

Hospitals as Community Hubs: Integrating Community Benefit Spending, Community Health Needs Assessment, and Community Health Improvement

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Executive Summary

Much public focus is being given to a broader role for hospitals in improving the health of their communities. This focus parallels a growing interest in addressing the social determinants of health as well as health care policy reforms designed to increase the efficiency and quality of care while improving health outcomes. This interest in the community role of hospitals has drawn attention to the federal legal standards and requirements for nonprofit hospitals seeking federal tax exemption. Tax-exempt hospitals are required to provide community benefits. And while financial assistance to patients unable to pay for care is a basic requirement of tax-exemption, IRS guidelines define the concept of community benefit to include a range of community health improvement efforts. At the same time, the IRS draws a distinction between community health improvement spending—which it automatically considers a community benefit—and certain “community-building” activities where additional information is required in order to be compliant with IRS rules. In addition, community benefit obligations are included in the Affordable Care Act (ACA). Specifically, the ACA requires nonprofit hospitals periodically to complete a community health needs assessment (CHNA), which means the hospital must conduct a review of health conditions in its community and develop a plan to address concerns. While these requirements are causing hospitals to look more closely at their role in the community, challenges remain. For instance, complex language in the rules can mean hospitals are unclear what activities and expenditures count as a “community benefit.” Hospitals must take additional steps in order to report community building as community health improvement. These policies can discourage creative approaches. Moreover, transparency rules and competing hospital priorities can also weaken hospital-community partnerships.

To encourage more effective partnerships in community investments by nonprofit hospitals:

- The IRS needs to clarify the relationship between community spending and the requirements of the CHNA.
- There needs to be greater transparency in the implementation strategy phase of the CHNA.
- The IRS needs to broaden the definition of community health improvement to encourage innovation and upstream investment by hospitals.

In recent years growing attention has been paid to the role of hospitals in improving community health, not only providing medical care, but also serving as “health hubs”¹ and as “intermediaries” in integrating health and economic mobility.² This interest in promoting a stronger role for hospitals in community-wide health is the result of several developments.

A Growing Focus On Social Determinants of Health

The first development is the increased focus now

being placed on social determinants of health, defined by public health experts as “conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.”³ Efforts to improve the social conditions that influence health necessitate a broad range of community actors, and as key institutions anchoring the communities they serve, hospitals emerge as a natural source of collaboration,

¹ Butler, Stuart M., Jonathan Grabinsky, Domitilla Masi. 2015.

² Butler, Stuart M. and Prabhjot Singh. 2015.

³ “Healthy People 2020 Social Determinants of Health.” *Office of Disease Prevention and Health Promotion*. <http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

leadership, and community support for broader health interventions. There are important examples showing how hospitals have assumed this type of expanded relationship with their communities, such as Boston Children’s Hospital’s child health initiative, which is aimed at not only treating serious illness but also at comprehensively addressing the underlying factors that affect the health of the city’s children.⁴

Reforming Health Care to Address Spending, Outcomes and Disparities

A second driver of change has been emanating from the health care system itself. Motivated by underlying social and economic conditions, as well as significant shifts in policy, the American health care system has begun to seriously confront a triple-threat situation: the highest per-capita health care spending in the world;⁵ relatively poor health outcomes,⁶ and significant racial, ethnic, and socioeconomic disparities in health and health care that leave burdened populations and communities vulnerable to preventable mortality and morbidity because of factors unrelated to either the need for services or the ability to benefit from high quality health interventions.⁷ This concern about excessive health care spending, poor health outcomes, and measurable disparities has led public and private insurers to place a growing emphasis on payment reforms designed to incentivize better and more efficient performance, such as incentives to reduce unnecessary and avoidable hospital inpatient readmissions. For hospitals serving communities with sizable populations facing health and social risks, achieving reduction in readmissions inevitably requires a focus on the underlying conditions of health, not only at discharge but generally.⁸ Similarly, payment reforms designed to foster overall efficiency, such as case payments, global payments, and capitation with opportunity for shared savings, aim to encourage integration of care and greater alignment between medical care and community social services that may alleviate poor health. As hospitals respond to payment incentives that are becoming industry-wide norms, the public health imperative and

