

April 23, 2012

Sarah Hall Ingram
Commissioner
IRS Tax-Exempt & Government Entities Division
Internal Revenue Service
1111 Constitution Ave., NW
Washington, DC 20224

Re: Letter from Public Health Organizations, March 13, 2012

Dear Commissioner Ingram:

The Affordable Care Act provision requiring tax-exempt hospitals to conduct community health needs assessments (CHNAs) (Internal Revenue Code section 501(r)(3)) presents an opportunity for the nation's tax-exempt hospitals to work with state and local health departments and others with public health expertise to improve health in our communities. However, as the Internal Revenue Service considers what additional guidance is necessary for hospitals to comply with the new statutory requirements, we would caution the IRS not to promulgate mandatory rules that go well beyond the scope of the statute or are inconsistent with the Congress's desire to allow for a flexible approach to community health needs assessments.

In recent years, the level of collaboration between hospital community benefit programs and public health organizations has increased significantly. Educational materials developed by several of our hospital organizations have relied heavily on public health resources. New tools made possible through the Centers for Disease Control and Prevention, the Robert Wood Johnson Foundation and schools of public health are widely used by hospitals. Many hospitals benefit from consultation with public health institutes, schools of public health and others with public health expertise. In many communities, that includes consultation with a local health department. Our member organizations have a longstanding commitment to improving health in their communities and providing access to health care. That mission is still very much a part of their work today.

The undersigned hospital organizations are writing to express our significant concern about several of the recommendations in a recent letter from national public health organizations that would adversely affect the ability of hospitals to engage in the very type of community health efforts the needs assessment and implementation requirements are intended to promote.¹ The creation of specific operational requirements is at odds with the law's recognition that every community is unique and that each hospital must assess the health needs of its community and develop a strategy specific to its own resources. They would impose unnecessarily burdensome

¹ Recently, a number of public health organizations filed additional comments with the IRS regarding IRS Notice 2011-52 making specific "recommendations to further guide tax-exempt hospitals in meeting Internal Revenue Service requirements to complete community health needs assessments and implementation strategies." See Letter of Georges C. Benjamin and others to IRS Commissioner Douglas H. Shulman (March 13, 2012).

requirements on hospitals while not necessarily improving the CHNA or implementation strategy. Many of its specific recommendations stray far beyond the statute and Congressional intent by proposing that IRS make certain models of collaboration among health care organizations into mandatory tax regulations. Here is why we think that such an approach is not only unnecessary, but also counterproductive.

Hospitals will conduct productive community health needs assessments.

We begin by addressing what appears to be the premise underlying many of the letter's recommendations-- that hospitals will do "the minimum" to meet new CHNA requirements. Tax-exempt hospitals have been responding to their communities' health needs since they were first established, and will continue to do so. Comprehensive resources to help hospitals conduct effective assessments, developed by national hospital associations working collaboratively with public health experts, have been embraced by hospitals.

Further, the transparency mandate contained in new Section 501(r)(3) will effectively ensure quality. The CHNA requirements direct hospitals to make their assessments "widely available to the public." This will allow community members, partners, oversight agencies and policymakers to evaluate the quality of these assessments. If community members recommend that changes should be made, they can engage with their local hospital to develop and implement an approach that works best for their own community.

One size does not fit all.

The legislative history of the mandate for hospitals to conduct CHNA is clear: there are many acceptable approaches hospitals can use to learn about their communities' needs. This is contrary to the recommendations requiring that all hospitals must conduct community health needs assessments in the same way, using the same processes and same types of advisors. Each community has unique needs and resources, so it is imperative that hospitals and community partners have flexibility in the way they conduct assessments.

