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Community Benefit and the ACA
A Brief History and Update

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Introduction

The Patient Protection and Affordable Care Act (ACA) revises the conditions that nonprofit hospitals must satisfy in order to qualify for federal tax-exempt status. Among these revisions is a new condition that establishes a formal "community health needs assessment" (CHNA) process, whose purpose is to increase the relationship between the health needs experienced by communities and the "community benefit investments" made by nonprofit hospitals as a condition of tax exemption.

The CHNA amendments build on and strengthen efforts by nonprofit hospital industry leaders to promote greater community engagement and population health orientation in their community benefit investment practices.[1] For this reason, the ACA amendments offer an important opportunity for community collaborations for health improvement at the local, regional, and state levels. This Overview discusses the context of the CHNA process and describes its elements, as implemented by the Internal Revenue Service (IRS) and Department of the Treasury, the federal agencies charged with oversight and enforcement.

The Concept of "Community Benefit"

The obligation to invest in health and health care in the communities they serve is a hallmark of federal policies that establish the conditions under which nonprofit hospitals can obtain tax-exempt status.[2] In 2012, more than half of all U.S. hospitals operated as nonprofit corporations, and their numbers surpassed 2900 that year.

Community benefit obligations applicable to nonprofit hospitals date to a 1969 IRS policy that broadened the classes of activities in which hospitals could engage[3] – beyond the provision of charity care – in order to maintain their tax-exempt status under Section 501(c)(3) of the Internal Revenue Code. Many states in turn follow IRS policy when determining whether their nonprofit hospitals will be entitled to tax-exempt status

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[1] See, e.g., Catholic Health Association, Community Benefit, http://www.chausa.org/communitybenefit/ (Accessed online May 7, 2012); see also, American Hospital Association, Richard Umbdenstock on the Ernst & Young Schedule H Project Benchmark Report, http://www.aha.org/content/12/09-sche-h-benchmark.pdf (Accessed online May 7, 2012); see also, American Hospital Association and Association for Community Health Improvement, Managing Population Health: The Role of Community Health Improvement (April, 2012)

[2] For a general discussion of tax policy affecting nonprofit hospitals, see Sara Rosenbaum and David Frankford et al., *Law and the American Health Care System* (Foundation Press, NY, NY 2012), Part Four.

[3] IRS (US). Revenue ruling 69-545, 1969-2, C.B. 117 [cited 2010 Sep 28]. Available from: URL: http://www.irs.gov/pub/irs-tege/rr69-545.pdf

under state law.[4] The most recent official estimates regarding the value of the federal community benefit obligation, developed for Congress in 2002 by the Joint Committee on Taxation, places the federal value of the tax exemption at $12.6 billion. [5] An updated estimate of the federal value of the tax-exemption would be significantly higher, and higher still were this estimate to be combined with the dollar value of state and local tax exemptions. This figure also does not include the philanthropic value of hospitals' tax-exempt status, which enables hospitals to generate charitable contributions. The added value created by hospitals' tax-exempt status in the context of private philanthropy was an estimated $5.3 billion in 2010.[6]

The concept of what constitutes a community benefit has evolved. Prior to 1969, Internal Revenue Service policies specified that the provision of charity care (i.e., care for which no compensation could be expected) was a required element of tax exemption, although IRS policy afforded hospitals a fair degree of latitude in establishing the amount of charity care they would provide. The 1969 IRS revision broadened the permissible range to include such activities as education, research, and activities that promote community health. At the same time, the IRS did not maintain precise definitions of community benefit, nor did the agency maintain a detailed method for collecting information about the size and scope of hospital community benefit activities.

As with many other IRS policies, whether hospital activities involve a "community benefit" turns on the "facts and circumstances" of any particular case.[7]

Schedule H

In 2009, the agency introduced Schedule H, a special tax form that hospitals file along with their annual Form 990 filings (a required filing for all federally tax-exempt corporations). Schedule H provides further guidance on how the agencies define "community benefit." Furthermore, Schedule H provides facility-specific information regarding hospitals' community benefit spending in relation to other costs they incur, such as costs related to bad debt expenses or the cost of participation in Medicare.

