency response to specific questions does not amount to the type of comprehensive guidance hospitals need in order to bring certainty to the types of community building activities that count toward meeting their community benefit obligations.

To be sure, under principles of law applicable to charitable organizations,[39] it is essential to distinguish between hospital expenditures that primarily benefit the health of a community and those that are intended to help a hospital in its marketing or business operations or that are undertaken in connection with a revenue-producing activity for the hospital. This is true for all types of community health improvement efforts, regardless of whether

[36] See e.g., Catholic Health Association, A Guide to Planning and Reporting Community Benefit (2015 ed.)
[37] See, e.g., Letter to the Honorable Keith Ellison from John Koskinen (February 17, 2016) regarding supported housing as a community benefit. See also Exempt Organizations Policy (December 18, 2015) https://www.irs.gov/charities-non-profits/exempt-organizations-update-archive
[38] Exempt Organizations Update Archive, IRS. https://www.irs.gov/charities-non-profits/exempt-organizations-update-archive
[39] Sara Rosenbaum and David Frankford, Sylvia Law, and Rand Rosenblatt, Law and the American Health Care System (Foundation Press, 2012; 2012-2016 Update)

Hospitals have the potential to serve as what leading policy figures have termed "hubs," with the capacity to influence not only the accessibility and quality of health care, but also the overall health of communities through activities that address the "upstream" factors that influence health.

the benefit to be gained is structured to flow primarily to individuals or to the community as a whole, such as environmental and housing improvements.

But, this is true for all forms of community benefit spending. Hospitals may offer free patient education classes primarily to benefit their community or as a marketing strategy. Similarly, hospitals may invest in supportive housing primarily to generate revenues through an affiliated joint venture, or they may do so primarily to support the most vulnerable community residents. In either case, the questions for charitable exemption purposes remain the same: What is the primary purpose of the activity? Most crucially, perhaps, is the activity based on a documented community need such as evidence gained from the community health needs assessment process? Will the activity generate revenue for the hospital or is it being conducted at a net loss? Is the hospital alleviating the burden placed on government through its charitable actions? Activities undertaken for business reasons clearly cannot be reported as a community benefit. But, from a tax law perspective, the same questions would arise regardless of whether the claimed community benefit is free lead screenings for children living in Flint, Michigan versus a water filter replacement program for Flint's families. Is the hospital's activity a response to a documented community need or one based on a business decision?

The Growing Role of Hospitals as Community Health Actors

As the IRS data show, in allocating their community benefit spending, hospitals overwhelmingly focus on financial assistance for patients, offsetting reported losses from Medicaid participation, research, and health professions education. Taken together, the community health improvement activities and cash and in-kind contributions to support such activities, as reported under Part I, reflect less than 1 percent of total hospital spending and less than 8 percent of total community benefit spending. Furthermore, under the current definition of community health improvement, hospitals' reported expenditures also include the cost of community benefit program administration, meaning that the amount actually spent on improving community health, whatever the definition, cannot be ascertained.

However, there is reason to believe that, over time, these historical patterns may begin to change. As noted, the CHNA process, with its broad definition of community health need and its implementation strategy requirement, is leading hospitals to broaden their scope of vision to include needs that operate at a broad community level and to implement strategies that help address those needs, often in partnership with organizations and agencies specializing in social welfare programs and services. Furthermore, health care financing restructuring is pulling hospitals toward a more holistic vision of their actual and potential patients: payment reforms that promote better and more stable post-discharge health; bundled and global payments that, at least indirectly, encourage hospitals to keep people healthier to begin with before they become patients; and the growth of integrated systems that can bridge health and social services. In the wake of these reforms – and in some cases well before the reforms were enacted – some hospital systems have taken on a leadership role in promoting hospital involvement in community-wide health improvement. The question is whether there are changes to tax policy that might further accelerate hospitals in this direction.

There are important examples of this trend. One is a special initiative launched by Trinity Health in 2016 to "encourage policy, systematic and environmental changes to promote healthy behaviors and reduce tobacco use and obesity," two of the "leading drivers of preventable chronic disease and high health care costs in the United States."[40] The Trinity Health Initiative, financed with special funding provided from the corporate parent to its hospitals, is designed to create community partnerships capable of carrying out multi-sector interventions aimed at tobacco reduction, transportation improvement, improving nutritional standards in early childhood development settings, improving workplace and community support for breast-feeding, and expanding school-based physical activities. Another example is individual hospitals and health systems in Massachusetts, which through separate planning efforts, have identified food insecurity with frequency in their needs assessments and report a wide range of activities aimed at making healthy food more accessible in their communities.[41] In yet another example, Dignity Health has

[40] See, Trinity Health Grant Initiative Seeks Community Transformations," https://www.chausa.org/publications/catholic-health-world/article/march-15-2016/trinity-health-grant-initiative-seeks-community-transformations (Accessed August 12, 2016)

