Background: Where We’ve Been and Where We Are
Medical care in the United States traditionally has focused on the treatment of disease rather than on its prevention. Heart disease, cancer, hypertension, diabetes, and other chronic diseases are the primary drivers of American health care costs; compared to other high-income countries, U.S. health indices are lowest and costs are highest.¹

A “triple aim” — “improving the individual experience of care, improving the health of populations, and reducing the per capita costs of care for populations”² — has gained traction, as the social determinants of health (non-genetic, non-clinical factors including health behaviors, social and economic factors, and the physical environment) are recognized as having significant effects on health outcomes.³

The Affordable Care Act (ACA) adopted a multi-pronged approach to improving individual and population health, reducing health care costs, and promoting health equity. Expanded public and private health insurance coverage promotes Americans’ access to clinical care, including preventive services. Other ACA provisions address health system accountability for quality and efficiency, promote innovative care delivery and payment models, and support public health system modernization and innovation.⁴ Acknowledging the importance of addressing non-clinical social conditions that lead to poor health, certain ACA provisions focus on improving the health of communities. Specific requirements for hospitals in § 9007 of the ACA (26 USC § 501(r)) have significant potential for advancing these aims.

Hospital Community Benefits
Since 1969, “community benefit” has been the legal standard by which a nonprofit hospital demonstrates its qualification for federal tax exemption as a § 501(c)(3) “charitable organization.” Since 2009, the Internal Revenue Service (IRS) has required categorical reporting of hospitals’ community benefit expenses via Form 990, Schedule H. Tax-exempt hospitals’ 2009 filings (the most recent tax year for which summary Schedule H data are available) show most community benefit expenses were allocated to individuals’ medical needs: charity care, subsidized health services, and Medicaid shortfall. Expenses associated with non-medical “community health improvement services,” however, were very limited.⁵ Yet these “activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health”⁶ can have the greatest potential for affecting health outcomes.

Improving social and economic factors such as education, child care, socioeconomic status, access to healthy food, housing, neighborhood conditions, and transportation have been shown to improve overall health.⁷ As recognized by the IRS, preventing illness, ensuring adequate nutrition, and addressing “social, behavioral, and environmental factors that influence health in a community” can be significant community health needs to which hospital community benefits may appropriately respond.⁸ Although hospitals acting alone may have limited capacity to address these

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kinds of issues, collaborative action by the health and community development sectors has been successful in several of these areas. Moreover, two federal statutes — the Community Reinvestment Act and the ACA’s community health needs assessment, planning, and implementation requirements — can bring banks, hospitals, local leaders, health departments, and community-based organizations together to study, plan, and address these upstream factors that affect health.

Community Health Needs Assessment
The ACA’s community health needs assessment (CHNA) requirements are intended to ensure tax-exempt hospitals’ responsiveness to their communities’ priority health needs. Under §9007 of the ACA (26 U.S.C. §501(r)(3)), each tax-exempt hospital facility must conduct and publicize a CHNA every three years that “takes into account input from persons who represent the broad interests of the community... including those with special knowledge of or exper-

As recognized by the IRS, preventing illness, ensuring adequate nutrition, and addressing “social, behavioral, and environmental factors that influence health in a community” can be significant community health needs to which hospital community benefits may appropriately respond. Although hospitals acting alone may have limited capacity to address these kinds of issues, collaborative action by the health and community development sectors has been successful in several of these areas. Moreover, two federal statutes — the Community Reinvestment Act and the ACA’s community health needs assessment and planning requirements — can bring banks, hospitals, local leaders, health departments, and community-based organizations together to study, plan, and address these upstream factors that affect health.

The Community Reinvestment Act
The Community Reinvestment Act (CRA) of 1977 and related regulations establish “continuing and affirmative obligations” of regulated financial institutions to help meet the credit needs of their local communities, especially low- and moderate-income (LMI) communities. CRA performance evaluations by appropriate federal agencies can impact applications for merger, acquisition, new branches, and expanded services. CRA-relevant community development investment includes:

- Affordable housing for LMI individuals
- Community services targeted to LMI
- Activities that promote economic development
- Revitalization/stabilization of LMI communities.

As an alternative to performance examination, a financial institution may develop a strategic plan for addressing community needs in its assessment area. The plan should be developed with community input; it must address the same evaluation criteria used in examinations, define the lender’s assessment area, and be made available for public review and comment.

CHNA process requirements found in 26 C.F.R. §1.501(r)—3 are designed to ensure inclusive, transparent assessment practices and community benefit programming responsive to community needs. This framework encourages — and in some respects mandates — that the process include consideration of input from outside individuals and entities that represent community interests.

Defining the Community
A hospital’s definition of its community — that is, the community targeted for assessment — need not mirror its geographic service area. It may also take into account target populations the hospital serves (e.g., children served by a pediatric hospital) and/or the hospital’s “principal functions,” (e.g., specialty areas or diseases that are the hospital’s focus). The Rule makes clear, however, that a hospital may not define its community in a way that excludes “medically underserved, low income, or minority populations” who reside in the hospital’s service area or who an evenhanded application of the hospital’s method of community definition.
would otherwise include. Subject to that condition, the Rule provides a hospital the flexibility to define its community and include in its assessment geographic areas and populations where the need is greatest or the health disparities most extreme, so that it may direct its community benefits accordingly. Flexible community definition can also set the stage for collaboration.

