



Association Of State And Territorial Health Officials
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September 23, 2011

Internal Revenue Service
CC:PA:LPD:PR (Notice 2011-52), Room 5203
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Comments of the Association of State and Territorial Health Officials on *Community Health Needs Assessment Requirements for Tax-exempt Hospitals Notice 2011-52*

The Association and State and Territorial Health Officials (ASTHO) thanks you for the opportunity to submit comments to Notice 2011-52 regarding the implementation of Section 501 (r)(3). ASTHO is a membership organization representing the state and territorial health officials in the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific territories: American Samoa, Federated States of Micronesia, Guam, Marshall Islands, Northern Mariana Islands, and Palau. ASTHO's members are the chief health officials responsible for ensuring the health of the residents in the states and territories. This includes ensuring access to health care, providing continuous surveillance, investigation, and response to emerging health issues, coordinating care via community health teams, carrying out statewide health and health care planning, and collecting data. In 19 states, the local health department is supported and staffed by state employees. This allows for a direct connection between state and local assessment and services. Importantly, all state health departments have the regulatory responsibility for determining medical underserved areas and critical care access through the state office of primary care. These offices have years of expertise in formal data which is critical to the community health needs assessment. This expertise provides an essential state and local perspective in comparing and contrasting methods of assessment, common data metrics and drawing on national standards of assessment.

Section 501 (r) (3) will require hospital organizations to conduct a community health needs assessment (CHNA) every three years and to adopt an implementation strategy to meet the needs identified through the CHNA. State health departments provide an essential resource that assures comprehensive and accurate community needs assessment throughout the state. Therefore, we strongly recommend that state health agencies must be a required contributor and reviewer of all community health needs assessments

State Health Agency Infrastructure:

The established state health agency infrastructure can readily support hospital organizations conducting community health needs assessments. State health agencies are an integral part of the health care delivery system. They partner with insurers, hospitals, local health departments, community health centers, and other providers to improve access to care and reduce demand on high costs of treatment through core public health functions. State public health officials

recognize the importance of community health needs assessments (CHNA) in generating a better understanding of the health needs of a community and have always supported the development of an articulated strategy that will address those needs with the help of multiple community-wide partners. A state or community implementation strategy that aligns with a CHNA can ensure that appropriate services are provided to communities and that fiscal resources are spent wisely.

According to the *2010 ASTHO Profile Survey*, a total of 28 state health agencies have developed a health assessment in the past five years, and five additional states plan to do so within the next year. ASTHO members have extensive experience working with a range of external partners in the implementation of health assessments and improvement plans. State public health agencies provide the core data that inform both state and local community health assessments. Furthermore, state health agencies implement numerous public health programs to meet identified needs. Twenty-three states have developed or participated in developing a health improvement plan in the past five years, and seven states plan to do so within the next year. Additionally, 23 states plan to update their health improvement plan within the next three years. Further, 35 states' health improvement plans are linked to local health improvement plans. Currently 28 states and the District of Columbia have participated in the National Public Health Performance Standards Program, which is an assessment of state public health system capacity and services. In addition, many state health agencies are in the process of preparing for a national accreditation program led by the Public Health Accreditation Board (PHAB) which requires that the agencies conduct a state health assessment and a state health improvement plan. 35 state health agencies intend to seek accreditation under a voluntary national accreditation program.

State Primary Care Offices are an integral part of the state public health infrastructure in their assessment of population needs and organizational and collaborative capacity to coordinate care. Their mandate by the Health Resources and Services administration includes formal needs assessments, workforce development, and technical assistance to organizations or communities wishing to expand access to primary care for underserved populations. An essential part of any state-level capacity is its ability to work with local partners and infrastructure. In many states and territories, there is no local health department or organization and a limited capability beyond state and territorial-level efforts.