[41] Center for Health Law and Policy Innovation, Hospital Community Benefit: Addressing Nutrition as a Primary Community Health Need, http://www.chlpi.org/wp-content/uploads/2014/01/Hospital-Community-Benefit-issue-brief-06.2015-V3.pdf (Accessed August 15, 2016)

undertaken initiatives to improve economic development, child care, and the development of supportive housing through an extensive array of partnerships that enable its hospitals and other community providers to integrate health and social services.[42]

Social Determinants as a Prioritized Health Need in Current Hospital CHNAs

A wealth of literature has documented the relationship between health outcomes and how they are influenced by underlying social conditions.[43] Research now shows that the presence or absence of health is not limited to a doctor's office, but instead starts in the homes, neighborhoods, and schools of communities where features such as safe housing, access to nutritious food and physical activity opportunities, and quality education lead to better health outcomes. Hospitals are recognizing that these broader social, economic, and environmental conditions have a tremendous impact on the health of their community, and recognize that investments in social interventions lead to much better health outcomes.

Nationwide Analysis of CHNAs

In order to better understand this growing trend on the part of hospitals themselves toward more upstream health spending as a form of community health improvement, we conducted a nationwide analysis during the summer of 2016, whose purpose was to examine the frequency with which issues related to the social conditions of health are identified as priorities in hospital community health needs assessments. In carrying out our analysis we built upon earlier work by the Health Research and Education Trust (HRET) and the Robert Wood Johnson Foundation,[44] which examined the first round of hospital CHNAs from Tax Year 2012 and reported on the emergence of problems linked to social determinants as high-priority community needs.

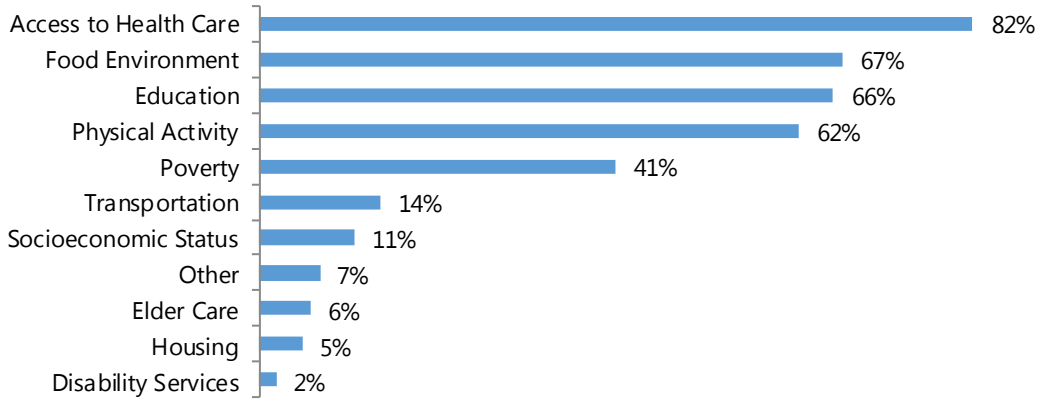
We randomly sampled 300 tax-exempt hospitals from across the country, representing diversity in geographic area, urban/rural designation, and hospital size, to determine which priorities hospitals identified in the most recently available CHNAs. Our expectation was that, once again, the planning process in the second round of needs assessments (which are required every three years under law) would reveal as the HRET report revealed a high degree of focus on the social, economic, and environmental challenges that underlie the health of community residents.

[42] Eileen Barsi, Dignity Sets Strategies to Better Serve the Poor (Catholic Health Association, 2016) https://www.chausa.org/publications/health-progress/article/november-december-2012/dignity-sets-strategies-to-better-serve-the-poor (Accessed August 15, 2016)

[43] Heiman, H. and Artiga, S. (2015). Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Retrieved from http://kff.org/report-section/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity-issue-brief/; Braveman, P., Egerter, S. and Williams, D.R. (2011). The Social Determinants of Health: Coming of Age. *Annu. Rev. Public Health,* 32:381-98. Retrieved from http://scholar.harvard.edu/files/davidrwilliams/files/2011-the_social_determinants-williams.pdf; Bradley, E.H., et al. (2015). Variation in Health Outcomes: The Role of Spending on Social Services, Public Health, and Health Care, 2000-09. *Health Affairs,* 35(5): 760-768. Retrieved from http://content.healthaffairs.org/content/35/5/760.long; Braveman, P. and Gottlieb, L. (2014). The Social Determinants of Health: It's Time to Consider the Causes of the Causes. *Public Health Rep.,* 129(Suppl 2):19-31. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863696/ (Accessed August 15, 2016)