In the 2011 version of Schedule H,[8] the IRS defines community benefit expenditures as consisting of several distinct categories of activities:

- financial assistance to the uninsured;

[4] Donna C. Folkemer et al., Hospital Community Benefits After the ACA (Hilltop Institute, UMBC, April 2011).
[5] General Accounting Office, Nonprofit Hospitals: Variations in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements (GAO-08-880, Sept. 2008), p. 1.
[6] Subsidyscope, Pew Charitable Trusts. Congressional Research Service estimates, 2008 [cited 2010 Sep 28]. Available from: URL: http://subsidyscope.com/nonprofits/tax-expenditures/health-charitable-contributions
[7] IRS (US). IRS exempt organizations (TE/GE) hospital compliance project final report [cited 2010 May 18]. Available from: URL: http://www.irs.gov/pub/irs-tege/frepthospproj.pdf
[8] Internal Revenue Service, Schedule H (Form 990) 2011: Hospitals (Revised 2012), accessed August 2, 2012, http://www.irs.gov/pub/irs-pdf/f990sh.pdf

- expenditures in connection with hospital participation in Medicaid and other means-tested public insurance programs that pay less than the reasonable cost of care;

- expenditures in connection with health professions education and health research;

- expenditures in connection with community health improvement activities; and

- expenditures in connection with certain "community-building" activities when these activities can be shown to be interventions that are known to improve community health.

Of particular interest is the term "community health improvement services," which the IRS defines as "activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health."[9] The IRS further notes that "[s]uch services do not generate inpatient or outpatient bills, although there may be nominal patient fee or sliding scale fee for these services."[10] IRS policies thus recognize that the concept of community benefit includes not only health care but also population-based activities that can improve overall health.[11]

In the 2011 version of Schedule H, the IRS terms "community building" activities that "improve the community's health or safety."[12] The agency also notes that "[s]ome community building activities may also meet the definition of community benefit"[13] when they rest on an evidence base linking the activity to improvements in community health. Schedule H offers the following examples of community building activities:

- physical improvements and housing such as housing rehabilitation for vulnerable populations such as removing harmful building materials (e.g., lead abatement), neighborhood improvement and revitalization, housing for vulnerable populations upon inpatient discharge, housing for seniors, and parks and playgrounds to improve physical activities;

- economic development activities such as assisting in small business development and creating employment opportunities in areas with high joblessness rates;

- community supports such as child care, mentoring programs, neighborhood support groups, violence prevention, disaster readiness and public health

[9] Instructions for Schedule H (Form 990) (2011) p. 13
[10] Instructions for Schedule H (Form 990) (2011) p. 13
[11] IRS Notice 2011-20, p. 5. http://www.irs.gov/pub/irs-drop/n-11-20.pdf (Accessed March 17, 2012)
[12] Id. p. 4
[13] Id.

emergency preparedness and community disease surveillance "beyond what is required by accrediting bodies or government entities";[14]

- environmental improvements to address "environmental hazards that affect community health such as alleviation of water or air pollution," the safe removal or treatment of garbage and waste products, and other activities to protect the community from environmental hazards (other than expenses made to comply with legal requirements);

- leadership development and training for community members such as training in conflict resolution, civil, cultural, or language skills, and medical interpreter skills;

- coalition building such as community coalitions to address health and safety issues;

- community health improvement advocacy such as efforts to support policies and programs to safeguard or improve public health, access to health care services, housing, the environment, and transportation; and

- workforce development, including recruiting physicians and other health professionals to underserved areas.

