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NEWSLETTER

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Community Benefit and the New IRS Mandate

Historically, not-for-profit hospitals and academic medical centers have been exempt from federal income taxes because of their mission and commitment to provide health services and outreach activities designed to address and improve community health, particularly for people who are most in need, such as the poor and those without adequate access to health care. Examples of how hospitals fulfill their mission and community benefit commitment in return for tax-exempt status include: charity care (uncompensated care), cash/in-kind contributions to community groups, health professional education, community-building activities that improve health and quality of life, generalizable research funded by tax-exempt sources, and providing outreach services designed to improve specific population health needs.[1,4] However, there has been growing concern that some hospitals' community benefit contributions may not be sufficient to warrant their tax-exempt status.[2,3]

In 2009, the Internal Revenue Service (IRS) revised the IRS Tax Form 990, and now requires more rigorous formal financial documentation of community benefit contributions. Hospitals must detail community benefit processes and contributions annually and report these expenditures on the IRS Form 990 and supporting Schedule H. The final specifications for such reporting are pending. In addition, a new federal mandate, Section 9007 of the Patient Protection and Affordable Care Act of 2010, contains requirements that non-profit hospitals must meet as 501(c)(3) charitable organizations. Key new obligations for tax-exempt hospitals include:

- Completion of a community health needs assessment (CHNA) at least once every three years by an individual with special knowledge or expertise in public health.
- Development of a written community benefit plan that addresses identified needs.
- Formal adoption of the community benefit strategic and implementation plan by the hospital's governing body.
- Publication of the CHNA findings and community benefit plan so that it is widely available to the public.
- Demonstration of effectiveness of community benefit efforts.

The CHNA, a pivotal component of the new requirement, is a process to identify and prioritize a community's health needs by collecting and analyzing data, including input from community stakeholders who represent the broad interests for the community (public health professionals, government, academic experts, business, health insurers and community residents). The hospital must list the key individuals/organizations with whom they consulted, describe how and when this information was obtained, and document the analytical methods used to assess the community served and the qualifications of the individual conducting the survey. Information gained from a CHNA is essential to developing an implementation plan that prioritizes and addresses each of the identified needs, with the goal of contributing to improvements in the targeted community's health. If a hospital chooses not to address a given health need, an explanation for this decision is required. Finally, the new rules mandate that the hospital's governing body formally adopt the plan and, once adopted, the report and implementation plan must be made publicly available.

These requirements take effect for tax years beginning after March 23, 2012. Failure to comply will result in a $50,000 excise tax penalty that will be applied to each hospital facility in the organization that fails to satisfy the requirements.

That leaves us to ponder the questions of how hospitals can comply with the new IRS and Patient Protection and Affordable Care Act (PPACA) mandates, and how the new PPACA components will impact community benefit levels given the expected decrease in the number of uninsured and changes in payment reforms.[3]

Since improving the health of the community has always been an integral mission of most hospitals, the majority of the new requirements will most likely be compatible with their historical approaches, particularly for hospitals involved in active healthy community initiatives. However, CHNAs, grounded in health data and community input that meet the new requirements, are not always conducted by hospitals, nor are CHNA results and intervention plans developed based on identified needs formally written and made publicly available. This may be a challenge for hospitals where local data is not readily available and resources to conduct such a survey are costly and/or limited.

In anticipation of these new regulations, Thomas Jefferson University Hospital (TJUH) initiated a Community Benefit Task Force in 2008 that included senior leadership and interdisciplinary representation from across departments. The Task Force has been meeting to create a more formal and systematic approach to addressing community health needs. TJUH has considerable experience with CHNAs, having contracted for Public Health Management Corporation's (PHMC) bi-annual survey in southeastern Pennsylvania for more than 2 decades.[5] TJUH utilizes expertise in the Center for Urban Health (CUH) and the Health Services Planning Department, as well as Jefferson School of Population Health faculty and students to access, analyze, and present PHMC and related demographic data and hospital emergency department data. To supplement the quantitative data, TJUH identified employees who live in or work with target communities and held a series of focus groups to gain their input on key issues. Additionally, the CUH has in-depth experience and contacts in the community that further informs the community health assessment process.

Based on the findings from the first CHNA, the Task Force recommended focusing its community benefit activities on neighborhoods near the

Continued on next page

Jefferson campus, where 20% or more of families are below the poverty level and experience the greatest disparities in health status and access. A plan was created that focused efforts on two neighborhoods with greatest disparities in cardiovascular disease and diabetes. In addition to its traditional community outreach activities – such as health screenings and health promotion programs held predominantly on campus – TJUH works with multiple community partners to develop programs that reflect community need, voice and culture, build on the assets of the community, and are neighborhood-based rather than hospital-based. Projects are planned and evaluated individually based on established baselines set from existing data. The following are examples of TJUH's approach to addressing access to primary care and high rates of cardiovascular disease and diabetes in our communities:

- **Philadelphia Urban Food and Fitness Alliance**
  A community partnership funded by the WK Kellogg Foundation to improve access to healthy affordable food and safe places for physical activity through policy and systems changes. TJUH is conducting community assessments and evaluation of the initiative.

- **Jeff HOPE**
  Since 1992, support from TJUH laboratory, radiology, and pharmacy; 35,000 weekly visits at 5 care sites serving the homeless.[6]

- **Refugee Health**
  Partnership with Nationalities Services Center, and the Department of Family and Community Medicine. Screening and primary care for over 700 refugees from Burma, Iraq, and multiple African countries.

- **Federation of Community Centers**
  JOINED-UP Program (Job Opportunities Investment Network Education in Diabetes in Urban Populations). Diabetes prevention and self-management education for 60 participants in a green workforce development project.

- **Stroke Hypertension and Prostate Education Intervention Team (SHAPE-IT)** *Reached 7,500 African American men in various locations, including polling stations, auto repair shops and barbershops.*

- **Diabetes Self-Management Education**
  Free diabetes education classes and support groups held in churches and Senior Centers, reaching over 1,500 individuals.

- **Cardiovascular Health Literacy Training**
  Leading train-the-trainer programs to enhance health literacy in 15 regional hospitals.

- **Project HOME's Wellness Center**
  Since 1995, support of free primary care and pharmaceuticals for formerly homeless men, women and children, serving over 1,200 individuals annually.

To fulfill the obligations of the proposed new regulations, TJUH will need to make several enhancements, including incorporating information from individuals who represent the broad interests of the community by forming a community advisory group with representation of key community stakeholders, including existing collaborative partners.

While TJUH has developed a three-year community benefit plan, regulations now require that a formal report be written for each hospital entity in the organization that not only documents the interventions and resources that will be utilized, but also the describes the process and criteria used to prioritize community health concerns identified through the CHNA. TJUH's next version of the implementation plan will include the required descriptive information and will be formally presented to the Board of Trustees for their approval. TJUH will communicate the CHNA results and approved implementation plans to the public by posting the written report and other communications on the TJUH website. Finally, reporting requirements include evaluation of community benefit programs. Currently this is accomplished in two ways. First, outreach programs provided by CUH are evaluated on an ongoing basis and modified to increase their reach and effectiveness. Second, TJUH requires all Departments to document their community benefit and leadership activities using the Community Benefit Inventory for Social Accountability software (CBISA) software. Regardless of the final IRS reporting requirements, Jefferson will continue its commitment to improving the health of our communities by structuring programs that have measurable positive impact on the health and welfare of the communities served. If proposed changes in health insurance reduce hospital costs for uncompensated care, the saved community benefit funds could then be reinvested in sustaining or expanding preventive health care services to vulnerable populations beyond the walls of hospitals. ■

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