the business imperative begin to converge.⁹

Expanding and Refining the Community Obligations of Tax-Exempt Hospitals

A third development, which touches the two-thirds of all U.S. hospitals that operate as tax-exempt charitable organizations,¹⁰ is a series of significant shifts in recent years in the underlying legal framework that defines the relationship between hospitals and their communities. It is important to understand these shifts and their interaction because of their implications for hospital efforts to assume a broader presence on issues of upstream health matters, the role of hospitals within their communities, and the issues and challenges that remain.

The Basic Community Benefit Obligation of Tax-Exempt Hospitals: Origins and Evolutions

Reflecting federal policy dating back to the original enactment of the federal income tax, § 501(c)(3) of the Internal Revenue Code confers tax-exempt status on organizations organized and operated for charitable purposes. The promotion of health is not an explicit charitable purpose under the Code; since 1956 however, the Internal Revenue Service (IRS) has recognized the promotion of health as the type of activity that would qualify as charitable when conducted by institutions that otherwise meet applicable federal requirements.¹¹ Under IRS standards, the mere fact of a hospital’s presence in a community does not confer a community benefit.¹² Instead, hospitals must demonstrate that they are involved in activities recognized by the IRS as benefitting their communities.

Back and forth on “community benefit” requirements. Originally, in the 1950s, the IRS focused on activities that made the hospital’s services accessible to community residents, with provision of charitable care to community residents as the defining hallmark of charitable status.¹³ In 1969, however, the IRS eliminated provision of charity care as a necessary precondition to tax-exempt status,¹⁴ adopting instead a more nebulous “community benefit” standard. This

⁴ “About Us.” *Boston Children’s Hospital*.

<http://www.childrenshospital.org/about-us/community-mission/priority-health-areas>

⁵ Squires, David and Chloe Anderson. 2015.

⁶ Blumenthal, David, Melinda Abrams, and Rachel Nuzum. 2015.

⁷ “CDC Health Disparities and Inequalities Report – United States 2013.” HHS. 2015.

⁸ Nagasako, Elna M., Mat Reidhead, Brian Waterman, and W. Claiborne Dunagan. 2014.

⁹ Butler, Stuart M. 2015.

¹⁰ “Fast Facts on U.S. Hospitals.” *American Hospital Association*. <http://www.aha.org/research/rc/stat-studies/fast-facts.shtml>

¹¹ Somerville, Martha H. 2012.

¹² *Geisinger Health Plan v Commissioner of Internal Revenue Service*, United States Court of Appeals Third Circuit. February 8, 1993.

¹³ “IRS Revenue Ruling 56-185.” IRS. 2012.

¹⁴ “Revenue Ruling 69-545.” IRS. 2012.

standard served to give hospitals broad discretion over what charitable activities they would pursue, such as research, health professions training, or general efforts to promote community health, while also qualifying for federal tax-exempt status. The IRS not only broadened the standard of community benefit to move away from the direct provision of free or discounted care but also provided little in the way of follow-on policy guidance and even less in the way of enforcement actions aimed at individual hospitals.

The early 2000s saw a renewed bipartisan focus, driven by the news coverage of the failure of many tax-exempt hospitals, on the conduct of these hospitals that, despite their poor performance in providing care to the underserved and poor, pursued aggressive and unreasonable billing and collection practices. In the Affordable Care Act (ACA), Congress amended the Internal Revenue Code to ban unreasonable billing and collection practices and added financial assistance for free or reduced cost care as a core requirement of all tax-exempt hospitals.¹⁵ Implementing federal regulations provide substantial guidance that addresses the basic elements of hospitals' financial assistance programs and practices, including the nature and structure of such programs, how programs must be adopted, publicized, and made accessible to patients, and the timing of when such assistance must be offered (i.e., at the point at which care is furnished, not after debt collection efforts).¹⁶

Clearer rules for community hospitals. Nearly simultaneously with the ACA reforms, the IRS adopted a comprehensive and more explicit definition of what constitutes recognized hospital community benefit spending activities. This definition is captured in Schedule H, a special reporting document that all hospitals claiming tax-exempt status must file as part of the IRS's Form 990, which covers all charitable organizations.