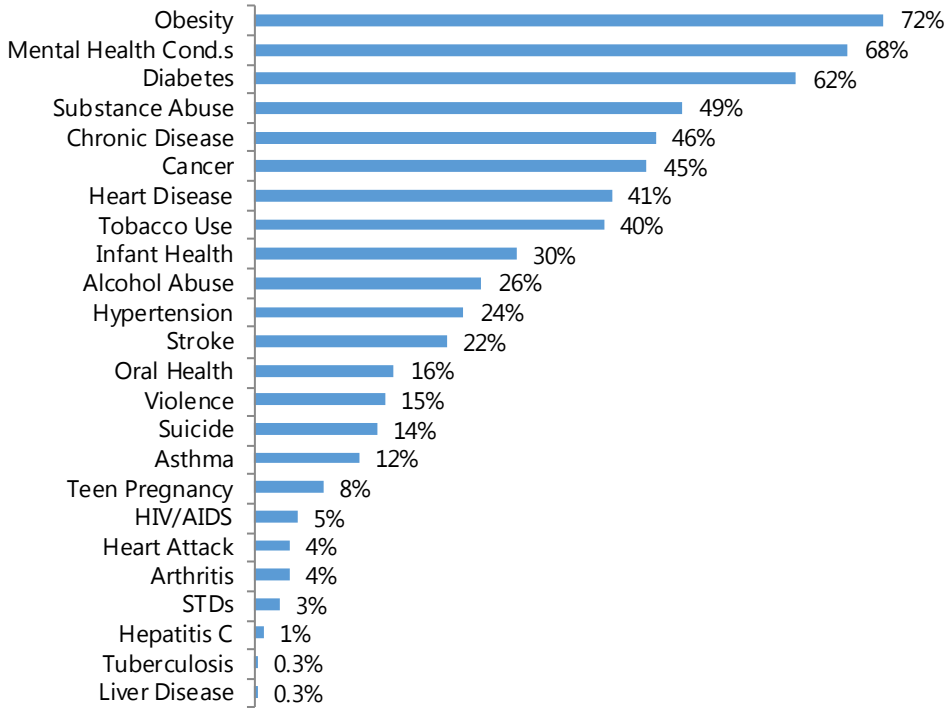
[44] HRET and Robert Wood Johnson Foundation, Hospital-Based Strategies for Creating a Culture of Health (2014), http://www.hpoe.org/Reports-HPOE/hospital_based_strategies_creating_culture_health_RWJF.pdf (Accessed August 15, 2016)

Figure 4. Community Health Needs: Challenges Identified in Hospital CHNAs



SOURCE: 2016 George Washington University Analysis of Hospital CHNA Data

Figure 5. Community Health Needs: Health Conditions Identified in Hospital CHNAs



SOURCE: 2016 George Washington University Analysis of Hospital CHNA Data

In carrying out our research we created a list of search terms based on a comprehensive literature review of the social determinants that impact health. The final 35 search terms include both the drivers of health conditions and the resulting health outcomes, which we searched for in each hospital's CHNA. We documented these community health needs identified in the CHNAs during our data collection process, and conducted analyses on the data to determine which community health needs were identified most often by hospitals across the country. Our findings are reported in **Figures 4** and **5**, and a more detailed study methodology can be found in the **Appendix**.

We also documented whether the needs identified by hospitals varied by the hospital's size, urban/rural designation, or geographic location; these additional findings can also be found in the **Appendix**.

Findings:

- *Access to health care*, *food environment*, *education*, and *physical* activity were the most common challenges identified by hospitals in their CHNAs, and more than half of all hospitals studied identified these top four challenges as significant drivers of health outcomes.
- Seventy-two (72) percent of hospitals identified *obesity*, 68 percent identified *mental health*, and 62 percent identified *diabetes* as the most prevalent health conditions in their communities.
- Just under half of all hospitals studied identified *substance abuse*, *chronic disease*, *cancer*, *heart disease*, and *tobacco use* as prioritized health conditions.

These results are consistent with the public health literature about social conditions and their relationship with health outcomes. In their CHNAs, hospitals both identified the most prevalent health conditions and the underlying social and environmental challenges in their communities that create them (for example, hospitals identified obesity and diabetes as health issues, as well as challenges with the food environment and the opportunity for physical activity). Our findings suggest that hospitals recognize that to tackle the community's health conditions, community health actors must address the larger environment in which community residents exist.

What the analysis of CHNAs cannot tell us, of course, is what types of challenges hospitals may face in developing the range of community health improvement relationships essential to building partnerships for community-wide health improvement efforts. Clearly hospital expertise and capabilities lie in the provision of health care. Responding to documented need to address the social conditions of health requires a different type of capability as well as roots in the social context of communities. Certainly as part of patient care, hospitals have relationships with a wide array of community health actors, from social service and welfare agencies to schools, correctional institutions, and other important institutions. But, having a patient care relationship is obviously different from developing one in which a hospital is part of a broader effort to tackle social challenges that bear on health. Hospitals are beginning to grow this type of capability, as the examples cited previously suggest. But, an important part of responding to broader health needs, which will be discussed in the policy opportunities section that follows, concerns the value of clearer IRS policies around community health improvement as a stimulus for propelling such relationships forward.

