

Michigan Journal of Race and Law

Volume 22

2016

Black Health Matters: Disparities, Community Health, and Interest Convergence

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Recommended Citation

Mary Crossley, *Black Health Matters: Disparities, Community Health, and Interest Convergence*, 22 MICH. J. RACE & L. 53 (2016).

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BLACK HEALTH MATTERS:
DISPARITIES, COMMUNITY HEALTH,
AND INTEREST CONVERGENCE

Mary Crossley*

Health disparities represent a significant strand in the fabric of racial injustice in the United States, one that has proven exceptionally durable. Many millions of dollars have been invested in addressing racial disparities over the past three decades. Researchers have identified disparities, unpacked their causes, and tracked their trajectories, with only limited progress in narrowing the health gap between whites and racial and ethnic minorities. The implementation of the Affordable Care Act (ACA) and the movement toward value-based payment methods for health care may supply a new avenue for addressing disparities. This Article argues that the ACA’s requirement that tax-exempt hospitals assess the health needs of their communities and take steps to address those needs presents a valuable opportunity to engage hospitals as partners in efforts to reduce racial health disparities. Whether hospitals will focus on disparities as they assess their communities’ health needs, however, is uncertain; preliminary reviews of hospitals’ initial compliance with the new requirement suggest that most did not. Relying on Professor Derrick Bell’s interest-convergence theory, this Article explores how hospitals’ economic interests may converge with interests in racial health justice. It presents two examples of interventions that could reduce disparities while saving hospitals money. The Article closes by identifying steps that health justice advocates, the federal government, and researchers should take to help, in Professor Bell’s words, “forge [the] fortuity” of interest convergence between hospitals and advocates for racial justice, and lead to progress in eliminating racial health disparities.

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* Professor, University of Pittsburgh School of Law. My thanks go to the Derrick Bell Fund for Excellence for supporting this project and for furthering the legacy of Professor Derrick Bell. The project also benefited from valuable comments offered by Lu-in Wang, Hosea Harvey, and Tom Juring and by participants at the conference *The Present and Future of Civil Rights Movements: Race and Reform in 21st Century America*, hosted by Duke Law School. I also thank Stephen Matvey and Gabrielle Morella for their helpful research assistance. All errors are my own.

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INTRODUCTION

“Black Lives Matter” has grown from a social media trend, to a protest chant, to an organized movement.¹ Originating as a call to action after the justice system acquitted the killer of seventeen-year-old Trayvon Martin in 2013, it has become the rallying cry for protests against state violence against Blacks, and against racism in U.S. society.² It has inspired various collective actions protesting racial injustice, including a series of “die-ins”

1. Alicia Garza, *A Herstory of the #BlackLivesMatter Movement*, BLACK LIVES MATTER, <http://blacklivesmatter.com/herstory> (last visited Sept. 2, 2016) (providing background on the origins and growth of Black Lives Matter).

2. *About the Black Lives Matter Network*, BLACK LIVES MATTER, <http://blacklivesmatter.com/about> (last visited Sept. 2, 2016).

staged by medical students across the country in December 2014.³ Those students recognized the impact of police brutality on the health and lives of Black people and framed it as a public health issue.⁴

Some medical student activists went further, connecting protests about institutional racism in law enforcement to concerns about bias and racism in medicine.⁵ The medical academy soon joined in. Editorials and opinion pieces in leading medical journals, such as the *New England Journal of Medicine* (“*NEJM*”) and the *Journal of the American Medical Association* (“*JAMA*”), called for renewed focus on addressing persistent racial disparities in health and health care,⁶ and highlighted potential areas for physician intervention.⁷

Racial health disparities were not a new discovery for these journals in 2015. In 1985, the Heckler Report, a report by the federal government’s Task Force on Black and Minority Health, shone a light on the existence of health and health care disparities.⁸ That same year, the *NEJM*

3. The name given to the die-ins was “White Coats for Black Lives.” The demonstrations were the “largest coordinated protests at U.S. medical schools since the Vietnam War era.” David A. Ansell & Edwin K. McDonald, *Bias, Black Lives, and Academic Medicine*, 372 *NEW ENG. J. MED.* 1087, 1087 (2015).

4. Oliver Laughland, *US Medical Students Stage “Die-ins” Nationwide in Protest Against Police*, *GUARDIAN* (Dec. 10, 2014), <http://www.theguardian.com/usnews/2014/dec/10/us-medical-students-stage-die-ins-protest-against-police>.

5. *Id.*

6. Although usage varies somewhat, the term “health disparities” generally refers broadly to population level differences between demographic groups in measurements of health status, particular health outcomes, and the access to, utilization of, and quality of care. See Olivia Carter-Pokras & Claudia Baquet, *What is a “Health Disparity”?*, 117 *PUB. HEALTH REP.* 426, 427 (2002). Thus, “health care disparities,” referring to differences in access to health care, the level and type of health care received, and insurance coverage, is a subset of the broader category of health disparities. For example, differences in the percentage of pregnant women receiving prenatal care would be a health care disparity, while differences in infant mortality rates would be a health disparity. For brevity’s sake, this Article will generally use the term “health disparities” to comprise both concepts.

7. See Howard Bauchner, *Race, Poverty, and Medicine in the United States*, 313 *JAMA* 1423, 1423 (2015) (cautioning that health-system centered attempts to address disparities will not succeed as long as social determinants producing disparities persist); Stephen A. Martin et al., *The Health of Young African American Men*, 313 *JAMA* 1415, 1415–16 (2015) (noting evidence of disparities and suggesting practices that physicians can implement to better meet the needs of young African-American men); David A. Ansell & Edwin K. McDonald, *supra* note 3; Mary T. Bassett, *#BlackLivesMatter – A Challenge to Medical and Public Health Communities*, 372 *NEW ENG. J. MED.* 1085, 1085–86 (2015) (noting the “dearth of critical thinking and writing on racism and health in mainstream medical journals” and asserting the importance of acknowledging the “legacy of injustice in medical experimentation” and “looking internally at . . . institutional structures”).

8. MARGARET M. HECKLER, DEP’T OF HEALTH, EDUC. & WELFARE, REPORT OF THE SECRETARY’S TASK FORCE ON BLACK AND MINORITY HEALTH (1985), <http://minorityhealth.hhs.gov/assets/pdf/checked/1/ANDERSON.pdf>.

published research on disparities in childhood mortality.⁹ Five years later, *JAMA* published a report by the American Medical Association's Council on Ethical and Judicial Affairs, decrying treatment disparities as unjustifiable and calling for their elimination.¹⁰ In the three decades since the medical profession and the federal government first formally acknowledged racial health disparities as an issue, policymakers, researchers, and health professionals have devoted significant and sustained attention to the problem.¹¹ Researchers have identified racial health disparities, unpacked their causes, and tracked their trajectories. In that time, however, health disparities have not been eliminated, or even significantly reduced.¹²

The sluggish progress of efforts to eliminate racial health disparities justifies frustration and the sense that little has changed in three decades.¹³ Recent developments in the health system landscape, however, provide renewed hope and new avenues for elimination of those disparities. The passage of the Affordable Care Act ("ACA") in 2010¹⁴ introduced systemic reforms in health care, including provisions meant to reduce disparities.¹⁵ Recent and projected changes in how providers are paid for health care emphasize the quality and value¹⁶ of care, seeking to supplant the tradi-

9. Paul H. Wise et al., *Racial and Socioeconomic Disparities in Childhood Mortality in Boston*, 313 *NEW ENG. J. MED.* 360, 360-61 (1985).

10. Council on Ethical and Judicial Affairs, *Black-White Disparities in Health Care*, 263 *JAMA* 2344 (1990).

11. See e.g., Mary Shaw-Ridley & Charles R. Ridley, *The Health Disparities Industry: Is It an Ethical Conundrum?*, 11 *HEALTH PROMOTION PRAC.* 454 (2010) (describing the "health disparities industry"). The Department of Health and Human Services created its Office of Minority Health in 1986 following the publication of the Heckler Report. Its stated mission is "to improve the health of racial and ethnic minority populations through the development of health policies and programs that will eliminate health disparities." *OFF. OF MINORITY HEALTH, U.S. DEP'T HEALTH & HUM. SERVS., HISTORY OF THE OFFICE OF MINORITY HEALTH*, <http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=1> (last modified Aug. 23, 2016). In 2000, Congress passed the Minority Health and Health Disparities Research and Education Act, establishing the National Center on Minority Health and Health Disparities within the National Institutes of Health ("NIH"). The ACA elevated the Center to the status of a full institute within NIH, now named the National Institute on Minority Health and Health Disparities ("NIMHD"). *Fact Sheet, NAT'L INST. ON MINORITY HEALTH & HEALTH DISPARITIES*, <http://www.nimhd.nih.gov/docs/about-nimhd-factsheet.pdf> (last visited Sept. 24, 2016).

12. See Part I below for a discussion of the persistence of disparities.

13. See, e.g., Raqaijah Yearby, *Sick and Tired of Being Sick and Tired: Putting an End to Separate and Unequal Health Care in the United States 50 Years After the Civil Rights Act of 1964*, 25 *HEALTH MATRIX* 1 (2015).

14. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) [hereinafter *ACA*], amended by Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.).

15. See Part III.A below.

16. Judgments of "value" in health care take into account the care's quality, but also its cost. If two treatments are equally effective in producing a good outcome for a patient, but one treatment costs twice as much as the other, the less expensive treatment has higher value. By the

tional focus on volume as the basis for payment.¹⁷ Increasingly, health equity—the absence of unjust disparities¹⁸—is emerging as a critical aspect of quality, suggesting the potential value of leveraging reimbursement methods to apply pressure for more equitable care.¹⁹

This Article examines how the intersection of a new requirement for tax-exempt hospitals under the ACA and value-based payment reforms creates a new avenue for addressing disparities. Specifically, it argues that the ACA's creation of the Community Health Needs Assessment obligation (“CHNA”) for tax-exempt hospitals could play a valuable role in reducing health disparities in local communities by making hospitals aware of how their financial interests align with the interests of advocates and Black community members seeking to reduce health disparities.

The CHNA requirement calls for tax-exempt hospitals to regularly assess the health needs of their communities and implement strategies that respond to those needs, and makes this process a condition of federal tax-exemption for the hospitals.²⁰ Internal Revenue Service (“IRS”) regulations implementing this requirement direct hospitals to solicit and consider input on needs from minority communities and encourage partnerships with community-based organizations to address community health needs.²¹ Given these instructions, infusing an emphasis on tackling disparities into this new obligation seems an obvious strategy for reducing disparities.²²

However, nothing in the ACA or the regulations implementing the CHNA requirement *requires* tax-exempt hospitals to focus on disparities in

same token, if two interventions cost the same, but one is less likely to accomplish the patient's desired health outcomes, the less effective intervention is less valuable. See Andrew M. Ryan & Christopher P. Tompkins, *Efficiency and Value in Healthcare: Linking Cost and Quality Measures*, NAT'L QUALITY FORUM (Nov. 2014), http://www.qualityforum.org/Publications/2014/11/Efficiency_and_Value_in_Healthcare__Linking_Cost_and_Quality_Measures_Paper.aspx.

17. See Sylvia M. Burwell, *Setting Value-Based Payment Goals – HHS Efforts to Improve Health Care*, 372 NEW ENG. J. MED. 897 (2015).

18. A leading authority has defined health equity as “the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage – that is, different positions in a social hierarchy.” Paula Braveman & S. Gruskin, *Defining Equity in Health*, 57 J. EPIDEMIOLOGY CMTY. HEALTH 254, 254 (2003); see also Sidney D. Watson, *Equity Measures and Systems Reform As Tools for Reducing Racial and Ethnic Disparities in Health Care*, COMMONWEALTH FUND (Aug. 2005), http://www.commonwealthfund.org/usr_doc/776_Watson_equitymeasuresystems_reform.pdf.

19. See Philip M. Alberti et al., *Making Equity a Value in Value-based Health Care*, 88 ACAD. MED. 1619, 1621 (2013).

20. 26 U.S.C. § 501(r)(3) (2012).

21. Additional Requirements for Charitable Hospitals, 79 Fed. Reg. 78,954 (Dec. 31, 2014) (to be codified at 26 C.F.R. pts. 1, 53, 602). See Part III below for description of these regulations.

22. Mary Crossley, *Tax-Exempt Hospitals, Community Health Needs and Addressing Disparities*, 55 HOW. L.J. 687, 689 (2012) (suggesting a strategy to emphasize the need for reduced disparities within the scope of new legal obligations).

their communities as they conduct their CHNAs; the hospitals are free to focus instead on other types of health needs. Preliminary reviews of hospitals' initial compliance with the new requirement suggest that, in fact, most hospitals paid little attention to disparities.²³ Some hospitals, however, did complete their assessment process with an eye to health equity and are deliberately pursuing strategies to respond to the disparities they found in their communities.²⁴ This preliminary evidence of how hospitals are complying with the CHNA requirement raises a question: Why, given the significant regulatory flexibility hospitals enjoy in assessing health needs, should hospitals choose to pay serious attention to racial disparities? What could prompt hospitals to seize the opportunity to make progress toward racial health equity in their communities?

Few think that any easy fix exists for racial disparities in health and health care. Racial justice has never come easily in the United States. But Professor Derrick Bell, one of the pioneers of the Critical Race Theory movement,²⁵ theorized that steps towards racial justice are most likely to occur when those steps also advance the self-interest of the White majority.²⁶ Bell originally developed the theory to describe how White interests during the Cold War explained the Supreme Court's decision in *Brown v. Board of Education*, holding racially segregated public schools unconstitutional. As applied to efforts to reduce racial health disparities, this interest-convergence theory suggests that health care providers and payers will embrace disparity-reducing efforts when their economic interests converge with the health justice interests of Blacks and other minorities. The increasing prevalence of value-based, rather than volume-based, methods of paying for health care is shifting providers' incentives and creating more reasons for them to invest in improving community health. Accordingly, hospitals may face scenarios where efforts to advance health equity in their communities can also yield financial benefits to the hospital.

Consequently, this Article argues that, because the CHNA requirement creates a potentially powerful catalyst for the convergence of interests between hospitals and health justice advocates, the time is ripe to involve hospitals as meaningful partners in efforts to address instances of health inequality in their communities. Because relatively few hospitals to date have recognized this potential for convergence, further action is needed to make the alignment of interests clearer. Community and health justice ad-

23. See Part III.B and III.D below for a description of these reviews.

24. See Part III.D.3 below.

25. The editors of a volume on Critical Race Theory briefly describe the movement as “embrac[ing] a movement of left scholars, most of them scholars of color, situated in law schools, whose work challenges the ways in which race and racial power are constructed and represented in American legal culture and, more generally, in American society as a whole.” CRITICAL RACE THEORY at xiii (Kimberlé Crenshaw et al. eds., 1995).

26. See Derrick A. Bell, Jr., *Brown v. Board of Education and the Interest-Convergence Dilemma*, 93 HARV. L. REV. 518, 523 (1980).

vocates, the federal government, and researchers all have critical roles to play in forging this convergence of interests so that this opportunity is not wasted.

This Article proceeds as follows: Part I briefly describes the problem of racial health disparities in the United States, emphasizing how deeply embedded, damaging, expensive, and enduring those disparities are. Part II delves into Professor Derrick Bell's interest-convergence thesis and preliminarily considers its potential application to engaging hospitals as partners in reducing racial health disparities. Part III describes what the CHNA requirement obliges hospitals to do and how the regulations implementing that requirement makes it a tool well-suited for identifying and addressing disparities; it also examines evidence suggesting that, in their initial efforts to comply with the CHNA requirement, most hospitals have not paid much attention to disparities. Part IV returns to the interest convergence theme, making the business case for hospitals to invest in disparities-reduction programs and providing examples of interventions that could simultaneously reduce disparities and provide hospitals with a financial return on their investment. Acknowledging that many hospitals have not yet recognized their self-interest in combating disparities, Part V identifies three avenues for action—by health justice advocates, federal regulators, and researchers—that could help foster interest convergence and thus encourage hospitals' engagement in efforts to address health disparities.