Under Part I of Schedule H, the term "community benefit" now is defined by and encompasses financial assistance at cost, losses related to participating in Medicaid and other means tested government health programs, health professions education, community benefit operations, research, and a category of services known as "community health improvement."¹⁷

Instructions accompanying Schedule H define community health improvement as "activities or programs subsidized by the health care organization, carried out or supported for the express purpose of improving community health," and specify that such services must not generate inpatient or outpatient revenue, although nominal cost-sharing is permitted.¹⁸

A new emphasis on building communities. Part II of Schedule H also recognizes—separate and apart from community benefit—certain "community building" activities. These activities include physical improvements and housing, economic development, community support, environmental improvements, workforce development, and other activities that lie outside the basic IRS definition of community benefit. Taken together, these activities can be thought of as focusing much more on the upstream conditions of health rather than on patient services furnished by a hospital (or through grants to community providers) and offered in community locations. Rather than involving traditional health care, these activities typically would entail hospital participation, perhaps through donated professional time, grants, and other efforts, in broader, community-wide efforts to improve health. Examples might be efforts to develop affordable and safe housing, reduce environmental threats, advance student achievement, or educate and train a workforce.

Under IRS policy, hospitals are permitted to count "community building" expenditures as a form of "community health improvement" activities—and thus as a form of community benefit. In order to do so, a hospital must describe "how its community building activities promote the health of the communities it serves."¹⁹ This policy thus effectively opens the door to greater involvement in upstream health activities on the part of tax-exempt hospitals as a form of community benefit spending. If the IRS uses this policy in a wise way, it could lead to nonprofit hospitals playing an increasingly important role in housing, education, and other key elements of a successful neighborhood.

How uncertainty can encourage innovation. But current uncertainty about the interpretation of Part II could, unfortunately, frustrate potentially valuable initiatives by hospitals. From a legal compliance perspective, the segregation of Part II community building from Part I community benefits may have important implications. Under the IRS approach,

¹⁵ Nikpay, Sayah and John Ayanian, "Hospital Charity Care – Effects of New Community Benefit Requirements," *New Eng. Jour. Of Medicine*. 2015.

¹⁶ 26 C.F.R. §1.501(r)-4

¹⁷ "Schedule H (Form 990), Hospitals." IRS.

<https://www.irs.gov/uac/About-Schedule-H-Form-990>

¹⁸ "Instructions for Schedule H." IRS. 2015.

¹⁹ "Instructions for Schedule H." IRS. 2015.

hospitals are responsible for justifying community building as community health improvement. But this required justification process is made more complex by the fact that IRS guidance does not elaborate on the range and type of evidence that the agency will find acceptable. This vagueness leaves hospitals potentially vulnerable to the IRS's rejection of the hospital's justification as not sufficient to classify Part II expenditures as community benefits. Furthermore, although federal law establishes no minimum community benefit spending requirements, some states, using the IRS's community benefit definition, in fact do so.²⁰ So hospitals could be taking a risk if they try to make a difference in their community. A hospital's submission regarding community building expenditures could be rejected by the IRS as not supporting a claim of community benefit. If that happens, it is also possible that a state using minimum spending standards similarly could disapprove the expenditure as a community benefit, thereby reducing the hospital's overall level of community benefit spending below state minimum requirements. Faced with such a possibility, many hospitals would likely take a less creative and safer course rather than, for instance, working with community organizations on new ways to help strengthen the neighborhood.