Current levels of hospital investment in activities that improve population health are modest. A study published in April 2013 in the *New England Journal of Medicine* calculated that in 2009 nonprofit hospitals spent 7.5% of total expenses on community benefit investments. Approximately 6.4% of all expenses (85% of community benefit) involved financial assistance and expenditures associated with Medicaid participation, which pays less than the cost of care. Less than one half percent (0.4%) of total hospital expenditures were devoted to community health improvement activities.[15]

It is possible that community health improvement investments will grow in the coming years. The potential for growth can be attributed to two important developments. First, many hospitals have taken a strong interest in improving the health of the communities they serve through investments that reduce the burden of illness and disability. Second, when fully implemented, the ACA itself can be expected to have two important effects. First, the insurance reforms under the ACA are projected

[14] Id.
[15] See Ernst & Young report, http://www.aha.org/content/12/09-sche-h-benchmark.pdf (Accessed online, May 7, 2012)

to significantly reduce the proportion of uninsured community residents, which in turn can be expected to lead to a decline in expenditures on financial assistance for uninsured residents as well as losses attributable to bad debt. Moreover, many of the ACA's most important initiatives in health system reform emphasize health improvement as part of a broader initiative aimed at improving the quality and efficiency of health care. Key among these initiatives are the formation of Accountable Care Organizations (ACOs) that emphasize the greater integration of health and health care for ACO patient populations, in order to reduce the economic and systemic burdens of poor health.

How the Affordable Care Act Modifies Conditions for Nonprofit Hospital Tax-Exempt Status

The ACA amendments related to nonprofit hospital tax exempt status create new standards that must be met as a condition of compliance with federal tax law. Specifically, Section 9007 amends the Internal Revenue Code by adding new subsection 501(r), "Additional Requirements for Charitable Hospitals,"[16] which in turn specifies four conditions of tax-exemption:

- First, hospitals must undertake a community health needs assessment (CHNA) process;
- Second, hospitals must develop and maintain "financial assistance policies" that provide clarity to the community regarding eligibility standards and determination procedures;
- Third, hospitals must maintain written policies related to compliance with Medicare's Emergency Medical Treatment and Active Labor Act (EMTALA) obligations;
- Fourth, hospitals must comply with standards related to limitations on charges and billing and collection policies.

Hospitals that fail to comply with the new requirements are subject to tax penalties of $50,000 in any taxable year.[17] In addition, the Secretaries of Treasury and Health and Human Services are expected to jointly and periodically report on expenditures by hospitals claiming tax-exempt status in connection with financial assistance, bad debt expenditures, costs associated with participation in Medicaid and other means-tested programs, costs associated with Medicare participation, and other "community benefit" activities.[18]

[16] 26 U.S.C. §501(r)
[17] 26 U.S.C. §4959
[18] PPACA §9007(e)

The ACA CHNA process

The ACA's CHNA provisions establish a triennial planning process; this process takes effect in the first tax year following the second anniversary of the ACA's passage (March, 2012).[19] Its purpose is to create a system by which hospitals continually and publicly assess community health needs and also devise implementation strategies that demonstrate how their community benefit expenditures link to publicly identified community health needs.

The CHNA process consists of two distinct phases.[20] The first phase is a "community health needs assessment" that meets the requirements of the law. The second phase is an "implementation strategy" whose purpose is to describe "how the organization is addressing the needs identified in each community health needs assessment," as well as "any such needs that are not being addressed together with the reasons why such needs are not being addressed."[21] As with Schedule H, hospitals' implementation strategies must be reported to the IRS as part of their annual Form 990 filings.[22] Taken together, the two reporting obligations (Schedule H and hospitals' implementation strategies) offer transparent information regarding overall hospital expenditures on community benefit activities and other activities, as well as specific hospital expenditures whose specific purpose is to implement the CHNA. The implementation strategy thus becomes the document that effectively links hospital community benefit expenditures to assessed community health needs. Because hospitals' CHNAs must be updated every three years, an additional, implicit and ongoing aspect of the CHNA process is an evaluation of the effectiveness of hospitals' implementation strategies in relation to evolving community health needs.

