Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

September 22, 2011

Sarah Hall Ingram
Commissioner
IRS Tax-Exempt & Government Entities Division
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

CC:PA:LPD:PR (Notice 2011-52), Room 5203

Subject: Notice 2011-52

Dear Commissioner Ingram:

The Catholic Health Association of the United States (CHA), representing Catholic sponsored hospitals and other health care facilities, their sponsoring organizations and health care systems, is pleased to provide comments on the Internal Revenue Service Notice 2011 -52 concerning the Affordable Care Act (ACA) requirements on community health needs assessments (CHNAs) for tax-exempt hospitals.

For over 20 years, CHA has been a leader in the field of community benefit, providing education and resources on how tax-exempt health care organizations plan and report their community benefit contributions. Since 1989, CHA materials have included guidelines and resources for assessing community health needs and developing plans to address those needs. This year CHA, working with our members, experts in public health and consumer advocates, developed a new resource *Assessing and Addressing Community Health Needs. (*Assessing and Addressing Community Health Needs)

To develop comments on this IRS notice, CHA convened over 50 individuals from our member health care systems and hospitals with experience in community health need assessment, tax policy and public health. This group represented hospital organizations that are large and small, resource rich and poor, urban, suburban and rural. Some of these hospitals have long-standing relationships with public health agencies and others are in areas where there is very little public health presence.

Based on discussion with our members and careful review of the notice, CHA recommends that IRS requirements for community health need assessment should focus on:

> **Congressional intent.** It is important to recall that the Affordable Care Act requirements for tax-exempt hospitals came from Congress's intention that hospitals understand and act upon the

- most pressing health needs in their communities. The intent was not for hospitals to conduct a standardized community health needs assessment process.
- **Transparency.** We agree with the overall approach of the notice that requires hospital organizations (filing EINs) and hospitals (individual facilities) to describe what they have done in terms of assessment and community benefit planning.
- **Reasonable Reporting of Collaborative partnerships.** We support the law's requirements for consulting with experts in public health and with persons knowledgeable about the community, and the IRS and Treasury intention to allow the assessment to be based on information collected by others and conducted in collaboration with others. However, we consider some of the requirements in the notice for reporting on these collaborations to be too detailed for Federal rules.
- **Flexibility.** Hospitals and communities come in different sizes with various resources and needs. We recommend that the IRS requirements be sufficiently broad to be applicable to all.

With the above principles in mind, we offer the following recommendations on the notice.

Community Health Needs Assessment Documentation

Page 9, IRS Notice:

Treasury and the IRS intend to require a hospital organization to document a CHNA for a hospital facility in a written report that includes the following information:

(1) A description of the community served by the hospital facility (as defined in section 3.05 of this notice) and how it was determined.

(2) A description of the process and methods used to conduct the assessment, including a description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs. The report should also describe information gaps that impact the hospital organization's ability to assess the health needs of the community served by the hospital facility.

We agree that the requirements should include:

- a description of the community served by the hospital facility and how it was determined.
- a description of the process and methods used to conduct the CHNA

We disagree that the requirements should include documentation of the "analytical methods applied to identify community health needs."

We recommend that the requirement for describing "analytic methods" be deleted. The term is used in public health research to refer to literature searches and data abstraction. It is not relevant for most CHNAs. We recommend that describing the methods used to conduct the CHNA is sufficient.

We disagree that the requirements should include documentation of information gaps that impact the hospital organization's ability to assess the health needs of the community served by the hospital facility.

Most assessments will have some gaps in information because available data is a few years old or does not drill down to the local/community/neighborhood level. We recommend either describing the expectation of what is to be reported or deleting this requirement.

Page 10 IRS Notice:

(3) A description of how the hospital organization took into account input from persons who represent the broad interests of the community served by the hospital facility (as defined in section 3.06 of this notice), including a description of when and how the organization consulted with these persons (whether through meetings, focus groups, interviews, surveys, written correspondence, etc.). If the hospital organization takes into account input from an organization, the written report should identify the organization and provide the name and title of at least one individual in such organization with whom the hospital organization consulted. In addition, the report must identify any individual providing input who has special knowledge of or expertise in public health (as provided in paragraph (1) of section 3.06 of this notice) by name, title, and affiliation and provide a brief description of the individual's special knowledge or expertise. The report also must identify any individual providing input who is a "leader" or "representative" of populations described in paragraph (3) of section 3.06 of this notice by name and describe the nature of the individual's leadership or representative role.

