

Non-profit Hospitals and Community Benefit – What's Next?

The latest federal Internal Revenue Service requirements offer an important new opportunity for non-profit hospitals to improve population health management in their communities by developing Community Health Needs Assessments (CHNAs) and Implementation Plans in collaboration with other hospitals and health systems serving the same communities. This requirement builds on the regulations issued three years ago.

As detailed in 2012,¹ Section 9007 of the Patient Protection and Affordable Care Act of 2010 contained requirements that non-profit hospitals must meet as 501(c)(3) charitable organizations. Key new obligations for tax-exempt hospitals included:

- Completion of a community health needs assessment (CHNA) at least once every 3 years by an individual with special knowledge or expertise in public health.
- Development of a written community benefit implementation plan (IP) 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.

Since that time, non-profit hospitals have performed community health needs assessments and implemented community health improvement plans. These have been posted on hospital websites throughout the country. For example, [Thomas Jefferson University Hospital's](#)

[assessment and plan](#) focuses on improving access to care, chronic disease prevention and management, and healthy lifestyle behaviors and the environment.²

To support hospitals embarking on their population health journey, the [Health Research & Educational Trust](#) and the [Association for Community Health Improvement](#), in partnership with the [Public Health Institute](#), conducted a nationwide survey of hospitals and health care systems to assess the state of population health efforts in 2015. The survey elicited responses from more than 1,400 hospitals and addressed how population health initiatives are structured, partnerships with community organizations, and the process of assessing community health needs.³ The most important use of a CHNA was to integrate population health into the hospital's strategic plan, with 85% of hospitals reporting strong or total commitment to population health or have population health in their vision statement. Although over 90% of hospitals agreed or strongly agreed that population health was aligned with their mission, only 19% strongly agreed that they had the financial resources available for population health, and less than 20% strongly agreed that their hospital has programs to address socioeconomic determinants of health.

Young and colleagues conducted a national study of the level and pattern of community benefits that tax-exempt hospitals provide.⁴ The study comprised more than 1800 tax-exempt hospitals, approximately two-thirds of all such institutions. They used reports that hospitals filed with the Internal Revenue Service for fiscal year 2009 that document expenditures for 7 types of community benefits. They combined these reports with other data to examine whether institutional,

community, and market characteristics are associated with the provision of community benefits by hospitals.

Overall, tax-exempt hospitals spent 7.5% of their operating expenses on community benefits during fiscal year 2009. More than 85% of these expenditures were devoted to charity care and other patient care services. Of the remaining community-benefit expenditures, approximately 5% were devoted to community health improvements that hospitals undertook directly. The rest went to education in health professions, research, and contributions to community groups. The level of benefits provided varied widely among the hospitals (hospitals in the top decile devoted approximately 20% of operating expenses to community benefits; hospitals in the bottom decile devoted approximately 1%). This variation was not accounted for by indicators of community need.⁴

As noted above, only 5% of community benefit activities were devoted directly to community health improvements, but this may be changing. Recent estimates from the Department of Health and Human Services (HHS) indicate that uncompensated care provided by hospitals is estimated to have declined by approximately \$7.4 billion in 2014.⁵ If a portion of community benefit contributions were redirected toward high-leverage community health improvement initiatives, it could represent a commitment of the estimated \$90 billion needed for critical community supports to help vulnerable children and families⁶ and build community capacity to leverage other potential sources of funding.⁷

Final Internal Revenue Service regulations issued December 29, 2014, include several significant changes from the guidance that governed the first cycle of CHNAs and IPs. These changes include:

CONTINUED ON PAGE 2

- Collaborating hospitals from the same or different health systems may develop a joint CHNA report if their community is defined to be the same and each of their governing bodies adopts the joint report.
- Hospitals that collaborated in developing a joint CHNA report also may develop a joint IP. The joint IP must clearly identify each hospital's role and responsibilities.
- Hospitals have additional time to complete their IPs. IPs may be adopted up to four-and-a-half months after the end of the tax year when the CHNA is "due." (This timing matches the due date, without extensions, of the hospital's Form 990.)

