Community Health Needs Assessments and Implementation Strategies: A Public Forum Hosted by the Centers for Disease Control and Prevention

Panel #13 –Reporting and Compliance: Local and Regional Dynamics
July 13, 2011 (2:15-3:30)

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Questions to be addressed:

- *What are key issues for local hospitals in meeting national and state reporting requirements?*
- *What are key issues for local public health agencies in meeting national and state accreditation standards?*
- *What is the role of local officials, advocacy groups, and the general public?*
- *What is needed to move from compliance to transformation?*

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Overview of Notice 2011-52

- Released 7/7/11; comments due 9/23/11
- Outlines anticipated provisions for proposed regulations
- Hospitals may rely on Notice 2011-52 until 6 months after IRS issues further guidance
  - Further guidance would include the proposed regulations
  - Hospitals finishing their first CHNA and adopting an implementation strategy in the same tax year, and prior to that 6 month date, may rely on these procedures

Overview of Notice 2011-52

- Defining "hospital organizations" (§3.01)
- Organizations with multiple hospitals (§3.02)
- Documentation of a CHNA (§3.03)
- How and When to Conduct a CHNA (§3.04)
- Defining the "community served" (§3.05)
- Persons Representing Broad Community Interests (§3.06)
- Defining "widely available" (§3.07)
- Implementation Strategy (§3.08)
- Adopting an Implementation Strategy (§3.09)
- Excise Taxes (§3.10)
- Reporting Requirements for CHNAs (§3.11)
- Effective Dates (§3.12)

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Overview of Notice 2011-52

- Defining "hospital organizations" (§3.01)
  - Limited to organizations operating state licensed hospitals
    - Includes hospitals operated indirectly through a disregarded entity, partnership or an entity treated as a partnership for federal tax purposes (e.g., LLCs); requested comments on a "small interest" exemption if organization is not a general partner or managing member
    - Includes "dual status" government hospitals; requested comments on alternative methods for government hospitals to satisfy IRC 501(r)(3)
    - Does not include hospitals located anywhere other than one of the 50 states or D.C.
  - Any future expansion will be prospective only following opportunity for notice and comment

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Overview of Notice 2011-52

- Organizations with multiple hospitals (§3.02)
  - Must conduct a CHNA and adopt an implementation strategy for each hospital facility
    - May collaborate with other organizations to conduct CHNA
    - Must document the implementation strategy separately for each facility
      - More efficient for systems to do on a coordinated basis; added cost if forced to recreate infrastructure at each hospital
      - May discourage collaborative implementation of strategies to address community needs where such collaboration is more efficient and effective but creates a higher administrative burden
  - IRS deferred addressing the exemption effect of noncompliance

Overview of Notice 2011-52

- Documentation of a CHNA (§3.03)
  - Documented in a written report including:
    - Description of the community served and how that was determined to be the community served
    - Description of process and methods used to conduct the CHNA, including (a) sources and dates of data, (b) analytical methods applied to identify needs, (c) all organizations with which it collaborated in conducting the CHNA, (d) identify and qualifications of all third parties it contracted with to assist in the process
    - Description of how the organization took into account public input, including when and how it consulted with those persons, name and title of at least one individual consulted if input was from an organization, and identification and description of special knowledge or expertise of anyone consulted for public health views, identify anyone consulted who represents a medically underserved or minority population

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Overview of Notice 2011-52

- Documentation of a CHNA (§3.03) (*Continued*)
  - Prioritized description of all community health needs identified in the CHNA, and a description of the process and criteria used to prioritize the needs
  - Description of existing health care facilities and other resources within the community available to meet the needs identified in the CHNA
  - Would not require that the written report include a description of the identified needs that the hospital intends to address, reasons for selecting those needs and the means by which they will be addressed
    - Must address all identified needs in implementation strategy
    - Requested comments on definition of a CHNA