We agree that the requirements should include a description of how the hospital organization took into account input from persons who represent the broad interests of the community served by the hospital facility.

However, we disagree that this information should include:

- **a description of <u>when</u> the organization consulted with these persons**
- **the name and title of at least one individual in organizations with whom the hospital organization consulted**
- **a description of the public health experts' special knowledge or expertise**
- **identification of any individual providing input who is a "leader" or "representative" of special populations by name and the nature of the individual's leadership or representative role.**

CHA views these requirements as too detailed for Federal rules.

For example, in conducting CHNAs, hospitals and their community partners will use multiple methods of contact including surveys, interviews and community meetings. One CHA member reported to us, "We send surveys out to hundreds of key stakeholders and sometimes they include their names on the completed survey and sometime not." Recordkeeping of all encounters and a description of all contacts is not always possible and is not necessary for hospitals' public reports.

Further, requiring information about leaders or representative of medically underserved, low-income, and minority populations and populations with chronic disease needs by name and role is not appropriate. These populations may not have leaders or representatives. For example, heart failure may be a significant chronic disease in the community, but there is unlikely to be a leader or representative of persons with this condition with whom to consult.

Finally, we believe the requirement should apply to hospital *facilities*, not *organizations*.

We recommend that a summary of how community members were consulted should be sufficient and that the guidance in the Notice should be revised as follows:

"A description of how the hospital facility took into account input from persons who represent the broad interests of the community served by the hospital facility (as defined in section 3.06 of this notice), including a description of ~~when and~~ how the organization consulted with these persons (whether through meetings, focus groups, interviews, surveys, written correspondence, etc.). If the hospital organization takes into account input from an organization, the written report should identify the organization~~ and provide the name and title of at least one individual in such organization with whom the hospital organization consulted.~~ In addition, the report must identify any individual providing input who has special knowledge of or expertise in public health (as provided in paragraph (1) of section 3.06 of this notice) by name, title, and affiliation ~~and provide a brief description of the individual's special knowledge or expertise. The report also must identify any individual providing input who is a "leader" or "representative" of populations described in paragraph (3) of section 3.06 of this notice by name and describe the nature of the individual's leadership or representative role."~~

Page 11 IRS Notice:
(4) A prioritized description of all of the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs.

Most assessments will identify an extensive list of community health needs. The entire list should not be included, but rather the most significant or highest priority needs.

We recommend in (4) replacing "all" with "significant."

How a CHNA is Conducted

Page 12 IRS Notice:

Treasury and the IRS intend to provide that a CHNA will satisfy the CHNA requirements with respect to a hospital facility only if it identifies and assesses the health needs of, and takes into account input from persons who represent the broad interests of, the community served by that specific hospital facility (as defined in section 3.05 of this notice). Treasury and the IRS intend to allow a hospital organization to base a CHNA on information collected by other organizations, such as a public health agency or non-profit organization. Treasury and the IRS also intend to allow a hospital organization to conduct a CHNA in collaboration with other organizations, including related organizations, other hospital organizations, for-profit and government hospitals, and state and local agencies, such as public health departments. However, in order to ensure that the hospital organization meets the CHNA requirements separately with respect to each hospital facility and that information for each hospital facility is clearly presented and easily accessible, Treasury and the IRS intend to require a hospital organization to document the CHNA for each of its hospital facilities in separate written reports that include the information described in section 3.03 for each hospital facility.

We agree and support that hospitals should be allowed to:

- **Base a CHNA on information collected by other organizations, such as a public health agency or non-profit organization**
- **Conduct a CHNA in collaboration with other organizations, including related organizations, other hospital organizations, for-profit and government hospitals, and state and local agencies, such as public health departments.**

However, we recommend clarification that when several hospitals within the same defined community work together on an assessment, their CHNA reports may be identical or they may submit the same CHNA report. We also recommend clarification that the documents required by the IRS rules may take different forms, such as combining the CHNA with the implementation strategy, making them separate documents, or including both CHNA and the implementation strategy as part of a larger community benefit report (required by many states) as long as the pertinent information is documented.