I. RACIAL HEALTH DISPARITIES: PERVASIVE, PERNICIOUS, PRICEY, AND PERSISTENT

Much has been written about racial health disparities in the United States.²⁷ It is not this Article's purpose to recount or summarize the full extent of the disparities in access to care, health indicators, and health out-

27. Numerous legal literatures already address such disparities. See, e.g., DAYNA BOWEN MATTHEW, *JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTH CARE* (NYU Press 2015); Martha E. Lang & Chloe E. Bird, *Understanding and Addressing the Common Roots of Racial Health Disparities: The Case of Cardiovascular Disease & HIV/AIDS in African Americans*, 25 *HEALTH MATRIX* 109, 110 (2015); David Barton Smith, *The "Golden Rules" for Eliminating Disparities: Title VI, Medicare, and the Implementation of the Affordable Care Act*, 25 *HEALTH MATRIX* 33, 34 (2015); Lindsay F. Wiley, *Health Law as Social Justice*, 24 *CORNELL J. L. & PUB. POL'Y* 47, 49 (2014); Rene Bowser, *The Affordable Care Act and Beyond: Opportunities for Advancing Health Equity and Social Justice*, 10 *HASTINGS RACE & POVERTY L. J.* 69, 70 (2013); Peter J. Hammer, *Health Evolution: (Quality=Learning) + (Ethics=Justice)*, 10 *IND. HEALTH L. REV.* 415, 419 (2013); Gwendolyn Roberts Majette, *Global Health Law Norms and the PPACA Framework to Eliminate Health Disparities*, 55 *HOW. L.J.* 887, 895 (2012); Emily Whelan Parento, *Health Equity, Healthy People 2020, and Coercive Legal Mechanisms as Necessary for the Achievement of Both*, 58 *LOY. L. REV.* 655, 657 (2012). See also Ruqaiyah Yearby, *Breaking the Cycle of "Unequal Treatment" with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias*, 44 *CONN. L. REV.* 1281 (2012) [hereinafter *Breaking the Cycle*]; Ruqaiyah Yearby, *Does Twenty-Five Years Make a Difference in "Unequal Treatment"?: The Persistence of Racial Disparities in Health Care Then and Now*, 19 *ANNALS HEALTH L.* 57 (2010); Kevin Outterson, *Tragedy and Remedy: Reparations for Disparities in Black Health*, 9 *DEPAUL J. HEALTH CARE L.* 735 (2005).

comes that research has shown to exist. Instead, this Part of the Article describes briefly how those disparities are pervasive, pernicious, pricey, persistent, and impervious to legal remedy. Sketching the scope of disparities, their causes and effects, their financial cost, and their resistance to remedy sets the stage for considering the value of using a provision of the ACA to enlist hospitals as partners in reducing racial disparities.

A. Pervasive

Health inequality for Black people and other minorities is pervasive—it permeates measures of health care access, health status, and health outcomes. Disparities exist across the life span. At the beginning of life, Black babies are far more likely than White babies to be low birth-weight and to die before reaching their first birthday.²⁸ At the end of life, Blacks are less likely than Whites to choose hospice care or execute advance directives, often as a result of a “toxic distrust of the health care system.”²⁹ They also appear less likely to receive palliative care at the end of life, resulting in increased suffering.³⁰ Moreover, the years spanning those two points are fewer for Blacks than for Whites: life-expectancy for Whites exceeds that for Blacks by more than four years,³¹ according to data published in 2014. Many disparities persist even when researchers compare groups that have similar socioeconomic status.³²

Furthermore, disparities exist on various matters of life and death: Black women are more likely to die from breast cancer than White women,³³ and Black men are more likely to die from low-risk prostate

28. MARCH OF DIMES, FACT SHEET: RACIAL AND ETHNIC DISPARITIES IN BIRTH OUTCOMES (Feb. 2015), http://www.marchofdimes.org/materials/March-of-Dimes-Racial-and-Ethnic-Disparities_feb-27-2015.pdf.

29. See Barbara A. Noah, *The Role of Race in End-of-Life Care*, 15 J. HEALTH CARE L. & POL’Y 349, 361 (2012); Sarah Varney, *A Racial Gap in Attitudes Toward Hospice Care*, N.Y. TIMES (Aug. 21, 2015), http://www.nytimes.com/2015/08/25/health/a-racial-gap-in-attitudes-toward-hospice-care.html?smid=tw-nythealth&_r=0.

30. Kimberly S. Johnson, *Racial and Ethnic Disparities in Palliative Care*, 16 J. PALLIATIVE MED. 1329, 1330 (2013) (acknowledging gaps in content and methods); Cardinale Smith & Otis Brawley, *Disparities in Access to Palliative Care*, HEALTH AFFAIRS BLOG (July 30, 2014), <http://healthaffairs.org/blog/2014/07/30/disparities-in-access-to-palliative-care> (suggesting that financial barriers to accessing pain specialists and a decreased likelihood that a provider of a different culture, religion, or ethnicity will explain palliative care options).

31. ELIZABETH ARIAS, DIV’N VITAL STATISTICS, UNITED STATES LIFE TABLES, 2009 (Jan. 2014), http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_07.pdf.

32. *Eliminating Racial/Ethnic Disparities in Health Care: What are the Options?*, KAISER FAMILY FOUND. 1, (Oct. 20, 2008), <http://kff.org/disparities-policy/issue-brief/eliminating-racial-ethnic-disparities-in-health-care-what/>.

33. Bijou R. Hunt et al., *Increasing Black:White Disparities in Breast Cancer Mortality in the 50 Largest Cities in the United States*, 38 CANCER EPIDEMIOLOGY 118 (2014) (finding that disparity increased over time).

cancer.³⁴ They also infect seemingly mundane aspects of medical care: Black patients spend more time traveling to, and waiting for, medical care than Whites.³⁵ A recent article in *JAMA* succinctly captures the range of disparities: “In the United States, compared with [W]hite individuals, [B]lack individuals have earlier onset of multiple illnesses, greater severity and more rapid progression of diseases, higher levels of comorbidity and impairment through the life course, and increased mortality rates.”³⁶

B. *Pernicious*

“Pernicious” describes both the causes and the effects of the health disparities that Blacks experience. Although researchers often seek to control for non-biological factors, such as socioeconomic factors and insurance coverage, to try to isolate a purely biological explanation for racial health disparities,³⁷ wide agreement exists that social determinants contribute significantly to health disparities.³⁸ Lower incomes, less schooling, higher unemployment, and residential segregation in poorer neighborhoods³⁹ all contribute to Blacks’ poorer health.⁴⁰ These social determinants of health are the products of racial discrimination in housing,

34. See, e.g., Brandon A. Mahal et al., *Racial Disparities in Prostate Cancer-Specific Mortality in Men with Low-Risk Prostate Cancer*, 12 *CLINICAL GENITOURINARY CANCER* 189 (2014) (finding a higher mortality risk in African-American men); but see, Jody A. Charnow, *VA Study Reveals No Race Disparities in Prostate Cancer Outcomes*, *PROSTATE CANCER ADVISOR* (Jan. 14, 2015), <http://www.renalandurologynews.com/prostate-cancer/va-study-reveals-no-race-disparities-in-prostatecancer-outcomes/article/392435/> (finding no significant differences in survival for patients receiving care in the Veterans Affairs health care system).

35. Kristin N. Ray et al., *Disparities in Time Spent Seeking Medical Care in the United States*, 175 *JAMA* 1983 (2015).

36. David R. Williams & Ronald Wyatt, *Racial Bias in Health Care and Health: Challenges and Opportunities*, 314 *JAMA* 555, 555 (2015).

37. Cf. Kevin Outterson, *Tragedy and Remedy: Reparations for Disparities in Black Health*, 9 *DEPAUL J. HEALTH CARE L.* 735, 745 (2005) (referring to this pattern as “etiologial reductionism” and suggesting that it produces results that likely understate the extent of actual disparities).

38. See HARRY J. HEIMAN & SAMANTHA ARTIGA, *KAISER COMM’N ON MEDICAID & THE UNINSURED BEYOND HEALTH CARE: THE ROLE OF SOCIAL DETERMINANTS IN PROMOTING HEALTH AND HEALTH EQUITY* (Nov. 2015), <http://kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promotinghealth-and-health-equity/> (discussing social determinants and their relevance to health equity).

39. See THOMAS A. LAVEIST ET AL., *SEGREGATED SPACES, RISKY PLACES: THE EFFECTS OF SEGREGATION ON RACIAL AND ETHNIC HEALTH* (2011), <http://www.racial equitytools.org/resourcefiles/SegregatedSpaces.pdf> (Where authors assessed the relationship between racial segregation and infant mortality disparities and concluded: “Segregated communities in the U.S. . . . tend to be places with limited opportunities and failing infrastructure, resulting from a lack of investment in social and economic development. The result is a community that produces bad health outcomes.”).

40. See David R. Williams & Pamela Braboy Jackson, *Social Sources of Racial Disparities in Health*, 24 *HEALTH AFF.* 325 (2005). Racial health disparities are simply one piece of a broader mosaic of racial inequality in the United States. For a recent summary of data regarding racial disparities in the areas of economics, criminal justice, education, and residential segregation see

employment, and mortgage lending, and of continuing institutional and structural racism in the United States.⁴¹ Another contributor to disparities is the disproportionate incarceration of Blacks and the resultant post-incarceration civil restrictions, which adversely affect the health of the offender and his family.⁴² Furthermore, racism can also harm health in stealthier ways. Mounting evidence indicates that simply being Black in a country where racism remains a powerful force can negatively affect one's health.⁴³ Both the increased stress resulting from experiencing discrimination⁴⁴ and the experience of "stereotype threat"⁴⁵ in clinical settings have been shown to affect health.⁴⁶

Medicine, medical research, and public health have their own distinctive histories of racism and bias.⁴⁷ In making the case for reparations for Black health disparities, Kevin Outterson details the history of unequal and biased health care, typified by segregation and neglect, provided to

Derrick Darby & Richard E. Levy, *Postracial Remedies*, U. MICH. J. L. REFORM 1, 7-13 (forthcoming 2017), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2745614.

41. See Brian D. Smedley, *The Lived Experience of Race and Its Health Consequences*, 102 AM. J. PUBL. HEALTH 933, 934 (2012).

42. See Martin Y. Iguchi et al., *How Criminal System Racial Disparities May Translate into Health Disparities*, 16 J. HEALTH CARE FOR POOR & UNDERSERVED 48 (2005); Stephen A. Martin et al., *The Health of Young African American Men*, 313 JAMA 1415, 1415-16 (2015).

43. See Joe R. Feagin & Karyn D. McKinney, *THE MANY COSTS OF RACISM* 65-93 (2003) (discussing in part the physical consequences of racism); Smedley, *supra* note 41 (calling for "a more comprehensive and sophisticated understanding of the cumulative, interactive effects of the difference forms of racism on health as they operate over the life course"); cf. O. Kenrik Duru et al., *Allostatic Load Burden and Racial Disparities in Mortality*, 104 J. NAT'L MED. ASSOC. 89 (2012) (finding that exposure to repeated or chronic life stressors partially explains higher mortality among Blacks, independent of SES and health behaviors); American Psychological Association, *Fact Sheet: Health Disparities and Stress*, <http://www.apa.org/topics/health-disparities/fact-sheet-stress.aspx>.

44. Elizabeth A. Pascoe & Laura Smart Richman, *Perceived Discrimination and Health: A Meta-Analytic Review*, 135 PSYCHOL. BULL. 531, 531 (2009); Tene T. Lewis et al., *Self-Reported Experiences of Discrimination and Health*, 11 ANN. REV. CLINICAL PSYCHOL. 407, 413 (2015); but see L. L. Black et al., *The Relationship Between Perceived Racism/Discrimination and Health Among Black American Women: A Review of the Literature from 2003-2013*, 2 J. RACIAL ETHNIC HEALTH DISPARITIES 11 (2015) (finding mixed evidence to support an association between the perception of racism or discrimination and objective health outcomes).

45. "Stereotype threat" is a term from social psychology that refers to the risk that a person's awareness of negative stereotypes of a group that he is part of may prove to be self-confirming. It originated in research into the reasons for Black students' lower performance on standardized tests. See Claude M. Steele & Joshua Aronson, *Stereotype Threat and the Intellectual Test Performance of African Americans*, 69 J. PERSONALITY & SOC. PSYCHOL. 797, 797 (1995).

46. See Diana J. Burgess et al., *Stereotype Threat and Health Disparities: What Medical Educators and Future Physicians Need to Know*, 25 J. GEN. INTERNAL MED. 169, 169 (2010).

47. For a comprehensive accounting of this history from the period of slavery to 2000, see generally W. MICHAEL BYRD & LINDA A. CLAYTON, *AN AMERICAN HEALTH DILEMMA: A MEDICAL HISTORY OF AFRICAN AMERICANS AND THE PROBLEM OF RACE: BEGINNINGS TO 1900* (2000); W. MICHAEL BYRD & LINDA A. CLAYTON, *AN AMERICAN HEALTH DILEMMA: RACE, MEDICINE, AND HEALTH CARE IN THE UNITED STATES, 1900-2000* (2001).

Blacks from slavery until the present.⁴⁸ The infamous Tuskegee Syphilis Study exemplifies the continued instrumental use of Black bodies by the public health and medical elite, but it is far from the only example.⁴⁹ More recently, the landmark 2003 Institute of Medicine Report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, found compelling evidence that providers' racial bias, discrimination, and stereotyping contribute to treatment disparities.⁵⁰ Research demonstrates that physicians are subject to implicit bias,⁵¹ and leaders within the profession have begun highlighting the importance of addressing clinicians' implicit bias as a means of addressing disparities.⁵² A 2016 study found that half of a sample of White medical students and residents held false beliefs about biological differences between Blacks and Whites, which contributed to racial bias in pain assessment and treatment recommendations.⁵³

Not only are the causes of racial health disparities pernicious, so are their effects. Most obviously, disproportionate rates of morbidity and mortality exact a human toll. In 2005, former U.S. Surgeon General David Satcher estimated that eliminating the mortality gap between Whites and Blacks would prevent more than 83,000 premature Black deaths each year.⁵⁴ Other, less obvious, effects on the social and political fabric also flow from pervasive health disparities. The Ferguson Commission's 2015

48. Kevin Outterson, *Tragedy and Remedy: Reparations for Disparities in Black Health*, 9 DEPAUL J. HEALTH CARE L. 735 (2005). Outterson, a professor of law at Boston University, argues that while lawsuits by Blacks seeking monetary reparations for the harms imposed by the legal institutions of slavery and Jim Crow segregation often fail because of the temporal remoteness of the injury, the practices giving rise to racial health disparities continue today. In his words, "Black health disparities are not remote but survive to the present day with remarkably deadly effect." *Id.* at 736.

49. See Vanessa Northington Gamble, *Under the Shadow of Tuskegee: African Americans and Health Care*, 87 AM. J. PUB. HEALTH 1773 (1997) (placing the Tuskegee Study in its broader historical context); see also HARRIET A. WASHINGTON, *MEDICAL APARTHEID: THE DARK HISTORY OF MEDICAL EXPERIMENTATION ON BLACK AMERICANS FROM COLONIAL TIMES TO THE PRESENT* (2007).

50. BRIAN D. SMEDLEY ET AL., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* (Adrienne Y. Smith ed., 2003).

51. Elizabeth N. Chapman et al., *Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities*, 28 J. GEN. INTERNAL MED. 1504 (2013) (reviewing evidence of implicit bias among physicians and presenting bias-reducing strategies); DAYNA BOWEN MATTHEW, *JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTH CARE* (NYU Press 2015).

52. Williams & Wyatt, *supra* note 36.

53. Kelly M. Hoffman et al., *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs about Biological Differences Between Blacks and Whites*, PROCEEDINGS NAT'L ACAD. SCI. (April 2016), <http://www.pnas.org/content/113/16/4296.full.pdf>. In this study, the researchers collected data from 418 medical students and residents. The medical students were enrolled at a large public university, and the medical residents were recruited from multiple sites.