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Overview of Notice 2011-52

- How and When to Conduct a CHNA (§3.04)
  - Deemed conducted in the tax year during which the written report of findings including the information outlined in §3.03 is made widely available to the public
    - Requested comments on guidance regarding when to conduct a CHNA for hospitals placed in service or acquired after 3/23/10
  - Must identify and assess health needs of, and take into account input from persons representing the broad interests of, the community served by that specific hospital facility
    - May base CHNA on information collected by public health agencies or departments, or other organizations, whether or not related, for-profit, nonprofit or governmental
    - CHNA must be documented in a separate written report for each facility; requested comments on using combined reports that still presents information for each facility in a clear, easily accessible format

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Overview of Notice 2011-52

- Defining the "community served" (§3.05)
  - Preserves flexibility for hospitals to define the community served
  - Generally expected to be by geographic location
  - In some cases may also consider target populations served and/or facility's principal functions (e.g., particular specialty or disease)
  - May not be defined in a manner to circumvent the requirements to assess the health needs of and consult with persons representing the broad interests of the community, e.g., by excluding medically underserved populations, low-income or minority patients or those with chronic disease needs
  - Requested comments on geographically-based definitions
    - Metropolitan Statistical Area or Micropolitan Statistical Area where the facility is located
    - County in which the facility is located if it is a rural area

Overview of Notice 2011-52

- Persons Representing Broad Community Interests (§3.06)
  - At a minimum, the CHNA must take into account input from the following (one person may satisfy more than one category):
    - People with special knowledge or expertise in public health (requested comments on necessary qualifications)
    - Federal, tribal, regional, State or local health or other departments or agencies that have "*current data or other information relevant to the health needs of the community served by the hospital facility*"
    - Leaders, representatives or members of medically underserved, low-income, minority and chronic disease populations in the community
  - May but not required to seek input from others including consumer advocates, community-based organizations, other health care providers and private businesses and insurers

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Overview of Notice 2011-52

- Defining "widely available" (§3.07)
  - Similar to rules for making Form 990 widely available
    - Posting on the hospital's website
    - Posting on a third party website linked from the hospital's website (or provide the URL on request if the hospital/hospital organization has no website)
    - Posted copies must be in a format allowing printing of an exact reproduction of the report, downloadable without paying for software, and no fee for accessing the material or the website
    - *May require in person/mailed copies as for Form 990*
  - Applies to the most recently completed CHNA only
  - Requested comments on other methods for making CHNAs widely available

Overview of Notice 2011-52

- Implementation Strategy (§3.08)
  - Separate document for each facility; requested comments on a combined implementation strategy document that still presents information for each facility in a clear, easily accessible format
  - Must be in writing and address each of the needs identified in the CHNA in one of two ways:
    - (1) Describe how the facility plans to meet the need
      - Must be tailored to the particular hospital facility and its programs, resources and priorities
      - Identify resources the hospital will commit to implementation and any planned collaboration in addressing the needs
    - (2) Identify needs the facility does not intend to meet and explain why
  - Must identify other organizations that collaborated in developing the implementation strategy
  - Copies must be attached to the Form 990 – Public Document

Overview of Notice 2011-52

- Adopting an Implementation Strategy (§3.09)
  - Deemed adopted on the date it is approved by the authorized governing body of the hospital organization (defined in the same manner as for the IRC 4958 regulations – board, committee or others as permitted by state law)
  - Must be adopted in the same tax year during which the organization conducted the related CHNA (and within 6 months of any further guidance if relying on Notice 2011-52)
    - Not clearly required by the ACA or IRC 501(r)(3)
    - Requires more lead time to complete CHNA
    - May punish early adapters not prepared for this timing
  - Requested comments on transition relief for the first year in which the organization is subject to IRC 501(r)(3)

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Overview of Notice 2011-52

- Excise Taxes (§3.10)
  - IRC 4959 imposes a $50,000 excise tax for failure to satisfy IRC 501(r)(3) in any three year period
    - Tax applies per hospital facility per tax year
    - Rolling three year period

