

**Advisory Group on Prevention, Health Promotion and Integrative and Public Health**  
Washington, DC

July 3, 2012

Commissioner of Internal Revenue Douglas H. Shulman  
IRS Tax-Exempt & Government Entities Division  
Internal Revenue Service  
111 Constitution Ave., NW  
Washington, DC 20224

Dear Commissioner Shulman:

The Advisory Group on Prevention, Health Promotion, and Integrative and Public Health (Prevention Advisory Group) respectfully submits recommendations to the Internal Revenue Service (IRS) in relation to Section 9007 of the Patient Protection and Affordable Care Act (Affordable Care Act). The Prevention Advisory Group, created as part of the Affordable Care Act, is currently composed of 22 non-Federal members appointed by the President. It includes a diverse group of public health experts, health professionals, and other civic leaders.

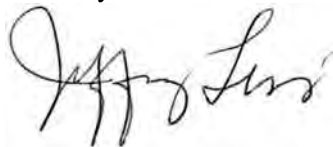
The Prevention Advisory Group strongly supports this section of the Affordable Care Act and realizes that the IRS can be instrumental in ensuring that tax-exempt hospitals are truly addressing community health needs through the community benefit requirement.

The community benefit requirements were a major subject of deliberation at our April 2012 meeting in Washington, DC. We are grateful to Mr. Christopher Giosa of the IRS for his participation in this discussion.

Thank you in advance for your consideration of these recommendations. We applaud your commitment to using the community benefit requirement to advance the nation's health. The Prevention Advisory Group is committed to continued collaboration with the IRS in support of these efforts.

Please do not hesitate to contact us for additional input if needed. I can be reached at [jlevi@tfah.org](mailto:jlevi@tfah.org).

Sincerely,



Jeffrey Levi, Ph.D.

Chair

Advisory Group on Prevention, Health Promotion, and Public and Integrative Health  
(Mailing Address: c/o TFAH, 1730 M Street, NW, Washington DC 20036)

Cc: Regina M. Benjamin, MD, Surgeon General of the United States  
Howard K. Koh, MD, MPH, Assistant Secretary for Health  
Thomas R. Frieden, MD, MPH, Director, Centers for Disease Control and Prevention

## **Statement from the Advisory Group on Prevention, Health Promotion, and Integrative and Public Health**

Approved Unanimously on June 25, 2012

### **Summary**

We are writing to express our strong support for Section 9007 of the Patient Protection and Affordable Care Act (Affordable Care Act) and to highlight ways in which the IRS can help to ensure that tax-exempt hospitals are truly addressing community health needs through their community benefit requirement. Our comments are designed to assure that community benefit activities assist the Nation in achieving the Vision articulated in the National Prevention Strategy:

Working together to improve the health and quality of life for individuals, families, and communities by moving the nation from a focus on sickness and disease to one based on prevention and wellness.

*Our overriding concern is how the IRS definition of community benefit accounts for community building activities, which typically reflect “upstream” investments (i.e. those that create the conditions that ensure health and well being) in community health improvement and are at the heart of our National Prevention Strategy.*

We want to thank the IRS for its participation in our April meeting and applaud your demonstrated commitment to using the community benefit requirement to advance the nation’s health.

### **Background**

The Affordable Care Act contains a broad array of provisions whose aim is to transform community and population health. One of these provisions called for the creation of a National Prevention Strategy, which was released by the Surgeon General on behalf of the National Prevention Council in June 2011. At the heart of this strategy is the recognition, based on years of research and evidence-based practice, that the strongest predictors of health and well-being fall outside the health care setting, and that social, economic, and environmental factors all influence health. As the National Prevention Strategy states:

We will succeed in creating healthy community environments when the air and water are clean and safe; when housing is safe and affordable; when transportation and community infrastructure provide people with the opportunity to be active and safe; when schools serve children healthy food and provide quality physical education; and when businesses provide healthy and safe working conditions and access to comprehensive wellness programs.