Policy Opportunities: Strengthening Hospitals' Role in Improving Community Health

Under the Internal Revenue Code, the IRS has broad authority to set community benefit policy. Specifically, this authority rests with the IRS Tax Exempt and Government Entities Division. The opportunities we describe here have two overarching goals. The first goal is to move to a definition of community health improvement, for purposes of community benefit spending, which fully embraces both patient-specific clinical care health supports, and activities that promote the health of communities as a whole. The second goal is to develop the range of policies and guidelines that actively encourage tax-exempt hospitals to contribute to and participate in community-wide efforts that emerge through the community health needs assessment process and that lift the health of communities as a whole. Through such changes, hospitals would be further incentivized to develop the range of relationships with community health partners that are indispensable to initiatives that are designed to improve health on a community-wide basis.

In order to achieve these goals, we have identified a series of policy opportunities that have several aims:

- First, to put community benefit spending to work in ways that can advance solutions to the community health needs that have emerged from the CHNA process.
- Second, to bring greater transparency to community benefit spending.
- Third, to better align hospitals' community benefit policies with the broader goals of meaningful health reform, by encouraging an expanded role for hospitals in fulfilling the far-reaching goal, embodied in the Triple Aim, of better health, better health care, and lower costs.[45]

Policy Opportunity 1. Broaden the definition of community health improvement

The IRS could resolve the ambiguities it has created in Schedule H by eliminating the distinction between community building and community health improvement. This could be accomplished by broadening the definition of community health improvement to encompass activities that improve patient or community health, are undertaken in response to a documented community health need (including needs identified through the CHNA process), are not undertaken primarily to advance a hospital's business interests, and that benefit patient or community health. Falling within this expanded definition would be both activities that assist people in gaining access to care or that improve patient outcomes, as well as activities that protect or improve community health and safety. Today, this latter group of activities is classified as community building; yet at the same time, IRS community building policy at best barely acknowledges hospitals' ability to report such activities as a form of community benefit spending and

[45] Institute for Health Improvement, Triple Aim, http://www.ihi.org/engage/initiatives/tripleaim/pages/default.aspx (Accessed August 19, 2016)

lacks the type of detailed guidance that would enable hospitals to distinguish between community building activities that are reportable community benefits and those that are not. As a result, hospitals, out of an abundance of concern over matters of tax compliance and mindful of the problems that can flow from overstating community benefit activities, may understandably veer away from expenditures whose classification is uncertain at best.

The IRS could move forward with a more explicit and comprehensive policy that acknowledges community-wide health efforts as a form of community benefit activities, by merging the community building section of Schedule H (Part II) into the description of community health improvement under the community benefit spending section of Schedule H (Part I). Such a change would eliminate the uncertainty that now confronts hospitals regarding whether expenditures aimed at promoting health on a community–wide basis can be included as a form of community benefit spending. Such a change also could ensure that hospitals that do engage in such activities can fully claim credit for such undertakings as a community benefit expenditure. This revision also would be consistent with the IRS regulation, noted above, that encourages hospitals, in preparing their CHNAs, to focus on the requisites for community health improvement, as well as on patient care needs within their service areas. In order to further underscore this shift and bring even greater transparency to community health improvement spending, the IRS could revise Part I to identify the specific types of activities now identified in Part II: physical improvements and housing, economic development, community support, environmental improvements, and workforce development. Other broad community building categories for the IRS to consider would be community support assistance to the elderly, persons with disabilities and serious and chronic conditions that elevate risk of institutionalization, and child and adolescent development.

Also of relevance to this expanded definition of community health improvement would be hospital support for community entities that have been structured to promote strategic community development through integration of financing across a broad range of funding sources, including health and health care, nutritional supports to reduce food insecurity, housing and social services, economic development, education and child development. This concept, which has been referred to as a "community quarterback" has been explicitly recognized by the Federal Reserve as playing an important role in advancing broader community health and well-being.[46]

In order to encourage hospitals to spend on activities that more broadly promote community health, the IRS also could consider exempting from offsetting revenues restricted grants and funds that the hospitals receive in order to support community-wide health improvement efforts that involve contributions to organizations and agencies whose mission is to engage in such activities. This type of spending is distinct from hospital spending to expand the availability of clinical or patient support services into communities on a free or nominal-fee basis. When a

[46] Speech by Federal Reserve Chair Janet Hellen to the National Interagency Community Reinvestment Conference, Chicago IL (March 31, 2014), available at http://www.federalreserve.gov/newsevents/speech/yellen20140331a.htm (Accessed August 15, 2016)

hospital uses revenues it receives (for example, from the proceeds of an endowment held by a parent corporation) to support community-wide activities (such as support for farmers markets, assistance in developing supportive housing, or assistance to coalitions working to reduce tobacco use or reduce obesity), the hospital is not enhancing its own work; instead, it is enabling the work of others. In these situations, hospitals may implement programs that support community health, but they are not engaged in the types of activities that hospitals themselves carry out. In such cases, hospitals should be able to report such expenditures without having to show offsetting revenues, since the funding is restricted to activities led by other organizations.