54. David Satcher et al., *What if We Were Equal? A Comparison of the Black-White Mortality Gap in 1960 and 2000*, 24 HEALTH AFF. 459 (2005).

report identified racial disparities in life expectancy and health care as factors contributing to racial unrest in Ferguson, Missouri.⁵⁵ Another recent study examined how higher mortality rates among Blacks decreased that group's voting population, thereby lowering their influence in the political process.⁵⁶ Similarly, because Blacks as a group have a shorter life expectancy than Whites, they receive less value from participation in the Social Security system.⁵⁷ Fundamentally, because poor health presents challenges to educational attainment⁵⁸ and employment,⁵⁹ health disparities feed back into and reinforce lower socioeconomic status in a vicious cycle. In another vicious cycle, Blacks' experience or awareness of discrimination in the health care system and medical research may result in mistrust, making them less likely to seek care or adhere to recommended treatment.⁶⁰

C. Pricey

Beyond their implications for social justice, racial health disparities also exact a heavy financial toll on society.⁶¹ One frequently cited study found that nearly a third of direct medical expenses incurred for African Americans, Asian Americans, and Hispanics were excess costs resulting from health inequalities.⁶² According to a recent study on the cost of disparities from 2003–2006, eliminating racial health disparities would have permitted a reduction of \$229.4 billion in direct medical expenditures over

55. See Mattie Quinn, *Will Ferguson Redefine Public Health?*, GOVERNING (Nov. 17, 2015), <http://www.governing.com/topics/health-human-services/gov-ferguson-report-public-health.html>.

56. David A. Graham, *A Million Missing Black Voters*, ATLANTIC (May 12, 2015), <http://www.theatlantic.com/politics/archive/2015/05/a-million-missing-black-voters/392972/> (describing the study).

57. Cf. Neil Irwin, *Rich People Are Living Longer. That's Tilting Social Security in Their Favor*, N.Y. TIMES (Apr. 22, 2016), <http://www.nytimes.com/2016/04/24/upshot/rich-people-are-living-longer-thats-tilting-social-security-in-their-favor.html> (“[B]ecause different groups of people have different life expectancies, some groups receive more value from every dollar of payroll taxes they and their employers pay into the system”).

58. Margot I. Jackson, *Understanding Links between Adolescent Health and Educational Attainment*, 46 DEMOGRAPHY 671 (2009).

59. Daniel Hale et al., *Adolescent Health and Adult Education and Employment: A Systematic Review*, 136 PEDIATRICS 128 (2015).

60. See Vernellia R. Randal, *Slavery, Segregation, and Racism: Trusting the Health Care System Ain't Always Easy! An African American Perspective on Bioethics*, 15 ST. LOUIS U. PUB. L. REV. 191 (1996); Irena Stepanikova et al., *Patients' Race, Ethnicity, Language, and Trust in a Physician*, 47 J. HEALTH & SOC. BEHAV. 390, 391 (2006) (reviewing literature suggesting possible reasons for minority patients' mistrust of physicians).

61. Accord ASS'N STATE & TERRITORIAL HEALTH OFFICERS (ASTHO), THE ECONOMIC CASE FOR HEALTH EQUITY (2012), <http://www.astho.org/Programs/Health-Equity/Economic-Case-Issue-Brief> (“Health equity is an economic issue as well as a social justice issue.”).

62. Thomas LaVeist et al., *Estimating the Economic Burden of Racial Health Inequalities in the United States*, 41 INT'L J. HEALTH SERVS. 231, 234 (2011) (studying costs of disparities from 2003–2006).

a three-year time period.⁶³ The cost of those racial disparities grows much higher—more than one trillion dollars—when researchers include indirect costs associated with lost work productivity, illness, and premature death.⁶⁴ An earlier study estimated that disparities experienced by Medicare and Medicaid beneficiaries alone cost the federal government \$17 billion in a single year.⁶⁵

D. *Persistent and Impervious to Legal Remedy*

The recognition of health disparities actually has a long history. That history has barely been altered by laws intended to advance racial justice. More than a century ago, W.E.B. Du Bois documented that Blacks suffered from some diseases at higher rates than Whites.⁶⁶ Moreover, he posited that the differences did not reflect physical inferiority on the part of Blacks, but represented “an index of a social condition,”⁶⁷ meaning the result of social and economic conditions. Nearly three-quarters of a century later, the government started paying attention to racial disparities, when the Heckler Report highlighted the extent of health and health care disparities for racial and ethnic minority populations.⁶⁸ Shortly thereafter, articles about disparities began appearing in leading medical journals.⁶⁹

After generations of inattention, the government, nonprofit sector, and researchers began ramping up the resources devoted to identifying racial health disparities and their causes. Recent efforts have begun focusing on interventions to address those disparities.⁷⁰ In 2003, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* confirmed the extent of the disparities and concluded that racial bias and discrimination are contributing factors. The federal government has included reducing or eliminating disparities among the nation’s central health promotion objectives

63. *Id.* at 233.

64. *Id.*

65. Timothy Waldman, *Estimating the Cost of Racial and Ethnic Health Disparities*, URBAN INSTITUTE (Sept. 2009).

66. W.E.B. DuBois, *The Health and Physique of the Negro American*, in 93 AM. J. PUB. HEALTH 272 (2003) (“The undeniable fact is, then, that in certain diseases the Negroes have a much higher rate than the [W]hites, and especially in consumption, pneumonia and infantile diseases.”).

67. *Id.* at 275–76 (attributing the higher rate of infant mortality among Blacks in Philadelphia in 1900 to social and economic conditions, rather than race).

68. DEP’T OF HEALTH, EDUC. & WELFARE, REPORT OF THE SECRETARY’S TASK FORCE ON BLACK AND MINORITY HEALTH (1985) [hereinafter HEW REPORT], <http://minorityhealth.hhs.gov/assets/pdf/checked/1/ANDERSON.pdf>.

69. *See supra* notes 9–10.

70. *See* Stephen B. Thomas et al., *Toward a Fourth Generation of Disparities Research*, 32 ANN. REV. PUB. HEALTH 399 (2011) (suggesting a “conceptual framework of three generations of health disparities research”).

in its *Healthy People 2000*, *Healthy People 2010*, and *Healthy People 2020* public health plans.⁷¹

In introducing the 1985 report that has come to bear her name, Secretary of Health, Education, and Welfare, Margaret Heckler, sounded optimistic: “It can—it should—mark the beginning of the end of the health disparity that has, for so long, cast a shadow on the otherwise splendid American track record of ever improving health.”⁷² But, despite many millions of dollars invested in research and programming and much attention (or at least lip service) by policy makers over the past three decades, we appear still to be far from the goal of health equity.⁷³ The *Healthy People 2010 Final Review* assessed a decade of progress made with respect to specific health condition objectives and found that “[a]mong 169 objectives with data for racial and ethnic groups, health disparities, on average, decreased for 27 objectives and increased for 25.”⁷⁴ Most findings regarding racial disparities in the *2014 National Healthcare Quality and Disparities Report*, issued by the Agency for Healthcare Research and Quality, are similarly discouraging.⁷⁵ Disparities between Whites and Blacks showed little improvement (and in some cases deterioration) on both measures of access and measures of quality.⁷⁶ This evidence clearly shows that the Heckler Report did not mark the “beginning of the end” of health disparities, as Secretary Heckler had hoped.

71. See generally Emily Whelan Parento, *Health Equity, Healthy People 2020, and Coercive Legal Mechanisms as Necessary for the Achievement of Both*, 58 *LOY. L. REV.* 655, 657 (2012) (describing the Healthy People project).

72. HEW REPORT, *supra* note 68.

73. Kevin Outterson writes: “Disparities in Black health have been studied to death, while the patients continue to die.” Outterson, *supra* note 27, at 740. Or as one pair of researchers probing the ethics of what they refer to as the “health disparities industry”, asked: “Are there substantial improvements in the quality of life for vulnerable populations served by the health disparities industry? Has the mileage on the odometer changed enough to suggest that the final destination is closer than it was 20 years ago?” Mary Shaw-Ridley & Charles R. Ridley, *The Health Disparities Industry: Is It an Ethical Conundrum?*, 11 *HEALTH PROMOTION PRAC.* 454, 458 (2010) (describing the “health disparities industry”). See also Ruqaiyah Yearby, *Does Twenty-Five Years Make a Difference in “Unequal Treatment”? The Persistence of Racial Disparities in Health Care Then and Now*, 19 *ANNALS HEALTH L.* 57 (2010).

74. *CTRS. FOR DISEASE CONTROL & PREVENTION, HEALTHY PEOPLE 2010 FINAL REVIEW 0-18* (2010), http://www.cdc.gov/nchs/data/hpdata2010/hp2010_final_review_overview.pdf.

75. The most positive trend regarding racial disparities in that Report is the narrowing in 2014 of the gap in insurance rates between Whites and racial and ethnic minorities, which is noted below in Part IIIA. See *AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, 2014 NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT 10* (May 2015).

76. *Id.* at 12 (out of twenty-one access measures, racial disparities improved on two measures and showed no change on nineteen), 18 (out of one-hundred-and-sixty-five quality measures, Blacks received worse care than Whites on sixty, about the same quality of care on eighty-five, and better care on twenty), 19 (out of one-hundred-and-forty-eight quality measures, racial disparities improved on thirteen, showed no change on one-hundred-and-twenty-six, and worsened on nine).

Unfortunately, these disparities have persisted despite the enactment of civil rights laws aiming to eradicate racial discrimination. Because many health care actors receive funding from the federal government, Title VI's prohibition of recipients of federal funding from discriminating on the basis of race, color, or national origin⁷⁷ was the part of the Civil Rights Act of 1964 that seemed most promising for advancing racial health justice. In reality, the passage of Title VI in 1964 and of Medicare in 1965 combined to advance the dismantling of racially segregated health care. Because Medicare's creation produced a generous stream of federal payments flowing to hospitals, the hospitals' desire to maintain their federal funding prompted the desegregation of hospitals throughout the South, without the need for lawsuits or enforcement actions.⁷⁸

In fact, the story of hospital desegregation provides an example of the interest convergence theory described in Part IV, by illustrating how attaching conditions to a massive federal funding stream can prompt hospitals to pursue actions advancing racial justice.⁷⁹ Indeed, hospitals' rapid and uncontested desegregation—once they realized that desegregation was in their financial self-interest because of the risk of losing federal Medicare payments—provides some historical precedent for this Article's assertion that self-interest may encourage hospitals' contemporary efforts to reduce racial health disparities.

And desegregation in the 1960s translated into improvements in Black health in some communities.⁸⁰ For example, researchers have found that federally mandated hospital desegregation led to better access to hospital care for Black infants, contributing to a steep decline in the Black infant mortality rate in the succeeding decade.⁸¹ Any early promise of Title VI reducing disparities, however, has faded over the past few decades.⁸²

77. 42 U.S.C. § 2000(d).

78. See DAVID B. SMITH, *HEALTH CARE DIVIDED: RACE AND HEALING A NATION* 121-42 (1999) (explaining beginnings of Medicare and Title VI enforcement).

79. See Part III *infra*; David Barton Smith, *The "Golden Rules" for Eliminating Disparities: Title VI, Medicare, and the Implementation of the Affordable Care Act*, 25 *HEALTH MATRIX* 33, 58 (2015) (Smith recognizes this parallel more broadly: "The implementation of the ACA . . . [.] offers an opportunity equivalent to the one so successfully captured with the implementation of Medicare fifty years ago. The ACA involves a similar infusion of new public funding and takes a similar forward-looking approach to nondiscrimination.").

80. See Outterson, *supra* note 27, at 775 (citing evidence that "desegregation of the hospitals translated into immediate health gains for Blacks"); Smith, *supra* note 79, at 52 (asserting that "for the first twenty years after the implementation of Medicare, racial disparities in health outcomes decreased").

81. Douglas Almond et al., *Civil Rights, the War on Poverty, and Black-White Convergence in Infant Mortality in the Rural South and Mississippi* (Nat'l Bureau of Econ. Research, Working Paper No. 7-04, 2006).

82. For fuller accountings of Title VI's inadequacies in addressing health inequality, see Ruqaiyah Yearby, *When is Change Going to Come?: Separate and Unequal Treatment in Health Fifty Years after Title VI of the Civil Rights Act of 1964*, 67 *SMU L. REV.* 287 (2014); Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Healthcare System: Reinwigorating the Role*

As blatant and overt racial discrimination by providers largely receded from view, disparities persisted, partly as a result of more subtle discrimination, implicit biases, and built-in structural features of the health care system. Title VI has proven ineffective in addressing these causes of disparities, particularly after the Supreme Court held in 2001 that Title VI creates no private right of action for plaintiffs alleging disparate impact discrimination.⁸³ That holding left administrative enforcement as the sole legal mechanism for addressing cases where providers' actions disproportionately burden racial minorities, and administrative enforcement has been tepid.⁸⁴ As Professor Dayna Bowen Matthew wrote in 2015: "The current state of affairs is this: Anti-discrimination laws are largely unenforced or unenforceable against health care entities, while an overwhelming body of empirical evidence makes clear that discriminatory practices in health care abound."⁸⁵

A natural response to the foregoing description of how damaging racial health disparities are is to question why they have proven so durable. Given their human and economic costs and the amount spent to study them, why has progress toward eliminating those disparities been maddeningly slow? Applying Professor Derrick Bell's interest-convergence theory to the problem of health disparities suggests a reason, namely that progress will occur only when addressing disparities advances the interests of Whites and others in power.

II. RACIAL HEALTH DISPARITIES AND INTEREST CONVERGENCE

A. *The Interest Convergence Theory*

The interest of blacks in achieving racial equality will be accommodated only when it converges with the interests of whites . . . Racial remedies may . . . be the outward manifestations of unspoken and perhaps subconscious judicial conclusions that the remedies, if granted, will secure, advance, or at least not harm societal interests deemed important by middle and upper class whites. Racial justice — or its appearance —

of the Federal Government in the Aftermath of Alexander v. Sandoval, 3 YALE J. HEALTH POL'Y L. & ETHICS 215 (2003); Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 HOW. L.J. 855 (2012); Brietta R. Clark, *Hospital Flight from Minority Communities: How Our Existing Civil Rights Framework Fosters Racial Inequality in Healthcare*, 9 DEPAUL J. HEALTH CARE L. 1023 (2005); cf. Dayna Bowen Matthew, *Health Care, Title VI, and Racism's New Normal*, 6 GEO. J.L. & MOD. CRIT. RACE PERSPECTIVES 3 (2014) (advocating for amendments to Title VI to address its inadequacies).

83. *Alexander v. Sandoval*, 532 U.S. 275, 293 (2001).

84. *Accord Rosenbaum & Teitelbaum*, 3 YALE J. HEALTH POL'Y L. & ETHICS 215, 216-17 (2003) (characterizing the executive branch's reaction following *Alexander*, 532 U.S. 275, as a "model of inaction and neglect").

85. DAYNA BOWEN MATTHEW, *JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTH CARE* 1, 28 (NYU Press 2015).

may, from time to time, be counted among the interests deemed important by the courts and by society's policymakers.⁸⁶

Professor Derrick Bell, who helped lay the intellectual foundations for Critical Race Theory,⁸⁷ originally developed the theory of interest convergence to explain both why the Supreme Court decided *Brown v. Board of Education* as it did and why later school desegregation decisions retreated from *Brown's* commitments.⁸⁸ According to Bell, a combination of forces gave Whites pragmatic, and not simply moral,⁸⁹ reasons for ending state-sponsored school segregation. These forces included America's efforts during the Cold War to demonstrate the superiority of a capitalist system to the developing world and the need to reassure Black World War II veterans that the principles they had fought for were not hollow—neither of which could be successful if American law continued to legitimate the second-class citizenship of Blacks. Similarly, the economic interests of Whites in stimulating the South's industrial development favored the end of segregated public education.⁹⁰ Although Bell developed the interest convergence theory to explain school desegregation, he reckoned that it had general applicability for analyzing when courts would grant fourteenth amendment remedies to racial minorities and when advances in racial justice, more broadly, were likely to occur.⁹¹

Subsequent scholars have applied Bell's insights to other decision makers and other racial justice issues. For example, legislative actions to abolish the death penalty can be framed as the product of interest conver-

86. *Id.*

87. This article is not the first attempt to tap into critical race theory insights for responding to racial health disparities. See Outterson, *supra* note 27. Outterson's argument for reparations for Black health disparities has met no more success than reparations arguments in other contexts. Stephen Thomas and his colleagues have argued for using "public health critical race praxis" as a conceptual framework for future research into addressing racial health disparities. See Thomas et al., *supra* note 70. Dorothy Roberts has argued for a social justice approach, informed by critical race theory, to deciding how biomedical research can properly use racial categories. See Dorothy E. Roberts, *Legal Constraints on the Use of Race in Biomedical Research: Toward a Social Justice Framework*, 34 J.L. MED. & ETHICS 526 (2006).

88. Bell, *supra* note 26.

89. Although he focused on the explanatory force of the convergence of the self-interest of the White elite with Black interests, Bell also recognized that moral commitments drove some Whites' pursuit of racial justice. Bell, *supra* note 26. So too, some hospitals may view reducing racial health disparities as part of the charitable or religious mission, regardless of whether a business case for disparities reduction efforts exists.