The CHNA process contains certain required elements. The CHNA must "take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health. In addition, a hospital's CHNA must be made "widely available to the public."[23]

Treasury/IRS Policy Implementation

Implementation policies issued by the IRS and Department of the Treasury in July 2011 (Notice 2011-52)[24] offer important additional guidance to aid operationalization of the CHNA process:

- *To which hospitals the CHNA process applies.* The CHNA process applies to hospitals that are public nonprofit entities (i.e., that operate as units of government), although the agencies have sought comments on whether the process should be modified to take these hospitals' public status into account.

[19] PPACA §9007(f)(2)
[20] See 26 U.S.C. §501(r)(3)(A)(i) and (ii), as added by PPACA §9007.
[21] PPACA § 9007 (d), adding paragraph (15)(A) to § 6033(b) of the Internal Revenue Code
[22] PPACA §9007(d), amending §6033(b) of the Internal Revenue Code
[23] 26 US.C. §501(r)(3) added by PPACA §9007
[24] IRS/Treasury Notice 2011-52 http://www.irs.gov/pub/irs-drop/n-11-52.pdf (Accessed March 14, 2012)

- *Multi-hospital planning.* Each hospital facility must comply with the CHNA process (i.e., the needs assessment and the implementation strategy), while in the case of multi-facility hospital organizations, the organization must file documents for each facility. At the same time, the agencies encourage joint planning both across individual facilities and even across hospital organizations. [25]

- *Documentation of the CHNA process.* The Notice outlines how hospitals must document their CHNA process, requiring a written report containing certain information:
    - a description of the community served by the hospital;
    - a "description of the process and methods used to conduct the assessment, including a description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community needs."[26] The document must "describe the information gaps that impact the hospital organization's ability to assess the health needs of the community served by the hospital facility."[27] Furthermore, the document must describe any "third parties" with whom hospitals collaborate;
    - a description of "how the hospital organization took into account input from persons who represent the broad interest of the community served by the hospital facility"[28] and "when and how the organization consulted with these persons (whether through meetings, focus groups, interviews, surveys, written correspondence, etc.),"[29] as well as documentation of consultation with "any individual providing input who has special knowledge of or expertise in public health, by name, title, and affiliation and provide a brief description of the individual's special knowledge or expertise."[30] Individuals who are "leaders" or "representatives" of populations who represent the broad interests of the community must be identified by name and by their leadership or representative role;[31]
    - a "prioritized description of all of the community health needs identified through the CHNA" as well as a "description of the process and criteria used in prioritizing such health needs ;"[32]
    - a "description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA."

  In sum, the Notice identifies five required elements of the CHNA's planning assessment phase: the *community served,* a description of the *process and*

[25] Notice 2011-52, p. 3.
[26] Id., pp. 9-10
[27] Id. p. 10
[28] Id.
[29] Id.
[30] Id.
[31] Id., p. 11.
[32] Id., p. 11

methods used to conduct the assessment, a description of the *sources and dates of the data used,* a description of the *consultation process* the hospital employed in order to secure input from both representatives of the community and persons with special knowledge or expertise in public health, a *prioritized description of community health needs identified and the process for prioritizing such needs*, and a *description of other community assets* for meeting these prioritized needs.

- *Conducting the CHNA.* The Notice specifies that the CHNA is considered "conducted" in the year that the written report containing all of the required documentation described above is made "widely available to the public."[33] The Notice further specifies that in order to be "conducted," the CHNA must take "into account input from persons who represent the broad interests of the community served"[34] by the specific hospital facility for which the CHNA is being developed. In obtaining this "input," the agencies clarify that hospitals may base their CHNA on "information collected by other organizations, such as a public health agency or nonprofit organization."[35] Furthermore, the Notice specifies that a hospital organization (which may encompass multiple facilities) can "conduct a CHNA in collaboration with other organizations, including related organizations, other hospital organizations, for-profit and governmental hospitals, and state and local agencies such as public health departments."[36]