The potential for increasing the amount of spending on upstream activities that might help improve community health is considerable. IRS data covering the 2012 tax year²¹ show that in 2011 hospitals reported nearly \$62.5 billion in community benefit spending, with the majority (over \$35 billion) spent on financial assistance furnished to 3 million patients and unreimbursed costs attributable to care for 11 million Medicaid patients. Hospitals spent a total of \$27.4 billion on other community benefits; of this amount, a little more than 10 percent (\$2.7 billion) was spent on community health improvement. This \$2.7 billion figure thus represents slightly more than 4.3 percent of all community benefit spending during the 2011 tax year. As hospitals realize economic gain from declining levels of uninsured patients, the public interest in greater community health improvement spending arguably grows given the impact of social conditions on health and the tax advantages hospitals gain from their tax-exempt status.²² But in view of the

fact that community building expenditures must be separately justified, this added compliance step may serve to disincentivize stronger performance in this area, although recent evidence suggests a growing hospital focus on upstream activities that pierce the wall between community benefit and community building.²³

Using the Affordable Care Act's Community Health Needs Assessment Requirement

Beyond establishing financial assistance as a minimum obligation of all tax-exempt hospitals, the Affordable Care Act also made periodic community health needs assessments (CHNA) a basic requirement. The CHNA is a new provision of the Internal Revenue Code, added as a part of the ACA, which requires nonprofit hospitals to conduct an assessment every three years of the health condition of their local community and produce a plan to address them. These assessments began with the 2012 tax year.²⁴ Each hospital facility is responsible for the assessment, meaning that unlike community benefit spending, which can be reported at an organization level across all facilities, health needs assessments must be facility-specific.²⁵ In performing needs assessments, a hospital 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."²⁶ Assessments must be made "widely available to the public"²⁷ and must be accompanied by annual "implementation strategies" "adopted" by the hospital, whose purpose is "to meet the community health needs identified through the needs assessment."²⁸

Community input required. IRS implementing regulations for CHNAs provide greater detail regarding the minimum elements of the community health needs assessment process. In conducting an assessment a hospital must define the community it serves in ways that do not exclude medically underserved, low income, or minority populations—living in the geographic areas from which the hospital facility draws its patients—because of their reliance on public insurance or their

²⁰ "Community Benefit State Law Profiles." The Hilltop Institute. 2015.

²¹ "Report to Congress on Private Tax Exempt, Taxable, and Government-Owned Hospitals." IRS. 2015.

²² Rosenbaum, Sara, David Kindig, Jie Bao, Maureen Byrnes, and

Colin O'Laughlin. 2015.

²³ Rosenbaum, Sara and Bechara Choucair. 2016.

²⁴ 26 U.S.C. §501(r)(3)

²⁵ 26 U.S.C. §501(r)(B)(i)

²⁶ 26 U.S.C. § 501(r)(3)(B)(i)

²⁷ 26 U.S.C. § 501(r)(3)(B)(ii)

²⁸ 26 U.S.C. § 501(r)(3)(A)(ii)

need for financial assistance.²⁹ A hospital must not simply take into account, but must also “solicit”, input from community residents and public health experts.³⁰ The CHNA itself must be a written report that is formally adopted by the hospital and made widely available to the public.³¹

In assessing community health needs, the IRS requires that the hospital’s assessment consider not merely the need for health care, but the “requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community.” This must include the need to “prevent illness, to ensure adequate nutrition, or to address social, behavioral and environmental factors that influence health in the community.” Needs must be prioritized, and resources for potentially meeting those needs must be identified.³² In other words, in framing the needs assessment process, the IRS focuses on the social determinants of health, not just health care services.

An implementation strategy also required. Hospitals must accompany the community health needs assessment with an implementation strategy. The strategy is perhaps the most crucial portion of the needs assessment process. Unlike needs assessments, the IRS does not require that implementation strategies be made widely available to the public, even though such strategies (which must be updated annually) effectively operate as the blueprint regarding the needs that the hospital will and will not focus on and the resources that the hospital may commit or seek in furthering their needs assessments. Hospitals’ implementation strategies, however, must be attached to Schedule H or else must be available through a web link.