90. *Id.* at 523–25. For a fuller description of Bell's theory, see Richard Delgado, *Why Obama: An Interest Convergence Explanation of the Nation's First Black President*, 33 LAW & INEQUALITY 345 (2015).

91. Bell, *supra* note 26, at 523.

gence.⁹² Commentators have also considered the explanatory force of interest convergence theory in areas ranging from immigration reform,⁹³ to prison reform,⁹⁴ to college sports.⁹⁵ Although early applications of interest convergence theory tended to focus on public (*i.e.*, governmental) decision makers, recent commentary has applied the theory to electoral politics⁹⁶ and to private decision making implicating racial justice.⁹⁷

Bell's insights regarding interest convergence, taken with later scholars' extensions of the theory, provide a lens for considering potential alignments of interest regarding efforts to advance Black health and diminish disparities. As discussed, health disparities are costly on numerous levels, and awareness of how some of those costs fall on businesses, health care providers, and the government is growing. This Article argues that the ACA's CHNA requirement for tax-exempt hospitals may provide a focal point for the convergence of White concerns about health care costs, productivity, and quelling social unrest with Black interests in health justice. This Article asserts that the CHNA requirement can be used to advance racial health justice and suggests further steps that will help foster that interest convergence.

In suggesting a pragmatic approach that is race sensitive without being race specific, an interest convergence approach to engaging hospitals as partners in addressing health disparities shares much in common with Professors Derrick Darby and Richard Levy's advocacy for the value of "post-racial remedies." Darby and Levy argue that remedies that seek solutions to continuing racial disparities in the United States without treating people differently based on their race are less socially divisive and more constitutionally sound (given current jurisprudence) than race-specific responses.⁹⁸ The backlash against the Black Lives Matter movement—perhaps best typified by the argument that "All Lives Matter" is more appropriate—makes this point particularly salient. The specific types of initiatives this Article suggests (reducing readmissions and using hospital

92. See Jolie McLaughlin, *The Price of Justice: Interest-Convergence, Cost, and the Anti-Death Penalty Movement*, 108 NW. U. L. REV. 675 (2014).

93. Maria Pabon Lopez & Natasha Ann Lacoste, *Immigration Reform in 2013–14: An Essay on the Senate's Bipartisan Plan, the House's Standards for Immigration Reform, Interest Convergence and Political Realities*, 17 HARV. LATINO L. REV. 121 (2014).

94. SpearIt, *Economic Interest Convergence in Downsizing Imprisonment*, 75 U. PITT. L. REV. 475 (2014).

95. Amy Christian McCormick & Robert A. McCormick, *Race and Interest Convergence in NCAA Sports*, 2 WAKE FOREST J.L. & POL'Y 17 (2012) (applying interest convergence analysis to integration of college athletics).

96. See Delgado, *supra* note 90, at 361.

97. See, e.g., Patience A. Crowder, *Interest Convergence as Transaction?*, 75 U. PITT. L. REV. 693, 703–09 (2014) (proposing a transactional approach to interest convergence in the context of metropolitan-level poverty alleviation efforts).

98. See Derrick Darby & Richard E. Levy, *Postracial Remedies*, U. MICH. J. L. REFORM at 2 (forthcoming), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2745614.

violence intervention programs) entail hospitals targeting communities where costly disparities are concentrated, rather than targeting groups based on race.⁹⁹

To be sure, Bell originally presented the interest convergence theory as a way of understanding history, not as a strategy for effecting racial progress.¹⁰⁰ Indeed, part of Bell's pessimism regarding the prospects of true racial equality in the United States grew from his recognition that —just as Blacks might make progress when their interest in racial justice converged with the interests of privileged Whites —ground could be lost when those interests began to diverge.¹⁰¹ Bell's realism about the difficulty of progress toward racial equality, however, did not produce a sense of impotence. Instead, Bell recognized that Blacks should not simply appreciate the progress that occurs when interests converge, they should act to “forge fortuity” by making continued racial injustice costly to Whites.¹⁰²

B. *Converging Interests in Addressing Racial Health Disparities?*

From an interest convergence perspective, the fact that Whites and the health care industry have not recognized their self-interest in addressing racial health disparities may help explain the lack of progress. In short, the powerful elite has not yet felt harmed by the continuation of disparities. The remainder of this Article argues that the community health needs assessment (“CHNA”) requirement of the ACA holds the potential to make many hospitals aware of how addressing disparities in their communities could advance their own financial interests. By doing so, the CHNA requirement could catalyze a convergence of hospitals' interests with the interests of health justice advocates.

III. THE AFFORDABLE CARE ACT AND COMMUNITY HEALTH NEEDS

A. *ACA Provisions Ameliorating Disparities*

Given how damaging and durable racial health disparities have been, it is unsurprising that the Affordable Care Act, a massive health reform legislation reaching into virtually every corner of the health care financing and delivery system, included numerous provisions meant to combat dis-

99. See also *id.* at 52 (“To the extent that the problems identified are disproportionately concentrated in the [B]lack community, solving those problems will tend to disproportionately benefit [B]lacks and thus ameliorate racial disparities.”).

100. Stephen M. Feldman, *Do the Right Thing: Understanding the Interest-Convergence Thesis*, 106 NW. U. L. REV. COLLOQUY 248, 250 (2012) (“To [Bell], interest convergence described the past; it did not predict or provide a blueprint for the future.”).

101. Bell, *supra* note 26, at 528; cf. Feldman, *supra* note 100, at 249–52 (describing stages in Bell's intellectual development).

102. DERRICK BELL, SILENT COVENANTS: BROWN V. BOARD OF EDUCATION AND THE UNFULFILLED HOPES FOR RACIAL REFORM 190 (2004) (citing to sit-ins as an example of “forging fortuity” and teaching that “a great many [W]hites would not maintain discriminatory policies if the cost was too high”).

parities, both directly and indirectly. Indeed, simply by extending health insurance coverage to millions of uninsured Americans through a combination of insurance market reforms, insurance purchase mandates, and publicly funded subsidies for low- and middle-income purchasers,¹⁰³ the law should lessen the racial disparity in insurance rates.¹⁰⁴

Less well-known parts of the ACA may also serve to decrease disparities. These measures include, for example, increased investments in community health centers (whose users are more racially and ethnically diverse than the low-income population overall),¹⁰⁵ increased funding for the National Health Service Corps to ease provider shortages in medically underserved areas with large minority populations,¹⁰⁶ and measures requiring all federally-supported health programs to collect and report data by race and ethnicity.¹⁰⁷ In addition, the ACA includes a broad civil rights measure that extends existing prohibitions on discrimination (including race, color, and national origin discrimination) to many more actors in the health care system.¹⁰⁸

103. King v. Burwell, ___ U.S. ___, 135 S. Ct. 2480, 2485–87 (2015) (describing the interacting combination of reforms).

104. In fact, early implementation of the Affordable Care Act has narrowed the racial gap in the percentages of insured Americans. See Stacey McMorrow et al., *Uninsurance Disparities Have Narrowed for Black and Hispanic Adults Under the Affordable Care Act*, 34 HEALTH AFF. 1774, 1774 (2015) (finding that after one year of ACA implementation, the uninsured rate for Blacks, Asian-Americans, and Hispanics dropped by more than eight percent, while the rate for the White Non-Hispanic population dropped by just over four percent). This narrowing likely would have been greater if all states had expanded their Medicaid programs, as envisioned by the ACA's framers. The states that have chosen not to expand Medicaid have disproportionately large low-income, minority populations who would have benefited by the expansion. RACHEL GARFIELD & ANTHONY DAMICO, KAISER FAMILY FOUND., *THE COVERAGE GAP: UNINSURED POOR ADULTS IN STATES THAT DO NOT EXPAND MEDICAID* (Jan. 21, 2016), <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update>. Because of this "coverage gap," these citizens are eligible for neither Medicaid coverage, nor federal subsidies to help buy private coverage on the exchanges. *Id.*

105. PETER SHIN ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, *A PROFILE OF COMMUNITY HEALTH CENTER PATIENTS* (Dec. 2013), <https://kaiserfamilyfoundation.files.wordpress.com/2013/12/8536-profile-of-chcpatients.pdf>.

106. See Joan Y. Reede, *A Recurring Theme: The Need for Minority Physicians*, 22 HEALTH AFF. 91, 91 (2003).

107. Public Health Service Act § 3101(a)(1), 42 U.S.C.A. § 300(k)(k) (as added by Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 4302(a), 124 Stat. 119 (2010)) (establishing Secretary's obligation to issue standards ensuring data collection). Advocates for the stricter enforcement of civil rights laws in health care settings have long called for improved data collection regarding patients' race and ethnicity, so that disparities can be measured and tracked. See Sidney D. Watson, *Health Care in the Inner City: Asking the Right Question*, 71 N.C. L. REV. 1647, 1669–70 (1993); Rene Bowser, *Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities*, 7 MICH. J. RACE & L. 79, 126 (2001).

108. Patient Protection and Affordable Care Act § 1557(a). 42 U.S.C.A. § 18116; see also Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 HOW. L.J. 855, 859 (2012).

Regulations implementing the new civil rights measure,¹⁰⁹ however, disappointed those who hoped it would support more robust and comprehensive enforcement of civil rights laws against health care financing and delivery practices that disadvantage communities of color. While the regulations expand the potential avenues for enforcement by permitting an individual to file a private suit alleging racially disparate impact,¹¹⁰ they fail to deal specifically with the types of subtle discrimination, implicit biases, or structural features that contribute to racial health disparities.¹¹¹

Without diminishing the importance of continuing advocacy for the effective implementation of the measures just described, this Article asserts that a provision of the ACA that is less often viewed as part of the reform law's health equity arsenal could become a potent weapon to combat disparities. Specifically, the new requirement that tax-exempt hospitals conduct community health needs assessments ("CHNAs") and develop and implement strategies to address the needs identified could spur hospitals to play meaningful roles in eliminating disparities in their communities.

B. *The Community Health Needs Assessment Requirement*

The majority of hospitals in the United States are organized as non-profits and have received an exemption from paying federal taxes. Seeking to more clearly define the *quid pro quo* that hospitals must provide in return for the substantial financial benefit of tax exemption, Congress attached new strings to hospital tax exemption in the ACA.¹¹² One of the new conditions of tax-exempt status is the CHNA requirement. The statute specifies a series of steps for hospitals to follow. First, at least once every three years, a hospital must conduct an assessment of the health needs of its community, taking 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."¹¹³ Having completed the assessment, the hospital must make its report available to the

109. See Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376 (May 18, 2016).

110. *Id.* at 31440; see also Timothy Jost, *HHS Issues Health Equity Final Rule*, May 14, 2016, HEALTH AFFAIRS BLOG (May 14, 2016), <http://healthaffairs.org/blog/2016/05/14/hhs-issues-health-equity-final-rule/>.

111. See *supra* Part I.

112. 26 U.S.C. § 501(r). Several of the new conditions established in §501(r) address hospitals' interactions with patients around matters of financial assistance, charges for services, and debt collection. See Erin C. Fuse Brown, *Fair Hospital Prices are Not Charity: Decoupling Hospital Pricing and Collection Rules from Tax Status*, 53 U. LOUISVILLE L. REV. 509, 510-11 (2015), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2451435. These conditions stop short of requiring hospitals to provide any particular quantum of free care to patients unable to pay. *Id.* at 529 (noting that § 501(r) contains "no specific requirements for the substance of or criteria for financial assistance").

113. 26 U.S.C. § 501(r)(3)(B)(i).

public.¹¹⁴ The hospital must then adopt an “implementation strategy to meet the community health needs identified through such assessment.”¹¹⁵ By establishing this multi-step process, Congress demands that hospitals justify their tax-exemption by taking steps to respond to their communities’ health needs.

Understanding the significance of the new CHNA requirement requires a bit of background. Prior to the ACA, the Internal Revenue Service (“IRS”) had used a “community benefit” standard for hospital tax exemption for nearly fifty years, but it did not use any quantitative measures or issue concrete directives to establish benchmarks for exemption.¹¹⁶ After media coverage of some tax-exempt hospitals’ unsavory billing and collection practices prompted increased public and Congressional attention, however, the IRS took its first step toward increased accountability and transparency for those hospitals. In 2007, it introduced a mandatory reporting schedule specifically for tax-exempt hospitals (“Schedule H”) to capture information about their expenditures on community benefit activities.¹¹⁷ The picture that emerged from those reports confirmed the conventional wisdom in health policy circles that nonprofit hospitals’ reported community benefit expenditures most often involved charity care (*i.e.*, care for patients unable to pay in full for the hospitals’ services) or offsets for claimed losses from treating Medicaid patients.¹¹⁸ Thus, hospitals’ actions to satisfy the community benefit standard most often benefited individual members of the public who received care at the hospital, not the community as a whole.

The new CHNA requirement means that these established community benefit practices no longer suffice to justify hospital tax exemption. The new requirement thus has the potential to prompt a radical change in hospitals’ role in promoting health and in their relationship to their communities. The requirement encourages hospitals to become involved in not only the treatment, but also the prevention of ill health. It directs a hospital to shift its gaze outward, to engage with its surrounding community, and to consider how the hospital might play a role in meeting the health needs of that community—that *group* of people—and not simply the medical needs of individual community residents. In so doing, the CHNA requirement is part of a broader emphasis on public health and prevention in the

114. 26 U.S.C. § 501(r)(3)(B)(ii).

115. 26 U.S.C. § 501(r)(3)(A)(ii).

116. See *infra* Part III.

117. Schedule H is part of the Form 990 annual information return for all tax-exempt organizations. INTERNAL REVENUE SERV., DEP’T OF THE TREASURY, OMB No. 1545-0047, SCHEDULE H (FORM 990), HOSPITALS (2010), <http://www.irs.gov/pub/irs-pdf/f990sh.pdf>.

118. See Sara Rosenbaum et al., *The Value of the Nonprofit Hospital Tax Exemption Was \$24.6 Billion in 2011*, 34 HEALTH AFF. 1225, 1226 (2015); Gary J. Young et al., *Provision of Community Benefits by Tax-Exempt U.S. Hospitals*, 368 NEW ENG. J. MED. 1519, 1519 (2013).

ACA¹¹⁹ that, however modestly, moves the U.S. healthcare system and public health system toward integration.¹²⁰

C. *The Potential Relevance of the CHNA Requirement to Disparities*

In December 2014, after tax-exempt hospitals had already completed their inaugural CHNA, the IRS published final regulations (“Regulations”) adding flesh to the statute’s bones.¹²¹ Although a full description is beyond this Article’s scope,¹²² several aspects of the Regulations are particularly relevant to addressing disparities.

First, the Regulations clearly expect that communities experiencing health disparities should have a voice in the CHNA process. Fleshing out the statute’s requirement of community input, the Regulations call for a hospital to solicit and take into account input from “[m]embers of medically underserved, low-income, and minority populations in the community served . . . or individuals or organizations serving or representing [their] interests”¹²³ The regulatory definition of “medically underserved populations” explicitly refers to disparities: they include “populations experiencing health disparities or at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers.”¹²⁴ The hospital must solicit

119. While the ACA is best known for its steps to achieve near-universal insurance coverage for Americans, the mammoth health reform bill also included numerous provisions seeking to shift more public and private resources towards promoting wellness, rather than simply responding to illness. See generally Laura Anderko et al., *Promoting Prevention Through the Affordable Care Act: Workplace Wellness*, 9 PREVENTING CHRONIC DISEASE E175 (2012); Frederic E. Shaw et al., *The Patient Protection and Affordable Care Act: Opportunities for Prevention and Public Health*, 384 LANCET 75 (2014). This shift in emphasis embodies the “Triple Aim” model of health policy, which includes “population health” as one of its three aims. See Donald M. Berwick et al., *The Triple Aim: Care, Health, and Cost*, 27 HEALTH AFF. 759, 764 (2008).

120. See Lawrence O. Gostin et al., *Restoring Health to Health Reform: Integrating Medicine and Public Health to Advance the Population’s Wellbeing*, 159 U. PA. L. REV. 1777, 1786–87 (2011); see also Stephen M. Shortell, *Bridging the Divide Between Health and Health Care*, 309 JAMA 1121, 1121 (2013) (“[C]onsensus is developing that truly controlling health care costs and improving the overall health of the American people will require a much closer partnership, permeable boundaries, and increased interdependence among the health care delivery system, the public health sector, and the community development and social service sectors.”); cf. David A. Asch & Kevin G. Volpp, *What Business Are We In? The Emergence of Health as the Business of Health Care*, 367 NEW ENG. J. MED. 888, 888 (2012) (“[W]hereas doctors and hospitals focus on producing health care, what people really want is health.”).