Overview of Notice 2011-52

- Reporting Requirements for CHNAs (§3.11)
  - Form 990 must include
    - Any excise tax paid under IRC 4959
    - Certain information regarding the CHNA process and implementation strategy (Schedule H)
    - Attach a copy of the most recently adopted implementation strategy for each hospital facility (even if it was attached to a prior Form 990)

Overview of Notice 2011-52

- Effective Dates (§3.12)
  - Three year period to comply with IRC 501(r)(3) for the first time ends at the end of the first tax year beginning after 3/23/12
    - Calendar year taxpayer has until 12/31/13 to comply
    - June 30 FYE would have until 6/30/13 to comply
    - Same timelines for related reporting requirements on Form 990 becoming effective
  - May complete the CHNA and adopt the implementation strategy in an earlier tax year
  - Compliance is determined on a rolling three year period

Putting it in Context … the Four Phases of CHNAs

- Community health needs assessment is a cyclical, iterative and evolving process
- Preserve flexibility for local circumstances and institutional resources … not one size fits all
- Important in terms of
  - Opportunity to improve health of community, contain costs
  - Part of general push toward quality-based payment
  - Compliance and avoiding federal tax penalties and perhaps state penalties or more onerous future requirements
- Four phases, each affecting the others
  - Phase One: Design
  - Phase Two: Conducting the Assessment
  - Phase Three: Developing an Implementation Strategy
  - Phase Four: Implementation and Reporting

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Four Phases of CHNAs

- Phase One - Design
  - Assemble internal team; consider whether/when to retain consultant to assist
  - Identify community served (self-defined, nondiscriminatory)
  - Initial list of potential need areas … a starting point
    - From most recent CHNA or community benefit report
    - Include additional strategic initiatives not identified in prior CHNA or community benefit report
    - Identify existing sources of appropriate data (e.g., local public health agencies, associations, consultants)
  - Develop process for seeking public input and prioritizing needs
  - Design the assessment tool(s) with a view toward a reasonable budget for implementation
  - Clearly communicate intent is to prioritize based on level of need and available resources
  - Board oversight of process – a flexible standard

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Four Phases of CHNAs

- Phase Two – Conducting the Assessment
  - Factor in community demographics and previously identified needs from existing databases; consider hospital's particular services and capabilities
  - Develop approach for obtaining public health input from other sources identified in Phase One, which may include:
    - Hospital Planning Staff, Medical Staff
    - Trade Associations
    - State and Local Health Departments
    - Centers for Disease Control, World Health Organization
    - Other (e.g., community foundations, consumer groups)
  - Determine whether it is necessary to conduct surveys, focus groups or interviews of Stakeholders (patients/family, uninsured, public health officials, educators)
  - Determine whether to retain consulting/survey firm to conduct CHNA and/or interpret results
  - Refine questions as necessary for future CHNAs

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Four Phases of CHNAs

- Phase Three – Developing an Implementation Strategy
  - Review results of CHNA and prioritize needs for the community served by the hospital facility
  - Rank degree of need in absolute terms
  - Determine which priority needs match hospital's strengths
  - Identify resources available to the hospital organization for addressing community needs; develop proposal for budget approval process
  - Determine other organizations or government agencies that also may be addressing certain priority needs (review CHNAs, community benefit reports, certificate of need filings, agency budgets/strategic plans)
  - Reassess composition of the implementation team

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Four Phases of CHNAs

- Phase Four – Implementation and Reporting
  - Assign responsibility for carrying out community need items from approved budget
  - Monitor progress on implementation
  - Publicize results (website, annual report, copies at each facility or business office)
  - Report implementation on Form 990
    - Describe basis for prioritizing community needs (assuming the hospital organization is not in a position to address all identified needs on its own)
    - Explain, attached copies of implementation strategy (becomes a public document, e.g., Guidestar, so do not include information that is proprietary and confidential)