States have collaborated with several partners, including non-profit hospitals, on the development of health assessments and subsequent health improvement plans. For example, the Maryland Department of Health is currently conducting a State Health Improvement Process that involves planning teams across the state. This effort is being led by local health officers and funded initially by local hospitals. Hospitals in Maryland are partnering with local health officers to better align their community health benefits as required by the IRS with the public health priorities of the counties and regions. These teams will cover the vast majority of the state and serve as a platform for local involvement in many other public health activities. Maryland's example illustrates how the assessment and planning efforts position state health agencies and non-profit hospitals to build and maintain important relationships that have the potential to be mutually beneficial. Further, a partnership between hospital organizations and state public health agencies could allow for more robust state and community health assessments.

ASTHO's Response to Solicitation of Comments:

Hospital Organizations Required to Meet the CHNA Requirements (.01)

Should government hospitals be subject to 501(r) (p. 7-8)?

The statutory language of section 501(r) applies to all hospital organizations that are (or seek to be) recognized as described in section 501(c)(3). Section 501(r) does not explicitly address government hospitals, nor does it include a specific exception for government hospitals. Accordingly, Treasury and the IRS intend to apply section 501(r) to every hospital organization that has been recognized (or seeks recognition) as an organization described in section 501(r)(3). However, in recognition of the unique position of government hospitals, Treasury and the IRS request comments regarding alternative methods a government hospital may use to satisfy the requirements of section 501(r)(3).

ASTHO encourages the Treasury and the IRS to consider locally-run public hospitals and university hospitals to be subject to 501(r). ASTHO also recommends that state or federal hospitals not be subjected to 501(r).

How and When a CHNA Is “Conducted” (.04)

Should health systems with multiple hospitals be required to document CHNAs and Implementation plans for each of their hospitals (p. 13, 21)?

Treasury and the IRS request comments regarding whether, and under what circumstances, documenting CHNAs for multiple hospital facilities together in one written report might improve the quality of the CHNAs, while still ensuring that information for each hospital facility is clearly presented and easily accessible.

ASTHO recommends that the regulation include language disallowing hospitals to collaborate with other hospitals on a CHNA process and on the development and prioritization of implementation strategies. Multiple hospitals, however, can contribute to the same CHNA. The shared CHNA can be supplemented with small area analyses, which individual hospitals could conduct to gather more detailed information. While hospitals can contribute to the same CHNA process, each individual hospital should identify the unique implementation strategies for which it will be responsible in addressing identified community needs.

Community Served by a Hospital Facility (.05)

How should the community served by a hospital be defined (p. 14)?

Treasury and the IRS request comments regarding the relative merits of different geographically-based definitions of community. Treasury and the IRS specifically request comments regarding whether future regulations should define the geographic community of a hospital facility as the Metropolitan Statistical Area (MSA) or Micropolitan Statistical Area (muSA) in which the facility is located or, if the hospital facility is a rural facility not located in a MSA or muSA, as the county in which the facility is located. (Page 14)

ASTHO recommends that the regulations require a geographic definition of community. However, the definition of *community* should not be limited to specific criteria, as certain populations at high-risk for under-service may not be geographically located in zip codes or counties. Further, the regulations should not define communities by a specific demographic, but rather the regulations should allow for a definition of community that includes the demographics of all populations living in the selected geographic area.

ASTHO also recommends that the IRS avoid defining community as the geographic area from which at least 75 percent of the hospital's patients reside. A hospital's patient population does not always reflect those populations in the community who may be underserved and who do not directly interact with that hospital. Narrowing the definition of community to include only a hospital's patient population excludes those individuals who may access community health centers or rural health clinics for health needs and who may not directly interact with a hospital.

Politically defined jurisdictions, such as county lines and zip codes, are not strongly correlated with hospital service areas. Defining a community to include a larger catchment area will often involve multiple health department jurisdictions, community health centers, rural health clinics, free clinics and/or additional partners. Hospital organizations should collaborate with these various stakeholders to conduct a single community health needs assessment.

Persons Representing the Broad Interests of the Community (.06)

Who in the community must a hospital consult with/who has knowledge of and expertise in public health (p.15)?

Section 501(r)(3)(B)(i) states that a CHNA must take into account input from 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.