- *Community served: geographic areas.* The agencies permit the use of geographic areas to define the "community served." The Notice specifies that the purpose of a CHNA is to focus on the "communities actually served by the hospital facilities whether those communities are defined by geographic area or target populations."[37] Thus, a community can be defined geographically or by population, and the agencies indicate that they will take all "facts and circumstances" into account in examining a hospital facility's approach.[38] Most significantly, the Notice emphasizes the importance of geographic definitions, providing that "a community may not be defined in a manner that circumvents the requirement to assess the health needs (or consult with persons who represent the broad interests of) the community served by a hospital facility by excluding, for example, medically underserved populations, low persons, minority groups, those chronic disease needs."[39]

- *Public and public health input.* The Notice requires input from persons who "represent the broad interests from the community served by a hospital facility."[40] Under the Notice, input must include at a minimum: "(i) persons with special

[33] Id. p. 12
[34] Id.
[35] Id.
[36] Id. pp. 12-13
[37] Id.
[38] Id. p. 14
[39] Id.
[40] Id. 15

knowledge or expertise in public health, (ii) federal, tribal, regional, state, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility; and (iii) leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility."

The agencies recognize that individuals may fall into more than one grouping, particularly in the case of groups (i) and (ii). The agencies also have sought input regarding "what special qualifications (whether in terms of degrees, positions, experience, or affiliations) should be necessary for an individual or organization to be considered as having special knowledge of or expertise in public health."[41] The Notice elaborates on the types of entities from whom input may be desirable, such as consumer advocates, nonprofit organizations, academic experts, local government officials, community-based organizations, other health care providers such as community health centers and providers focusing on medically underserved populations, private businesses, and health insurers.[42]

- *Making the CHNA widely available.* In clarifying the concept of "widely available," the agencies have adopted the same approach that governs hospitals obligations to publish their Form 990 (to which their Schedule H worksheets and their implementation strategies are attached).[43] Thus, the CHNA document, including its prioritized health needs and the other community assets available to meet prioritized needs, must be posted on the hospital organization's website. If a hospital facility operated by a hospital organization does not have its own website, the Notice specifies that the planning document must be posted on the hospital organization's website. In addition, the Notice encourages posting on other organizational websites along with clear instructions for obtaining the report from the hospital organization. Furthermore, a hospital organization and its facility must make the document available (in writing or electronically) to any individual who requests it.[44]

  The Notice clarifies that the "widely available" standard will be considered satisfied in the context of website posting if the website where it is available informs readers of the availability of the document and provides downloading instructions, the downloaded and printable document "exactly reproduces" the online version, the document can be viewed and downloaded without paying a fee, the download site is free, and the CHNA remains available until it is updated in later years.[45]

[41] Id., p. 16
[42] Id.
[43] Id., p. 17
[44] Id. 18
[45] Id.

- *Implementation strategy.* The Notice defines the implementation strategy as a "written plan that addresses each of the community health needs identified through a CHNA for such a facility."[46] The Implementation Strategy (1) describes how the hospital facility plans to meet the prioritized health needs identified in the CHNA [and also] (2) identifies health needs that the hospital facility does not intend to meet and explains why the facility is not investing in meeting a particular need.[47] The Notice specifies that each facility must adopt an implementation strategy in the tax year in which it conducts the assessment. The implementation strategy is considered "adopted" when it is "approved by an authorized governing body of the hospital organization."[48]

  The agencies further specify that the implementation strategy must be published under the "widely available" standard as an attachment to the hospital facility's annual Form 990.[49] The Notice clarifies that as with the CHNA, the implementation strategy must be particular to the hospital facility filing it and must take into account all of the evidence contained in the needs assessment, that is, its "specific programs, resources, and priorities."[50] The agencies anticipate that the implementation strategy will clarify the extent to which, in investing its community benefit obligations, a hospital will tie those obligations to a data-driven planning process that is structured to measure needs and priorities. As with the planning phase, the Notice clarifies that implementation strategies can be developed by hospital organizations for their facilities "in collaboration with other organizations, including related organizations, other hospital organizations, government agencies, and state and local health agencies."[51]