### **Community Building**

Historically, community benefit activities under the IRS definition have tended to emphasize investments in the provision of hospital care for the community served, specifically the provision of care that is otherwise uncompensated. Further, we recognize and appreciate that the IRS definition also encompasses activities that improve community health and enhance public health agency activities, as evidenced by line “e” on the Schedule H Worksheet entitled “Community health improvement service and community benefit operations.” *Our concern is how the IRS will count community-building activities, the kind of*

activities that typically reflect the “upstream” investments that have long been associated with community health improvement and are at the heart of our National Prevention Strategy. In the 2012 version of Schedule H, the IRS notes that some community-building activities may meet the definition of community benefit, but the agency does not specify which ones. It is our understanding that the IRS will recognize certain community-building activities for community benefit credit if the activities are accompanied by evidence from research regarding the health effects of the intervention. Since the National Prevention Strategy provides evidence-based recommendations for improving health and wellness, and addressing the leading causes of death, we urge the IRS to make clear that any evidence-based activities that fall within the four strategic directions of the National Prevention Strategy will be recognized as a true community benefit for which the hospital will receive community benefit credit. The four strategic directions are:

- Clinical and community preventive services;
- Healthy and Safe Community Environments;
- Empowered people;
- Elimination of Health Disparities

The NPS identifies evidence-based strategies and actions, together with indicators, for each of these Strategic Directions. In addition to the NPS (<http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf>), the Guide to Community Preventive Services (<http://www.thecommunityguide.org/index.html>), Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov)), and the Cochrane Collaboration ([www.cochrane.org](http://www.cochrane.org)), among others, can serve as a guide for hospitals in assuring the IRS that the approaches they take have been proven effective.

### **Collaboration-- Implementation Strategies as well as Assessment**

An essential aspect of community health improvement is multi-sector collaboration. As the National Prevention Strategy states, “Engaging partners across disciplines, sectors, and institutions can change the way communities conceptualize and solve problems, enhance implementation of innovative strategies, and improve individual and community well-being.” We appreciate the efforts made by the IRS in its July 2011 Notice (2011-52) to emphasize the desirability of hospital participation in multi-sector collaborative efforts in creating their community health needs assessments. Such efforts should be configured to reflect true community participatory health improvement planning that involves multiple hospital organizations within a geographic region as well as other planning partners such as public health agencies, community-based health care and social service organizations, private businesses, philanthropy and other government agencies and programs. *We urge the IRS to continue to make clear that multi-sector collaboration is not only permissible, but strongly encouraged.* In particular, we wish to highlight the critical importance of engaging the relevant state/local public health agency in coordination of both assessment and implementation efforts. Public health agencies are both a vital source of data and evidenced-based approaches, as well as an important link to related activities in the community.

In addition, *we recommend that the IRS clarify that multi-sector collaboration should extend beyond the assessment process and include the actual development and execution of hospitals’ implementation strategies.* Such a result is contemplated by the Act, which envisions the implementation strategy as an

outgrowth of a transparent community needs assessment process. Transparency should be understood as extending to both the planning and the investment phase of the Community Health Needs Assessment process. With full implementation of the Affordable Care Act, community input into both the assessment and the implementation strategy grows in importance. As more Americans gain health insurance under the Act, nonprofit hospitals, like all hospitals, will realize an important dividend in the form of billions of dollars of reduced uncompensated care costs. At the same time, however, nonprofit hospitals' obligations to engage in community benefit activities remain unaltered. The expansion in health coverage combined with the need to tackle the root causes of the huge burden of chronic illnesses will thus drive hospitals' ability and willingness to invest in "upstream" activities and programs that in turn help transform the health of communities. Where and how to invest this dividend is an important discussion to be held throughout each community as it must reflect community needs. Under the Affordable Care Act, the first round of community health needs assessment activities will take place in 2012, prior to full implementation of the coverage reforms. Subsequent community health needs assessment activities, however, will occur in an environment in which communities may be able to realize a health dividend from expanded health insurance coverage. Collaboration in the process of determining how that dividend is utilized becomes a basic aspect of hospitals' charitable involvement with their communities.

### **Transparency-- Implementation Strategies as well as Assessment**

Just as collaboration on implementation strategies is essential so is transparency. We recognize that the statute requires all hospitals to make their Community Health Needs Assessments (even those developed jointly with other hospitals) "widely available", and we appreciate that the IRS in its July 2011 Notice provided the following clarification of what would satisfy the "widely available" standard:

"(1) the website where it is available clearly informs readers that the document is available and provides instructions for downloading it; (2) the document can be viewed, downloaded and printed in a form that "exactly reproduces" the image of the report; (3) any person can view and download the document without paying a fee; (4) the hospital gives all persons requesting a written version of the report with access to a free download site; and (5) the CHNA remains available until it is replaced by a subsequent CHNA."

We urge the IRS to ensure that all implementation strategies also meet this "widely available" standard so that what individual hospitals, in collaboration with others, do with the information and insights they gain from the Community Health Needs Assessment is easily accessible to the public and others. We understand that the IRS expects hospitals to attach the implementation strategy to their 990 Tax Form, but nothing precludes the hospitals from making these strategies even more widely available. Since the Community Health Needs Assessment process encompasses the adoption of an implementation strategy, we believe the implementation strategy should be included on a hospitals' web site along with the assessment itself, and be subject to the widely available standard. We also hope that the IRS will encourage hospitals to include in their implementation plans (and post on their websites) performance metrics and evaluations of their implementation plans.