Challenges in Using the CHNA

The CHNA is potentially an important tool to encourage nonprofit hospitals to increase their efforts to work with local institutions to improve community health. But obstacles remain.

Impact analyses to help guide strategic planning and investment. The needs assessment process has understandably garnered a good deal of attention from the Centers for Disease Control (CDC), given that agency’s focus on health promotion and

preparedness.³³ Public health experts have discussed how implementation strategies for the CHNA could build on other programs and investments.³⁴ However, there has been no analysis of the effectiveness of actual implementation strategies, even though the strategy phase is most likely to provide the crucial information needed to guide hospitals on how best to invest their own and other resources to address community health needs.

Insufficient transparency that makes coordination within the community more difficult. The lack of a transparency provision for implementation strategies equivalent to that required during the planning phase makes it difficult for community institutions to coordinate their spending and activities with those of their local hospitals or for local hospitals to coordinate with one another. To be sure, communities may be able to discover their hospital’s implementation strategy by searching Schedule H or viewing the hospital’s website. But that is not ideal.

Priorities for hospitals might compete with upstream CHNA priorities. Although the ACA establishes needs assessment and implementation strategies as basic requirements for all tax-exempt hospitals, the legislation does not draw a legal connection between community benefit spending and the needs assessment and implementation strategy components of the law. But that means, as a legal compliance matter, that it would be permissible for hospitals to devote most or all of their community benefit spending to activities that directly relate to the hospital’s own operations (such as financial assistance, Medicaid shortfalls, research, health professions education and training, or community benefit administration), rather than on activities actually identified as high priority community health investment matters as part of CHNA process.

A definition of “community benefit” more focused on the community. This tendency to emphasize the hospital’s own operations in making community benefit spending allocation decisions has the potential to be further reinforced by the definition of “community benefit.” This definition encompasses many activities that focus on hospital operations. Community building can count as community health improvement, but only with added justification. As a result, although the community health needs assessment process attempts

²⁹ 26 C.F.R. § 1-501(r)-3(b)(3)

³⁰ 26 C.F.R. § 1-501(r)-3(b)(1)(i) and (iii)

³¹ 26 C.F.R. § 1-501(r)-3(b)(1)(iv)

³² 26 C.F.R. § 1-501(r)-3(b)(4)

³³ “CDC Community Health Improvement Navigator.” Center for Disease Control and Prevention.

<http://www.cdc.gov/chinav/>

³⁴ Barnett, Kevin. 2012.

to position hospitals as outward-looking entities focused on the geographic areas from which they draw their patients and employs a broad definition of “community health need,” the definition itself doesn’t sufficiently focus on the community. This, coupled with the burden of reporting Part II spending as community benefit spending along with the absence of transparency surrounding the implementation strategy phase, may serve to disincentivize hospital investments in upstream need.

Creating a Closer Link Between Community Benefit Spending and Community Health

The community health needs assessment process is, under IRS rules, intended to focus on the need for improvements in health, not simply on health care services and spending. Furthermore, under IRS and other agencies’ policies, it is agreed that the concept of community health improvement can and should be broadened to include upstream health investments through additional justifications by the hospital to support its claim that such expenditures improve health. In view of these policies, it would appear to be a propitious time to formally broaden and encourage community-wide health spending as a core element of community health improvement.

Given the broad agreement on community health, this is a pivotal time for encouraging upstream investments. There is a high level interest in underlying social conditions of health and a strongly emerging business case for encouraging such investments given the growing emphasis on health in hospital and health system payment policy. For this reason, it is an especially good time to focus on how IRS policy might be revised to encourage upstream investments by hospitals as a community benefit.

To this end, three basic reforms might advance the goal of broader hospital investment in community health.

