COMMUNITY CATALYST

VIA ELECTRONIC MAIL

September 23, 2011

Douglas Shulman, Commissioner, Internal Revenue Service
Sarah Hall-Ingram, Commissioner, Tax Exempt and Government Entities Division
Internal Revenue Service
CC:PA:LPD:PR (Notice 2011-52), Room 5203
P.O. Box 7604
Ben Franklin Street
Washington, DC 20044

Re: Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-Exempt Hospitals (Notice 2011-52)

Dear Commissioners Shulman and Ingram:

On behalf of the organizations signed below, Community Catalyst is pleased to submit the following comments regarding the Affordable Care Act's community health needs assessment (CHNA) requirement for tax-exempt hospitals.[1] Collectively, we work to improve access to affordable, quality care; strengthen relationships between hospitals and our communities; and address the social and physical determinants of health that disproportionately impact low- and moderate-income families, communities of color, and other vulnerable populations. Hospital community benefit programs can provide a rich opportunity to achieve these objectives.

We applaud the Internal Revenue Service ("the Service") and the Department of the Treasury ("the Treasury") for setting out a strong initial framework for hospital community health needs assessments and implementation strategies in Notice 2011-52.[2] In our collective experience, strong community benefit programs target hospital resources to meet the needs of vulnerable populations, deliberately engage community members and public health experts, and choose priorities identified by the community. In general, the Notice elevates these values and strikes an appropriate balance between allowing hospitals the flexibility to tailor their community benefit operations and establishing parameters that will increase transparency, public accountability and collaboration with other stakeholders—including community members. Our comments focus on ways the Service and the Treasury can strengthen future regulations in these areas.

[1] Section 9007 of the Affordable Care Act amends the Internal Revenue Code by requiring tax-exempt hospitals to conduct a regular community health needs assessment ("CHNA") at least every three years and adopt an implementation strategy to meet the community health needs identified through the assessment. Hospitals that fail to meet this requirement face a $50,000 penalty.

[2] Internal Revenue Service, "Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-Exempt Hospitals," available at http://www.irs.gov/pub/irs-drop/n-11-52.pdf.

Engage Communities Throughout the Community Benefit Process

Under the Affordable Care Act, hospitals must conduct regular community health needs assessments that "[take] into account input from persons who represent the broad interests of the community served," including public health experts, and develop implementation strategies to address the needs identified through the assessment.[3] Notice 2011-52 gives hospitals considerable latitude in defining the communities they serve,[4] but requires hospitals to consult the following in the course of conducting their assessments:

- Public health experts
- Agencies at all levels of government "with current data or information relevant to the health needs of the community served," including local health departments
- "[L]eaders, representatives, or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs."[5]

Notice 2011-52 permits hospitals to also consult with others situated in the hospital's community, including health care consumer advocates, non-profit organizations, academia, insurers, other providers, and businesses, in conducting their assessments. Hospitals must use the assessment to develop and adopt an implementation strategy, defined as a written plan to address the community health needs identified through an assessment and approved by an authorized governing board.

We support this approach and are particularly appreciative of the express requirement to consult community members from underserved, low-income, and minority populations as well as community members living with chronic illness, in the course of conducting a community health needs assessment.[6] This is appropriate in that it encourages hospitals to target their resources and outreach efforts to the most vulnerable members of their communities, and to involve them in naming problems and identifying solutions. We note, however, the importance of providing the community—both grasstops leaders and grassroots members—with meaningful opportunities to provide input throughout the entire community benefit planning process, from assessment to implementation to evaluation. Continued community involvement provides an advantage to hospitals as well: it can be vital to accurately assessing community needs, identifying existing community assets and potential partnerships, and choosing strategies that resonate with community members and lead to community-wide ownership of an issue. The following recommendations are intended to ensure that community members have a meaningful role throughout the entire community benefit process.

Recommendation 1: Require public review and comment of community health needs assessments and implementation strategies prior to finalization[7]

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[3] See Section 501(r)(3) of the Internal Revenue Code, as amended by Section 9007 of the Patient Protection and Affordable Care Act.
[4] See Notice 2011-52, Section 3.05.
[5] See Notice 2011-52, Section 3.06.
[6] Community Catalyst defines "community benefit" as follows "The unreimbursed (or partially reimbursed) goods, services and resources provided by health care institutions that address community-identified health needs and concerns, particularly of those who are uninsured, underinsured or underserved." See Community Catalyst, *Commentary to the Health Care Institution Responsibility Model Act*, p. 1. Available at http://www.communitycatalyst.org/doc_store/publications/commentary_to_the_health_care_institution_responsibility_model_act_1999.pdf.
[7] See Notice 2011-52, Sections 3.03 and 3.04.

