Leveraging the Opportunity of the *The Affordable Care Act:*
A Hospital-Funded Community Organizing and Planning Process

In return for billions of dollars in federal tax subsidies, non-profit hospitals are required to operate for the public good by providing "community benefits" beyond the types of medical services that can also be provided by for-profit institutions. Until recently, the nature and scope of required "community benefits" were vague and rarely enforced by the Internal Revenue Service, which has the power to deny or revoke a hospital's tax-exempt status for non-compliance.

The 2010 Affordable Care Act included a new provision requiring tax-exempt hospitals to develop community health needs assessments, participatory processes, implementation plans, and evaluation procedures in order to justify and maintain their tax-exempt status. Additionally, the Internal Revenue Service (IRS) has in the past several years prescribed a transparent reporting regime and signaled that increased scrutiny of "community benefits" compliance is on the horizon. Further, the IRS has indicated that a broad range of activities, including community organizing, may qualify as "community benefits."

It is not clear how much money hospitals will be required to spend on community benefits processes and programs, but currently, under requirements in some states, hospitals spend between 1.5%- 8% of patient healthcare expenditures on Community Benefits Agreements (CBAs). Patterns of community benefits vary by both state and by the degree of pressure on hospitals, but most experts believe that hospitals will choose to spend between 3-5% of revenues on CBAs in an effort to insulate themselves from IRS challenge. Last year, the top 50 non-profit hospitals had annual revenues of $214 billion. Under the 3-5% regime, between $6.4 billion and $10.7 billion would be available for community development each year from the top 50 non-profit

hospitals alone, in an effort to meet their non-profit status requirements. If we consider the more than 2,800 additional non-profit hospitals in the U.S., the aggregate numbers will be much higher.

A 2009 IRS survey of 500 large hospitals showed that total community benefits expenditures were allocated to the following activities: 56% toward uncompensated care; 23% toward medical education and training expenditures; 15% toward medical research; and 6% toward community programs. When the Affordable Care Act is fully implemented by 2014, it could well reduce the number of uninsured patients and thus total hospital expenditures on charity care. This means more community benefits dollars will be freed up to flow out into surrounding communities, and hospitals will have to invest more aggressively in addressing the negative social and physical conditions that lead to poor health, rather than in simply treating patients.

These developments offer a major opportunity for progressive activists to convince tax-exempt hospitals to invest a portion of their "community benefit" funds in efforts that:

1. Engage community residents in a planning process about their future with local institutions and organizations such as schools, businesses, labor unions, and others;

2. Introduce green infrastructure and economic development programs and processes that leverage the buying power of community institutions (such as hospitals, schools, and housing complexes) to create local service and manufacturing jobs to supply goods and services that local institutions buy; and

3. Build multi-stakeholder partnerships between community groups, participating local businesses, local government, and trade unions to guide and expand local economic development and policy/political initiatives.

The faculty, staff, student and community partners at CoLab believe that these new legal requirements could be a significant first step towards creating the civic capacity needed to build a different U.S. economy. The result could forge a strong mechanism for transferring wealth from the healthcare industry to communities in need. Seizing this opportunity will require a comprehensive, participatory planning process that engages community organizers, labor organizers, and community-based organizations. It will take significant planning, engagement, innovation, and imagination to fully meet the letter and spirit of the new provisions as it is doubtful that most hospitals now fully understand their responsibilities or have the capacity to meet them. Moreover, many hospitals may seek to limit their responsibilities under the new IRS requirements, arguing that their existing programs, which often too narrowly address unmet healthcare needs, are sufficient. It will take concerted advocacy and monitoring to ensure that these new provisions are meaningfully put into effect.

(A) The Community Planning Process

The 2010 Affordable Care Act now requires all 2,904 non-profit (including Catholic) hospitals in the U.S. to do community needs assessments to address problems in communities that lead to poor health: unemployment, unhealthy food, housing deficiencies, local environmental problems, and climate change. These new requirements are in line with longstanding World Health Organization (WHO) principles for community development. Hospitals will now be required to include community residents in a local planning process and they are encouraged to help communities build their capacity to knowledgeably participate in health and environmental planning. Hospitals that do not comply with the Act may be fined $50,000 and could lose their tax-exempt status.

