COMMUNITY CATALYST

ONE FEDERAL STREET, BOSTON, MA 02110
MAIN: 617.338.6035
FAX: 617.451.5838
www.communitycatalyst.org

June 29, 2015

Ms. Sunita Lough
Commissioner
Tax Exempt and Government Entities Division
Internal Revenue Service
SE:T
NCA-660
1111 Constitution Avenue, NW
Washington, D.C.

Dear Ms. Lough:

Community Catalyst is a national consumer advocacy organization focused on health and health care issues. We work with a range of community-based organizations and consumer advocates on issues related to community benefit and community health. We are writing to support the inclusion of improved housing that enhances the health of a hospital's community as a community benefit on Part I of the Form 990 Schedule H.

Currently, hospitals can report their expenditures on "physical improvements and housing"[i] that promote health as a "community building activity" on Page 2 of Schedule H. The Instructions to the Schedule further clarify that hospitals may report their expenditures on improved housing as a "community health improvement service"—that is, as a community benefit—on Page 1 of the Schedule H, provided that the service meets additional parameters. Namely, non-profit hospitals must be able to demonstrate that they are either carrying out or supporting the housing initiative (or other community health improvement service) "for the express purpose of improving community health"; that the effort is not generating patient revenue, and is neither primarily a marketing strategy or of greater benefit to the hospital than to the community at large; and, importantly, that there is a demonstrated community need for housing services.[ii] Hospitals can demonstrate community need for improved housing by pointing to the findings of their triennial community health needs assessments, now mandated by the Affordable Care Act; a documented need or request from a non-profit or government agency; or the involvement of other tax-exempt or government entities in partnership for the express purpose of improving the community's health.[iii]

We believe that this language provides a pathway for hospitals to report their efforts to address housing, along with other "upstream" determinants of health, as community benefit. Yet initial summary data on hospitals' community benefit expenditures suggest that hospitals are allocating relatively small amounts of their community benefit resources to community health improvement initiatives like housing[iv], and even less to community building activities.[v]

There are likely multiple factors that help to explain the current allocation of resources, not the least of which is the continuing need for hospital support for safety net resources like financial assistance and means-tested public programs for the millions of Americans who remain uninsured or underinsured. **But we have also heard anecdotally from hospital and community allies that the current language in Schedule H creates a barrier—even if it is merely a barrier of perception—that makes a hospital's investment in housing and other community health initiatives a harder internal sell.** Additionally,

new scholarship has highlighted ways the Schedule H could be improved to strengthen the connection between community benefit and community health. As noted in a recent *Health Affairs* article:

> "The IRS's definition of community health improvement is both overly broad and overly narrow. On the one hand, the definition allows hospitals to count fund-raising and compliance costs tied to community health planning as community health improvement. **On the other hand, as noted, the IRS excludes many types of community building activities that have an evidence base in health improvement.** A more refined definition that focused on evidence-based community health improvement and excluded compliance expenditures would be more consistent with the concept of community benefit."[vi]

We believe that the time is ripe for the Internal Revenue Service to revisit the definition of "community health improvement services" in order to help strengthen the linkage between hospital community benefit investments and the upstream determinants of health. We believe that this would meet a need expressed by community partners and hospital allies who have indicated that additional clarity would be helpful to encourage investment and foster partnerships to address housing, nutrition, public safety, education and employment, and other longstanding needs in the communities they serve.

We recommend that the definition of "community health improvement services" be revised so that it clearly encompasses hospitals' efforts to address the social and economic determinants of health—including efforts to improve housing. We encourage the IRS to revise the Instructions for Schedule H, specifically for community health improvement activities," Part I, line 7(e) on Page 1 so that it includes:

> "**activities and services that are provided to improve the health of individuals in the community by addressing the determinants of health, including the social, economic, and physical environment,** such as improved housing for vulnerable populations by removing building materials that harm the health of residents, housing for vulnerable patients and low-income seniors."

We believe this is an important step to encouraging hospitals, as major economic players and institutions anchored in the communities they serve, to invest more strategically and effectively in housing and other initiatives that will improve community health.

I am happy to discuss these recommendations further with you and can be reached at (617) 275-2859 or jcurtis@communitycatalyst.org. As always, thank you for your time and attention to these issues.

Sincerely,

Jessica L. Curtis
Senior Advisor, Hospital Accountability Project

---

[i] Part II, Line 1, 2014 Schedule H Instructions, p. 4 (defining "physical improvements and housing" to include "the provision or rehabilitation of housing for vulnerable populations, such as removing building materials that harm the health of residents, neighborhood improvement or revitalization projects, provision of housing for vulnerable patients upon discharge from an inpatient facility, housing for low-income seniors, and the development or maintenance of parks and playgrounds to improve facility activity.").

[ii] Worksheet 4, Community Health Improvement Services and Community Benefit Operations (Part I, Line 7e), pp. 16-17.

[iii] Id.

[iv] Gary J. Young, Chia-Hung Chou, Jeffrey Alexander, Shoou-Yih Daniel Lee, and Eli Raver. "Provision of Community Benefits by Tax-Exempt U.S. Hospitals." New England Journal of Medicine, April 2013, v. 368, pp. 1519-1527 (finding that hospitals allocated 5.3 percent of their community benefit expenditures to community health improvements).

[v] "Results from 2011 Tax-Exempt Hospitals' Schedule H Community Benefit Reporting," Ernst & Young LLP, August 2014 (finding that tax-exempt hospitals spent an average of .15 percent of total expenses on community building activities).

[vi] Sara Rosenbaum, David A. Kindig, Jie Bao, Maureen K. Byrnes and Colin O'Laughlin. "The Value Of The Nonprofit Hospital Tax Exemption Was $24.6 Billion In 2011," *Health Affairs*, no. 7 (2015), p. 8.