**Community and Expert Input**

In addition to requiring input from “a broad range of persons located in or serving its community,” 26 C.F.R. § 1.501(r) – 3(b)(5)(i) identifies three sources of community input that hospitals must solicit and take into account as part of their CHNA process. These include:

- At least one “state, local, tribal, or regional governmental public health department (or equivalent department or agency), or a State Office of Rural Health... with knowledge, information, or expertise relevant to the health needs of the community,”
- Medically underserved, low-income, and minority populations, and
- Written comments the hospital has received on its most recently adopted CHNA and implementation strategy.15

Requiring consideration of health department input ensures a place at the table for public health (and public health expertise), encourages the alignment of community benefit initiatives with public health priorities, and can facilitate health department leadership of multi-hospital and multi-sector needs assessment and community health improvement efforts. In addition, the alignment of hospital CHNA and health department accreditation activities can enhance mutually supporting assessment processes and outcomes.16 The mandate to “solicit and take into account” input from medically underserved, low-income, and minority populations acknowledges the appropriateness of targeting the needs of vulnerable populations for special focus, and obligates hospitals to actively seek out their input into the CHNA process. New tools developed by the CDC facilitate the assessment of factors affecting health across populations and a collaborative approach to improving the health of communities; these are available as part of the CDC Community Health Improvement Navigator at <http://www.cdc.gov/CHInav>.

**Cross-Sector Collaboration for Community Health Improvement**

Collaboration across sectors can incorporate complementary expertise and diverse perspectives into the needs assessment process. Shared goals will be critical to effectively leverage the regulatory opportunities discussed above. In addition to nonprofit hospitals, public health agencies, community-based organizations, and other community representatives, important stakeholders may also include CRA lenders, community action agencies, community development corporations, and community development financial institutions.

**Challenges and Possible Solutions**

Although hospitals’ community benefit responsibilities encourage cross-sector collaboration and resource sharing to promote community health, hospitals may question the adequacy of financial and other incentives to do so. Reimbursement mechanisms that reward hospitals for reducing utilization and achieving better health outcomes for defined populations are only beginning to emerge, and may inadequately address the higher costs associated with serving the most vulnerable and needy populations. As these care delivery and payment models mature, will they incorporate features to address this concern?

A hospital’s failure to conduct CHNA exposes it to only a relatively small tax penalty ($50,000).18 The potential loss of tax-exempt status for failure to provide adequate community benefits, while more serious, has yet to be meaningfully applied. The ACA requires the Treasury Secretary to study and report to Congress on community benefit performance trends no later than March 23, 2015. In the future, the results of that study may affect how available penalties for hospitals that fail to discharge their community benefit obligations evolve.

The law does not fully address existing hospital competition — the concern that one hospital’s efforts will benefit its competitors, or that hospitals with the most capacity to take on payment risk or make community investments may not be located in communities where the risk or investment is most needed. Can the pressure of public opinion and hospitals’ desire to be perceived as good corporate citizens overcome these competitive concerns? As the ACA’s coverage initiatives reduce uninsurance, hospital costs associated with unreimbursed care and bad debt have fallen in states that have expanded Medicaid eligibility; though less significant, reductions in these costs have been projected for non-expansion states, as well.20 To the extent that these factors positively impact their bottom lines, tax-exempt hospitals may seek out meaningful new ways to increase the impact of their community benefit investments. Will this overcome hospitals’ competitive instincts and foster greater collaboration? The help of public health agencies, the
involvement of the community development sector, and the robust engagement of communities themselves can surely advance this goal.

Acknowledgement
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References


4. Patient Protection and Affordable Care Act of 2010 (ACA), e.g., Titles I and II (expanding access to care); ACA §§ 3001 and 3025 (Medicare value-based purchasing and ACO shared savings); C. Davis and S. Somers, Public Health Provisions of PPACA Title IV: Prevention of Chronic Disease and Improving Public Health (2011), Network for Public Health Law website, available at <https://www.networkforphl.org/_asset/xmcm6h/ACA-chart-formatted-FINAL.pdf> (last visited February 11, 2015).

5. A mean of 85% of community benefit expenses was attributed to charity care or other patient care services; only 5% was reported as community health improvement services. G. Young, C. Chou, J. Alexander, S. D. Lee, and E. Raver, “Provision of Community Benefits by Tax-Exempt U.S. Hospitals,” New England Journal of Medicine 368, no. 16 (2013): 1519-1527. More recent evidence suggests that hospitals are continuing to assign relatively low priority to non-medical community health improvement efforts. See K. Barnett, Supporting Alignment and Accountability in Community Health Improvement (April 2014); National Network of Public Health Institutes website, available at <http://nnphi.org/CMSuploads/SupportingAlignmentAndAccountabilityInCommunityHealthImprovement.pdf> (last visited February 11, 2015).


12. 12 C.F.R. § 228.12(g) (2014).


14. 79 Federal Register 78954-79016, at 79001-04 (December 31, 2014).


16. If a hospital is unable to obtain input from any of these mandatory sources, it must describe its efforts to solicit such input in its CHNA report. 26 C.F.R. §1.501(r) – 3(b)(6)(iii), 79 Federal Register 78954-79016, at 79003 (December 31, 2014).