1) There needs to be a clear articulation by the IRS of the importance of the relationship between community benefit spending on the one hand and community health needs assessments and implementation strategies on the other.

Such a relationship currently is not legally required under the Internal Revenue Code. But the IRS’ own regulatory focus on health as part of the needs assessment process, coupled with the IRS’ recognition of community health improvement as a category of recognized community benefit spending, could support

more refined IRS policy encouraging the use of community health needs assessments to guide community benefit spending as part of hospitals’ implementation strategies. In other words, in revised regulations, the IRS could draw the logical link across community health planning, community health improvement, and allocation decisions related to community benefit spending. This would be especially wise at a time when hospitals are seeing the financial benefits that flow from greater insurance coverage under the ACA.

2) Greater transparency around the implementation strategy phase of the community health needs assessment process could spur greater hospital financial allocations to upstream community health improvement.

The ACA describes community needs assessments and implementation strategies in the same subsection of the law. Although making hospital spending information publicly available is explicitly required only for community health needs assessments, the connection between transparent planning and transparent spending priorities is sufficient for the agency to actively encourage, if not require, wide availability of implementation strategies. This is especially true if we consider the fact that IRS regulations encourage an upstream focus as part of the health needs assessment process. Communities may be able to obtain their hospitals’ implementation strategies by getting copies of attachments to Schedule H, but that places a high burden on communities, who often lack the means to secure, search, and understand Schedule H information. Posting the implementation strategy and thereby making it widely available would seem to be a logical extension of the effort to ensure greater transparency in hospital responsiveness to communities.

3) It’s time to eliminate the distinction between Part I and Part II of Schedule H.

A wealth of expert reports and studies establishes the link between social conditions and health. Keeping upstream activities separate from community health improvement activities is outmoded. Moreover, the additional documentation requirement, coupled with uncertainty about the level of proof required, inevitably serves as a disincentive to upstream investment.

In this regard, the Community Reinvestment Act (CRA) of 1977 serves as a potential precedent for adopting a broader community benefit standard for nonprofit hospitals. The purpose of the CRA is to

ensure that the financial institutions subject to its requirements helps to address the capital and credit needs of their local communities. Although the CRA originally focused narrowly on lending and credit practices in relation to specific customers—a parallel of sorts to the original concept of hospital community benefit with its emphasis on charity care—CRA policy today is much broader and recognizes that a wide range of community development programs can be aimed at lifting the well-being of entire at-risk communities and not only people who are customers of a lending institution.³⁵ The evolution of the CRA might serve as a useful model for being broader and more imaginative in thinking about the potential community impact of IRS rules for nonprofit hospitals.

Were the IRS to consider broadening the definition of community health improvement, there could be two approaches for doing so. One would be simply to eliminate Part II of Schedule H as a separate and distinct reporting classification and merge the enumerated activities into the Part I definition of community health improvement. Another option would be to recognize specific types of spending—affordable and safe housing, environmental improvements, or spending that strengthens student achievement—as automatically recognized community health improvement spending. Indeed, in the case of safe and affordable housing, hospitals have sought an expanded recognition of such spending.³⁶

Conclusion

The proposed policy shift on the part of the IRS is consistent with the weight of the evidence regarding what constitutes a benefit to communities. It is also consistent with the IRS' own regulations stressing the broader concept of community health as falling within the purview of hospitals' planning activities, and thus, their decisions over how to best invest their own resources to achieve these outcomes. So this is a case where a relatively small shift in community benefit spending toward a broader range of community health improvement activities could spur a sizable increase in total resources available to address the social conditions of health. And that shift would be consistent with the nation's longer-range health goals.

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³⁵ *CRA Investment Handbook*. Federal Reserve Bank of San Francisco. 2010.

³⁶ Hatton, Melinda, Lisa Gildea, and Janis M. Orlowski. "Ensuring Schedule H Instructions for 2015 Reflect Current Research on Housing as Community Benefit." Letter to Sunita Lough and Tamara Ripperda, IRS. December 9, 2015.

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