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Hospital Reporting

- Federal Reporting
  - Form 990, Schedule H (501(c)(3) hospitals) – CHNA questions optional for 2010 tax year
    - Describe the last CHNA conducted
    - Describe source of public input in CHNA by name
    - List other hospitals involved in a joint CHNA
    - Describe how the CHNA was made widely available
    - Describe steps taken to address identified needs
    - *Describe which needs are not being addressed and why*
    - Describe excise taxes paid for 501(r)(3) noncompliance
    - *Attach most recent implementation strategy*
  - Official Statement; secondary market disclosures
  - The occasional Congressional inquiry …

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Hospital Reporting

- CHNA results may support expenditures to be reported as costs of community benefit operations on Schedule H, Part I, Line 7e
- Schedule H, Part V, Section B (Optional for 2010) includes 7 questions designed to provide the IRS with an overview of basic steps taken to comply with the requirements of 501(r) for hospital organizations to conduct a CHNA and develop an implementation strategy to address the needs identified in the CHNA
- Schedule H, Part VI, Line 2 – other needs assessments

Hospital Reporting

- Various State Reporting Requirements
  - Require reporting on activities, resource allocation; no concept of prioritization or evidence-based standards
  - May be included in:
    - CON/licensure standards where applicable
    - Community Benefit Reporting
    - Property Tax Exemption
    - State version of Schedule H (Oregon)

Hospital Reporting

- Key Challenges for Hospitals
  - Distinguishing bad debt (unwilling to pay) from charity care (unable to pay)
  - Finding legitimate ways to capture all charity care provided
  - Capturing and allocating other community benefit costs
  - Lead time for board/committee review; exacerbated for affected systems if group returns are eliminated
  - Overlay of providing community benefit in practice on a coordinated basis (e.g., within a system or local network) vs. reporting on a single hospital/entity basis
  - Double reporting and inconsistent state/federal requirements
    - Should hospitals in states with detailed community benefit reporting have the option of filing a "Schedule H-EZ" and attach the state filing?
    - Should Schedule H suffice for all state reporting?

LPHA Accreditation Standards

- Distinguish between parallel requirements of IRC 501(r)(3) which focus on effort and transparency and broader policy considerations which focus on results
- IRC 501(r)(3) does not reinstate federal health planning
  - National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641
    - Intended to control Medicare costs, address duplication and misdistribution of facilities
    - Required that states adopt a CON law in order to receive federal funding for programs such as Medicaid
    - Repealed in 1986 with shift away from cost-based reimbursement
  - Proprietary and non-501(c)(3) governmental hospitals are not subject to IRC 501(r)(3)

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LPHA Accreditation Standards

- Challenges for State and Local Health Departments
  - S/LHDs are one possible source of public health input but not the only source (may seek input from federal agency instead)
    - Demonstrate value added to the CHNA process
  - Speed, cooperation and flexibility
    - Data gathering and distribution
    - Ability to produce evidence of community need that matches varying definitions of "community" based on provider circumstances
  - Facilitate collaborative, cost effective approaches in the broader public interest
    - Broad community perspective
    - Consideration of providers' particular strengths

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Roles of Stakeholders

- IRC 501(r)(3) requires that the CHNA process include input from:
  - People representing broad interests of the community served by the hospital facility, including people with special knowledge or expertise in public health
- Webster's defines input as "advice, opinion, comment"
- Compare "market survey" concept for strategic planning … hospitals may already be obtaining significant community input
- Notice 2011-52 would prescribe three specific categories as the minimum sources of public input related to the community served:
  - Special knowledge or expertise in public health (not defined)
  - Federal, tribal, regional, state or local agencies
  - Leaders, representatives or members of underserved, minority and chronic disease populations

