



NEW REQUIREMENTS FOR NONPROFIT HOSPITALS PROVIDE OPPORTUNITIES FOR HEALTH DEPARTMENT COLLABORATION

Issue Brief

Summary

The majority of hospitals in the United States are recognized as nonprofit organizations by the Internal Revenue Service (IRS). This designation provides these hospitals with a number of financial benefits, including an exemption from the federal income tax as well as the ability to have tax-exempt bonds issued on their behalf. Many states and municipalities also provide nonprofit hospitals with exemptions from property, sales and other taxes. This favorable tax treatment comes with the responsibility that hospitals provide certain benefits to the communities they serve.

In 2008, as a result of claims that it can be difficult to confirm if nonprofit hospitals meet these responsibilities, the IRS began requiring hospitals to provide a more in-depth accounting of the benefits they provide to the community. The Affordable Care Act (ACA) contains several additional measures regarding hospital community benefits, including a measure that requires each nonprofit hospital to conduct an assessment of the health needs of the people in the community it serves and take steps toward addressing those needs. The measure requires hospitals to consult with community members in this process, including those with expertise in public health.

State and local health departments (HDs) are increasingly being subjected to enhanced reporting and action requirements as well. In particular, many HDs will be conducting community health needs assessments similar to those required of nonprofit hospitals by the ACA either as part of a voluntary accreditation process or as a requirement to receive continued funding. Because nonprofit hospitals and HDs have similar goals and often serve similar people, this new ACA community health needs assessment requirement represents an opportunity for collaboration between HDs and nonprofit hospitals.

This paper begins by describing the requirements nonprofit hospitals must meet to obtain and retain nonprofit status and the benefits of that designation. It then discusses changes made by recent legislation and agency action and the impact these changes may have on hospitals and community members. Finally, it suggests ways in which HDs and hospitals may be able to combine resources to address these new requirements as well as to improve the health of the people in the communities in which they serve.

Background

The IRS recognizes about 59 percent of hospitals in the United States as nonprofit organizations.¹ Sixty-eight percent of Medicare beds are located in nonprofit hospitals.² Not including government-run hospitals, about 77 percent of community hospitals are nonprofits.³ Collectively, nonprofit hospitals own 86 percent of private hospital fixed assets.⁴



Nonprofit Hospital Tax Benefits

Qualified nonprofit organizations—those meeting the requirements of Internal Revenue Code 501(c)(3)—enjoy a number of benefits not available to profit-making corporations and organizations. Chief among these is favorable treatment under the tax code.⁵ Qualified nonprofit organizations are exempt from federal income tax, and donations to them are tax-deductible to the donor.⁶ They may also have the ability to have tax-exempt debt issued for their benefit.⁷ Many nonprofits are also exempt from state and local taxes, including property, income and sales tax.⁸

Favorable tax treatment significantly reduces the cost of capital for nonprofit hospitals compared to similarly situated for-profits.⁹ According to the nonpartisan Joint Committee on Taxation (JCT), the income tax exemption and the ability to have tax-exempt bonds issued for their benefit provided nonprofit hospitals with about \$4.3 billion in savings in 2002.¹⁰ JCT estimated that, when state and local tax exemptions are included, nonprofit hospitals received tax benefits of \$12.6 billion.¹¹ According to information provided by the House Ways and Means Committee, in 2001 nonprofit hospitals made up less than two percent of qualified nonprofit organizations but received 41 percent of nonprofit tax benefits.¹²

Nonprofit Hospital Qualification

Although not specifically recognized in the Internal Revenue Code, hospitals may qualify as exempt nonprofit organizations if they meet certain criteria.¹³ Like all qualified nonprofits, they must be “organized and operated exclusively for” an exempt purpose.¹⁴ Hospitals must also meet several other criteria to qualify for the preferential treatment afforded to nonprofits under the federal tax code.¹⁵

These criteria have changed over time. From 1956 through 1969, the IRS required nonprofit hospitals to provide care at no or low cost to those who could not afford it to the extent the hospital was financially able to do so.¹⁶ With the advent of Medicaid and Medicare, hospitals began advocating for a relaxation of this requirement on the grounds that the new legislation would eliminate or greatly reduce the demand for charity care.¹⁷ IRS agreed, and in 1969 removed the charity care requirement in favor of a broad standard that required only that hospitals provide benefits to the community.¹⁸ This ambiguous “community benefit” requirement remained generally unchanged from 1969 to 2008.¹⁹

According to the Government Accountability Office (GAO), without clear guidelines in law or regulation, community benefit activities vary across hospitals and hospital organizations, and even where similar benefits are recognized they are often measured inconsistently.²⁰ Some private efforts have been made to standardize and quantify the benefits that nonprofit hospitals provide to the community, but they are largely voluntary and unenforceable.²¹ The standards by which states decide if hospitals qualify for preferential treatment under state law also vary considerably.²²

The Importance of Demonstrating Community Benefit

While many nonprofit hospitals provide substantial community benefit (often as part of a formal quality improvement process), there was concern that some either did not or did not keep records in such a way that the amount of community benefit provided could be easily determined. Around 2005, a number of federal agencies and officials began questioning whether the existing system to determine which hospitals deserve nonprofit status was in need of reform. The key problem these officials identified was a lack of standards, accountability and transparency that made it difficult to distinguish hospitals that were providing substantial community benefits from those that were not.²³