The Relationship of the CHNA Process to the Broader Framework of Community Health Improvement: Policy Considerations

The CHNA process can be viewed as a dimension of community health improvement, a core principle in public health. Community health improvement recognizes that "health is a dynamic state that embraces well-being as well as the absence of disease."[52] The parallels between community health improvement and the CHNA statute are striking. Community health improvement recognizes that many factors beyond health care lead to health, and that these factors encompass the social and physical environments, genetic endowment, behavioral health responses, disease and health care, health function, and prosperity.[53] Through community health improvement, communities attempt to comprehensively address their health, formulate roles and responsibilities, create the multi-sector investments that improve health, and measure the impact of their investments.

[46] Id.
[47] Id. p. 20
[48] Id. p. 21
[49] Id, p. 20
[50] Id.
[51] Id. p. 20
[52] Id., p. 20
[53] Id.

As defined by experts, the community health improvement process encompasses four key elements: (1) assessment of population health; (2) planning; (3) implementation; and (4) evaluation. These elements parallel the elements of the CHNA process. The CHNA process envisioned under the Act further reflects the key functional areas of community health improvement: (1) creation of a common agenda; (2) multi-sector collaboration; (3) community participation; (4) comprehensive approaches to improving population health; (5) evidence-based approaches to health improvement; (6) innovations that address the social determinants of health; and (7) performance monitoring to assess progress in improving community health.[54] Experts have further identified certain recommended practice areas that are integral to the process, shown in **Figure 1**.

Figure 1: Community Health Improvement:
Twelve Key Practice Areas

1. Shared ownership among stakeholders
2. Community involvement
3. Assessments that span jurisdictions
4. Small area analysis
5. Data on the social determinants of health
6. Identification of community health needs
7. Explicit criteria to set priorities
8. Shared investment in implementation
9. Monitoring and evaluation
10. Collaboration across sectors
11. Oversight
12. Public reporting

Source: Stephen Fawcett, Christina Holt, Jerry Schultz, *Recommended Practices for Enhancing Community Health Improvement* (Work Group for Community Health and Development, Univ. of Kansas, October 7, 2011) p. 1 http://ctb.ku.edu/en/tablecontents/chapter2_section16_main.aspx (accessed online April 3, 2012)

The community health improvement concept is captured in the ACA in many ways:

- the community health transformation program, administered by the Centers for Disease Control and Prevention (CDC);[55]

- the National Prevention Strategy[56] and its Prevention and Public Health Trust Fund[57] that enables investments that improve community health;

[54] Stephen Fawcett, Christina Holt, Jerry Schultz, *Recommended Practices for Enhancing Community Health Improvement* (Work Group for Community Health and Development, Univ. of Kansas, October 7, 2011) p. 5 http://ctb.ku.edu/en/tablecontents/chapter2_section16_main.aspx (accessed online April 3, 2012)
[55] PPACA §4201
[56] http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf (Accessed March 17, 2012)
[57] PPACA §4002

- medical homes that emphasize patient health; [58]

- the National Quality Strategy, which targets not only improvements in health care quality, but also evidence-based investments that address the social, behavioral, and environmental determinants of health, in addition to interventions that improve the quality of care;[59]

- improvements in coverage for clinical preventive services of proven effectiveness;[60]

- maternity, infant, and early childhood home visiting programs, expanded programs in schools, and expansion of community health centers;[61] and

- Accountable Care Organizations[62] and community-based care arrangements[63] that emphasize the alignment of clinical quality improvement, cost efficiency on and health improvement.

In aligning the CHNA process with the broader policy considerations that underlie community health improvement, a number of issues become important.