Community needs related to health, environmental degradation, unemployment, poverty, and climate change are generally well known. We believe that the key for successful CBA planning will be in reaching agreement between hospitals and community actors on priorities to be addressed through CBA initiatives, and on funding for such initiatives.

The law is clear that input from community members and representatives is a key element in defining the substance of community benefits. The assessment is to be informed by data about a defined target community that does not exclude the medically underserved, low-income people, minorities, or the chronically ill. The assessment must be based upon sufficient input from the broader community that is served by the hospital and is made publicly available.

The faculty, staff, student and community partners at CoLab believe that the assessment process should involve several activities, including, but not limited to:

- State policy review
- Political engagement
- Selection of focus hospitals and communities
- Stakeholder identification, mapping, and analysis
- Data gathering from secondary and primary sources and analysis
- Public convenings
- Priority setting, plan writing, and adoption
- Local capacity-building to implement change

(B) Implementation

After the assessment is performed, hospitals and community groups must develop an implementation strategy for addressing all community health needs that are identified in the assessment. The challenge is significant: hospitals are likely to struggle without community-engaged planning expertise and support, and communities will miss the opportunity if they are not sufficiently informed, prepared to advocate, and organized. Expert technical assistance could help far-sighted hospitals in orchestrating an inclusive planning process that takes into account long-term aspirations of community members and ties together the goals around improving health, retrofitting infrastructure, mitigating climate change, growing community wealth, and realigning community and organized labor. In this vision, ideally, every implementation plan would include three major components:

1. Greening infrastructure to support health needs and reduce local costs;
2. Leveraging anchor institutions to launch community-owned enterprises; and
3. Engaging organized labor in a long-term wealth- and movement-building strategy.

Tying these three components together and engaging community organizers in the strategy, would make the most out of this unfolding opportunity.

(C) Greening Infrastructure and Health Benefits

The IRS has suggested that expenditures to improve the environment may qualify as acceptable "community benefits." This may provide new leverage to convince hospitals to invest in green infrastructure and community development activities that improve the overall health of the community. Here, we define "green" to apply broadly to all planning and development activities that seek to promote social, economic, and environmental sustainability. Some potential activities might include: upgrading housing units to meet health and safety codes; increasing energy efficiency in homes and businesses and increasing energy supply from alternative sources; increasing access to green space, parks, and recreational spaces; increasing access to healthy food; and facilitating better access to public transportation and mitigating harmful vehicular traffic patterns. The activities above represent a sampling of what might be explored in a hospital community benefits health needs assessment and implementation strategy. Other community engagement activities would likely be launched in tandem, and they would cover programs for community education, outreach, training, organizing and advocacy. Under this comprehensive approach, the physical environment could begin to be reconfigured in accordance with a community's social and economic realities.

(D) Leveraging Anchor Institutions to Create Jobs and Launch Community-Owned Enterprises

It is highly likely that the dominant tendency among hospitals and community development groups will be to use CBA funds to directly support and expand initiatives already underway in low-income communities, such as "healthy home" initiatives that retrofit houses to improve air quality and to reduce rodent and cockroach infestation, lead paint, and other health hazards. Since these programs are underfunded, no doubt they will seek CBA money to fill in gaps. Others will want to expand their healthy home approach to include other eligible activities, such as housing retrofits to reduce energy consumption. Local governments will also be interested in using CBA money to fill in budget shortfalls on their own community improvement initiatives, from expanding bicycle lanes to building affordable housing.

(E) Engaging Organized Labor in a Long-Term Wealth- and Movement-Building Strategy.

Ideally, long-term collaborations between anchor institutions, community organizations, local governments, local business, and labor unions can emerge that will create, sustain, and expand the kinds of initiatives outlined above. These local "tables" could take the form of holding companies that jointly own and administer local businesses and initiatives, or many other forms. Many unions may want to participate: the building trades due to projects involving construction and operation of plants such as clean energy producing turbines; teachers because of community education components, school retrofits, and school procurement links; UAW and USW because of local manufacturing; SEIU because of hospital engagements; and so on. These local tables would engage in policy advocacy to support their local initiatives and cooperate politically for the same reason.