121. Community Health Needs Assessments for Charitable Hospitals, 79 Fed. Reg. 78954.

122. For a fuller description and assessment of the Regulations, see Mary Crossley, *Health and Taxes: Hospitals, Community Health, and the IRS*, 16 YALE J. HEALTH POL’Y L. & ETHICS 51, 54 (2016).

123. 26 C.F.R. § 1.501(r)-3(b)(5)(i)(B) (2014). The regulations also require the solicitation and consideration of input from “[a]t least one . . . governmental public health department . . . with knowledge, information, or expertise relevant to the health needs of that community.” § 1.501(r)-3(b)(5)(i)(A).

124. § 1.501(r)-3(b)(5)(i)(B).

input from these groups, and it must consider any input they actually provide in identifying and prioritizing the community's needs, as well as in identifying resources potentially available to meet those needs.¹²⁵

Of course, before a hospital can seek input on health needs from the community it serves, it must decide what and whom that community encompasses.¹²⁶ The Regulations suggest the relevance of geography and target populations, but generally give hospitals significant leeway in defining their communities.¹²⁷ They are clear, however, that a hospital cannot cherry-pick its community: “[A] hospital may not define its community to exclude medically underserved, low-income, or minority populations who live in geographic areas from which the hospital draws its patients.”¹²⁸ In short, they cannot exclude the very populations most likely to have significant health needs or to experience disparities.¹²⁹

In describing the health needs a hospital should consider, the Regulations again refer to disparities. Allaying hospitals' concerns that they might be expected to catalog exhaustively every health need existing in their communities, the Regulations clarify that hospitals must identify only “significant health needs.”¹³⁰ In so doing, a hospital can consider both the needs of its community as a whole and the needs of “particular parts of the community (such as particular neighborhoods or populations experiencing health disparities).”¹³¹ Once a hospital has identified significant health needs, it must prioritize them.

125. § 1.501(r)-3(b)(5)(i). By calling for hospitals to “solicit” input and “take into account” input received, the Regulations do not require that either (1) the hospital actually receive input from the solicited groups (who may not respond to the solicitation), or (2) the hospital make any specific use of input received. *Id.* The Regulations go on to provide a laundry list of additional sources of input (e.g., consumer advocates, academic experts, and healthcare providers that the hospital may consider in its assessment). § 1.501(r)-3(b)(5)(ii).

126. As a practical matter, hospitals vary in how they carry out the mechanics of the CHNA process. In the CHNA reports I reviewed (see *infra* Part II.D.2) many hospitals going through this process for the first time in 2013 either engaged consultants or partnered with public health academics or officials to assist the hospital in designing and executing the process. Some hospitals, by contrast, relied on their own administrative and medical staff to complete the process.

127. § 1.501(r)-3(b)(3) (providing that a hospital “may take into account all of the relevant facts and circumstances, including the geographic area served . . . , target population(s) served . . . , and principal functions (for example, focus on a particular specialty area or targeted disease.”).

128. *Id.*

129. *But see* PUB. HEALTH INST., SUPPORTING ALIGNMENT AND ACCOUNTABILITY IN COMMUNITY HEALTH IMPROVEMENT: THE DEVELOPMENT AND PILOTING OF A REGIONAL DATA-SHARING SYSTEM 1, 22 (2014) [hereinafter SUPPORTING ALIGNMENT AND ACCOUNTABILITY], <http://nnphi.org/CMSuploads/SupportingAlignmentAndAccountabilityInCommunityHealthImprovement.pdf> (finding that hospitals failed to pay sufficient attention to disparities in their communities).

130. § 1.501(r)-3(b)(4).

131. *Id.*

But what counts as a “health need”? Is the concept limited to conditions requiring the sort of medical response that hospitals are accustomed to providing to patients? The Regulations reject such a cabined conception of health needs, instead embracing a more expansive conception:

[T]he health needs of a community include requisites for the improvement or maintenance of health status. . . . These needs may include, for example, the need to address financial and other barriers to access care, to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in a community.¹³²

Based on this description, social determinants of health—factors like the availability or absence of healthful foods, transportation options, living wages, and safe neighborhoods¹³³—are clearly among the health needs that hospitals should consider in their CHNAs. As noted above, these social determinants are often powerful contributors to health disparities. Thus, the Regulations clearly contemplate that hospitals can meet the obligations attached to tax-exempt status by working to address these social determinants and mitigate disparities.

Is it realistic to think that hospitals acting alone are equipped to affect these social determinants? A final aspect of the Regulations worth noting is their encouragement to hospitals to collaborate in assessing and addressing community health needs. Without requiring hospitals to collaborate (beyond the requirement to solicit and consider input, as described above) the Regulations strongly endorse hospitals’ working with others in their community in conducting the CHNA and pursuing related strategies. Potential collaborators might include health departments, other hospitals, community-based organizations, and businesses. The growing literature on advancing health equity highlights the value of collaborative approaches,¹³⁴

132. *Id.*

133. See CTRS. DISEASE CONTROL & PREVENTION, HEALTHY PEOPLE 2020, <http://www.healthypeople.gov/2020/about/foundation-healthmeasures/Determinants-of-Health> (last visited Dec. 2, 2015). The Centers for Disease Control and Prevention lists social environment and physical environment, along with biology and genetics, individual behavior, and health services as primary determinants of health. CTRS. DISEASE CONTROL & PREVENTION, SOCIAL DETERMINANTS OF HEALTH DEFINITIONS, <http://www.cdc.gov/nchhstp/socialdeterminants/definitions.html>. For scientific research regarding the impact of social determinants, see CTRS. DISEASE CONTROL & PREVENTION, SOCIAL DETERMINANTS OF HEALTH (Michael Marmot & Richard G. Wilkinson eds., 1999).

134. See Committee on Accounting for Socioeconomic Status in Medicare Payment Programs, National Academies of Sciences, Engineering, and Medicine, SYSTEMS PRACTICES FOR SOCIALLY AT-RISK POPULATIONS, 4, 44–47 (Washington DC: National Academies Press, 2016). The article lists “collaborative partnerships . . . within and across provider teams and services sectors” as one of six “community-informed and patient-centered systems practices [that] show promise for improving care for socially at-risk populations.” *Id.* at 23.

and the IRS's encouragement gives hospitals a green light to pursue partnerships as they fulfill their new obligations.¹³⁵

Thus, as a whole, the Regulations' explication of the CHNA requirement establishes it as a tool that could readily be used to address racial health disparities. The Regulations direct hospitals to seek and use input from medically underserved and minority populations in identifying and prioritizing the significant health needs of the hospital's community, and they expressly prohibit hospitals from defining their communities in a fashion that excludes those populations. They do not confine hospitals to considering a narrow range of medical needs, but instead embrace a broad conception of health needs, encompassing social determinants of health that often contribute to health disparities. Finally, hospitals are encouraged to collaborate with others in their community throughout the process of identifying and responding to health needs.

Despite this rosy assessment of the CHNA requirement's potential value, it remains uncertain whether many hospitals completing the CHNA process will pay any particular attention to racial health disparities in their communities. For one thing, nothing in the ACA or the Regulations requires hospitals to focus on disparities when they identify and prioritize community health needs. Even as the Regulations refer repeatedly to disparities and describe a process well suited to addressing disparities, they reserve a high degree of flexibility and discretion to hospitals for carrying out assessments and devising implementation strategies. Communities may well have many health needs that do not involve racial disparities, and under current law, hospitals can legitimately choose to focus on those needs in meeting this new obligation. In another article, I have recognized encouraging elements of the Regulations, but criticized the IRS for not pushing hospitals to "think big" about working with others to improve community health.¹³⁶ Ultimately, it remains up to a hospital to decide whether to prioritize disparities in addressing its community's health needs.

D. *Hospitals' Attention to Disparities in the CHNA Process*

The ACA's CHNA requirement provides a new means for hospitals to identify health disparities in their communities and to pursue strategies to address them, but, thus far, how many have actually focused on disparities? This Section describes preliminary evidence on that question, which suggests that relatively few hospitals paid close attention to disparities. That evidence includes the report of a broad empirical evaluation of hospitals' initial CHNA processes, and observations from a reviewing the CHNA

135. Although the Regulations do generally encourage collaboration, I have argued elsewhere that the IRS should provide further guidance that will increase the likelihood of hospital partnerships. See Crossley, *supra* note 122.

136. *Id.* at 71-80.

reports of two states (Georgia and Pennsylvania). It concludes with accounts of several hospitals and hospital partnerships that did address disparities in conducting their CHNAs and, as a result, are participating in community health improvement initiatives to reduce particular disparities.

1. Public Health Institute Report

As part of a project to develop and test tools for comparing and evaluating CHNA reports, the Public Health Institute (“PHI”) conducted a pilot study of forty-four hospitals’ CHNA reports.¹³⁷ The resulting report, *Supporting Alignment and Accountability in Community Health Improvement*, is one of the most rigorous and in-depth reviews to date of hospitals’ inaugural efforts in completing the ACA’s CHNA requirement. The report suggests that a substantial majority of hospitals did not pay close attention to identifying or addressing health disparities in their communities.¹³⁸ The template used in evaluating reports with respect to disparities included questions relevant to disparities, even though that was not the project’s primary goal.¹³⁹ Specifically, researchers examined how hospitals defined their communities, whether and how they engaged community stakeholders, how they prioritized the health needs identified, and (for the hospitals that had posted implementation strategies on their websites) what areas their implementation strategies focused on.¹⁴⁰ The resulting report by PHI, *Supporting Alignment and Accountability*, includes several pertinent observations regarding hospitals’ attention to disparities as part of the needs assessment process.

First, all the hospitals studied defined their community based on their patient service area. In describing that area, though, fewer than a quarter of the hospitals identified particular communities where health disparities were concentrated.¹⁴¹ Some additional hospitals noted the existence of disparities in defining their communities, but failed to say where in the com-

137. SUPPORTING ALIGNMENT AND ACCOUNTABILITY, *supra* note 129. The hospitals whose reports were reviewed were located in metropolitan, micropolitan, and rural areas in ten states. *Id.* at 3–4, 43.

138. *Id.* at 47–49. It bears noting that these hospitals were completing the CHNA process without the benefit of the final IRS Regulations that provided more specific guidance on how they should carry out the new CHNA obligation. The final Regulations followed the publication of proposed regulations regarding hospitals’ CHNA obligation in April 2013, 78 Fed. Reg. 20,523 (Apr. 5, 2013) (to be codified at 26 C.F.R. pts. 1, 53), which followed a Preliminary Guidance issued in July 2011. The hospitals whose reports were reviewed as part of the PHI project may have relied on those preliminary communications. I.R.S. Notice 2011-52, I.R.B. 2011-30, http://www.irs.gov/irb/2011-30_IRB/ar08.html.

139. SUPPORTING ALIGNMENT AND ACCOUNTABILITY, *supra* note 129, at 41–42.

140. *Id.* at 45–69 (describing findings in each of these areas).

141. The SUPPORTING ALIGNMENT AND ACCOUNTABILITY report highlights the growing availability of geocoding tools that permit hospitals and others conducting CHNAs to identify geographic concentrations of disparities in local communities. *Id.* at 33–34. These tools use poverty rates and high school non-completion rates as proxies for health disparities. *Id.*

munity those disparities existed.¹⁴² Other hospitals identified disparities elsewhere in the CHNA report (again, without locating them geographically). A quarter of the hospitals failed entirely to identify health disparities in their CHNA.¹⁴³ Thus, while a majority of hospitals noted the existence of disparities in their communities at some point in their CHNA reports, fewer than one in four drilled down in the data to determine where those disparities were concentrated.

Input from racial and ethnic minority members of a community is a rich resource for understanding the existence of disparities and identifying strategies for their reduction. The PHI's review of how hospitals included community stakeholders in the assessment process revealed that most hospitals sought input either directly from people from racial or ethnic minority groups, or from representatives of those groups.¹⁴⁴ However, researchers could not determine from the CHNA reports whether the hospital provided meaningful opportunities to permit community members to help the hospital decide on the community's most pressing health needs. In other words, it was not clear from the reports whether the hospitals simply went through the motions of consulting with diverse and disadvantaged community members or whether it actually *engaged* with them¹⁴⁵ to give them a real voice in the process. Moreover, only five hospital reports indicated that community members played a role in the hospital's processes for prioritizing the needs identified and in developing strategies to address those needs.¹⁴⁶

Finally, in their implementation strategies, the hospitals in the pilot study focused primarily on strategies related to providing clinical care and incorporated few strategies related to social determinants of health.¹⁴⁷ Similarly, relatively few hospitals focused their strategies on the particular neighborhoods experiencing concentrated disparities.¹⁴⁸ Overall, the PHI Report found much room for improvement with respect to hospitals' attention to disparities in the CHNA process and suggested how hospitals could improve their focus on areas of concentrated disparities, "where

142. *Id.* at 76.

143. *Id.* at 48.

144. *Id.* at 55 (41% of hospitals received input from representatives of people from racial or ethnic minority groups and 27% received input directly from people in those groups).

145. *Id.* at 84 (drawing a distinction between community consultation and community engagement).

146. *Id.* at 56.

147. *Id.* at 79–80.

148. *Id.* at 80. The researchers suggested that the lack of a geographical focus on disparities may have been the result of "somewhat confusing guidance from the IRS, a historical tendency to frame programs as 'serving the community at large,' and a lack of internal population health expertise." *Id.*

there are both the greatest needs and most significant potential to produce measurable outcomes.”¹⁴⁹

2. My Impressionistic Review of CHNA Reports

To develop my own sense of what hospital CHNA reports look like and to what extent they reference disparities, I reviewed CHNA reports from thirty-eight hospitals in Pennsylvania and Georgia, using a rubric that posed questions pertinent to each hospital’s solicitation and consideration of input from minority communities and its identification and prioritization of community health needs.¹⁵⁰ This admittedly limited and impressionistic review¹⁵¹ permits preliminary observations¹⁵² about the attention these hospitals seemingly paid to disparities when conducting their CHNA reports, and those observations were similar to the findings in the PHI Report.

The CHNA reports typically included data regarding the demographic make-up of their community, including the racial composition and prevalence of poverty. In addition, many reports provided data regarding the prevalence of different health issues in the community by different demographic groups, often in the form of tables presenting a range of data. However, it was unclear how (or whether) most hospitals used that information. Although many reports stated that the process included input from medically underserved or minority communities, few indicated specifically who provided input or which minority or underserved populations were represented. Fewer still described the content of any input received from those communities. Although a handful of hospitals provided a narrative discussing health disparities within their community and how the hospital might help address them,¹⁵³ most did not. Overall, these observations echo

149. *Id.* at 83–87.

150. The evaluation rubric and completed evaluation forms for the hospitals reviewed are on file with the author.

151. While the hospitals reviewed did not comprise a representative sample in statistical terms, they were diverse. My review included reports from large hospitals and small hospitals; from hospitals in rural, suburban, and urban settings; and from hospitals operating as stand-alone institutions, as part of multi-hospital systems, and as part of an academic medical center. The two states – Georgia and Pennsylvania – were chosen because they are both large states with numerous hospitals; they include both major urban centers and large rural areas; and they have populations that are racially and socioeconomically diverse.

152. It was frequently difficult to discern from the reports exactly how the hospitals sought input, whether community participants providing input were from minority communities, and the substance of the input received. Nonetheless, taking the reports in the aggregate, several observations can be offered.

153. *E.g.*, NORTHSIDE HOSP. ATLANTA, COMMUNITY HEALTH NEEDS ASSESSMENT: FY2013-FY2015 1, 3 (2016), <http://www.northside.com/CHNA>; COLUMBUS REG’L HEALTH CARE SYS., 2013 COMMUNITY HEALTH RESPONSE PLAN 9 (2013), https://columbusregional.com/media/1455/2013_community_health_response_plan-themedicalcenter.pdf (discussing disparity in diabetes mortality rate).

the findings in the PHI report and reinforce its conclusion that there is much room for improvement when it comes to hospitals' engagement with community stakeholders and discerning disparities.¹⁵⁴

3. Hospitals Identifying and Prioritizing Racial Disparities

The previous two sections describe findings that suggest most hospitals did not pay much attention to racial disparities as they conducted their inaugural round of CHNAs. However, examples exist of hospitals (working either alone or as part of a collaborative partnership) that deliberately focused on the needs of underserved groups in their communities.¹⁵⁵ Although hospitals that emphasize health disparities in the CHNA are not currently the norm, their existence demonstrates the feasibility of such an effort. For example, four hospitals in the Lehigh Valley of Pennsylvania, an area that has had significant growth in its minority population over the past decade, sought community input by partnering with community-based organizations that were highly respected in the African-American and Hispanic communities. Doing so helped engage members of those communities, who had repeated opportunities to provide their ideas and perspectives and identify their health promotion priorities.¹⁵⁶ The four-hospital partnership responded by choosing to focus on health literacy, maternal and child health, and access to healthcare—three areas related to the communities' priorities.¹⁵⁷

Other hospitals completing a CHNA in a disparities-attentive fashion have participated in broader collaborative partnerships that include local government and community-based organizations. For example, the hospital members of the Central Ohio Hospital Council partnered with civic, academic, health, and philanthropic organizations to develop *Franklin County HealthMap 2013*, a health assessment that found the infant mortality rate for African-American infants in the county exceeded the rate for

154. See BETH STEPHENS, HEALTHCARE GEORGIA FOUND., NONPROFIT HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENTS IN GEORGIA 5 (2015), <http://www.georgiawatch.org/wp-content/uploads/2015/06/Formatted-CHNA-Report-06022015-FINAL.pdf>. A comprehensive review of the CHNA reports from 38 Georgia hospitals, conducted by the Georgia Watch Health Access Program, produced similar results with respect to the engagement of members of vulnerable populations. Although all the hospitals gathered input from community members, only 18% "explicitly and intentionally gathered input from members of vulnerable populations" and fewer than a third of hospitals "incorporated community members into their CHNA project leadership teams." *Id.*

155. See AM. HOSP. ASS'N, ELIMINATING DISPARITIES IN HEALTH OUTCOMES: EXAMPLES FROM THE FIELD, <http://www.aha.org/advocacy-issues/disparities/casestudies.shtml> (last visited Sep. 16, 2016) (listing hospitals or health systems that have programs focusing on disparities).

156. See Alexandra F. Lightfoot et al., *Engaging Underserved Populations in Affordable Care Act-required Needs Assessment*, 25 J. HEALTH CARE POOR & UNDERSERVED 11, 12, 14 (2014).

157. *Id.* at 17; see Chaya T. Merrill et al., *DC Health Communities Collaborative (DCHCC): A Promising Collaboration to Reduce Health Disparities in the Nation's Capital*, 25 J. HEALTH CARE FOR THE POOR & UNDERSERVED 30 (2015) (describing another multi-hospital initiative).

White infants threefold.¹⁵⁸ The Hospital Council then participated in Greater Columbus Infant Mortality Task Force, which was charged with reducing the overall rate of infant mortality by forty percent and cutting the racial gap in half by 2020.¹⁵⁹ The Task Force engaged community members to determine the underlying causes of high infant mortality rates and to gather ideas for interventions. In the resulting Implementation Plan, the Hospital Council is named as the “Lead Entity” for three separate strategies to reduce infant mortality rates.¹⁶⁰ This example demonstrates that, even when hospitals working alone may not be equipped to have a measurable impact on health disparities, they can play integral roles in broad-based initiatives.

A hospital need not be part of a broader partnership, however, in order to identify and respond to racial disparities as it complies with the CHNA requirement. A 2015 article describes how the H. Lee Moffitt Cancer Center in Tampa intentionally set about conducting its CHNA process so as to meaningfully address local health disparities.¹⁶¹ Its decisions included giving the Cancer Center’s diversity department responsibility for coordinating the CHNA, recruiting racial and ethnic minority community members to serve on an advisory committee, and using a social determinants of health framework in its data collection.¹⁶² Several of the assessment’s findings referred to disparities or the needs of underserved populations, and the Cancer Center’s Implementation Plan identified five priority areas for action, including health disparities and cultural competence.¹⁶³

4. What the Evidence Suggests

This initial evidence suggests that many hospitals may not be eager to highlight disparities in their communities or feel a responsibility for addressing matters they view as being beyond their bailiwick. This judgment is in line with a paper studying an early (pre-ACA) collaborative partnership of ten hospitals that received grant funding to develop and implement

158. COLUMBUS PUB. HEALTH, FRANKLIN COUNTY HEALTH MAP 2013: NAVIGATING OUR WAY TO A HEALTHIER COMMUNITY TOGETHER 1, 22 (Jan. 2013). Each participating hospital also produced a hospital-specific CHNA, as required by law. *Id.* at 1.

159. GREATER COLUMBUS INFANT MORTALITY TASK FORCE, THE PLAN (2014), <http://gcinfantmortality.org/the-plan/>.

160. GREATER COLUMBUS INFANT MORTALITY TASK FORCE, FINAL REPORT AND IMPLEMENTATION PLAN, CITY OF COLUMBUS COUNCIL 49-50 (June 2014), <http://gcinfantmortality.org/wp-content/uploads/2014/07/IMTF-2014-Final-Report-FINAL.pdf>.

161. Cathy G. Grant et al., *Community Health Needs Assessment: A Pathway to the Future and a Vision for Leaders*, 34 HEALTH CARE MANAGER 147, 147 (2015).

162. *Id.* at 148.

163. *Id.* at 153. The five priority areas for action identified were cultural competence; health disparities; prevention, screening, and outreach; access; and community benefit structure.

a project to reduce disparities in cardiac care.¹⁶⁴ Health system leaders interviewed for the study did not view health care disparities as an organizational priority for hospitals, and they tended to assume that the care their institutions provided to different populations was of equal quality. Fundamentally, they understood disparities as “essentially a problem of the social fabric, as opposed to one that, even in part, reflected inconsistencies or inequities in the way that health systems deliver care.”¹⁶⁵ Notwithstanding the failure of most hospitals to focus on disparities, however, the evidence also shows that some hospitals have decided to pay particular attention to the health needs of minority populations in their communities and to pursue strategies responding to the inequality that they find.

I acknowledge the limitations of reviewing hospitals’ CHNA reports as a basis for discerning hospitals’ attention to disparities. These reports vary in their length (from a few dozen to a few hundred pages) and in the detail and sophistication with which they present a hospital’s processes and findings. As a result, it is often difficult, if not impossible, to assess with a high degree of confidence the extent to which a hospital’s processes actually considered racial inequality in treatment, status, or outcomes as possible community health needs.¹⁶⁶ Simply reading CHNA reports to determine whether a hospital paid attention to disparities may produce both false positives (findings that a hospital paid attention to disparities, when in reality the hospital paid lip service to disparities in its report but devoted no serious attention to the problem) and false negatives (findings that a hospital paid no attention to disparities, when in fact the hospital’s attention to the issue simply was not reflected in its report). Some hospitals may pursue strategies to reduce a disparity in their community, such as differences in cancer mortality rates, without labeling the problem as a disparity. Despite these limitations, the evidence here strongly suggests that, in the first round of CHNA reports under the ACA, some hospitals deliberately used the CHNA process to identify racial disparities in their community and devise ways to address those disparities, but many (and probably most) hospitals did not.

IV. INTEREST CONVERGENCE AND THE BUSINESS CASE FOR ADDRESSING DISPARITIES

The preceding Part describes the apparent failure by most hospitals to pay careful and deliberate attention to racial health disparities in conducting their initial CHNA under the ACA. In considering this failure,

164. See Bruce Siegel et al., *Assumed Equity: Early Observations from the First Hospital Disparities Collaborative*, 29 J. HEALTHCARE QUALITY 11, 12 (2007).

165. *Id.* at 13.

166. It is similarly difficult to determine how seriously hospitals sought to engage with members or representatives of minority communities in identifying and prioritizing community health needs. SUPPORTING ALIGNMENT AND ACCOUNTABILITY, *supra* note 129, at 77.

the question naturally arises: Why *would* hospitals focus their attention on identifying and addressing racial health disparities? Hospitals typically have viewed their primary mission as providing clinical care to patients and are often inexperienced with community health initiatives.¹⁶⁷ The ACA requires that they complete a CHNA every three years in order to retain their tax exemption, but it does not require them to pay particular attention to disparities in doing so. Given these factors, hospitals' lack of attention to disparities is hardly surprising. Returning to the concept of interest convergence, this Part identifies a reason for hospitals to focus on disparities, arguing that initiatives that reduce racial disparities may sometimes be in hospitals' financial self-interest. Particularly as payment methods emphasize quality and health promotion, hospitals may be able to improve their financial positions by identifying and responding to disparities in their communities.

A. *The Business Interest in Addressing Disparities*

In light of the enormous financial costs of racial health disparities,¹⁶⁸ the general economic rationale for tackling racial health disparities is apparent. Certainly the federal government, as the single largest payer for health care,¹⁶⁹ would benefit financially from eliminating health disparities.¹⁷⁰ But might private parties also find their economic interests advanced by disparities' elimination?

In fact, some employers and health plans have demonstrated an interest in finding ways to decrease disparities. Their interest, reflected in a number of reports, represents one aspect of a broader conversation regarding the "business case" for improving health care quality¹⁷¹ and commu-

167. Cf. Stephen M. Shortell et al., *The Contribution of Hospitals and Health Care Systems to Community Health*, 30 ANN. REV. PUB. HEALTH 373, 379-80 (2009) (describing the overlapping strategic, cultural, technical, and structural barriers to engaging hospitals in community health efforts).

168. See *supra* Part II.C.

169. CENTERS FOR MEDICARE & MEDICAID SERVICES, NHE FACT SHEET, <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpend-data/nhe-fact-sheet.html> (stating that in 2014 the federal government supplied 28% of national health expenditures).

170. This economic interest bolsters the recognized justice-based rationale. Citing the need to address "historical and contemporary injustices," Healthy People 2020 sets "achiev[ing] health equity, eliminat[ing] disparities, and improv[ing] the health of all groups" as one of the two overarching goals in the federal government's public health plan for the nation. U.S. Dep't of Health and Human Serv., *Disparities*, HEALTHY PEOPLE 2020, <http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities> (last updated Sept. 22, 2016).

171. See Sheila Leatherman et al., *The Business Case for Quality: Case Studies and An Analysis*, 22 HEALTH AFF. 17, 17 (2003). Leatherman et al. define a "business case" for a health care improvement intervention as existing "if the entity that invests in the intervention realizes a financial return on its investment in a reasonable time frame, using a reasonable rate of discounting. . . . in addition a *business case* may exist if the investing entity believes that a positive indirect

nity health.¹⁷² As the non-White segment of the workforce and insurance pools grows, employers and health plans can reap benefits by ensuring that this population does not receive poorer quality or less appropriate care. For example, a report from the Alliance of Community Health Plans Foundation identified business benefits “in many different areas such as equity, efficiency, quality and reduction of medical errors” that health care organizations could achieve when they follow standards regarding culturally and linguistically competent care.¹⁷³ Similarly, a report from the National Business Group on Health highlighted that the costs of unequal health care include employee disability and premature death, costs borne in part by employers. That report asserts that “[b]y addressing health disparities . . . employers stand to benefit in both direct and indirect ways.”¹⁷⁴

B. *A Business Case for Hospitals to Reduce Disparities?*

But what about hospitals? Does a “business case” exist for hospitals to undertake initiatives addressing racial health disparities in their communities? Unlike employers and health plans, hospitals do not typically have ongoing relationships with patients experiencing health disparities, so efforts to diminish disparities and thereby improve patients’ health status and functioning over the long haul do not offer hospitals the same sort of benefits accruing to employers and health insurers.¹⁷⁵ Instead, hospitals’ business interest in their patients revolves primarily around whether and how they are paid for the care they provide.

Forecasts of fundamental shifts in how hospitals are paid suggest that hospitals’ financial health will increasingly depend at least partly on their communities’ health. In simple terms, health insurers (most notably, but not exclusively, the federal government) are moving from volume-based

effect on organizational function and sustainability will accrue within a reasonable time frame.” *Id.* at 18.

172. In her blog post, Risa Lavizzo-Mourey, the CEO of the Robert Wood Johnson Foundation predicts that in 2016 companies and financial institutions will embrace “the business case for investing in community health”. Risa Lavizzo-Mourey, *Community Health is a Business Issue. Here’s Why.*, LINKEDIN PULSE (Dec. 28, 2015), <https://www.linkedin.com/pulse/big-idea-2016-community-health-business-issue-heres-lavizzo-mourey>.

173. ALL. OF CMTY. HEALTH PLANS FOUND., *MAKING THE BUSINESS CASE FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTH CARE* 4, 5 (2007).

174. NAT’L BUS. GROUP CTR. PREV. & HEALTH, *ELIMINATING RACIAL AND ETHNIC HEALTH DISPARITIES* 7 (Feb. 2009),

175. *E.g.*, Marshall H. Chin, *Creating the Business Case for Achieving Health Equity*, 31 J. GEN. INTERN. MED. 792, 792 (2016) (noting that “the societal case for health equity is not pertinent for the individual provider group or hospital considering its own interests”). Dr. Chin goes on to characterize the community needs assessment requirement as supporting a “largely indirect” business case from a hospital’s perspective.

reimbursement systems to value-based reimbursement systems.¹⁷⁶ An increased payer focus on quality of care and health outcomes is prompting the hospital industry to adopt a new focus on population health and health promotion.¹⁷⁷ In recent years, the American Hospital Association appears to have “found religion,” embracing the importance of hospitals’ promoting health:

As delivery and reimbursement systems change to incentivize keeping patients healthy and out of the hospital, the hospital field must be looking at a holistic approach to care, prevention needs to be front and center, and more than just hospitals and the health care system will be needed to impact change. Our focus should be on determinants of health, not just health care or hospital care.¹⁷⁸

The growing focus on value-based reimbursement and attention to health promotion provide a foundation for asserting that disparities-reduction efforts¹⁷⁹ may sometimes align with a hospital’s financial self-interest.¹⁸⁰

If that is the case, then the financial interests of tax-exempt hospitals and the interests of racial health justice advocates may converge, permitting

176. See Julia James, *Health Policy Brief: Pay-for-Performance*, HEALTH AFFAIRS (Oct. 11, 2012), [hereinafter *Oct. Policy Brief*] http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=78 (reviewing public and private pay-for-performance initiatives).

177. See Melinda Chen, et al., *Hospitals’ Engagement in Population Health: Moving Past the Medicine and Into the Community*, HEALTH AFFAIRS BLOG (April 5, 2016), <http://healthaffairs.org/blog/2016/04/05/hospitals-engagement-in-populationhealth-moving-past-the-medicine-and-into-the-community>.

178. COMMS. ON RESEARCH & PERFORMANCE IMPROVEMENT, AM. HOSP. ASS’N, LEADERSHIP TOOLKIT FOR REDEFINING THE H: ENGAGING TRUSTEES AND COMMUNITIES (2015), http://www.aha.org/content/14/redefining_H_report_w_appendix.pdf.

179. It bears noting here that hospitals may not always view or name a particular problem as involving a racial disparity, even though disparities may exist in how the problem is experienced across racial groups. For example, hospitals might view the initiatives described below simply as efforts to reduce readmissions or to lower recidivism among victims of violent injury. Because minorities are disproportionately likely to be readmitted or to experience violent injuries, however, I include those initiatives as efforts to address disparities. For example, the 2013 Community Health Needs Assessment and Implementation Plan adopted by Piedmont Atlanta Hospital includes “Reduced preventable admissions and emergency department re-encounters” as one of three priority issues in its community. PIEDMONT ATLANTA HOSP., COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION PLAN (May 21, 2013), <http://www.piedmont.org/media/file/CB-PAH-2013-CHNA.pdf>. Although the report’s discussion of this priority does not refer to racial disparities, the strategies adopted to address this issue include references to patients with “limited health literacy” and “members of more vulnerable communities,” suggesting that the hospital recognizes that readmissions implicate equity concerns. *Id.* at 5-6.

180. Professor Gwendolyn Majette makes a similar point about how reimbursement methods should be used to incentivize physicians to address disparities as an aspect of quality improvement. See Gwendolyn Roberts Majette, *Global Health Law Norms and the PPACA Framework to Eliminate Health Disparities*, 55 HOW. L.J. 887, 929-31 (2012).

real progress in combatting health disparities. And the ACA's requirement that hospitals regularly assess and respond to their communities' health needs provides further impetus for hospitals to attend to how disparities affect their communities. Two examples—hospital efforts to lower readmission rates and curb violent injury recidivism—illustrate this potential interest convergence.

1. Lowering Hospital Readmission Rates

When a patient is readmitted to a hospital soon after being discharged, it often suggests that the hospital provided poor quality care during the initial hospitalization or failed to appropriately coordinate the patient's post-discharge care.¹⁸¹ In addition to signaling poor quality care, readmissions cost payers large sums of money. For example, one study estimated that about 75 percent of patient readmissions were potentially preventable and that the Medicare program paid \$12 billion annually for potentially preventable readmissions.¹⁸² Moreover, researchers have documented that minority patients who suffer chronic conditions are more likely to be readmitted.¹⁸³ These facts suggest that taking steps to lower readmission rates could potentially save health insurers money and, by improving the quality of care provided to minority patients, also decrease the disparity in readmission rates.

The federal government, which pays for nearly 60 percent of hospital admissions in the United States, through the Medicare and Medicaid public insurance programs,¹⁸⁴ has a particular interest in lowering readmission rates. The ACA furthered the government's dual interest in saving money and improving quality by authorizing the Hospital Readmissions Reduction Program ("HRRP"), which imposes financial penalties on hospitals whose readmission rates for Medicare patients are relatively high.¹⁸⁵ The

181. "Readmissions" are typically defined as a patient who is admitted to a hospital within 30 days after a previous hospital discharge. Julia James, *Health Policy Brief: Medicare Hospital Readmissions Reduction Program*, HEALTH AFFAIRS 1, 1-5 (Nov. 12, 2013) [hereinafter *Nov. Policy Brief*], http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_102.pdf.

182. *Id.*

183. JOSEPH R. BETANCOURT ET AL., MONGAN INST. FOR HEALTH POLICY AT MASS. GEN. HOSP., *GUIDE TO PREVENTING READMISSIONS AMONG RACIALLY AND ETHNICALLY DIVERSE MEDICARE BENEFICIARIES* (2015), https://www.cms.gov/About-CMS/Agency-information/OMH/Downloads/OMH_Readmissions_Guide.pdf.

184. See Erin Dietsche, *60 Things to Know about the Hospital Industry*, BECKER'S HOSP. REV. (Jan. 14, 2016), <http://www.beckershospitalreview.com/lists/50-things-to-know-about-the-hospital-industry-2016.html>.

185. *Nov. Policy Brief*, *supra* note 181. Although the HRRP's penalties are based solely on Medicare readmissions, Medicare admissions make up such a large percentage of hospitals' patient census that policies shaping hospital behavior toward Medicare patients are likely to influence hospitals' behavior more broadly. See NICOLE HUBERFELD ET AL., *THE LAW OF AMERICAN HEALTH CARE* 45 (2017) (noting that "Medicare and Medicaid are also powerful tools for the federal government to drive healthy policy, often through rules and regulations that reach far beyond these programs.").

HRRP program effectively shifts some of the costs for excessive hospital readmissions from the federal government to hospitals themselves and thus creates incentives for hospitals to take steps to lower their readmission rates. With HRRP in place, hospitals' incentives to lower readmissions becomes more concrete and may align with an interest in reducing racial disparities in their communities.

Recognizing that racial disparities exist in both the prevalence of certain chronic conditions and in hospital readmissions for patients with those conditions,¹⁸⁶ the Centers for Medicare and Medicaid Services ("CMS") has developed guidance to assist hospitals in targeting improvements to those populations.¹⁸⁷ CMS's *Guide to Preventing Readmissions Among Racially and Ethnically Diverse Medicare Beneficiaries* urges hospitals to develop strategies to respond to barriers that contribute to higher rates of readmission for minority patients and suggests the key components those strategies should include.¹⁸⁸ One of the case studies included in the guidance describes how a health system in Kentucky decreased admissions, length of stay, and readmissions—all yielding a 100 percent return on investment—by increasing the coordination of services for “super users” of care.¹⁸⁹ The health system used data to identify hospital patients at high risk of readmission. It then sent multidisciplinary teams on home visits to help discharged patients better manage health conditions and to provide medical and social support services.¹⁹⁰

This case study suggests that a hospital that discovers through its CHNA process that minority populations in its community experience a high level of readmissions or disproportionate barriers to quality care may

186. *Id.*

187. In HRRP's first year, more than 2,200 hospitals collectively suffered a total of about \$280 million in penalties for their excess readmissions. *Oct. Policy Brief, supra* note 176, at 2. Some critics of HRRP point out that its penalties are falling disproportionately on hospitals serving the sickest and poorest populations. Lena Sun, *Medicare Unfairly Penalizes Hospitals Treating Sickest, Poorest Patients, Study Finds*, WASH. POST (Sept. 14, 2015). Preliminary evidence suggests that HRRP is producing the intended effect of lowering readmission rates. *Nov. Policy Brief, supra* note 181. Some evidence suggests, however, that the reduction in readmission rates reflects not hospitals' success in preventing the need for readmission, but rather their ingenuity in coding patients as being in “observation status” when they return to the hospital within thirty days. A patient who is in “observation status” does not count as a readmission. See Christopher Weaver et al., *Medicare Rules Reshape Hospital Admissions*, WALL ST. J. (Dec. 1, 2015); but see Rachael B. Zuckerman et al., *Readmissions, Observation, and the Hospital Readmissions Reduction Program*, 374 NEW ENG. J. MED. 1543 (2016).

188. Betancourt, *supra* note 183.

189. *Id.* at 13–15 (describing the Health Connections Initiatives of Kentucky One Health).

190. *Id.* at 13 (“Home visits focus on medical and social-support service delivery, such as addressing basic needs like housing, transportation, food insecurity, and low literacy, with the ultimate goal of promoting health management and transition the participant to a medical home.”). The results of this initiative included not only lower readmission rates, but also a decline in depression rates, an increase in patients' ability to manage their own health, and an increase in patient satisfaction. *Id.* at 14.

be able to simultaneously address those quality issues and advance the hospital's financial self-interest. Strategies for overcoming quality barriers, such as low health literacy, constrained socioeconomic resources, and multiple co-morbidities,¹⁹¹ may both improve the quality of care received by minority patients (reducing disparities associated with poor quality¹⁹²) and prevent readmissions (reducing associated penalties).¹⁹³ In short, a hospital's attentiveness to disparities in the CHNA process may illuminate this potential interest convergence.

2. Lowering Violent Injury Recidivism

In a second example of potential interest convergence, a CHNA that identifies high rates of violent injury in a community may lead to the hospital's developing a program that could both reduce health disparities and produce financial benefits to the hospital. In recent years, a growing number of hospitals have developed programs to provide persons who come to the hospital's emergency department with a violent injury with services to prevent the patient from suffering similar injuries in the future.¹⁹⁴ A growing body of evidence suggests that these hospital violence intervention programs ("HVIPs") are effective both in decreasing the number of patients who subsequently return to the hospital with another injury *and* in saving money for society and the hospitals.¹⁹⁵

The underlying concept for these programs is that the high incidence of violent injuries is a public health problem.¹⁹⁶ Moreover, this problem

191. *Id.* at 4–5 (listing factors contributing to disparities in readmission rates and strategies affecting readmissions for diverse populations).

192. Because the effectiveness of strategies for addressing various health disparities is not yet well established, the assertion that reducing barriers to receiving quality care will reduce disparities remains somewhat speculative, but is consistent with thinking in the field. See Christine Bahls, *Health Policy Brief: Achieving Equity in Health*, HEALTH AFFAIRS (Oct. 6, 2011), http://healthaffairs.org/healthpolicybriefs/brief_pdfs/health_policybrief_53.pdf.

193. Of course, the fear is that rather than pursuing strategies designed to lower readmissions of minority patients by addressing barriers contributing to disparities, hospitals either will seek to avoid providing care for minority patients or will suffer such severe financial penalties that they will be driven out of business.

194. See Jonathan Purtle et al., *Hospital-Based Violence Prevention: Progress and Opportunities*, 163 ANNALS INTERNAL MED. 715, 715 (2015) (describing the National Network of Hospital-based Violence Intervention Programs).

195. See Kyle Fischer et al., *The Affordable Care Act's Medicaid Expansion Creates Incentive for State Medicaid Agencies to Provide Reimbursement for Hospital-Based Violence Intervention Programs*, 20 INJURY PREVENTION 427 (2014).

196. Although some accounts describe interpersonal violence using the language of epidemics and infectious diseases, others suggest that a chronic disease model is more apt. A chronic disease model recognizes that many people who suffer violent injuries live in environments where low-level threats of violence are a near constant, with flare-ups occurring with some regularity and threatening serious harm or death. Viewed in this light, an approach emphasizing coordinated interventions may best interrupt the progression of the health threat. Fischer et al., *supra* note 195, at 715.

disproportionately affects racial and ethnic minority males who live in low-income neighborhoods.¹⁹⁷ In short, it is an instance of a racial health disparity that has been concentrated in urban areas.¹⁹⁸ HVIPs aim to address this public health problem by preventing patients who have suffered a violent injury from being re-injured and from responding to their injury by violently retaliating.¹⁹⁹ Based on the thinking that suffering a violent injury severe enough to result in hospitalization may present a teachable moment in a person's life, the programs combine in-hospital engagement of patients with a range of community-based case management services provided after the patient's discharge. The continuum of services seeks to promote psychological healing from the trauma and to decrease the risk of re-injury by addressing underlying risk factors like poverty, unemployment, and substance abuse.²⁰⁰

Evidence of HVIPs' effectiveness and cost are beginning to accumulate. The research suggests that the programs are effective in decreasing the rates of violent re-injury, hospital readmission, and subsequent participation in criminal activity.²⁰¹ Early research also suggests that these programs represent a good investment, not only from a societal perspective, but also from the hospital's perspective. Researchers comparing a hospital's upfront costs of providing violence intervention services to the hospital's cumulative costs of providing standard medical treatment and referrals to violent injury victims, as well as re-hospitalization costs for recidivist victims, have found that HVIPs are cost-effective interventions for hospitals.²⁰² In short, it appears to cost hospitals more to provide care for re-injured victims of violence than to provide violence intervention programs to help them avoid re-injury.

The growing recognition that, for hospitals, HVIPs are "good medicine and good business"²⁰³ suggests a potential convergence of interests with respect to hospitals in communities with high levels of violent

197. *Id.*

198. Recent data suggest, however, that the gap between levels of violent crime victimization in urban, suburban, and rural areas has been narrowing. See JENNIFER L. TRUMAN & LYNN LANGSTON, BUREAU OF JUSTICE STATISTICS, BULLETIN: CRIMINAL VICTIMIZATION, 2013, at 10 (Sept. 2014), <http://www.bjs.gov/content/pub/pdf/cv13.pdf>.

199. Fischer et al., *supra* note 195, at 427.

200. *Id.*

201. *Id.* at 427–28. See also DEFENDING CHILDHOOD TASKFORCE, DEP'T OF JUSTICE, DEFENDING CHILDHOOD: PROTECT, HEALTH, THRIVE 47 (2012).

202. Vincent E. Chong et al., *Hospital-Centered Violence Intervention Programs: A Cost-Effectiveness Analysis*, 209 AM. J. SURGERY 597 (2015); C. Juilliard et al., *Saving Lives and Saving Money: Hospital-Based Violence Intervention Is Cost-Effective*, 78 J. TRAUMA ACUTE CARE SURGERY 252 (2015).

203. Shefali Luthra, *For Hospitals, Treating Violence Beyond the ER is Good Medicine and Good Business*, KAISER HEALTH NEWS (Jan. 20, 2016), <http://khn.org/news/for-hospitals-treating-violence-beyond-the-er-is-good-medicine-and-good-business/>.

injuries.²⁰⁴ Hospitals may save money over time by implementing a HVIP and, because data shows that violent injury victims are disproportionately minority men, HVIPs' effectiveness in decreasing the risks of re-injury and retaliation also offers an evidence-based response to a health disparity. Thus, the health equity interests of minorities living in violence-plagued communities and the financial interests of hospitals serving those communities may converge. In this scenario, the CHNA requirement serves as an important catalyst for hospitals to recognize violent injuries as a health need in their communities and to take steps to address that need.

V. "FORG[ING] FORTUITY": PROMOTING THE CONVERGENCE OF HOSPITALS' INTERESTS WITH HEALTH EQUITY AIMS

Thus far, this Article has described how the ACA's new CHNA requirement for tax-exempt hospitals could, in theory, serve as a mechanism for hospitals to identify racial health disparities in their communities. In addition, the Article has considered how steps to remedy those disparities might advance a hospital's financial self-interest in some instances. But, it also has recognized that early evidence of how hospitals have implemented the CHNA requirement indicates that this potential for interest convergence has not yet caused hospitals to pursue those steps. Based on this evidence, a convergence of interests leading to hospital actions that "move the needle" on disparities in their communities is not a sure thing. Part V identifies three avenues for action that could help, in Professor Bell's words, "forge fortuity" in bringing about interest convergence. Specifically, it will identify steps that health justice advocates, federal regulators, and researchers should take to increase the likelihood that a convergence of interests will prompt hospitals to focus on disparities in their community health efforts. It concludes by acknowledging and responding to several potential objections to the Article's reliance on interest convergence to address racial health disparities.

A. *Health Justice Activism*

One step that could foster interest convergence is for community health justice advocates to seek a seat at the table and a voice in the health needs assessment process. As discussed above, the Regulations detailing the CHNA requirement require hospitals to solicit input from minority and underserved communities and to take into account any input received as they assess and prioritize community health needs,²⁰⁵ thus providing a platform for advocates to press for the inclusion of health disparities as high-priority community health needs. These Regulations, however, do not specify any particular process that hospitals must use in soliciting or

204. Currently, HVIPs are funded primarily by public sources, philanthropic grants, and hospital support. Purtle et al., *supra* note 194, at 716.

205. See Treasury Regs. 26 U.S.C. § 1.501(r)(3)(b)(i).

incorporating community input, and they implicitly recognize that a hospital unable to secure input from these groups may still proceed with the needs assessment process.²⁰⁶ As a result, some responsibility remains with community members to respond to (or even seek) invitations to give input and to share their knowledge about their community's greatest health needs.

In addition, even an individual or group that is not invited by a hospital to give input can have a voice. For each CHNA after the first, the Regulations require a hospital to consider written comments received (presumably from its community) regarding its most recently adopted CHNA report and implementation strategy.²⁰⁷ Community health justice advocates are permitted to present concerns about disparities and propose solutions, even if the hospital has not reached out to them to participate in the assessment process. The Regulations clearly intend that community members should have a voice in the CHNA process, but leave them some responsibility to speak up and raise community concerns. The Regulations also permit significant discretion for hospitals in choosing which health needs to prioritize and how to address them.²⁰⁸ However, robust participation by racial justice advocates in the CHNA process can help surface the existence of disparities. Moreover, well-informed advocates may be able to highlight how disparities-reducing measures could advance the hospital's interests, thus sharpening the alignment of interests between the hospital and the community.²⁰⁹

B. Regulatory Action to Foster Convergence

Regulatory action provides a second front to help accelerate the convergence of interests so more hospitals will treat health *disparities* as health *needs* that they should remedy. The existing Regulations implementing the ACA's requirement that hospitals assess community health needs already direct hospitals to solicit and consider input from populations likely to experience disparities, but early evidence suggests that relatively few hospitals have paid serious attention to disparities or engaged minority communities in a meaningful and sustained fashion.²¹⁰ The IRS should more strongly encourage hospitals performing CHNAs to attend to disparities, a step it could take even without undertaking another round of notice-and-com-

206. See 79 Fed. Reg. 78963 (Dec. 31, 2014) (noting and responding to comments on proposed regulations expressing concern about "the situation in which a hospital facility, despite its best efforts, is unable to secure input on its CHNA from a required category of persons").

207. 79 Fed. Reg. 78965.

208. See Crossley, *supra* note 122.

209. See, e.g., Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORNELL J. L. & PUB. POL'Y 47, 101 (2014) ("the health justice framework might root ongoing efforts to ensure access to health care and healthy living conditions more firmly in community engagement and participatory parity").