Policy Opportunity 2. Bring greater transparency to community benefit reporting

Individual hospital facilities must report on their CHNA-related activities under Part V of Schedule H. Separately, under Part I, hospital organizations must report on their community benefit spending. The IRS does not connect the two activities. In other words, the IRS does not ask hospitals to report on what proportion of their community benefit spending is conducted in connection with a community health need identified through the community health needs assessment process. The situation is made more complex by the fact that hospital systems that encompass multiple hospital facilities can aggregate their community benefit reporting activities; under such circumstances, individual communities are unable to determine what percentage of the organization's community benefit spending was returned to their specific community.

The purpose of the CHNA requirements goes well beyond simply encouraging hospitals to find out about community needs. The implementation strategies that accompany the CHNA must explain what a hospital intends to do to advance the high priorities identified through the CHNA process. An important question thus becomes to what extent the CHNA process actually results in shifts in hospitals' own community benefit spending choices, particularly in the case of hospitals that have begun to realize some economic relief from insurance reform. Although many sources of information may help hospitals prioritize community health need, the CHNA process is designed to encourage community-wide input and thus its result merits special attention already accorded it through the ACA Internal Revenue Code amendments and implementing regulations.

In order to address this basic disconnect between needs assessment and community health improvement spending, the IRS could add a reporting element to Part I of Schedule H that would instruct hospitals to provide an estimate of organizational expenditures attributable to each one of the priority health needs identified in their CHNAs. In the case of hospital systems that report community benefit spending in the aggregate for all facilities under Part I, the IRS could further transparency at the facility level by revising Schedule H, which does apply on a facility-specific basis, to include information from each facility regarding the CHNA-related community benefit expenditures made by the organization's facility serving that community. With these changes, the IRS thus would enable individual communities served by hospitals that are part of multi-facility systems to better understand the relationship between the needs identified

in their hospital CHNAs to the parent organization's community benefit spending allocations.

The IRS could further the goal of community benefit spending transparency by revising its rules[47] to adopt the same "widely available" standard for hospital implementation strategies that applies to the CHNAs. Under current rules, CHNAs must be made widely available; however, the IRS does not extend this standard to implementation strategies, essentially the blueprint for transforming CHNA priorities into action. The ACA amendments themselves define the implementation strategy as part of the CHNA process itself, giving the IRS the authority it needs to make the implementation strategy step as transparent as the CHNA.

Finally, because transparency is a touchstone of modern health policy thinking, the IRS could revise Part I to specify that hospitals separately report expenditures in connection with community benefit program administration apart from their expenditures on community health improvement. Costs associated with administering community benefit programs in their entirety are necessary and appropriate. But, just as insurers must now separate their medical and quality improvement spending from their administration costs, so, too, is it appropriate that hospitals provide their communities with information regarding what it costs to run their community benefit programs overall, separate and apart from what they spend to actually improve community health.

Policy Opportunity 3. Establish community-wide health improvement guidance, along with goals and metrics for reallocating community benefit spending toward a broader set of community health improvement activities

As an authority no less than the United States Supreme Court has noted,[48] in the modern health care system, tax policy is health policy. As the health policy landscape evolves in the wake of health reform, community benefit policy also should evolve, informed by a wide lens and carried out across various policy realms.

The history of community benefit policy itself underscores this fact. Originally hospital obligations focused on charity care, a crucial activity in the absence of health insurance. As public and private health insurance coverage grew, the IRS updated charitable policies for tax-exempt hospital organizations in order to broaden the scope of what it means to be a charitable hospital to reach activities that benefit communities as a whole, such as research and health professions education. With the CHNA amendments, Congress indicated its strong preference for a broader vision still; even as the ACA amendments have reaffirmed charitable patient care as an essential element of tax exemption, the law also creates a role for hospitals that goes beyond activities in which they traditionally have engaged and establishes a broader place for hospitals in their communities' overall health. Under the Internal Revenue Code, as revised, hospitals are now expected to look outward

[47] 26 C.F.R. § 501(r)-3
[48] *King v Burwell* 576 US ___ (2015)

through a formalized health planning process that considers not only health care access but the conditions under which people live and work. And, they are expected, through implementation strategies, to act on what they find.