ASTHO recommends that hospital organizations be required to seek input from state health agencies during the CHNA process and implementation plans. State health agencies serve important roles in health needs assessments in that they are often the primary source of data on the burden of disease in a state and provide source data for local communities. Furthermore, their collaborations with hospital organizations in community health needs assessments will be beneficial in understanding the challenges with community engagement, setting priorities for community health needs, and data sharing. State health agencies are poised to enhance collaboration among community partners, including providers, insurers, schools, businesses, consumers, and hospital organizations.

As a part of the CHNA process, hospitals will need to identify the community they are serving and identify the priority need areas. Data from state health agencies should be an important part of this multi-step process. Community health needs assessments are currently required for state health department accreditation , and with the beginning of the Public Health Accreditation Board's voluntary accreditation process there will be opportunities for hospitals to collaborate with state health agencies to gather best/promising practices. Hospitals can fund

state and local health departments to conduct these CHNAs instead of contracting with other for-profit organizations.

A strong collaboration can also ensure that planning and assessment activities are not duplicative. This relationship can lead to greater opportunities for the communities being served. Statewide oversight is also imperative in encouraging the use of evidence-based public health practices in CHNAs.

Treasury and the IRS request comments regarding what specific qualifications (whether in terms of degrees, positions, experience, or affiliations) should be necessary for an individual or organization to be considered as having special knowledge of or expertise in public health.

ASTHO recommends that a health agency staff person with expertise as a state health official, public health director or a designee, such as a public health professional, be required. Individuals with credentials such as a Master of Public Health, Master of Health Science Administration, or Master of Science from an accredited school of public health and experience in community health assessment and planning would be qualified to conduct a CHNA.

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... In addition to persons described above in paragraphs (1), (2), and (3), a hospital organization or facility may also consult with and seek input from other persons located in and/or serving the hospital facility's community. For example, a hospital organization or facility may consult or seek input from healthcare consumer advocates; non-profit organizations; academic experts; local government officials; community-based organizations, including organizations focused on one or more health issues; health care providers, including community health centers and other providers focusing on medically underserved populations, low-income persons, minority groups, or those with chronic disease needs; private businesses; and health insurance and managed care organizations.

ASTHO recommends that hospital organizations be required to seek input and participation from health care providers who serve medically underserved populations, low-income persons, minority groups, or those with chronic disease needs, including section 330- funded health centers and others. State health agencies, particularly the state primary care offices and state offices of rural health, can convene these various stakeholders as part of a broad collaborative. State health agencies can facilitate discussion between the state's hospital association and the State Associations of County and City Health Officials (SACCHO) in working toward a memorandum of understanding that would commit to collaboration between hospitals and their local health departments in the development of CHNAs and CHIPs. State health agencies can collaborate with the state hospital associations to provide access to data, distribute information about state-run public health programs working at the local level, and possibly technical support/assistance in conducting a needs assessment or developing a community health improvement plan. State health departments can monitor communities served by the various CHNAs and CHIPs to minimize duplication of efforts and to identify gaps and/or needs.

Implementation Strategy (.08)

Should a hospital be required to submit a CHNA and an implementation plan in the same taxable year?

Section 501(r)(3)(A)(ii) provides that a hospital organization meets the CHNA requirements with respect to any taxable year only if it has adopted an "implementation strategy" to meet the community health needs identified through the CHNA.

ASTHO recommends that hospitals be required to adopt an implementation strategy for community health needs assessments. We also recommend that hospitals be required to submit an implementation plan in the same taxable year unless they can document involvement in a community wide process with local and/or state health departments. CHNA documentation should include collaborations among stakeholders and either the local or state health agency officials should endorse the documentation. The implementation plan should describe how the hospital organization will prioritize the needs identified in the community health needs assessment and should describe the prioritization method that was used. In addition, the hospital organization needs to document why certain health needs are not being addressed. ASTHO recommends the implementation plan describe collaborations with state health agencies and other partners in meeting the communities' health needs.

Thank you for providing the opportunity to comment.

Sincerely,



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ASTHO