



**Comments Regarding IRS Notice 2011-52:
Community Health Needs Assessments Requirements for Tax-Exempt Hospitals**

Community Health Councils is pleased to submit the following comments in response to the Internal Revenue Service's Notice 2011-52 regarding Community Health Needs Assessment requirements for non-profit hospitals. Community Health Councils (CHC) is a health policy and advocacy organization working to improve access to quality healthcare services, develop health-promoting communities, and expand coverage to uninsured and underinsured residents and families. Our work is conducted in collaboration with a diverse and robust network of community-based organizations, policymakers, and other advocates with supportive visions and objectives. The comments contained within this document are a collective reflection of these advocates' and other community members' interests, thoughts, and expertise in eliminating health disparities and improving population health.

CHC commends the Internal Revenue Service (Service) for proposing initial guidelines for the Community Health Needs Assessment (CHNA) provision on tax-exempt hospitals, as required by the Affordable Care Act (ACA). Nonprofit hospitals are critical providers and essential access points for vulnerable populations seeking care, including the uninsured, under-insured, low-income, marginalized residents and families who too often are those most in need. This fundamental commitment to providing high-quality services regardless of ability to pay was the original intent of allowing tax exemptions for eligible institutions; over time, that standard of "charity care" evolved into a general provision of "community benefits." Though the term offers flexibility to include the numerous services, both clinically and socially, that a tax-exempt hospital provides, CHC asks the Service to reiterate the direct connection between tax-exempt status and an eligible hospital institution's 1) commitment to lowering the cost of care for low-income patients, and 2) supplemental programming that offers benefits to the community-at-large.

We trust the Service will continue to make the distinction between "charity care," "bad debt" and "community benefit." While these terms are often used interchangeably – the impact of each is distinctly different. It is critical the calculation of "charity care" exclude any charges for which an operator or their agents attempted to collect from a patient. Charity care must be assigned at the time of care and not after failed attempts to recover cost.

Additionally, while assessment processes and resulting reports are often helpful in identifying community needs and processes, they should not be accepted as the fulfillment of either "charity care" or "community benefits." Assessments and other research studies are only the tools by which a service institution provides the rationale for its subsequent actions. It is these actions, i.e. providing free medical care, health promotion programs, supplemental services, which are considered the true benefit to the community. We firmly believe that in order for an eligible institution to earn a favorable tax status, the economic value of all benefits provided to the community by the institution must equal or exceed the institution's financial savings due to tax-exemption. **We ask the Service to incorporate this expectation as part of its final regulations regarding hospitals' CHNA and implementation plans by**

requiring an economic value assigned to each strategy or activity, and an aggregate total benefit, included in the implementation plan. This financial expectation, and calculation, is critical to ensuring that tax-exempt hospitals are deserving of the economic benefits provided by the federal government and should be based upon the actual cost of providing services.

Additionally, CHC proposes the following recommendations to the specific requests for comments in Notice 2011-52. These recommendations were developed with the purpose of strengthening the guideline, and are meant to protect and simplify the processes by which hospitals, and the communities which they serve, can work collaboratively to advance health outcomes and eliminate health disparities.

SECTION 3.01(3) Hospital Organizations Required to Meet the CHNA Requirements

CHC makes no distinction between non-profit tax-exempt hospitals and government hospitals that also benefit from public funding and are thus accountable to the general community. While we understand that government hospitals are not considered tax-exempt under the IRS 501©3 determination, these hospitals financially benefit from tax exemption as well as the receipt of public funding. Additionally, there are institutions such as the University of California health system which receives the benefits of holding both a government and 501©3 classification. As non-profit and government institutions hold similar missions of service to the community, CHC recommends that government and government-affiliated hospitals also be required to conduct CHNAs and submit implementation strategy plans in same manner as tax-exempt hospitals.

SECTION 3.02 Hospital Organizations with Multiple Hospital Facilities

CHC agrees with the Service's determination that hospital systems with multiple facilities must conduct individual CHNAs and submit separate reports for each facility. CHC also supports the Service's decision to allow for collaboration between multiple facilities in conducting CHNA, so long as these facilities prove 1) a shared geographical service area or patient population and 2) each facility submits an individual, unique implementation plan.

SECTION 3.04 How and When a CHNA is "Conducted"

CHC recommends that the Service provide enough flexibility for CHNA processes and planning to align with existing state provisions, so long as the assessment processes and reports meet minimum federal standards. CHC has a deep history of working with stakeholders, including non-profit hospitals, in complying with the State of California's 1994 legislation (SB 697) mandating non-profit hospitals to conduct triennial CHNAs and annually update or submit the resulting community benefits plans. We ask that the IRS work with designated entities and hospital stakeholders in order to achieve alignment with each state that already has assessment and community benefits plan reporting requirements. Several states adopted CHNA requirements (i.e. California, New York) prior to the passage of ACA, and we are concerned about the possibility that this new, additional Service requirement will lead to hospitals conducting duplicative, and thus unnecessarily burdensome, processes to meet both the existing state and new federal mandates. While we strongly support the need for a baseline set of standards to guide tax-exempt hospitals and ensure full compliance with the intent of the ACA, we also hope that the IRS will make every effort to coordinate with states such that hospitals are not unduly stressed.

