Hospital Community Benefit Program

The Hilltop Institute

analysis to advance the health of vulnerable populations

Community Benefit Briefing

October 2011

Through news updates, state research and policy analysis, and policy questions, this newsletter is meant to assist state and local policymakers to understand and monitor hospital community benefit activities. The Community Benefit Briefing will report, discuss, and analyze various aspects of hospital community benefits, including the effects of the Affordable Care Act (ACA).

News

Sara Rosenbaum Discusses IRS Notice No. 2011-52: Community Health Needs Assessment Requirements for Tax-Exempt Hospitals

Sara Rosenbaum is the Harold and Jane Hirsh Professor of Health Law and Policy and founding chair of the Department of Health Policy at the George Washington University School of Public Health and Health Services. Professor Rosenbaum is also a member of the faculty of the Schools of Law and Medicine. Her August 23 post in HealthReformGPS *analyses Internal Revenue Service (IRS) Notice 2011-52, "Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-exempt Hospitals."*

***Hilltop*:** Your recent post in *HealthReformGPS* provides a succinct analysis of IRS Notice 2011-52, in which Treasury and the IRS request public comments on community health needs assessment (CHNA) requirements that the agencies anticipate proposing as formal regulations. In your view, what are the most significant aspects of the notice?

Rosenbaum: I think the notice indicates that Treasury and the IRS take the CHNA requirement seriously; the notice represents a strong effort to make the ACA's CHNA requirements have real meaning for communities. The points in the notice that I consider most important are:

1. The anticipated requirement that hospitals complete their community benefit planning and implementation within a year of conducting the CHNA supports a stronger relationship between a hospital's community benefit activities and identified community needs and priorities.
2. The notice's emphasis on consultative processes demonstrates a strong interest in ensuring that a hospital's required "implementation strategy" reflects an inclusive planning process featuring real dialogue with the community.
3. The discussion of multihospital collaborations is encouraging in that it will allow hospitals to think about addressing the health needs of communities in a way that recognizes how communities are actually organized, rather than from just a service area or market area perspective.

***Hilltop*:** There seems to be a lot of concern among hospitals that they won't be able to address all the community health needs that their needs assessments identify, or that they have insufficient resources to do so.

Rosenbaum: There are competing health interests in any community. The law requires hospitals to describe community health needs identified by CHNA, how they are addressing them, and the reasons that any identified needs are not being addressed. If a hospital's community needs assessment and planning processes are inclusive and transparent, and the implementation strategy adopted by the hospital reflects the community's priorities, that legitimizes the hospital's explanation that limited resources prevent it from addressing other identified needs that are lower priorities for the community.

***Hilltop*:** The American Hospital Association (AHA), Healthcare Financial Management Association (HFMA), and VHA Inc. responded to the IRS notice with a 20-page line-by-line review of Schedule H. Do you have any thoughts about the hospital associations' comments?

Rosenbaum: Some of their comments are valid, particularly those requesting the elimination of redundancies. Other comments—those that would impair the degree to which Schedule H will capture compliance documentation—should be rejected. Arguments that the IRS should defer to states' existing reporting requirements are exactly backward; this is an area in which uniformity is needed. If anything, states should consider revising their reporting requirements to reflect the new federal model.

***Hilltop*:** The hospital industry is concerned about the requirement that CHNAs be conducted and reported on a facility-by-facility basis. The comments by AHA, HFMA, and VHA reinforce that view. What public policy benefits are served by facility-by-facility CHNA and reporting? What kinds of challenges do you foresee for hospital systems as they attempt to satisfy CHNA requirements for each facility they operate?

Rosenbaum: The facility-by-facility requirement is essential to meaningful monitoring of hospitals' discharge of their community benefit responsibility to address the health needs *of the community a hospital serves*. Depending on where a hospital facility is located, community needs may be very different from those of a community served by another hospital facility, even when both hospitals are part of the same hospital system. In terms of challenges, the systems recognize that it's a fair amount of work to do a good needs assessment.

***Hilltop*:** The IRS notice appears to provide a lot more clarity about its expectations for hospitals' documentation of CHNA activities. What about the notice's description of approaches hospitals legitimately may adopt in defining the "community" they target for CHNA and implementation strategies?