Community Served by the Hospital

Page 14 IRS Notice:

Treasury and the IRS intend to provide that a hospital organization may take into account all of the relevant facts and circumstances in defining the community a hospital facility serves. Generally, Treasury and the IRS expect that a hospital facility's community will be defined by geographic location (e.g., a particular city, county, or metropolitan region). However, in some cases, the definition of a hospital facility's community may also take into account target populations served (e.g., children, women, or the aged) and/or the hospital facility's principal functions (e.g., focus on a particular specialty area or targeted disease). Notwithstanding the foregoing, a community may not be defined in a manner that circumvents the requirement to assess the health needs of (or consult with persons who represent the broad interests of) the community served by a hospital facility by excluding, for example, medically underserved populations, low-income persons, minority groups, or those with chronic disease needs.

We have concerns with the following statement.

> **"Community may not be defined in a manner that circumvents the requirement to assess the health needs of (or consult with persons who represent the broad interests of) the community served by a hospital facility by excluding, for example, medically underserved populations, low-income persons, minority groups, or those with chronic disease needs."**

We agree that community must be defined in a way that allows a hospital to assess the health needs of the whole community, including the needs of vulnerable groups. However, the statement about excluding vulnerable groups to circumvent this intent implies this is something that most hospitals try to do and creates a negative impression of hospitals in general. In addition, we consider the term "those with chronic disease needs" is too broad and that it could be interpreted to require consultation on every chronic disease or condition.

CHA recommends this section be revised as follows:

"Community should be defined in a manner that includes assessment of the health needs of (or consult with persons who represent the broad interests of) the community served by a hospital facility, including medically underserved populations, low-income persons, and minority groups."

Input from Persons

Page 15 IRS Notice:

Treasury and the IRS intend to provide that a CHNA must, at a minimum, take into account input from—
(1) Persons with special knowledge of or expertise in public health;
(2) Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility;

We agree the hospital should take into account input from:

> **Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility.**

We believe it is important that there be an option (as is given with the word "or") to work with various levels of public health because some communities may not have local public health resources available to participate in the CHNA.

Page 16 IRS Notice:

Treasury and the IRS intend to provide that a CHNA must, at a minimum, take into account input from—
(3) Leaders, representatives, or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility.

As described earlier, we are concerned that requiring input from populations with chronic disease needs is not appropriate.

CHA recommends revising to:

"(3) Persons with broad knowledge of the community who may include leaders, representatives, or members of medically underserved, low-income, and minority populations, and/or populations with chronic disease needs, in the community served by the hospital facility."

Implementations Strategy

Page 19 IRS Notice:

Treasury and the IRS intend to define an "implementation strategy" for a hospital facility as a written plan that addresses each of the community health needs identified through a CHNA for such facility.

We recommend that the definition above be amended to delete the word "each" and that IRS guidance permits the implementation strategy to list the most significant prioritized community health. We also recommend adding the words "and through other means" at the end of the sentence.

The ACA legislation does not use the word "each" in its description of what the implementation strategy should cover. In our experience it is reasonable for a hospital, after assessing community health needs, to identify a manageable list of significant needs. We do not find it practical for a hospital to document whether it will or will not address what is likely to be an extensive list of health and health-related problems in the community. For transparency purposes, it is important to document the needs identified as being of the highest priority.

Further, Instructions for the IRS Form 990, Schedule H say that in addition to using a community health needs assessment, the need for community benefit activities may be demonstrated through:

- Documentation that demonstrated community need or a request from a public agency or community group was the basis for initiating or continuing the activity or program
- The involvement of unrelated collaborative tax-exempt or government organizations as partners in the activity or program.

We recommend that the implementation strategy should be able to include initiatives identified in these additional ways, not just initiatives that address needs identified in the CHNA.

Therefore, CHA recommends revising this statement to:

"A written plan that addresses ~~*each*~~ significant community health needs identified through a CHNA and through other means."

Page 20 IRS Notice:

Treasury and the IRS intend to allow hospital organizations to develop implementation strategies for their hospital facilities in collaboration with other organizations, including related organizations, other hospital organizations, for-profit and government hospitals, and State and local agencies, such as public health departments

We agree with this intention and recommend that when hospitals within the same defined community collaborate on an implementation strategy, all the partners may use the same implementation strategy.