SECTION 3.05 Community Served by a Hospital Facility

CHC recommends that tax-exempt hospitals define their community service area by patient discharges **and** geographic locale. CHC recommends that the tax-exempt hospital's primary service area is delineated by patient discharges; an example would be the boundary surrounding the collective zip codes in which at least 50% of the tax-exempt hospital's discharged patients reside. Patient residences

are a critical measure in defining a tax-exempt hospital's service area as there are regions which suffer from severe shortages of healthcare workforce and infrastructure, forcing community members to travel long distances for care. Additionally, tax-exempt hospitals which provide specialized services (i.e. children's hospitals, rehabilitation, respiratory services, burn centers) remain a destination for patients from all communities in need of highly specialized care. Because patient discharges may result in a large and burdensome service area, we ask the Service to allow tax-exempt hospitals the flexibility to determine what percent of patient discharges would constitute a meaningful and manageable service area. We additionally suggest that as a secondary service area, tax-exempt hospitals then subscribe to a geographic scope, determined by length of distance from the hospital's location, in providing community benefits and seeking out partnerships. The hospital should be required to provide data assessing the needs in both the primary (discharge) and secondary (geographic) areas.

SECTION 3.06 Persons Representing the Broad Interests of the Community

CHC believes that tax-exempt hospitals must actively engage community residents, stakeholders and other persons representing the broad interests of the community in designing and conducting CHNA and developing collaborative implementation plans and strategies to address needs identified through the assessment. The Notice stipulates that the CHNA must account for contributions provided by "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."¹ The Notice goes on to specify that the CHNA must take into account, at minimum, input from: public health experts; health departments or agencies with current data or information; and leaders, representative or members of medically underserved, vulnerable populations. CHC wholeheartedly supports collaboration and coordination in conducting CHNA and developing benefit programs and plans. We understand that the details included in the Notice speak to a minimum level of participation by identified experts, however, we ask that the Service consider including a stronger emphasis on expectations of extensive collaboration amongst a broad and diverse range of stakeholders, including but not limited to: patients or consumers of hospital services, healthcare providers serving or located in the same community, health plans and managed care organizations, social service agencies, community-based organizations, researchers and academics, advocates, private businesses, local schools and school districts, elected representatives and local governments, labor and workforce representatives.

SECTION 3.08 Implementation Strategy

In keeping with previous recommendations, CHC reiterates that the implementation strategy and its activities are the core of tax-exempt hospitals' community benefits and should not only be detailed, but assessed a financial value based on actual cost. We support the Service's determination that each facility must submit individual implementation plans, but ask that additional guidance regarding the standardization and impact of these plans be specified. In evaluating each facility's progress at meeting community needs, there must be uniformity and measurable outcomes to assess progress. Implementation activities, and possible unintended consequences and externalities, may only be accurately measured and analyzed as a result of studied observation, data collection, tracking, and quality assurance. We ask that hospitals be given the flexibility to create their own impact statements and objectives appropriate to the unique communities that they serve, so long as they reasonably show dedication to improving population health and community benefit, and accompanying measures of success.

¹ Internal Revenue Service Notice 2011-52, Section 3.06, Page 15.

Finally, we ask that community members and persons representing community interests be allowed to provide input into the creation the implementation plans. While the Notice speaks to the participation of select individuals, it does not provide guidance on the meaningful exchange of ideas, discussion, active engagement or continued collaboration beyond the CHNA process. Several years after implementing SB 697 in California, a report detailing successes and challenges of assessments and community benefit reporting to the state legislature indicated that one unexpected, non-quantifiable benefit was the catalyzing of collaborative partnerships and increased collective capacity within the community for leadership, advocacy, accountability, and community-wide health planning.² Hospitals are essential community leaders who can and should leverage their capacity and assets in leading and developing collaborations with critical stakeholders. Collaborative processes, community partnerships, joint-programming, and coordination would respect and support the intent of the ACA to improve the quality of care while achieving cost efficiencies. On a broader scale, we firmly believe that improving population health and eliminating health disparities requires multiple approaches, strategies, shared assets and cooperative agreements across a spectrum of providers and stakeholders. We also ask that these stakeholders be allowed to provide input on prioritizing the needs and developing the strategies to address these needs cooperatively with hospitals and their governing boards.

CHC is a strong supporter of the network of critical, safety-net hospitals, and firmly believes that the majority of these tax-exempt institutions sincerely uphold their obligation and commitment to their community and patients. We are hopeful that the ACA will transform the entire safety-net system for the better, but are also mindful that increasing patient coverage will have some affect on charity care levels and community benefit spending. In order to ensure that tax-exempt hospitals continue to fulfill their social responsibility during and after these market changes, we ask that the Service consider our recommendations for incorporation into the final guidelines. We appreciate the Service's initial steps towards instructing the CHNA process, and would welcome any opportunity to discuss these and other recommendations in the future. Please feel free to contact me by telephone at (323) 295-9372, or email at lark@chc-inc.org should you have any questions or concerns.

Sincerely,



Lark Galloway-Gilliam
Executive Director
Community Health Councils

² Office of Statewide Health Planning and Development, "Not-for-Profit Hospital Community Benefit Legislation: Report to the Legislature." January 1998.