- *Multi-organizational planning.* At the heart of community health improvement lies the goal of multi-stakeholder involvement in the continuous process of assessing need, developing priorities, targeting resources to meet priorities, and evaluating impact. The Treasury/IRS Notice contemplates multi-organizational collaborations. While there are important limitations on collaborations among competitors that entail unlawful restraints of trade by fixing prices, the community health improvement collaboration process that undergirds CHNA has a health improvement goal and does not involve decisions about how much to charge third parties for hospital services. Antitrust policy concerns arise when competitors act collectively to fix prices. By contrast, the CHNA process involves planning to improve community health, not determine the price at which hospital care will be sold. Furthermore, in communities in which CHNA activities are formally carried out as part of a broader public health planning activity, the collective action of the stakeholders is designed to further the public interest. Of particular importance is the transparency of the effort along with its inclusiveness, and the fact that the focus is not on the generation of revenue for participants but instead on support for activities that, if anything, may lessen the need for the types of services sold by hospitals to their patients.

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[58] PPACA §2703
[59] http://www.hhs.gov/news/press/2011pres/03/20110321a.html (Accessed March 18, 2012)
[60] PPACA §4003
[61] PPACA §§2951, 4101, and 5601
[62] Section 1899 of the Social Security Act.
[63] See, e.g., Community Choice First Option, PPACA §2401

- *Broad geographic planning.* The agencies make clear that they favor planning across broad geographic areas that transcend defined hospital markets. Indeed, the agencies require facilities to avoid defining their planning areas in a manner that excludes medically underserved populations who experience discrimination in health care and carry an added burden of poor health.

- *Input from persons with public health knowledge.* The ACA itself, as well as implementing agency policies, requires input from persons with public health knowledge and expertise. Neither the statute nor the Notice defines "input" or "knowledge or expertise in public health," although the agencies seek input on this question. One approach to this statutory expectation would be to establish objective standards (training, experience, both written and oral input opportunities) for measuring what constitutes the requisite input from knowledgeable persons. Another would be to allow hospitals to use individual discretion in defining the level and quality of the input they receive. One set of commenters suggests the use of objective standards defined in relation not only to education and credentialing but also to experience in "technical community health needs assessment competencies"[64] related to collecting and analyzing community health needs and assets using qualitative and quantitative data, methods for effective community engagement, interpretation of community health data and prioritization of community health needs, and knowledge of science-based health promotion and disease prevention interventions. The commenter group also notes the value of public health input at both the needs assessment and prioritization phases, as well as in the development of an implementation strategy, when actual investments will be tied to prioritized need.

- *Transparency.* A goal of the CHNA process is transparency. To that end, the law requires community and public health input in the assessment phase, as well as use of "widely available" techniques for both the assessment and the implementation strategy. Because the implementation strategy flows from the assessment, consideration could be given to using a public and public health consultation process as the actual investment strategy is prepared, similar to the consultation process that the agencies identify as integral to the assessment of need.

- *Making the case for community building activities that constitute community benefits involving community health improvement.* As the Schedule H instructions make clear, community building activities that have an evidence base in public health can receive credit as community benefit expenditures. An important consideration therefore becomes the role played by certain forms of evidence. For example, the Federal Task force on Community Preventive Services has extensively documented evidence-based interventions that improve community health.[65]

[64] Consensus Statement on Maximizing the Community Health Impact of Community Health Needs Assessments Conducted by Tax-exempt Hospitals (March 13, 2012)
[65] http://www.thecommunityguide.org/index.html

The National Prevention Strategy is similarly evidence-based.[66] Both documents offer examples of community investments that improve health and thus provide the evidence base that hospitals would need in order to gain "community benefit" credit for community building activities. As hospitals begin to focus more intensively on community health as a target of their investments, these two documents might serve as crucial resources for both guiding community health investments as part of hospitals' implementation strategies. Both documents, as well as other CDC resources on community health improvement could, in turn, serve as the evidence base on which hospitals reply in claiming community building activities as a community benefit expenditure under Schedule H.

[66] http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf