

POLICY FORUM

How Should Nonprofit Hospitals' Community Benefit Be More Responsive to Health Disparities?

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Abstract

In 1956, the Internal Revenue Service created the expectation that nonprofit hospitals would offer uncompensated care for those unable to pay; this was the beginning of Community Benefit (CB). CB efforts tend to prioritize inpatient medical care over developing community-based health improvements, and few CB resources are directed toward responding to health disparities. Changes to federal policy should address these concerns by (1) requiring community partners' involvement in CB implementation strategies, (2) requiring that community health needs assessments (CHNAs) be completed every 5 years instead of every 3 years, (3) changing the Internal Revenue Code to recognize organizations' work on social determinants as CB, and (4) requiring CHNAs to describe a community's health disparities and clarify how their implementation strategies address them. These changes would likely promote hospitals' engagement with public health departments, collaboration with community-based nonprofit organizations, and greater focus on health equity.

Purpose of Community Benefit

Just over half of all hospitals in the United States are nongovernmental, nonprofit community hospitals.¹ Due to their tax-exempt status, these hospitals have long had an obligation to the communities they serve. This obligation was formalized at the federal level by the Internal Revenue Service (IRS) in 1956 and created the expectation of community benefit (CB), defined as [charity care](#). Internal Revenue Code requires that a nonprofit hospital "must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay."² The enactment of Medicare and Medicaid in 1965 generated concern that nonprofit hospitals would no longer have to provide as much charity care, prompting the IRS in 1969 to broaden CB to include the "promotion of health" as long as it was "deemed beneficial to the community as a whole."³ Most recently, the Affordable Care Act of 2010 specified that nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy to respond to identified community needs every 3 years.^{4,5} In addition to federal regulations, some states have

additional CB regulations for state and local tax exemptions, which often specify mandatory minimum CB spending thresholds.⁶

Limitations of CB Regulations

Despite the increased attention to CB over the past decade, current CB regulations still fall short of their potential to direct nonprofit hospitals' activity toward improving the health of their communities. Publicly available documents, both state and federal, describe hospitals' community needs assessments, their annual CB spending, and their financial assistance policies. The tasks associated with these documents—assessing community needs, tracking dollars spent, and being transparent about assistance—are baseline expectations. If we want to leverage CB's true potential for improving community health, we must consider how current policy might be inadequate for doing so.⁷

The current focus of CB, like the focus in the overall health care system, is medical care. A 2015 report from the IRS to Congress indicated that approximately 92% of the \$62.4 billion spent in 2011 on CB supported activities related to clinical care—charity care, payment shortfall from Medicaid or similar programs, and graduate medical education—as well as research.⁸ Slightly more than 7% was divided between community health improvement and contributions to community groups.⁸ There are many reasons why this distribution leans so strongly toward clinical care. Certainly, providing a health care safety net serves an important community need. Hospital experience and expertise reside in clinical care, so hospitals naturally lean toward doing what they do best. Additionally, because of the way hospital accounting systems are designed, spending in clinical areas is easier to calculate and report than spending on other community health efforts.

However, a broader perspective on how to improve community health is needed. Clinical care is only one of a wide range of activities that influence community health—and rarely the most effective. Likewise, although a fair and just health care system requires equitable access to care and treatment, health equity requires more than medical treatment. Community health and health equity could become more central goals of CB—but only if we consider how to encourage nonprofit hospitals to advance these objectives.

Four Policy Proposals

A shift toward community health improvement requires hospitals to view themselves as part of the larger community health ecosystem. Local schools, law enforcement, religious congregations, government agencies, and other nonprofits working in health, housing, and employment are part of that ecosystem and can either work in parallel or in partnership with hospitals to improve community health. A CHNA forces hospitals to look outside their walls and engage new partners to consider the breadth of community

health needs and properly prioritize those needs. Relatively simple policy changes could foster even greater collaboration with key community partners. To that end, we offer the following suggestions (see Figure).

Figure. Policy Proposals to Focus Community Benefit Spending on Community Health and Health Equity

- Require engagement of community partners in formulating a nonprofit organization's implementation strategy, as is required for the community health needs assessment (CHNA).
- Change the required frequency of CHNA from every 3 years to every 5 years.
- Clarify, for IRS Form 990 Schedule H, that community building activities intended to address a community health need count toward a nonprofit hospital's total community benefit spending.
- Require CHNAs to include a description of concerning health disparities and implementation strategies to indicate how they will address disparities and measure change.

Collaborate on implementation strategies. We should require involvement of community partners in implementation strategy, just as we do for CHNAs. This would ensure that hospitals look to their community for expertise not only in identifying community needs but also in prioritizing and addressing them. The mayor's Healthy City Initiative in Baton Rouge, Louisiana, for example, has brought together 5 area hospitals and more than 75 other community organizations to create a single CHNA and a regularly revised implementation strategy.⁹

Assess needs every 5 years. We also suggest changing the requirement that nonprofit hospitals conduct a CHNA from every 3 years to every 5 years. A 3-year cycle entails that hospitals plan their next CHNA less than 2 years after beginning implementation of their community health strategy, leaving little time to see meaningful change in health outcomes before the cycle begins again. Local health departments that seek accreditation by the Public Health Accreditation Board are required to conduct community health assessments (CHAs) at least every 5 years. Allowing the time cycles for hospitals and health departments to align could improve collaboration around the CHNA, ideally resulting in a single document endorsed by all major organizations working to improve community health. Joint CHNAs-CHAs would facilitate better coordination of community-wide health improvement and make hospitals more [publicly accountable](#) for their efforts, thus resulting in the possibility of greater hospital investment in community health activities.¹⁰

