

Linking Community Assessment and Community Benefit Strategies

John Gale

Maine Rural Health Research Center

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Overview of Today's Session

- Review of IRS Guidelines on community health needs assessments (CHNA)
- Reasons for Concern
- Disconnect between IRS Guidelines and Community Benefit Reporting Requirements
- Discussion of CDC Guidance to the IRS
- Opportunities to Move the Needle on Community Benefit Activities



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ACA Additions to Tax Code for Tax Exempt Hospitals

- Sections 501(r)(3)
 - Community health needs assessments every 3 years
 - Effective for tax years beginning after March 2012
- Sections 501(r)(4-6)
 - Financial assistance and emergency care policies; limitations on patient charges; limits on billing and collection practices
 - Effective for tax years beginning after March 2011
- Must be viewed within the context of changes to Form 990 community benefit reporting requirements (Schedule H)



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Community Health Needs Assessment (CHNA)

- CHNA must:
 - Be conducted not less than every three years
 - Adopt strategy to address needs identified through CHNA
 - Incorporate input from persons representing the broad interests of the community, including those with interest/expertise in public health
 - Be made widely available to the public
- As part of its Form 990 filing, hospital must describe:
 - Its CHNA process
 - How it is meeting identified needs through CHNA
 - Any needs that are not being addressed and why



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Status of IRS Guidelines

- Notice 2011-52 details provisions that the Treasury Department/IRS anticipate will be in proposed regulations
 - Recognizes that hospitals may start CHNA prior to the effective date
- Hospitals can rely on the terms of Notice 2011-52 with respect to their CHNAs until further guidance is issued
- Applies to all 501(c)(3) hospitals
 - Includes government hospitals with dual status even though they do not currently file Form 990



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Reasons for Concern

- CHNA requirements developed within the ongoing policy debate about hospital tax exemptions and community benefit
- Community benefit activities are “expected” to address identified community needs
- Hospitals must adopt strategies to address needs identified through CHNA and, as applicable, explain why it has chosen not address needs identified
- Linking CHNAs and community benefit is intended to bring **accountability and transparency** to the process
- IRS to examine community benefits and report to Congress



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More Reasons for Concern....

- ***Do No Harm*** examined the case of two whistle blowers who exposed “aggressive” business/billing practices in Albany, GA
- Illinois Supreme Court ruled against reinstating tax exempt status of Provena for providing insufficient charity care
- The battle still rages in Illinois over the appropriate level of charity care
- NH Attorney General threatened review of tax exempt status of Lake Region General Hospital when it discontinued service to Medicaid enrollees
- Children’s Hospital Boston charity care levels have been questioned in the news



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Key Issues Covered in 2011-52

- Hospital organizations affected – multi-hospital facilities
- CHNA documentation – When/how to conduct CHNA
- Definition of community served
- Community input into process and plan
- Widely available to the public
- Implementation strategy - how/when to adopt strategy
- Excise taxes
- CHNA reporting requirements
- Effective date



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CHNA Written Report

- A written report must be prepared describing:
 - The community served and how it was determined
 - The process and methods used to conduct CHNA and a list of all collaborating organizations (if any)
 - How input from persons representing the broad interests of the community served, how and when they were consulted; and the individuals consulted
 - A prioritization of the community needs and the basis for prioritizing such needs
 - Existing healthcare facilities and other resources in the community available to meet need identified in CHNA



Defining the Community Served

- Hospital must describe the community it serves and how it was determined. Options:
 - Geographic location (i.e., city, county, or metropolitan region)
 - Target populations served (i.e., children, women, or the aged)
 - Principal functions (i.e., specialty area or targeted disease)
- May not be defined in a manner to exclude:
 - Medically underserved populations, low-income persons, minority groups, or chronic disease needs
- Can use billing/patient records to identify areas where the majority of the hospital's patients come from
- Key is to be reasonable in defining service area