To bring community benefit policy into alignment with these broader health goals is, as noted, in keeping with the IRS' own CHNA rules. But, it also will require expertise beyond what the IRS alone possesses. Community benefit spending practices should position hospitals not only as health care providers attuned to patients' holistic needs, but as a portal into the health needs of their communities and as partners at the health improvement table.

To this end, the IRS could establish an interagency advisory committee consisting of experts drawn from across the federal government to advise the agency on an ongoing basis regarding the categories of community-wide health improvement community benefit spending that the agency should actively encourage as a form of community benefit, as well as development of specific examples of community-wide health improvement practices that the agency seeks to encourage. As a regulatory agency, the IRS is accustomed to making "facts and circumstances" findings in individual cases. But, transforming community benefit spending in order to promote reallocation toward community-wide health improvement will require an effort of a different kind than individual responses to individual inquiries. As regulated entities, hospitals need proactive guidance and some degree of prospective certainty. Just as regulatory agencies use "safe harbor" and "safety zone" concepts to nudge regulated entities toward compliance, the IRS can draw on experts to develop a compilation of policies that exemplify community health improvement. The policies obviously need not be exclusive, since innovation in community health is valued. But, the IRS could develop broad categories of recognized community-wide health improvement spending and could present hospitals with information on specific types of recognized initiatives within these categories.

To create this type of policy framework for community benefit spending, the IRS could draw on experts from across the federal government: experts in food and nutrition from the United States Department of Agriculture; experts in public health, mental health, community health, aging, human services, and child development from the United States Department of Health and Human Services; experts in housing and housing support from the United States Department of Housing and Urban Development; experts in education and child development from the United States Department of Education; experts in community transportation from the United States Department of Transportation; experts in job creation and employment from the United States Department of Labor; experts in veterans health from the United States Department of Veterans Affairs; experts in community development and community reinvestment from the United States Treasury Department and the Federal Reserve; experts in environmental health from the United States Environmental Protection Agency; and those with expertise in interventions that address the social conditions of health from other agencies. This interagency group could in turn consult with outside experts in health and health care to create a rich body of classifications and examples to guide

hospital activities. The IRS could also draw on the expertise of the National Prevention Council, established under the ACA to advise the government on health matters.

Working with its advisors, the IRS could develop recognized community health improvement spending categories for inclusion in Schedule H, as well as specific examples of community health improvement spending that are under way and recognized as falling within Part I. The agency could also create a broad set of principles to guide hospitals as they move forward. In articulating the criteria to apply to community health improvement activities, the agency could emphasize interventions that: have been shown to have a reasonable evidence of effectiveness; have been shown to produce successful outcomes; are feasible; and have the potential to contribute to health improvement. Community health improvement spending guidance must not hold hospitals to the highest evidentiary standards used in randomized controlled trials; what should be encouraged are activities that reflect high priority community needs, have a track record in measurable outcomes, and show promise through research and evaluation. The CDC[49] and other agencies have already done much to develop such information. For example, the CDC's Health Impact in 5 years (HI-5) initiative highlights non-clinical, community-wide approaches that have evidence reporting positive health impacts, results within five years, and cost effectiveness or cost savings over the lifetime of the population. HI-5 recommends activities such as school-based programs to promote physical activity and prevent violence, multi-component obesity prevention, and public transportation introduction or expansion.[50]

Given our earlier findings regarding the priorities that have emerged from hospitals' CHNAs, priority areas of focus might be the food environment, education, physical activity, poverty amelioration, services for the elderly and persons with disability, and housing. Key health conditions that should also be the focus of such an effort to identify community-wide health improvement interventions that would be immediately classifiable as Part I community benefit expenditures would be obesity, mental health and substance abuse, diabetes, cancer, tobacco use, oral health, violence, and infant and child health. Hospitals could, of course, identify other activities that they believe merit classification as community health improvement and provide justification to the IRS. But, we simply know too much about promising interventions to burden every reporting hospital organization with the obligation to continually justify such expenditures.

A second major task for an interagency working group could be to develop measures that encourage hospitals who seek to rebalance their community benefit spending portfolios. Federal law contains no minimum community benefit spending requirement thresholds, although some states do set minimum requirements. In 2011, hospitals devoted only 4.2 percent of total community benefit spending to community health improvement, less than one half of one percent of total hospital spending. Were the concept of community health improvement spending to be

[49] See, e.g., the CDC's Guide to Community Preventive Services, https://www.thecommunityguide.org/ (Accessed October 11, 2016)
[50] Centers for Disease Control, HI-5, http://www.cdc.gov/policy/hst/hi5/ (Accessed October 11, 2016)

broadened to clearly include activities that benefit communities as a whole, and were hospitals actively encouraged through policy guidance to spend on activities that promote health, then hospitals and communities also could benefit from metrics that guide the reallocation process.