The tables would be self-financed from the combined sources of hospital CBAs and locally owned businesses. Community organizations can also be supported from the same sources to ensure broad community participation in these local projects at all levels. In summary, the community benefits planning process will become a long-term economic development strategy through which the healthcare sector supports cooperatively-owned enterprises that supply goods and services to the hospitals and other anchor institutions. The result could be a comprehensive reconfiguration of local and regional economies.

THE OPPORTUNITY: Using CBAs to Build Community-Owned Businesses to Generate Community-Owned Wealth

Using CBA funds solely to expand healthy homes misses significant opportunities to leverage these dollars to increase local communities' ability to generate wealth for themselves by producing goods and services to meet the procurement needs of institutions in their neighborhoods. Hospitals spend more than 20% of their annual revenues for procurement. In the case of the University of Pittsburgh hospital, a 3% CBA contribution amounts to $30 million/year. However the hospital's annual procurement budget is likely to be in the $2 billion/year range. The core of a self-sustaining

community improvement strategy would be to use the tens of billions of annual CBA community investments as start up capital for job-creating community owned businesses to supply the hundreds of billions in goods and services that hospitals, schools "eds and meds" and other major community institutions now import from other areas. This "anchor institution" strategy is already gaining acceptance nationally (more than 100 case studies can be found on the Initiative for a Competitive Inner City). In Cleveland, for example, hospitals and universities are supporting the creation of cooperatively-owned local businesses to produce food for the local *eds and meds*. They are also requiring that local contractors on their construction projects hire local residents and ensure that their workers receive health coverage ("Why should hospitals," one administrator asked, "hire contractors whose workers can't afford to use our hospital?").

In Pittsburgh and Cincinnati, local cooperative businesses are being formed to provide laundry services for *eds and meds*. Initiatives such as these are the tip of the iceberg of what could be produced in communities for local markets. Major institutions in cities purchase a wide range of manufactured goods such as washing machines, vacuum cleaners, cleaning supplies, ovens, and light bulbs. Many, if not all, of these types of goods could be produced locally. As noted above, with rapid advances in digital manufacturing already emerging (see MIT's FabLab) manufacturing will be increasingly local and accessible to urban communities with community college level technical training. The increasing move of educational institutions to put their curricula on line opens up many possibilities here. For example, a pitfall for federal minority-owned businesses/women-owned businesses (MBE/WBE) procurement set-aside programs has been lack of training of WBE/MBEs, and lack of financial capital for MBE/WBE to scale up to capture large contracts. Part of hospital CBA resources can be used to address these kinds of weaknesses in local communities, using existing training material such as the Mondragon Cooperative's online MBA program for managing and developing cooperative businesses.

The anchor approach, combined with the creation of local worker-owned businesses (potentially unionized as well—see the US Steelworkers-Mondragon collaboration), offers great opportunities for quality job creation in low-income and minority communities. Going beyond the goal of addressing environmental health issues, the implementation plans can lay out long-term, implementable strategies that also address the social determinants of poor health, including persistent poverty and exposure to violence and insecurity. In our view, each plan should contain four common elements:

1. **Utilize "community benefit" requirements to access hospital procurement as an economic driver**. Although the "community benefit" resources that will be redirected into community development are significant, the purchasing power of hospitals (procurement) is a far greater source of wealth and in most

communities is an untapped asset for business and job creation.

2. **Harness the procurement of additional anchor institutions.** Although hospitals are typically the largest anchor institutions in communities in terms of employment, revenue, and procurement, other significant anchor institutions are often present as well, including education, arts and cultural institutions, and housing authorities. Activists could work with the leadership of selected hospitals to join additional institutions in a collective procurement strategy for community economic development.

3. **Develop worker-owned enterprises to meet the procurement needs of the community anchor institutions.** The first part of this strategy is about capturing a source of wealth for economic development that typically leaks out of communities. The second part is about ensuring that workers and community members own and control the businesses that are created and broadly share in the wealth that is created from these enterprises. By creating employee owned businesses (worker cooperatives), the workers collectively own the company and democratically decide on the management, operations, and strategy of business.

4. **Build a community enterprise network.** In order to support the long-term viability of these newly-created businesses and establish an environment for continual community enterprise development, the development strategy would seek to build a network made up of worker owned enterprises, anchor institutions, and support organizations. This network would serve as the long-term support infrastructure for the local economy, and would include capacity for finance, business development, education and civic engagement.