The Patient Protection and Affordable Care Act of 2010 (ACA) created several new community benefit requirements for tax-exempt hospitals. In addition to strengthening consumer protections related to financial assistance policies, billing, and collection practices, the ACA also requires charitable hospitals to both conduct community health needs assessments (CHNAs) and develop implementation plans for addressing the needs identified. On April 5, 2013, the Internal Revenue Service (IRS) released a proposed rule on these CHNA requirements which largely conforms to anticipatory guidance the agency released in July 2011.

The rule proposed by the IRS would require hospitals to:

• conduct a CHNA at least every three years (beginning in the current tax year or in either of the two preceding tax years);

• define the community it serves and assess the significant health needs of that community;

• obtain input from people representing the broad interests of the community served, including those with public health expertise and members of medically underserved, low-income, and minority populations;

• prioritize the needs identified using any criteria the hospital deems appropriate;

• document the CHNA in a written report that is formally adopted by an authorized body of the facility and make that report widely available to the public;

• develop a written implementation plan that describes how the hospital intends to address each of the needs identified (including an explanation for any of the needs the hospital does not intend to address); and
include the most recently adopted implementation plan in the hospital's annual Form 990 filing and provide a description of actions taken during that year to advance this plan.

Hospitals are allowed to collaborate with other facilities to conduct CHNAs and develop implementation plans. In order to facilitate such collaborative efforts, the IRS explicitly authorizes hospitals to adopt a definition of the community served that is broader than their own geographic service area. Every hospital must document the results of the CHNA and implementation in a separate report, although the language can be identical, in whole or in part, with that of collaborating facilities. Hospitals are also allowed to produce joint CHNAs if collaborating hospitals have identified the same community, if they jointly conduct the assessment, and if the CHNA is adopted by the authorized body of each facility. Similarly, joint implementation plans may also be developed if the roles and responsibilities of each collaborating facility are clearly identified.

Only 11 states require tax-exempt hospitals to conduct CHNAs and 10 states require hospitals to develop implementation plans for their community benefit activities. The nature and scope of these requirements vary across states. State law regarding CHNAs is generally less prescriptive than requirements proposed by the IRS. For example, only three states (California, New Hampshire, and Texas) require collaboration with local government officials. However, at least seven states have adopted requirements for community benefit planning that are stronger than the IRS's requirements for implementation plan development, such as mandated evaluation of community benefit plans or required use of evidence-based interventions.

Public health experts have stressed that hospitals should work collaboratively with state and local public health agencies to conduct community health assessment and planning activities. Public health agencies must complete a community health needs assessment and community health improvement plan as a prerequisite to voluntary accreditation through the Public Health Accreditation Board (PHAB). The periodicity of PHAB-required assessments for public health agencies differs from IRS requirements for tax-exempt hospitals (every five years and every three years, respectively). Despite some procedural discrepancies, CHNA goals and processes for health departments and hospitals are clearly aligned and suggest promising opportunities for future collaboration. Yet, hospitals and public health agencies seeking to develop meaningful partnerships will confront a variety of challenges related to resource constraints, differences in jurisdictional definitions, competing priorities, and
historically weak relationships that could complicate shared responsibility for CHNAs and community health improvement planning.

This Forum session reviewed new CHNA requirements for tax-exempt hospitals and explored the challenges and opportunities likely to emerge from these assessment and planning efforts.

**SPEAKERS**

Martha Somerville, JD, MPH, director of the Hospital Community Benefit Program at The Hilltop Institute, provided an overview of new CHNA requirements proposed by the IRS and compared this proposed rule to existing requirements established under state law. (**Due to unforeseen circumstances, Julie Trocchio, senior director of community benefit and continuing care at the Catholic Health Care Association of the United States, presented Ms. Somerville’s slides.**)

Vondie Moore Woodbury, MPA, director of community benefit for Trinity Health, described her 18-year history of conducting CHNAs and community health planning in Muskegon County, Michigan, and discussed the challenges and benefits of implementing these activities throughout Trinity Health’s 82-hospital system that spans 21 states. Uma Ahluwalia, MSW, director of the Montgomery County Department of Health and Human Services, shared her experiences leading collaborative CHNAs involving multiple hospitals.

**KEY QUESTIONS**

- How do CHNA requirements proposed by the IRS compare to existing state laws?
- What challenges are hospitals likely to encounter in conducting CHNAs and developing implementation plans?
- What factors are likely to help or hinder collaborative efforts to conduct CHNAs? To what extent are competitive tensions likely to undermine cooperation among hospital facilities? To what extent are resource and capacity constraints likely to influence the role of state and local public health agencies?
- What processes and partnerships appear to improve the efficiency and utility of CHNAs?
- What types of criteria have hospitals and their partners used to prioritize community health needs? How do the development and nature of these criteria influence community acceptance of priorities identified?
• To what extent are CHNAs and implementation plans likely to increase hospitals’ community benefit contributions or improve responsiveness to community needs?

ENDNOTES