Include community building activities as CB. We also recommend that all activities related to the social determinants of health be counted as CB. When calculating their annual spending on CB, nonprofit hospitals can only include spending in certain categories of activity. Current regulations clearly explain the kind of spending related to charity or subsidized care that hospitals can include as part of their CB on their IRS Form 990 Schedule H. Whether hospitals can count spending that addresses the social determinants of health suffers a lack of clarity. On Schedule H, the IRS asks hospitals to report spending on community health improvement activities separately from spending on community building activities (eg, investment in housing).¹¹ For example, community health improvement services, such as diabetes education, testing and treating children for lead poisoning, or training community members in mental health first aid often count as CB. On the other hand, community building activities, which the IRS describes as improvements to housing, economic development, and addressing environmental hazards, are listed separately from CB, even though all of these efforts can significantly improve health.¹² Spending on community building activities is not included in the hospital's total spending on CB, unless the hospital submits additional documentation demonstrating the link between community building efforts and health. Yet such links are often difficult to prove. Given that hospitals are justifiably concerned with being compliant with the law as well as reporting as much CB spending as possible, this differential treatment of community health improvement and community building disincentivizes hospitals' spending on community building, which is often connected to the social determinants of health.

Some health care organizations nonetheless proceed with community investments. Boston Children's Hospital supports a program to reduce home triggers for asthma,¹³ Bon Secours Mercy Health (formerly Bon Secours Baltimore Health System) invests in affordable housing,¹⁴ and many others have also chosen to invest in community building activities, recognizing the value for community health in doing so. Yet, the lack of clarity in current regulations creates a situation in which, from a compliance perspective, it is easier to document clinical care than investment in the social determinants of health as CB. Instructions from the IRS should make clear that community building activities count toward a nonprofit hospital's total CB spending if the activities are intended to address a community health need.

Make addressing health disparities an explicit goal. Finally, addressing health disparities should become an explicit goal of CB. CB regulations do not mention health disparities or the role nonprofit hospitals should play in their remediation. Some regulations, however, obliquely convey the duty to reduce health disparities—for instance, the inclusion of medically underserved populations in the CHNA process and the reasonable assumption that funds for charity care and Medicaid shortfalls largely go to patients from communities of need.¹⁵ However, there is a disconnect between hospitals' awareness of the importance of addressing health disparities and their actually doing so. A recent

study found that 65% of hospital CHNAs referenced health disparities or health equity, but only 9% of hospitals' implementation strategies included activities explicitly designed to improve health equity.¹⁶ While some organizations choose to make health equity a strategic priority, addressing health disparities through community health interventions should not be optional. Instead, we could require hospital CHNAs to describe which health disparities in their communities are most concerning and require hospital implementation strategies to indicate how they will address the disparities and measure outcomes. A similar requirement is currently being discussed as part of upcoming changes to Public Health Accreditation Boards' accreditation process for local health departments.¹⁷ In 2012, Oregon identified health equity as a central goal of its Medicaid program.¹⁸ The revised Medicaid program incorporated equity in strategic goals, included community health workers in health care delivery, and established regional coalitions for advancing health equity. Early results show the Oregon Medicaid program's success in reducing key health disparities.¹⁸

Conclusion

Some may question whether hospitals are the right vehicles for community health improvement and advancing population-level health equity. Why push an organization with expertise in clinical care to take on work that might be done best by others? While a fair concern, we should not discount the role hospitals play as "anchor" institutions in many communities¹⁹ and their ultimate mission to relieve suffering and improve health and well-being. If we are serious about improving community health and health equity, hospitals must be fully engaged in this work.

Community health is taking on new relevance for traditional health care organizations. Value-based and population-based payment reforms, such as the hospital readmission reductions program (which reduces Medicare reimbursements to hospitals with excess readmissions) and accountable care organizations (which incentivize providers to achieve quality measures at lower costs through upside or downside risk), have created financial incentives for hospitals to pay closer attention to community-level health determinants.²⁰ The hospital division responsible for CB could be a strong partner to the hospital division responsible for [value-based care](#) by raising the profile of community health programs as these new reimbursement models are implemented. At the same time, these new payment models do not always have equity as a central goal and may unintentionally contribute to inequity. For example, when providers are held accountable for patient outcomes, poor risk adjustment can result in medically complex and socially vulnerable patients being discriminated against.²¹ But proper risk adjustment can appropriately compensate providers for taking on more vulnerable populations. If carried out with attention to potential pitfalls, new payment reforms and CB policies can reinforce the commitment to both community health and health equity.

The goal with regulatory changes should not be to dictate exactly how nonprofit hospitals spend CB resources. Those decisions should be community specific. Rather, the goal of regulation should be to encourage hospitals to identify and respond to the community's most significant health needs. Spending a large portion of CB resources on clinical care often represents the familiar and even the default path. We should refocus our goals so that improving community health and advancing health equity are more prominent in the minds of nonprofit health care leadership. The recommendations outlined in this article represent first steps that we can take to better align hospitals' CB activities with our health system's population-level goals.

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