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Roles of Stakeholders

- Use of existing resources/tools for CHNA process
  - Association for Community Health Improvement, http://www.communityhlth.org/#
  - Assessing and Addressing Community Health Needs (CHA), available online at http://www.chausa.org/Assessing_and_Addressing_Community_Health_Needs.aspx
  - Community Catalyst, ACA Implementation Resources, http://www.communitycatalyst.org/projects/implementing_reform
  - CDC: http://www.cdc.gov/nceh/ehs/topics/CommunityHealth.htm
  - Health Resources and Services Administration: http://hpsafind.hrsa.gov/
  - University of Kansas – The Community Toolbox: http://ctb.ku.edu/en/tablecontents/index.aspx
  - National Association of County & City Health Officials (NACCHO) – Mobilizing for Action through Planning and Partnerships (MAPP): http://www.naccho.org/topics/infrastructure/mapp/index.cfm
  - State and local public health agencies
  - Public Health Institute: http://www.phi.org/
  - World Health Organization: http://www.who.int/research/en/

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Roles of Stakeholders

- There are many variables to be considered by hospital boards and management as they define "community served":
  - Distribution of discharges and outpatient visits (zip codes)
  - Underserved, disadvantaged or minority populations
  - Community Hospitals (density of hospitals and other providers in the area, range of services/acuity)
  - Governmental/dual status hospitals
  - Academic Medical Center/Teaching & Research Hospitals
  - Specialty Hospitals and Centers of Excellence
  - Urban vs. Rural; patient travel patterns
  - Critical Access Hospitals
  - Religious Hospitals
- Notice 2011-52 notes flexibility, assumes primarily geographic
- May be local, regional or national; may not coincide with a state health planning area or strategic planning "market"

Roles of Stakeholders

- Hospital boards and management will have several key task areas to address in conducting and operationalizing a CHNA, including:
  - Defining the community served
  - Designing survey, focus group and interview questions
  - Managing the process
  - Collating and interpreting the results
  - Prioritizing needs to be addressed
  - Developing work plan for implementation of strategies, programs and activities to address the community needs
- Public health agencies may have experience to share from their own accreditation processes.

From Compliance to Transformation

- Baseline for IRC 501(r)(3) compliance
  - Hospitals must conduct a CHNA once every three years
    - Input from people representing broad interests of community served (agencies, underserved populations)
    - Input from people with special knowledge / expertise in public health
    - Results of assessment made widely available to the public
  - Adopt implementation strategy to address those needs
  - Provide required disclosure in Form 990
    - Schedule H, Part V.B., Lines 1-7 regarding CHNAs is optional for the 2010 tax year
- IRS annual and five year trend reporting … all sectors (nonprofit, governmental, proprietary)

From Compliance to Transformation

- Importance of prioritizing needs
  - Limited financial resources
    - Many identified needs may be projected to lose money
    - Need may be met more cost effectively by other facilities/agencies
    - Long-term capital needs for all services the hospital provides
  - Areas of expertise and available service lines
  - Providing a reasonable explanation on Form 990
    - Schedule H should take into account collaborative efforts to assess and plan for addressing community needs where permitted by law
    - Excessive focus on individual hospital statistics may detract from the effectiveness of implementation plans overall for the community

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From Compliance to Transformation

- Note – IRC 501(r)(3) requires engaging in the assessment process, developing a plan and reporting on it, it does not mandate specific results
- Achieving overall improvements of community health, however, may benefit a hospital directly and indirectly:
  - Contain costs of care, fewer complications
  - Healthier workforce
  - Ability to earn quality incentives from payors
  - Support for community benefit standard of exemption

From Compliance to Transformation

- CHNA may be conducted on a collaborative basis with other public/private parties
  - Community served must be identifiable
  - Avoid sharing any competitively sensitive information (e.g., price, supplier terms, strategic plans)
  - Avoid market allocation or other agreements about areas of competition – geographic or service/product line
  - Quality, completeness and utility of public health source data may vary widely from community to community

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From Compliance to Transformation

- Efficiencies vs. Competition … the Antitrust dilemma of collaboration, especially for implementation phase
  - Potential concerns include agreement on price, allocation of markets, other agreements not to compete
  - More flexibility as part of system under common control. *Copperweld v. Independence Tube*, 467 U.S. 752 (1984)
  - Clinically integrated providers, not clearly defined
  - State action doctrine (immunizes state sanctioned conduct); may be highly political

Moderator Q&A and Public Discussion