The Notice gives hospitals considerable discretion with regard to the ways they can gather community input. This is appropriate, since communities differ. We note that strong assessments will have both a qualitative aspect (data collection through interviews, focus groups and surveys) and a quantitative aspect (statistical public health data), and that health care institutions should be encouraged to work with the community in deciding:

- What type of data will be collected
- Who will be interviewed and surveyed
- What the interviews and surveys will include
- Who will conduct the survey
- How the barriers to care will be identified
- Who will analyze and write the assessment

To encourage full collaboration and accountability, both the community health needs assessment and the implementation strategy should be available to the public for review and comment, prior to their finalization. This is important to ensure that the assessment aligns with the community's understanding of available resources and unmet needs, that it accurately reflects the community's views, that needs were accurately prioritized, and that the data was adequately analyzed and presented. We recommend adding the following language under Section 3.04:

> "Each health care services provider shall make its community health needs assessment and its implementation strategy available to the public for review and comment prior to finalization."

This approach is similar to New Hampshire's, which requires health care charitable trusts to include opportunities for the general public in their service areas to provide input on the development of a community benefit plan,[8] and encouraged by the Massachusetts Attorney General's guidelines on community benefit.[9]

Recommendation 2: Require hospitals to include impact statements and evaluation measures in their implementation strategies[10]

In addition to the elements required under these sections, we recommend that implementation strategies include the following:

- A statement describing the intended impact on health outcomes attributable to the plan, including short- and long-term measurable goals and objectives; and
- Mechanisms to evaluate the plan's effectiveness, including a method for soliciting comments by community members.

This follows the approach taken by California, Maryland and Texas. Notably, the Massachusetts Attorney General's Guidelines recommend their inclusion in hospital community benefit planning but leave discretion to the hospitals as to what measures and outcomes to choose.[11]

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[8] N.H. Rev. Stat. § 7:32-e(VI).
[9] Massachusetts Attorney General's Community Benefit Guidelines for Nonprofit Hospitals, pp. 9-12. Available at http://www.mass.gov/?pageID=cagoterminal&L=2&L0=Home&L1=Health+Care&sid=Cago&b=terminalcontent&f=healthcare_communitybenefits&csid=Cago.
[10] See Notice 2011-52, Sections 3.03 and 3.09.

Increase Transparency and Public Accountability

The Affordable Care Act requires hospitals to make their community health needs assessments "widely available" to the public. Notice 2011-52 states that the Service and the Treasury intend to use the same standard that currently applies to making tax-exempt organizations' Form 990 filings available to the public:[12] that is, hospitals will meet the "make widely available" standard if they provide working links to the direct URL where the full assessment can be accessed.[13] However, we believe this standard is not strong enough to facilitate full accountability to the community and should be strengthened significantly.

Recommendation 3: Expand requirements for making a community health needs assessment "widely available" to the public

Because transparency is so critical to effective community benefit programming, we recommend that the Service and the Treasury adopt a more comprehensive definition of "make widely available," as follows:

> "Each hospital shall prepare a statement announcing that its community health needs assessment is available to the public. The statement shall be posted in prominent locations throughout the hospital facility, including the emergency room waiting area, the admissions waiting area, and the business office. The statement shall also be included in any written material that discusses admissions or financial assistance. A copy of the report shall be given free of charge to anyone who requests it."[14]

This approach is similar to that taken by Indiana (regarding community benefit reports) and New Hampshire (regarding community benefit plans, *i.e.* implementation strategies).[15] Indiana law requires health care service providers to prepare a statement notifying the public that their annual community benefit reports are public information, filed with the state department, and available to the public. This statement must be posted in prominent places throughout the hospital, including the emergency room waiting area and the admission office waiting area. It must also be printed in the hospital patient guide or other material that provides the patient with information about the admissions criteria of the hospital.[16] Similarly, New Hampshire requires health care charitable trusts to prominently display notices about the availability and process for obtaining a copy of its community benefit plan (which includes elements of the community health needs assessment and implementation strategy as discussed in Notice 2011-52) in their lobbies, waiting rooms, and other areas of public access.

Recommendation 4: Maintain facility-level reporting for hospitals and work with other agencies to disseminate data from hospital submissions effectively

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[11] See the Massachusetts Attorney General's Community Benefit Guidelines for Nonprofit Hospitals, pp. 17-18. Note that the Guidelines suggest the use of operational (process) and outcome measures, depending upon the nature of the program to be evaluated.
[12] See Treasury Regulation § 301.6104(d)-2(b).
[13] See Notice 2011-52, Section 3.07.
[14] See Community Catalyst, *Health Care Institutions Responsibility Model Act* Section 105.2. Available at http://www.communitycatalyst.org/doc_store/publications/the_health_care_instititution_responsibility_model_act_1999.pdf
[15] See the discussion of public record requirements in Community Catalyst's *Health Care Community Benefits: Compendium of State Laws.* Available at http://www.communitycatalyst.org/doc_store/publications/community_benefits_compendium_2007.pdf
[16] Ind. Code § 16-21-9-7(c).

To promote the greatest amount of transparency at the local level, the Service should maintain strong, facility-level reporting requirements for all of the new Affordable Care Act requirements for tax-exempt hospitals in Schedule H in future reporting years.[17] In addition, the Service and the Treasury should work with the Department of Health and Human Services (HHS) to provide public access to the information gathered through reporting initiatives or otherwise required of hospitals as part of Section 501(r), e.g., financial assistance policies and community health needs assessments, so that community members and professionals may easily sort, search, aggregate and download the data.