210. See *supra* Part III.D.

ment rule making. For example, ongoing guidance could emphasize the importance of health equity as a community health concern and provide hospitals with tools for identifying and responding to disparities.²¹¹ The IRS could announce an expectation that CHNA reports will describe more fully and precisely how hospitals engaged community participants and the substance of their input.²¹² Or, along the same lines, the IRS could revise Schedule H to direct hospitals to provide more specific information about community engagement and to identify strategies actually pursued that target health disparities.

By taking these steps, the IRS could amplify the community's voice and draw hospitals' attention to the disparities existing in their communities, thereby fostering interest convergence. According to interest convergence theory, the federal government should be keen to take these steps, regardless of any policy maker's or bureaucrat's particular commitment to racial health justice. The high cost of racial disparities borne by the federal government in its role as payer under the Medicare program confirms its strong interests in addressing disparities and, presumably, in enlisting hospitals' participation in disparities-reduction efforts.²¹³

More broadly, the industry-wide push toward value-based reimbursement methods, led by the Centers for Medicare and Medicaid Services ("CMS"),²¹⁴ may help hospitals recognize an alignment between providing high quality, equitable care and their financial well-being. Financial penalties for hospitals with excessive readmissions²¹⁵ provide a specific example of how federal payment policies can forge fortuity. Penalizing hospitals for excessive readmissions — a marker of poor quality care experienced disproportionately by minority populations — effectively

211. For a fuller discussion of possible additional guidance by the IRS, see Crossley, *supra* note 122. An example of the kind of tools that could assist hospitals in identifying disparities is the Vulnerable Populations Footprint. See generally Michelle Windmoeller, *What Does the Vulnerable Population Footprint Mean?* COMMUNITY COMMONS (Nov. 20, 2014), <http://www.communitycommons.org/2014/11/what-does-the-vulnerable-population-footprint-mean>. In 2015, a new rule issued by the Obama Administration provided a similar data tool for use in complying with the Fair Housing Act's prohibition on discrimination. See Athena Jones, *Obama Administration Announces New Fair Housing Rules*, CNN (July 8, 2015), <http://www.cnn.com/2015/07/08/politics/fair-housing-rules-obama-administration>. For a description of several place-based initiatives seeking to address social determinants of health, see Heiman & Artiga, *supra* note 38, at 3-4.

212. *Accord* SUPPORTING ALIGNMENT AND ACCOUNTABILITY, *supra* note 129.

213. See *supra* Part IV.A.

214. See Burwell, *supra* note 17. CMS reimbursement methods apply directly only to patients covered by Medicare, which is the single largest payer for hospital care in the country. The influence of CMS actions extends beyond that patient population, however. Because the federal government is the dominant payer for hospital services, adjustments to a hospital's practices in response to a change in the Medicare program are likely to influence the hospital's practices across the board. By the same token, reimbursement policy initiatives spearheaded by CMS are often taken up by private insurers as well. *Id.*

215. See *supra* Part IV.

gives them a financial incentive to address some factors producing disparities. Many of the conditions targeted by value-based payment models are preventable conditions that racial and ethnic minorities suffer from disproportionately.²¹⁶ In continuing its initiatives to craft and implement reimbursement measures to promote care of high quality and value, CMS can and should incorporate factors directly targeting disparities.²¹⁷ It should act more directly to create financial and non-financial incentives that align providers' interests with achieving health equity.²¹⁸ For example, CMS's redesign of payment systems to incorporate clinical performance measures could explicitly include measurements of reductions in disparities.²¹⁹ These steps would help crystallize hospitals' financial interest in addressing disparities.

C. Research Identifying Potential Convergence

A third way to assist the convergence of interests is to continue research into the types of interventions that are effective in reducing disparities and their potential return on investment for hospitals.²²⁰ A body of knowledge regarding effective interventions is emerging, providing hospitals with evidence for investing in disparities-reduction strategies, but a more fully developed knowledge base could facilitate and accelerate the convergence of interests.²²¹ Many experts in this area assert that the most effective interventions involve coordinated efforts by a range of actors, including health care providers, public health servants, community-based organizations, and business and education leaders.²²² Thus, research into how hospitals most effectively contribute to successful initiatives would be particularly valuable.

216. See Alberti et al., *supra* note 19.

217. Accord Timothy Stoltzfus Jost, *Racial and Ethnic Disparities in Medicare: What the Department of Health and Human Services and the Centers for Medicare and Medicaid Services Can, and Should, Do*, 9 DEPAUL J. HEALTH CARE L. 667 (2005).

218. See Chin, *supra* note 175.

219. Chin, *supra* note 175; see also Alberti et al., *supra* note 19, at 1620 (advocating for the federal government to develop direct financial incentives for hospitals to address social determinants and community health needs identified in CHNA and suggesting that data regarding local needs be used to develop risk-adjustment mechanisms for value-based hospital reimbursement to avoid penalizing hospitals serving high-need areas).

220. See Crossley, *supra* note 122 (making this point about research regarding community health improvement initiatives broadly); Darby & Levy, *supra* note 98, at 49 ("pragmatism begins by identifying the problem to be addressed (in this case black disadvantage), and then takes an incremental, experimental, and evidence-based approach to finding solutions").

221. See, e.g., Chin, *supra* note 175 (urging the Center for Medicare and Medicaid Innovation and private payors to "conduct and fund demonstration projects to test payment and delivery system reform interventions to reduce disparities").

222. See generally Paul W. Mattessich & Ela J. Rausch, *Cross-Sector Collaboration to Improve Community Health: A View of the Current Landscape*, 33 HEALTH AFF. 1968 (2014).

D. Potential Objections

This Article proceeds from a premise that engaging hospitals in efforts to address racial health disparities is desirable and argues that the interest convergence theory suggests an opportunity to leverage the CHNA requirement to that end. Possible objections²²³ to an approach that relies on appeals to hospitals' self-interest should be noted, however. These include concerns about sanitization, co-optation, over-claiming, and durability.

1. Sanitization

Some racial justice activists might object that attempts to persuade hospitals of an alignment between their self-interest and the elimination of racial health disparities in their communities will sanitize and soft-pedal the problem at hand. In short, attempts at persuasion fail to acknowledge the role of racism in disparities' creation and persistence, a role that some argue must be highlighted in order to effectively address widespread structural racism. Indeed, calls to action by policy makers and public health funders often employ language designed to appeal to business interests and medical providers, rather than provoke a defensive response. A recent blog post by the head of the Robert Wood Johnson Foundation provides an example. Titled "Community Health is a Business Issue," it describes the value to the business community of investing in "poverty-stricken areas" in order to improve the health of "disadvantaged groups," but does not mention race.²²⁴

It is possible, of course, to explain why one would talk about health disparities without talking specifically about race. Disparities exist across many axes, and poverty and low socioeconomic status are also significant predictors of poor health outcomes.²²⁵ Some studies have found class or location to be more predictive of some poor health outcomes than race.²²⁶ And, as the saying goes, you catch more flies with honey than with vinegar. Calling out racism may provoke defensiveness, rather than buy-in.²²⁷

223. Because the thesis relies on critical race theory's interest-convergence theory, I am particularly concerned with objections that a critical race theorist might raise.

224. See Lavizzo-Mourey, *supra* note 172.

225. See, e.g., Ichiro Kawachi et al., *Health Disparities by Race and Class: Why Both Matter*, 24 HEALTH AFF. 343, 345-46 (2005) ("[the] magnitude of health disparities across income groups (or other indicators of class) is much bigger than the size of the difference between blacks and whites . . . [thus research and policy should] simultaneously account for the independent and interactive effects of both class and race in producing health disparities.").

226. See Thomas LaVeist et al., *Place, Not Race: Disparities Dissipate in Southwest Baltimore When Blacks and Whites Live Under Similar Conditions*, 30 HEALTH AFF. 1880 (2011).

227. See Darby & Levy, *supra* note 98, at 26-27 (discussing how the psychological "desire to avoid feelings of guilt" generates defensive reactions making it "difficult to build consensus around racial issues").

Is invoking the interest convergence theory—by appealing to hospitals’ self-interest—fundamentally incompatible with the methods of the Black Live Matter movement, whose power comes in part from its ability to disrupt, agitate, and discomfort listeners? Indeed, some racial justice advocates criticize mainstream initiatives combatting racial health disparities as providing more benefits to the academics and program personnel involved than to Black communities,²²⁸ or as failing to sufficiently acknowledge the role racism plays in producing poor health.²²⁹ I argue that these criticisms and racial activists’ confrontations complement, rather than conflict with, an appeal to hospital self-interest. More confrontational approaches may play a vital role in holding accountable those who work in the health disparities field, as well as the health care industry more broadly. They may open a space for serious reflection and conversation by well-meaning Whites.²³⁰

Derrick Bell, the original source of the interest convergence insight, wrote of the importance of “professionals able to articulate racially realistic positions, that touch some whites in the pocketbook, expecting that their sense of justice will follow,”²³¹ but he also recognized that sometimes Whites would end discriminatory policies only when the cost of maintaining them became high.²³² Activists may also help make racial injustice so uncomfortable for Whites that they find it in their best interest to take actions benefiting Blacks, and protests over continuing manifestations of institutional racism are not inconsistent with efforts to identify potential alignments of interest.²³³ Activists’ continued demands for racial justice create part of the societal backdrop against which hospitals consider how to prioritize the health needs of their communities. In this way, activists’ demands may indirectly help persuade hospitals of their self-interest in adopting strategies to target health disparities in their communities. In other words, interest convergence’s appeal to hospitals’ self-interest need not deny the role of racism in order to provide hospitals an inviting alternative for moving forward. The two approaches to advancing racial justice may complement one another.

228. Mary Shaw-Ridley & Charles R. Ridley, *The Health Disparities Industry: Is It an Ethical Conundrum?*, 11 HEALTH PROMOTION PRAC. 454, 464 (2010).

229. Jessie Daniels, *Racism, Whiteness and the Health Disparities Industry*, RACISM REV. BLOG (Mar. 9, 2011), <http://www.racismreview.com/blog/2011/03/09/racism-whiteness-and-health> (criticizing disparities research for adopting a white racial frame and failing to acknowledge the role of racism in producing disparities).

230. See Conor Friedersdorf, *A Conversation About Black Lives Matter and Bernie Sanders*, ATLANTIC (Aug. 21, 2015), <http://www.theatlantic.com/politics/archive/2015/08/a-dialogue-about-black-lives-matter-and-bernie-sanders/401960> (considering whether disruption of campaign event by Black Lives Matter activists generated increased cross-racial dialogue).

231. See BELL, *supra* note 102, at 191.

232. *Id.* at 190.

233. Feldman, *supra* note 100 at 252.

2. Co-Optation

A related concern is the possibility that enlisting hospitals to help address disparities could co-opt a grass-roots racial health justice movement that is finding a stronger voice as part of Black Lives Matter. In short, will emphasizing the roles of researchers and powerful institutions undercut a commitment to the affected communities?²³⁴ Even if hospitals partner with community-based organizations to address local disparities, some healthy skepticism is in order regarding hospitals' willingness to cede much power or responsibility to community members.²³⁵ Preliminary reviews of hospital CHNA reports questioned how meaningfully hospitals engaged minority and underserved communities in assessing and prioritizing health needs.²³⁶ Increasingly, researchers studying how collaborative initiatives produce meaningful change in local communities emphasize the essential role of true community engagement.²³⁷ Authentic community engagement is by no means simple or straightforward. But examples of it exist, and the number of those examples is increasing. Thus, while caution is called for regarding the potential co-opting of community-based health justice initiatives, partnerships involving true community empowerment are possible.

3. Over-Claiming and Durability

Finally, this Article must avoid over-claiming. Even if every tax-exempt hospital in the United States vigorously pursued efforts to eliminate some of the health disparities in their communities, it would not produce the broad-based social change needed to disrupt the social and economic forces contributing to disparities. Serious advocates for the elimination of racial health disparities emphasize the need for structural change addressing the broad range of forces contributing to disparities.²³⁸ In addition, an integral part of Professor Bell's interest convergence theory is that gains in racial justice that occur when interests converge may be lost when circumstances change and White interests diverge once again from those of Blacks.²³⁹ As a result, engaging hospitals as partners in disparities-reduction initiatives will not "fix" the problem of racial health disparities. Engaging

234. *E.g.* Shaw-Ridley & Ridley, *supra* note 228, at 455 (questioning whether the stakeholders in the health disparities industry reap more benefit than do vulnerable populations).

235. *Id.* at 461–62 (questioning whether collaborations are illusionary).

236. *See supra* Part III.

237. *See* Melody Barnes & Paul Schmitz, *Community Engagement Matters (Now More Than Ever)*, 14 STAN. SOC. INNOVATION REV. 32, 34 (2016).

238. *See* Outterson, *supra* note 27, at 780; Shaw-Ridley & Ridley, *supra* note 228, at 464.

239. *See* Bell, *supra* note 26, at 526–28.

hospitals would be neither sufficiently broad in scope, nor sufficiently durable.²⁴⁰

Nonetheless, harnessing the energy and resources of hospitals as partners in local efforts to address disparities offers the potential for a bottom-up, community-driven approach to counteract and disrupt macro forces on a local level.²⁴¹ Recent data regarding geographic variations in the life expectancy gap between the rich and poor in the U.S. confirm the value of local initiatives to improve health outcomes.²⁴² These data show that local policies in places like New York City and Birmingham can narrow income-based health disparities, even when those policies are small in scale and do not address broad societal problems of income inequality.²⁴³ Moreover, this Article's thesis taps into a legal mechanism that already exists. Because the IRS Regulations implementing the CHNA requirement are still relatively new, hospitals' patterns of compliance remain to be shaped by further regulatory guidance and industry practice.²⁴⁴ Even if the promise of the CHNA requirement for reducing disparities is limited to making local progress, rather than advancing broad societal changes, squandering that promise would be wasteful, particularly when legal tools for addressing disparities are already so few in number.²⁴⁵

In sum, despite the existence of legitimate concerns, efforts to ensure that powerful actors within the health care industry recognize the alignment of their interests with the interests of advocates for racial health justice are worthwhile. Engaging hospitals will not by itself eliminate racial health disparities, but it promises to be a useful tool in the larger toolkit of disparities-reduction strategies.²⁴⁶

240. *Accord* Darby & Levy, *supra* note 98, at 61 (asserting that post-racial remedies are necessary, but not sufficient by themselves, to mitigate racial inequality).

241. ROBERT PUTNAM, *OUR KIDS: THE AMERICAN DREAM IN CRISIS* (2014) (suggesting the value of diverse local initiatives to improving opportunities for low-income children); Wiley, *supra* note 209, at 102 (“[T]he most impactful public health measures are being pioneered at the local level”).

242. Neil Irwin & Quoc Trung Bui, *The Rich Live Longer Everywhere. For the Poor, Geography Matters*, N.Y. TIMES (Apr. 11, 2016) (“Small-scale, local policies to help the poor adopt and maintain health habits may succeed in extending their lives, regardless of what happens with trends in income inequality.”), http://www.nytimes.com/interactive/2016/04/11/upshot/for-the-poor-geography-is-life-and-death.html?_r=0.

243. *Id.*

244. Crossley, *supra* note 122, at 90; *accord* Alberti et al., *supra* note 19, at 1620 (“Efforts to align the shifts in our health care landscape toward equity are more likely to be successful if they are made before policies and programs are fully implemented and the opportunity to exert influence has passed.”).

245. *See supra* Part I.D for a description of the failure of Title VI of the 1964 Civil Rights Act to address disparities.

246. *Accord* Alberti et al., *supra* note 19.

CONCLUSION

Health disparities represent a significant strand in the fabric of racial injustice in the United States—a strand that has proven exceptionally durable. Despite the investment of many millions of dollars, three decades of research and programming have produced only limited progress in narrowing the health gap between Whites and racial and ethnic minorities. Those disparities embody the devaluation of Black health that parallels the devaluation of Black lives.

According to Professor Derrick Bell, opportunities to advance racial justice may be greatest when interests in racial progress converge with the interests of the powerful majority. The ACA's new CHNA requirement and the movement in health care toward value-based payment methods may produce such a convergence of interests between advocates for racial health justice and tax-exempt hospitals. The CHNA requirement provides health justice advocates with an opportunity to engage hospitals as valuable partners in efforts to reduce racial health disparities by appealing to hospitals' financial interests in an evolving health care landscape. Community health advocates, researchers, and the federal government should all help to "forge fortuity" so that this opportunity for measurable progress toward eliminating racial health disparities is not wasted.