- ***Hospitals are able to assess the qualifications and credentials of individuals with public health expertise***

Recommendation #1 unnecessarily limits with whom a hospital may work. Attempting to prescribe the exclusive credentials and qualifications of someone with public health expertise unreasonably narrows the field of useful resources and capable individuals to assist in assessing the needs of a community. As a practical matter, the level at which the recommendation defines "expert" is also unnecessary and often unavailable in a community, especially rural areas. Hospitals are fully capable of determining the qualifications of consultants in public health the same way they determine qualifications of all other professional experts with whom they consult in meeting their obligations. Further, this is not an appropriate subject for IRS regulations.

- ***Hospitals can determine the level of public health expertise that is needed for a successful completion of a CHNA***

The recommendation for public health expertise at three or four levels is unnecessary. The recommendations call for consulting with 1) experts in public health 2) local health departments 3) state health departments, and 4) when available, tribal health offices. While some assessments might use this configuration, it is not necessary for all or most assessments and will not be feasible in many communities.

Requiring hospitals to use very specific resources is neither necessary nor practical

- ***Flexibility is key.***

Recommendation #3 inappropriately attempts to prescribe exactly how hospitals must use public health expertise. The recommendation asks hospitals to document how public health experts and offices were involved in each of the following: collecting and analyzing data, coordinating efforts, ensuring meaningful engagement, interpreting findings, prioritizing needs, identifying interventions and developing goals and objectives. We interpret this to mean that IRS would require each of these steps. However, we believe that Congress intended and envisioned a flexible approach to the conduct of CHNAs. Hospitals will use various levels of consultation and expertise depending on their internal capacities, availability of public health resources and community relationships. They must determine whether it is necessary to use outside assistance at each of these steps.

Hospitals are accountable for meeting the CHNA requirements and the responsibility for determining appropriate implementation strategies must rest with them.

Implementation strategies are hospitals' internal community benefit plans, similar to their strategic and operational plans. Neither the statute nor the legislative history mandates that hospitals consult with others on their implementation strategies, and the IRS should resist any temptation to promulgate administrative guidance imposing requirements that Congress did not see fit to impose.

- ***Each hospital needs flexibility to determine an implementation strategy that is consistent with its mission and resources.***

Recommendation #5 would inappropriately require mandatory involvement of public health experts, local and state health departments in hospitals' implementation strategies. Implementation strategies, as required by the Affordable Care Act and discussed in IRS Notice 2011-52, describe how each hospital will address the health needs identified in its community health needs assessment. These documents, previously known as hospital community benefit plans, are part of a hospital's strategic planning process. While informed by community and public health expert views, they must remain the responsibility of each implementing hospital or health system. Further, the implementation strategy must be consistent with the hospital's mission and its available resources, decisions that only the hospital can make.

- *Hospitals know how to define their own communities.*

Recommendation # 6 sets out a prescriptive method to be used by hospitals to define a community, going well beyond the IRS notice. With no substantiating evidence, the recommendation seems to be premised on the assumption that hospitals intend to define their communities to exclude certain populations. This is not the case. Every hospital is best positioned to know how to define the community it serves. This is based not only on the hospital's patient population but also on the particular services that it provides, as well as whether the hospital is a general acute care hospital or a specialty hospital.

In summary, hospitals value the resources and expertise of public health experts and departments but do not agree that public health input should be so narrowly and prescriptively defined. By making the CHNA process both transparent and flexible, Congress intended to make it easier for the community, local health departments, community representatives and other important stakeholders to provide local oversight and to find new opportunities for partnerships. We and our members are ready to be engaged with the public health community in advancing access to care and improving health in our communities. However, the CHNA and other tax-exemption requirements are statutory obligations for which hospitals alone are accountable. Congress has set the objectives that must be met. But imposing prescriptive and intrusive requirements to achieve those objectives would be at odds with the statute, and would work against hospitals' fulfillment of their overall community benefit responsibilities.

If you would like to discuss this letter or related issues, please contact Julie Trocchio at the Catholic Health Association at jtrocchio@chausa.org or 202 721-6320.

Sincerely,

The American Hospital Association
The Association of American Medical Colleges
The Catholic Health Association of the United States
VHA Inc.