Address Financial Assistance and Billing Practices

Although Notice 2011-52 does not specifically address this, Section 9007 of the Affordable Care Act also requires tax-exempt hospitals to meet certain requirements related to financial assistance, billing and collection practices, and charging. To their great credit, many hospitals provide significant amounts of charity care ("financial assistance," in the parlance of the Affordable Care Act) and other programs that benefit underprivileged, vulnerable communities. Many of these hospitals will point to organizational mission or to the ethics of social responsibility, rather than compliance with existing law or justification of tax status, as the driving force behind their commitment to community benefit. Nevertheless, numerous studies have shown systemic and anecdotal problems related to patients' abilities to access information about financial assistance, aggressive billing and collection procedures, and inadequate financial assistance policies or expenditures when compared to community need, across the hospital industry. Our recommendations suggest ways to address these issues in future guidance that will protect consumers.

Recommendation 5: Integrate evaluations of financial assistance and billing practices and policies into the community health needs assessment and implementation strategy

Today, the need for financial assistance is great. The U.S. Census statistics released last week show that the average U.S. income has declined, that the number of Americans living in poverty is at an 18-year high, and that almost 50 million Americans were uninsured in 2010.[18] Even families with insurance are struggling with the costs of health care. [19] Obstacles to health services such as the impediments caused by lack of insurance coverage, high cost and language barriers, are included in Healthy People 2020's list of determinants of health.[20] There is a link, in other words, between financial access and healthy communities.

Accordingly, hospitals should be encouraged to use the community health needs assessment as an opportunity to gather data that will help them evaluate the adequacy and impact of their financial assistance, billing and collection policies to meet the needs of their community. For example, Catholic Healthcare West's *Community Need Index* goes beyond strict public health data to evaluate the

[17] See Community Catalyst, Letter to The Honorable Timothy Geithner, Secretary, United States Department of the Treasury, June 20, 2011. Available at http://www.communitycatalyst.org/doc_store/publications/Letter_to_Treasury_re_Schedule_H_Optional_July_2011.pdf.
[18] U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2010." Available at http://www.census.gov/newsroom/releases/archives/income_wealth/cb11-157.html.
[19] A recent Kaiser Health Tracking Poll found that "half (51%) of the privately insured under 65 say their deductibles and co-pays have been going up lately, including 29 percent who say the increase is a financial burden (up from 19% in March)." Kaiser Health Tracking Poll, July 2011. Available at http://www.kff.org/kaiserpolls/8209.cfm.
[20] "Determinants of Healthy," Healthy People 2020. Available at http://www.healthypeople.gov/2020/about/DOHAbout.aspx#healthservices.

"underlying social and economic barriers that affect overall health" and measure access based on the severity to which individual communities experience barriers to care due to income, culture and language, education, insurance status, and housing.[21]

Hospitals should also use the assessment process to gather qualitative data from community members and leaders, as well as other providers and partners, about the adequacy of their financial assistance and billing policies in addressing access issues. This can help hospitals to understand ways in which certain practices may affect access to care (for example, should a financial assistance policy be translated into a different language? Do frontline hospital staff routinely know where to send patients who ask about financial assistance?). Engaging the community on financial assistance and responding to their concerns is often critical to building trust. Having open, honest, and responsive dialogues about these issues can also lead to future collaborations and exchanges of ideas on other fundamental issues, such as creating more avenues for access to preventive services among low-income, uninsured/underinsured, and underserved communities.

Recommendation 6: Issue regulations that set clear parameters for financial assistance, billing and collections, and charges

We urge the Service and the Treasury to move quickly to issue clear, strong regulations on financial assistance, billing and collections, and charges that will protect consumers. Requiring hospitals to establish policies to meet the needs of vulnerable patients in their communities is an important step to providing patients with access to care. There is also a need for minimum federal requirements that serve as a floor for hospital practices in these areas. Because state requirements vary widely, the Service and the Treasury should consider what educational resources may be necessary to adequately inform community members and state or local policymakers about the new federal requirements for tax-exempt hospitals.

We appreciate your work on these issues to date and welcome the opportunity to speak with you in greater detail. Please contact Jessica Curtis at jcurtis@communitycatalyst.org if you have additional questions about our recommendations.

Sincerely,

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Robert Restuccia
Executive Director
Community Catalyst

[21] Catholic Healthcare West, "Improving Public Health & Preventing Chronic Disease: CHW's Community Need Index," p. 4. Available at http://www.chwhealth.org/stellent/groups/public/@xinternet_con_sys/documents/webcontent/212782.pdf.

ALSO SUBMITTED ON BEHALF OF:

The Access Project
Alabama Arise
Alliance for a Just Society
The Annie Appleseed Project
Boston Public Health Commission
California Pan-Ethnic Health Network
Center for Community Change
Center for Independence of the Disabled
Champaign County Health Care Consumers
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Florida CHAIN
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