### **In the Absence of a Minimum Level of Investment**

The Joint Committee on Federal Taxation, which advises Congress on federal tax policy matters, has estimated that in 2002, nonprofit hospitals received a total of \$12.6 billion in tax benefits at the federal,

state, and local levels of government. Trended forward to 2012 dollars, this figure rises substantially. Given the size of these tax benefits we believe a strong case can be made for requiring a minimum level of community benefit investment from each hospital. However, in the absence of such a requirement, it is imperative that the process for determining and reporting on the level of community benefit investment by each hospital meets the highest standards of transparency and collaboration.

It is distressing to read reports about the small percentage of hospital revenues devoted to community benefit activities. It is also distressing to read how few community benefit dollars are allocated to community health improvement and community-building activities. According to a 2012 report prepared by Ernst & Young for the American Hospital Association, only 11.3 percent of total hospital revenues were allocated to community benefit in 2009. Of this, 8.4 percent was reported as charity care, means tested programs and other benefits. Only 0.5 percent went to community health improvement and only 0.1 percent went to community-building activities. Indeed, it is not always clear how a hospital's charity care dollars are divided among the various categories of free care, unreimbursed means-tested government programs and contractual allowances. We are pleased that the need to clearly account for these various categories is expressly addressed in the Affordable Care Act, which requires the Secretary of the Treasury, in consultation with the Secretary of HHS, to clarify these issues through reporting. This reporting should include goals and objectives and timetables for community-benefit activities and indicia of success and related metrics that are tied to health outcomes.

Greater transparency in reporting and broad collaboration with community partners on assessment, planning and implementation activities that are made widely available to the public are essential if we are to truly address community health needs. Section 9007 of the Affordable Care Act calls for greater transparency and collaboration, but it is how the new requirements are implemented that will determine whether or not they translate into programs and strategies that will result in improved community health.

We thank you for your attention to these issues, and we stand ready to assist you in any way that we can.

## APPENDIX

### Members of the Advisory Group on Prevention, Health Promotion and Integrative and Public Health

**JudyAnn Bigby, MD**, Secretary of Health and Human Services, Commonwealth of Massachusetts

**Richard Binder, MD**, Medical Director, McKesson/US Oncology

**Valerie Brown, MA**, First District County Supervisor, County of Sonoma, California

**Jonathan Fielding, MD, MPH, MA, MBA**, Director, Los Angeles County Department of Public Health

**Ned Helms Jr., MA**, Director, New Hampshire Institute of Health Policy and Practice at the University of New Hampshire

**Patrik Johansson, MD**, Director, Rural Health Education Network and Associate Professor, University of Nebraska Medical Center College of Public Health

**Jerry Johnson, MS, MA**, Principal Partner, Heffler, Radetick & Saitta, LLP

**Janet Kahn, EdM, PhD**, Research Assistant Professor, University of Vermont College of Medicine

**Charlotte Kerr, RSM, BSN, MPH, MAc**, Tai Sophia Institute

**Jeffrey Levi, PhD**, Executive Director, Trust for America's Health

**Jacob Lozada, MA, PhD**, Member, Board of Directors of AARP

**Elizabeth Mayer-Davis, PhD**, Professor of Nutrition, The Gillings School of Global Public Health and Professor of Medicine, School of Medicine at the University of North Carolina at Chapel Hill

**Vivek Murthy, MD, MBA**, Brigham and Women's Hospital, Harvard Medical School, and Founder, Doctors for America

**Dean Ornish, MD**, Founder and President, Preventive Medicine Research Institute

**Barbara Otto**, CEO, Health and Disability Advocates

**Herminia Palacio, MD, MPH**, Executive Director, Harris County Public Health and Environmental Services

**Linda Rosenstock, MD, MPH**, Professor of Medicine and Environmental Health Sciences, UCLA Jonathan and Karin Fielding School of Public Health

**John Seffin, PhD**, CEO, American Cancer Society

**Ellen Semenov, JD**, Assistant City Manager for Human Services, Cambridge MA, and Vice Chair, Cambridge Health Alliance

**Susan Swider, PhD**, Professor, College of Nursing, Rush University Medical Center

**Sharon Van Horn, MD, MPH**, pediatrician

**Kimberlydawn Wisdom, MD, MS**, Senior Vice President of Community Health & Equity and the Chief Wellness Officer, Henry Ford Health System