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Process

- Must describe the process and methods used for CHNA, including identities and qualifications of 3rd party collaborators
- Must identify information gaps that impact ability to assess the health needs of the community served by the hospital facility
- Must identify/assess health needs of community served
- Must incorporate input from persons who represent the broad interests of the community served
- May collaborate with other organizations and use information collected by other organizations (e.g., public health agency)



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Community Input

- Must incorporate input from persons who represent the broad interests of the community served
 - Special knowledge of or expertise in public health
 - Federal, tribal, regional, state, or other local health departments
 - Leaders, representatives or members of medically underserved, low income, minority or chronic disease populations
- May incorporate input from other community representatives
 - Health care consumer advocates, non-profit organizations, community organizations/agencies, academic experts, local government and school officials, health care providers, low-income persons, minority groups, individuals with chronic needs, businesses/Chamber of Commerce, health insurers/managed care organizations



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Documenting Community Input

- Document how the hospital took into account input from persons representing the broad interests of the community
- Document when/how these individuals/groups were consulted
 - Meetings, focus groups, interviews, survey, written correspondence, etc.
- Identify names, titles, and affiliations of individuals consulted
- For individuals with special knowledge/expertise in public health, briefly describe their expertise/knowledge
- For individuals representing vulnerable populations, briefly describe their leadership/representative role



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Other Reporting Requirements

- Prioritization of community health needs
 - Describe all community health needs identified by CHNA, their prioritization, and the process/criteria used in prioritizing such needs
- Resource inventory
 - Describe existing health care facilities and resources within the community available to meet community health needs identified through CHNA
- One assessment must be conducted every 3 years and considered conducted in the taxable year that the written report is made widely available to the public.



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Dissemination of CHNA Results

- Must be made widely available to the public and remain available until a subsequent CHNA is made widely available
- Must be posted on hospital's/organization's website or, for those without a website, on another entity's website as long as either:
 - A link is provided with instructions for accessing the report; or
 - A direct access website address/URL is provided to anyone requesting it
- Considered “widely available” if:
 - Website provided clear instructions for downloading the report;
 - Document available must be an exact version;
 - Access is free and does not require special hardware/software; and
 - Direct access website address/URL is provided to anyone requesting it



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Implementation Strategy

- As part of its CHNA process, a hospital is expected to develop a written implementation strategy describing how it plans to meet each of the health needs identified through the CHNA
- The hospital is required to attach a copy of the most recently adopted implementation strategy to its annual Form 990
- For multi-hospital organizations, each hospital must meet this requirement separately
- The written plan must describe:
 - How the hospital plans to meet identified needs, or
 - Identify the health needs that the hospital does not intend to meet and explain why it does not intend to meet it



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Details of Implementation Strategy

- Describe how the hospital plans to meet each health need that it intends to address
 - Identify programs and resources used to meet the health need
 - Describe anticipated impact of the commitment of programs/resources
 - Describe any planned collaboration with other organizations (related organizations, other hospitals, nonprofit organizations, state and local agencies, etc.) – All organizations must be specifically identified
- Each hospital must adopt its implementation strategy by the last day of the first tax year beginning after March 23, 2012
 - Strategy must be adopted in same tax year as the CHNA was conducted
 - Strategy is considered adopted when it is approved by the governing body of the hospital



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Linking the CHNA and Form 990: Implementation Strategy

- IRS guidance doesn't explicitly link CHNAs to Form 990 community benefit reporting requirement
- How does it all fit together?
 - **CHNA** – Posted on hospital website/internet and made widely available
 - **Implementation Strategy** – Submitted each year as part of each hospital's Form 990 filing
 - **IRS Form 990, Schedule H** – Hospital community benefit activity reported on Schedule H
- How might the IRS use this information?
 - Compare community benefits reported in Schedule H to the needs identified in CHNA and those addressed in the implementation strategy