How and When Adopted

Page 22 IRS Notice:

Treasury and the IRS intend to provide that a hospital organization must adopt an implementation strategy to meet the community health needs identified in a CHNA by the end of the same taxable year in which it conducts that CHNA.

CHA recommends revising this schedule to within the same twelve months.

Hospitals and other groups collaborating on the implementation strategy may not have the same tax years so this timing may be unrealistic.

In addition, this section should refer to a hospital facility (individual hospital) adopting the implementation strategy, not the hospital organization (EIN).

Therefore, we recommend the following revision:

"A hospital ~~organization~~ facility must adopt an implementation strategy to address the community health needs identified in a CHNA ~~by the end of the same taxable year in which it conducts~~ within twelve months of conducting that CHNA."

Questions Raised by IRS

The notice asked for comments regarding several issues not addressed above. These issues and CHA recommendations follow:

- Whether multiple hospitals should be able to report together when they jointly conduct a CHNA, and whether multiple hospitals should be able to adopt a single implementation strategy.

  We recommend that when organizations share the same defined community, they should be able to develop one CHNA and implementation strategy report for use by all organizations. In some cases a single report may be issued with different sections for each entity. All of these should be permissible.

- The merits of specifying geographically-based assessments.

  We do not recommend specifying geographically-based assessments.

- Whether IRS should specify the qualifications of public health experts.

  We do not recommend specifying the qualifications of public health experts.

- The need for guidance on how to make the CHNA publicly available.

  We find the guidance in the notice to be sufficient.

Additional Comments:

- CHA recommends that the term "hospital facility" mean a separately licensed hospital facility. For example, if two buildings on the same or different campus are under the same licensure, there should be a single CHNA and implementation strategy for the licensed entity. Additionally, as stated earlier, we recommend that multiple hospitals serving the same defined community should be able to produce a single or the same assessment and implementation strategy.

- We recommend that the IRS guidance make clear that health care needs currently being addressed by a hospital through its community benefit programs can be reported in the CHNA and that the needs can be included in the implementation strategy, as long as the need continues. For example, a hospital working with schools to immunize children may not find lack of immunizations as a problem in its needs assessment. This is because the hospital and school are addressing the need for immunizing children. We recommend that sustaining successful efforts be should be included in CHNAs and the implementation strategies.

- IRS guidance should allow needs that are beyond the geographic area served by a hospital to be included in the CHNA and implementation strategy. For example, there may be a statewide or regional initiative to address a regional or statewide need. Hospitals may (and should) work to address these needs in their implementation strategies in collaboration with health care systems, state health departments, hospital associations or other organizations.

- Alternative CHNA schedules should be permitted. Local health departments are required by new certification requirements to conduct community health needs assessments every five years. Because of this and other community-wide assessment timing issues, hospitals may be on an alternative schedule. We recommend that hospitals working with health departments and community partners be permitted to continue to do so on the community's schedule as long as the reason for the alternative schedule is disclosed.

- We recommend that when a hospital is in compliance with a state requirement for conducting a community health needs assessment and/or developing an implementation strategy that it be deemed to be in compliance with federal requirements.

- We recommend reporting requirements not be duplicative. In the 2010 IRS Form 990 Schedule H, similar information is collected on parts V and VI. The redundancy should be eliminated.

- Finally, we recommend that IRS, not the Centers for Disease Control and Prevention (CDC), maintain authority over rules pertaining to hospital tax-exemption. During the past summer we have seen the CDC's Office of Prevention through Healthcare attempt to take leadership on the ACA requirements for community health needs assessment and implementation strategies. It convened a three day meeting and released a paper, "Best Practices for Community Health Needs Assessments and Implementation Strategies." The meeting and paper revealed the CDC office's preference for what we consider to be a rigid, costly, bureaucratic, one-size-fits-all approach. We disagree with this direction and strongly recommend that it not be adopted by IRS either in rulemaking or any other guidance, such as a model or "safe harbor" because it is not appropriate for most hospitals and communities.

Thank you for consideration of these comments. If you have any questions, please address them to Julie Trocchio at jtrocchio@chausa.org or 202-721-6320.

Sincerely,

Sister Carol Keehan, DC
President and Chief Executive Officer