To be sure, these changes would happen only over time, but community benefit spending is a long-evolving policy. Thus, as the need for charity care and the demand for uncompensated care begins to decline in communities, reallocation guidance might help hospitals capture their savings and increase their community health improvement spending. The number of uninsured Americans remains too high, and many are experiencing under-insurance as a result of their insurance policies' high cost sharing requirements. They will continue to need financial assistance. But, improved insurance coverage will bring room for change. Furthermore, to the extent that payment reform initiatives produce greater hospital efficiencies and a decline in the cost of admissions, these savings could translate into reduced Medicaid shortfalls and a concomitant growth in spending on health improvement activities that benefit a poor population more generally. In other words, community benefit spending should not go down in the wake of reform; it should just look different. Experts could advise the IRS on how to guide hospitals through such a rebalancing effort.

The public has an enormous interest in community benefit policy; indeed, in 2011 taxpayers nationwide invested nearly $25 billion in tax-exempt hospitals. It also can be measured in the growing public interest in the question of hospital community benefit spending. Indeed, this level of interest is expected to grow. The Robert Wood Johnson Foundation is expected to launch a community benefit online resource that will provide easy access to the community benefit spending information that hospitals report to the IRS.

As greater transparency comes to hospital community benefit spending, and as hospital involvement in community-wide health planning grows, the importance of policy reforms that can more effectively align community health and community benefit grows. The policy opportunities outlined here are designed to encourage hospital integration into the health of their communities. With changing policies could come the new relationships that hospitals will need to develop over time if community-wide health improvement efforts that happen outside the hospital campus are to succeed. The opportunities identified here are designed to help move national policy toward a 21st century vision of what hospitals can become: actors on a larger community health stage.

Appendix

Methods

The most recent publicly available community health needs assessments (CHNAs) for 300 non-profit hospitals were reviewed to assess the frequency with which hospitals identified community health needs, and how the type of community health need varied by the characteristics of the hospital. This sample of 300 hospitals was randomly selected from a list of 1,817 non-profit hospitals that reported community benefit expenditures in 2011. The sample was selected in a manner that proportionally matched the larger list in terms of size (by number of beds), urban or rural designation, and geographic variation (Census regions: Northeast, Midwest, South, and West). We conducted a review of the social determinants of health literature to compile a list of community health needs that would be searched for in the CHNAs. Thirty-five search terms were created to represent community health need, including social and environmental challenges (e.g., access to care, inadequate transportation, poor housing) as well as health conditions (e.g., diabetes, obesity, asthma). Synonyms and related keywords were used when searching for prioritized community health need (e.g., food environment, food insecurity, food desert, poor nutrition, etc.). If the hospital had closed or merged, or if no CHNA was publically available, another hospital with the same size, urban/ rural designation, and geographic location characteristics was substituted in its place to ensure a proportional sample.

Bivariate analyses (X^2 tests) were conducted to determine if the percentage of hospitals identifying each community health need varied according to hospital size (comparing hospitals with fewer than 100 beds to those with 100 or more beds), urban or rural location, whether the hospital is located in a state that has expanded Medicaid, and location by geographic region (Northeast, Midwest, South, and West). Bivariate analyses were limited to only the 17 community health needs identified by more than one-fifth (20%) of the hospitals included in the sample, while multivariate analyses—logistic regression and OLS regression models—were limited to only the five community health needs with more than one statistically significant bivariate finding.

Findings

Appendix Table 1 presents the results of the bivariate analyses for the following 17 community health needs identified by more than 20 percent of hospitals: access to health care, obesity, mental health conditions, food environment, education, physical activity, diabetes, substance abuse, chronic disease, cancer, poverty, heart disease, tobacco use, infant health, alcohol abuse, hypertension, and stroke. Our analysis of the data showed that large hospitals more frequently identified the selected search terms in their CHNAs compared to small hospitals. Urban hospitals more commonly identified almost all of the selected community health needs in their CHNAs compared to rural hospitals, however this difference was only statistically significant for poverty, tobacco use, and infant health. Significant differences by geographic region were found in the frequency by which hospitals identified food environment, education, alcohol abuse, and hypertension. The Northeast identified alcohol

abuse and hypertension significantly more often than any other region. While not statistically significant in most cases, the geographic West had the lowest percentage of hospitals identifying 11 of the 17 analyzed community health needs.

Appendix Table 2 shows the results of the logistic regression and OLS regression models, which were limited to only the five community health needs with more than one statistically significant bivariate finding: food environment, education, poverty, tobacco use, and hypertension. Being a small hospital was significantly associated with identifying food environment (OR: 0.66), education (OR: 0.25), and poverty (OR: 0.13) as prioritized health needs. The variables for urban location and Medicaid expansion did not remain significant in any of the multivariate models. Compared to the reference group of Northeastern hospitals, hospitals in the South had significantly lower identification of food environment (OR: 0.49), hospitals in the Midwest had significantly lower identification of education, and hospitals in both the Midwest (OR: 0.33) and West (OR: 0.15) had significantly lower identification of hypertension as prioritized community health needs.