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Recommendations

- Focus strategy implementation plan on priority needs identified through CHNAs
- Review IRS and Catholic Health community benefit reporting guidelines
- Align strategies with key community benefit activities
- Make sure the two reports are in sync
- Form 990 community benefit activities encompass activities not likely to appear in a CHNA
- Capture and report full range of allowable community benefit activities



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CHNA Is Part of a Larger Process



HRET's Description of a Community Responsive Hospital

- Look beyond delivery of medical care to role of hospital leadership in:
 - Community issues (e.g., substance abuse, domestic violence, etc.)
 - Health issues (e.g., oral health, mental health, obesity, etc.)
 - Equity (e.g., barriers to access or health status disparities among vulnerable populations)
 - System barriers (e.g., limited public health infrastructure, limited integration of providers and services, etc.)
 - Community's role in process (e.g., involve residents in addressing above issues, reducing risky behaviors, partnering with schools, etc.)

From: *Where Do We Go from Here? The Hospital Leader's Role in Community Engagement* (2007)
by the Health Research and Educational Trust.



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Assessing Community Needs

- Two approaches (both are needed):
 - Identify and monitor community health problems through data driven needs assessments and performance management (“**deficiency model**”)
 - Directly involve local community members in making decisions about community health (“**asset model**”)
- Benefits of community engagement
 - Demonstrates hospital commitment to community
 - Increases community “ownership” of programs
 - May identify issues not revealed by a data driven assessment
 - Identifies areas for collaboration
 - Increases likelihood that initiatives will be successful



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Coordinate CHNA Efforts

- Federal grantees, state/local health departments, FQHCs, etc have needs/mandates to conduct CHNAs
 - National voluntary accreditation program for PH departments requires a CHNA and a community health improvement plan
 - MAPP process for local health departments
- Find a way to coordinate efforts; maximize information, minimize cost
- Requires a broader focus; may be more time consuming and labor intensive; collaboration can be messy
- Benefits: greater involvement and acceptance by community, participants can share costs



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Center for Disease Control and Prevention Involvement

- CDC's prevention branch has been engaged to provide guidance to the IRS in developing CHNA requirements
- CDC focus is on public health not hospital activities
- Heavy focus on collaboration – exceeds ACA requirements
- Strong emphasis on public health activities and evidence base
- Developing mapping and data tools for small hospitals
- Recruiting CAHs to “pilot test” tools
- Advisory group recruited to work with CDC includes rural hospital stakeholders



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Potential Partners by Issue Area

- **Community:** Schools, businesses/employers, elected officials, organizational trustees, faith community, media
- **Health:** Public health officials, physicians, dentists, nurses, pharmacists, mental health specialists, community providers/agencies, insurers
- **Equity:** Community-based groups, activists, safety net providers, faith community, public health leaders
- **System barriers:** Health care and public health leaders, physicians, insurers
- **Community's role:** Patients/consumers, schools, service organizations, neighborhood associations, organizational trustees

After the CHNA: Next Steps

- Develop an implementation strategy
- Choose evidence-based strategies:
 - Centers for Disease Control and Prevention, Catholic Health Association, Public Health Institute, and St. Louis University School of Public Health are sources of evidence-based strategies
 - Critically evaluate existing “legacy” activities
- Develop ways to measure and communicate progress
 - Develop performance indicators tied to community priorities
 - Look for and use proven tactics to address priorities
 - Share information with community – A crucial step in building trust



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Moving the Community Benefit Needle

- Choose evidence-based strategies:
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 - Critically evaluate existing “legacy” activities
- Develop ways to measure and communicate progress
 - Develop performance indicators tied to community priorities
 - Share information with community – A crucial step in building trust
- Focus on charity/discounted care policies to expand access
- Look carefully at bad debt levels to understand access issues



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Contact Information

John A. Gale, M.S., Research Associate

Flex Monitoring Team

Maine Rural Health Research Center –U. of Southern Maine

207-228-8246

jgale@usm.maine.edu