Nationally, efforts to promote collaboration in conducting CHNAs and developing Implementation Plans (IPs) are underway. In the Southeastern Pennsylvania region the [Hospital and Health System Association of Pennsylvania \(HAP\)](#) and the [Department of Health and Human Services \(HHS\) Region III](#) are convening hospitals and health systems, public health departments, and other community stakeholders to explore how greater collaboration about CHNAs and IPs might play a part in the development

of population health strategies. They have indicated that joint CHNAs/IPs would help achieve greater efficiency and effectiveness in:

- Meeting federal requirements
- Identifying common health needs in communities served
- Aligning IPs and hospital efforts and investments to achieve greater improvements in community health as well as progress toward effective population health management and the pursuit of the Triple Aim
- Enhancing the public's perception of the hospital brand through community meetings convened by multiple health systems, demonstrable improvements in community health, and media coverage of these activities and results

With [Public Health Accreditation Board \(PHAB\)](#) standards also calling for local health departments to conduct or participate in *collaborative* processes for assessing, prioritizing, and addressing community health needs, there now is an opportunity for mutually beneficial cooperation among

hospitals, public health departments, and others who desire to improve community health. For example, the [Philadelphia Department of Public Health](#) recently completed a CHNA and will focus on maternal and child health, access to care and behavioral health as priorities.⁸

It is hoped that hospital and health department leaders seize this opportunity and collaborate in bringing about transformational change, rather than simply complying with IRS regulations.⁹

Rickie Brawer, PhD, MPH, MCHES

*Assistant Professor, Department of Family and Community Medicine
Associate Director, Center for Urban Health
Thomas Jefferson University Hospitals
Sidney Kimmel Medical College at
Thomas Jefferson University
Rickie.Brawer@jefferson.edu*

James Plumb MD, MPH

*Professor, Department of Family and Community Medicine
Thomas Jefferson University
Director, Center for Urban Health
Thomas Jefferson University Hospitals
James.Plumb@jefferson.edu*

REFERENCES

1. Elkis J, Brawer R, Plumb JD. Community benefit and the new IRS mandate. *Pop Health Matters*. 2012; 25(2):3.
2. Jefferson University Hospitals. In the Community. <http://hospitals.jefferson.edu/about-us/in-the-community/>. Accessed December 19, 2015.
3. Health Research & Educational Trust. Approaches to Population Health in 2015: A National Survey of Hospitals. www.hpoe.org/pophealthsurvey. Accessed December 19, 2015.
4. Young, GJ, Chou CH, Alexander J et al. Provision of community benefits by tax-exempt U.S. Hospitals. *N Engl J Med*. 2013;368:1527. <http://www.nejm.org/doi/full/10.1056/NEJMs1210239>. Accessed December 19, 2015.
5. U.S. Department of Health and Social Services. Economic impact of Medicaid expansion. https://aspe.hhs.gov/sites/default/files/pdf/139231/ib_MedicaidExpansion.pdf. Accessed January 25, 2015.
6. Andrews N. National Academy of Medicine Commentary. How much do healthy communities cost? <http://nam.edu/perspectives-2014-how-much-do-healthy-communities-cost/>. December 9, 2014. Accessed December 19, 2015.
7. Fisher ES, Corrigan J. Accountable health communities, getting from there to here. *JAMA*. 2014;312(20):2093-2094.
8. Philadelphia Department of Public Health. Commissioner's Office. Data Reports and Research. Community Health Assessment 2015. <http://www.phila.gov/health/commissioner/DataResearch.html>. Accessed December 19, 2015.
9. Rosenbaum S, Rieke A, Byrnes M. Encouraging nonprofit hospitals to invest in community building: the role of IRS 'Safe Harbors.' <http://healthaffairs.org/blog/2014/02/11/encouraging-nonprofit-hospitals-to-invest-in-community-building-the-role-of-irs-safe-harbors/>. February 11, 2014. Accessed December 19, 2015.