Rosenbaum: This is an important issue. The notice makes it clear that "community" means something more than just the hospital's patients. A hospital's service area would be the minimum acceptable "community" for purposes of needs assessment; the notice makes it clear that hospitals can adopt a more expansive definition of community to include, for example, special populations for specific focus.

***Hilltop*:** Do you think the notice will be useful for guiding hospitals' compliance with the ACA's community benefit requirements?

Rosenbaum: Between the revised Schedule H and Notice 2011-52, I think hospitals now have enough information to know what is expected of them. Hospitals will need to do a fair amount of work to put together a good process and to engage the community effectively in that process. Schedule H and the notice give them clarity about what is involved.

References

American Hospital Association (AHA), Healthcare Financial Management Association (HFMA), & VHA Inc. Letter of 8/24/11 to Sara Hall Ingram re: IRS Notice 2011-52. Retrieved from http://www.aha.org/advocacy-issues/letter/2011/110824-let-aha-hfma-vha-shall.pdf

Rosenbaum, S. (2011). IRS notice and request for comments regarding the community health needs assessment requirements for tax-exempt hospitals. *HealthReformGPS.* Retrieved from http://healthreformgps.org/wp-content/uploads/CHNA-Sara.pdf

United States Department of the Treasury and the Internal Revenue Service. (2011). Notice No. 2011-52: Community health needs assessment requirements for tax-exempt hospitals. Retrieved from http://www.irs.gov/pub/irs-drop/n-11-52.pdf

Minnesota's State Health Improvement Program: an Interview with Ellen Benavides, Assistant Commissioner, Minnesota Department of Health

As Assistant Commissioner, Ellen Benavides is responsible for the Minnesota Department of Health's (MDH's) Policy, Quality and Compliance Bureau. She is working with leadership of Minnesota's State Health Improvement Plan (SHIP) to implement a new Minnesota law that requires hospital community benefit reporting and HMOs, in collaboration with local health departments, to develop a four-year plan that explains how the HMO will contribute to achieving one or more priority public health goals during that period (Minn. Stats. §144.699; Minn. Stats §62Q.075).

***Hilltop*:** Recent legislation funded SHIP and imposed some interesting requirements on MDH, the hospitals, and the HMOs.

Benavides: Yes. The legislation requires the Commissioner to confer with hospitals and HMOs on developing an implementation plan to incorporate evidence-based strategies as part of hospitals' community benefit programs and HMOs' collaboration plans. MDH must establish an advisory board to determine priority health improvement needs for reducing obesity and tobacco use. The plan must be implemented by July 1, 2012, and the Commissioners of MHD, Management and Budget, and Human Services have to report to the legislature in February 2013. That report must include estimated savings attributable to SHIP, along with an explanation of the methodologies and assumptions used for the estimate.

***Hilltop*:** Please tell us how Minnesota's SHIP came about.

Benavides: Minnesota's SHIP was part of health reform legislation that was enacted with bipartisan support in 2008. The Statewide Health Promotion Plan evolved from the Steps for a Healthier Minnesota initiative. In July 2009, MDH made grant awards totaling $20 million to reduce obesity and tobacco use. All 53 of the state's community health boards and 9 of the state's 11 tribal governments received grants. With sustained funding at this level, state savings were projected to be as high as $1.9 billion by 2015.
A new administration was in place during the 2010 legislative session. A substantial budget deficit prompted proposals for elimination of SHIP, based on a two rationales: one philosophical (smaller government), the other practical (with only 18 months of experience, it was too early to demonstrate that the program had saved the state money). The legislature adjourned without passing a budget, resulting in a government shutdown from July 1 to July 20, 2011. A special session was convened to adopt a compromise budget, which included $15 million to fund SHIP during the 2012-2013 biennium. This was a fraction of the $41 million the original budget bill would have allocated to SHIP, but the law also authorized the Commissioner to use tobacco and health disparities funding to support SHIP activities.