Appendix Table 1: Bivariate Analyses of Identified Community Health Needs by Hospital Size, Urban or Rural Designation, Current Medicaid Expansion Status, and Census Region

	Hospital Size			Urban/Rural Location			Medicaid Expansion			Geographic Region				
Community Health Needs	Large (100+ beds)	Small (<100 beds)	p value	Rural	Urban	p value	Non-expansion states	Expan-sion states	p value	North-east	Mid-west	South	West	p value
n	165	135		130	170		98	202		69	112	79	40	
Access to Health Care	88%	74%	0.002	78%	85%	0.120	79%	83%	0.335	86%	77%	85%	83%	0.391
Obesity	77%	66%	0.034	72%	72%	0.876	69%	73%	0.483	81%	73%	67%	63%	0.128
Mental Health Conditions	70%	64%	0.280	66%	69%	0.624	64%	69%	0.383	68%	73%	60%	68%	0.262
Food Environment	76%	57%	0.001	62%	71%	0.105	66%	68%	0.796	80%	73%	57%	50%	0.001*
Education	78%	50%	0.000	62%	69%	0.188	66%	65%	0.867	78%	55%	66%	73%	0.012x
Physical Activity	72%	50%	0.000	58%	66%	0.147	62%	62%	0.982	70%	63%	61%	50%	0.234
Diabetes	72%	50%	0.000	58%	65%	0.179	62%	62%	0.951	70%	55%	67%	58%	0.173
Substance Abuse	53%	45%	0.194	50%	49%	0.840	48%	50%	0.740	64%	47%	48%	33%	0.015
Chronic Disease	59%	30%	0.000	40%	51%	0.054	48%	46%	0.694	57%	42%	48%	38%	0.165
Cancer	53%	35%	0.001	46%	44%	0.725	44%	46%	0.785	54%	40%	51%	33%	0.083
Poverty	60%	19%	0.000	33%	48%	0.011	37%	44%	0.260	52%	38%	35%	43%	0.180
Heart Disease	52%	28%	0.000	38%	44%	0.263	34%	45%	0.061	49%	38%	43%	35%	0.358
Tobacco Use	46%	34%	0.046	33%	46%	0.025	39%	41%	0.702	48%	40%	43%	23%	0.068
Infant Health	43%	15%	0.000	23%	36%	0.017	26%	33%	0.206	41%	30%	23%	28%	0.127
Alcohol Abuse	25%	28%	0.519	22%	29%	0.166	24%	28%	0.433	46%	25%	17%	15%	0.000†
Hypertension	27%	20%	0.177	25%	23%	0.735	16%	27%	0.037	44%	18%	22%	10%	0.000v
Stroke	28%	14%	0.004	19%	24%	0.370	18%	23%	0.334	29%	18%	24%	15%	0.217

* Northeast significantly higher than South and West; Midwest significantly higher than West
x Northeast significantly higher than Midwest
† Northeast significantly higher than each other region
v Northeast significantly higher than each other region

Appendix Table 2: Results from Logistic Regression and OLS Regression Models

Logistic regression models	Odds Ratio	Standard Error	p value	95% C.I. (lower)	95% C.I. (upper)
Food Environment					
Small hospital	0.66	0.11	0.016	0.47	0.92
Midwest	0.84	0.22	0.518	0.51	1.41
South	0.49	0.13	0.005	0.30	0.81
West	0.57	0.17	0.064	0.32	1.03
Constant	19.00	4.17	0.000	12.36	29.22
Education					
Small hospital	0.25	0.07	0.000	0.14	0.45
Urban location	0.62	0.19	0.118	0.34	1.13
Midwest	0.43	0.16	0.021	0.21	0.88
South	0.59	0.23	0.181	0.27	1.28
West	0.93	0.45	0.882	0.36	2.38
Constant	8.11	3.40	0.000	3.57	18.44
Poverty					
Small hospital	0.13	0.04	0.000	0.07	0.24
Urban location	0.69	0.22	0.232	0.37	1.27
Constant	2.02	0.60	0.018	1.13	3.60
Tobacco Use					
Small hospital	0.75	0.20	0.288	0.44	1.28
Urban location	1.50	0.41	0.142	0.87	2.56
Constant	0.61	0.16	0.062	0.36	1.03
Hypertension					
Medicaid expansion	1.67	0.61	0.165	0.81	3.43
Midwest	0.33	0.12	0.002	0.16	0.66
South	0.48	0.20	0.076	0.21	1.08
West	0.15	0.08	0.001	0.05	0.46
Constant	0.47	0.20	0.080	0.20	1.09

Milken Institute School
of Public Health

THE GEORGE WASHINGTON UNIVERSITY

Department of Health Policy & Management
2175 K St. NW, Suite 500
Washington, DC 20011