***Hilltop*:** Were hospitals and HMOs involved in developing the original SHIP program?

Benavides: Yes, in the sense that they were already doing SHIP-type activities before SHIP was in place. In the early 1990s, the Minnesota Public Health Association, in conjunction with the Minnesota Council of Health Plans (MCHP) and other local public health leaders, launched a self-directed initiative to develop informal collaboration plans. In 1995, these plans were mandated. Prior to 2010, HMOs designed their collaboration plans individually. For 2010-2014, with the active participation of the state and local public health departments, MCHP drafted a joint collaboration plan on behalf of its members.

***Hilltop*:** You mentioned earlier that the law requires the Commissioner to develop a SHIP implementation plan for incorporating evidence-based strategies as part of hospitals' community benefit programs and HMOs' collaboration plans. What kind of evidence-based strategies have you identified?

Benavides: We discussed this in MDH's annual report (see reference below) that came out in March, reporting on the progress SHIP made in its first year. We're working to identify the strategies that HMOs, hospitals, public health agencies, and SHIP partners have used; where activities overlap; and potential gaps. In mid-December, we'll meet with individual health plans and hospitals, as well as with public health and community groups, with the goal of engaging the broader community in the conversation. This is a work in process.

References

Minnesota Department of Health. (2011). Statewide Health Improvement Program progress brief: Results from the first year. Retrieved from http://www.health.state.mn.us/healthreform/ship/about/shipbriefmarch2011.pdf

Minnesota Statutes *§§144.699 and §62Q.075*

Webinars

From October 29 to November 2, 2011, the **American Public Health Association (APHA)** is hosting its 139th Annual Meeting & Exposition, "Healthy Communities PROMOTE Healthy Minds & Bodies" in Washington, D.C. More information about the meeting is available at www.apha.org/meetings/AnnualMeeting. Online access to recorded sessions will be available for purchase within three weeks after the meeting. Questions should be directed to APHA's Conventions Department. See http://www.apha.org/meetings/sessions/recordedpresentations.htm.

On Monday, November 14, 3:30 p.m. EST, "The Nuts & Bolts of Preparing for PHAB Accreditation," hosted by the **National Association of County and City Health Officers (NACCHO)**, will feature three representatives of local health departments in Arizona, Washington, and Kentucky that are currently seeking accreditation. Carol Moehrle, Public Health District Director, Idaho North Central District, will present. Issues to be addressed include staff engagement, accreditation team member selection, and documentation requirements. For more information, see: https://cc.readytalk.com/cc/s/showReg?udc=unb47spuabqj

The Association for Community Health Improvement will host two webinars of interest (see http://www.communityhlth.org/communityhlth/education/audio.html):

November 16, 2011, 11:00 a.m. PST/ 2:00 p.m. EST, "Integrating Health Care, Public Health, and Communities to Improve Population Health" will address integration of public health and medical care systems.

December 8, 2011, 11:00 a.m. PST/ 2:00 p.m. EST, "Moving from Community Assessment to Priorities and Action in a Hospital-Public Health Collaboration," will consider community capacity-building through

partnerships among hospitals, public health, and community organizations. A case study of a coalition for obesity prevention will illustrate an integration model for engaging local public health resources, community health improvement activities, cross-system partnerships, and linking clinical care to community-based efforts.

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a nationally recognized policy and research center dedicated to improving the health and wellbeing of vulnerable populations. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations, and nonprofit organizations at the national, state, and local levels.

Hilltop's Hospital Community Benefit Program *is the central resource created specifically for state and local policymakers who seek to assure that tax-exempt hospital community benefit activities are more responsive to pressing community health needs. The program provides tools to state and local health departments, hospital regulators, legislators, revenue collection and budgeting agencies, and hospitals, as these stakeholders develop approaches that will best suit their communities and work toward a more accessible, coordinated, and effective community health system. The program is funded for three years through the generous sponsorship of the Robert Wood Johnson Foundation (www.rwjf.org) and the Kresge Foundation (www.kresge.org).*

The Hilltop Institute
University of Maryland, Baltimore County
Sondheim Hall, 3rd Floor
1000 Hilltop Circle
Baltimore, Maryland 21250
410.455.6854
www.hilltopinstitute.org