In 2005, the GAO reported that many of the nonprofit hospitals it surveyed in five states were not operated significantly differently than for-profit hospitals in those states.²⁴ The IRS Commissioner, testifying before a Senate committee, shared similar concerns.²⁵ The Congressional Budget Office (CBO) noted that some nonprofit hospitals issued tax-exempt bonds to finance capital investment even when the hospital held assets sufficient to cover the costs for which the bonds were issued and that many nonprofit hospitals were not located in areas with the highest needs.²⁶

The House Committee on Ways and Means held hearings in 2005 at which the IRS Commissioner testified about problems with the then-existing system for determining which hospitals deserve nonprofit status.²⁷ Senator Grassley (R-Iowa), then ranking member of the Senate Finance Committee, also questioned the nonprofit status of some hospitals in a series of well-publicized hearings.²⁸ That Committee subsequently proposed a number of reforms, including some that



would later appear in the Affordable Care Act.²⁹ Uninsured consumers also filed a number of lawsuits against nonprofit hospitals,³⁰ and some state and local officials also challenged hospital charitable behavior and tax-exempt status.³¹

Several state legislatures have enacted laws requiring hospitals to implement community benefit practices.³² Twenty states and the District of Columbia now have laws requiring providers to notify patients and the public of available financial assistance programs,³³ and fifteen states have adopted billing and debt collection requirements that apply exclusively to medical debt.³⁴ Moreover, several state attorneys general have taken investigative and enforcement action in an effort to ensure that nonprofit hospitals within their states meet their tax-exempt obligations.³⁵

New Transparency and Community Benefit Requirements

The IRS in 2008 introduced a new form, Schedule H, in an attempt to “combat the lack of transparency surrounding the activities of tax-exempt organizations that provide hospital or medical care” and “quantify, in an objective manner, the community benefit standard applicable to tax-exempt hospitals.”³⁶

The ACA contains additional requirements that nonprofit hospitals must meet and report on Schedule H as a condition of retaining their tax-exempt status.³⁷ The ACA also authorizes, for the first time, tax penalties for failing to comply with one of the new requirements.³⁸

Beginning in tax years after March 23, 2010, nonprofit hospitals are required to have a written financial assistance policy that includes eligibility criteria, whether free or discounted care is available to low-income individuals, how charges to patients are calculated, the process for applying for financial assistance and an explanation of how the policy will be widely publicized.³⁹ Also beginning in 2010, charges to patients who are eligible for financial assistance are limited to “amounts generally billed” to patients who have insurance coverage, and gross charges are prohibited.⁴⁰ Additionally, nonprofit hospitals are prohibited from engaging in “extraordinary collection actions” unless and until they have made “reasonable efforts” to determine whether the patient is eligible for financial assistance.⁴¹ Nonprofit hospitals must also have a written policy to provide emergency medical care regardless of the patient’s ability to pay.⁴²

Notably, the ACA also requires that nonprofit hospitals conduct a community health needs assessment (CHNA) every three tax years. This assessment must reflect 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,” and be made “widely available” to the public. The hospital must have an implementation strategy for meeting the needs identified in the assessment, report how it is addressing those needs and describe any needs that are not being addressed together with the reasons they are not being acted on.⁴³ Any nonprofit hospital organization that does not meet these requirements must be assessed a tax of \$50,000 per year per non-compliant facility.⁴⁴ Hospitals must report that they have completed the CHNA requirements beginning in tax years after March 23, 2012.⁴⁵

In July 2011 the IRS released an Announcement (2011-52) that provides guidance on the CHNA requirements.⁴⁶ This Announcement clarifies some of the ambiguities present in the statute and requests additional comments. The Announcement clarifies that the community to be assessed “may not be defined in a manner that circumvents the requirement to assess the health needs (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.”⁴⁷

Announcement 2011-52 further states that the CHNA must take into account input from not only persons with special knowledge or expertise in public health, but also “[f]ederal, tribal, regional, [s]tate 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.”⁴⁸ It also requires that the hospital report the name, title, affiliation and a description of the special knowledge or expertise of the public health expert or experts consulted.⁴⁹



Opportunities for Public Health Departments to Collaborate with Hospitals

In some communities, nonprofit hospitals and HDs already operate formal or informal partnerships, either regarding specific issues or as standing agreements. The new ACA CHNA requirement represents an opportunity for more in-depth collaboration between nonprofit hospitals and public HDs where interaction already exists, and may provide an opportunity to develop partnerships where they are currently lacking. In many cases, the CHNA may be able to be completed as a joint venture between a nonprofit hospital and HD.

Many agencies and organizations endorse such collaboration. The Joint Committee on Taxation noted that the required CHNA “may be based on current information collected by a public health agency or non-profit organizations and may be conducted together with one or more organizations, including related organizations.”⁵⁰ The American Hospital Association has suggested that the CHNA be developed “alone or in conjunction with others.”⁵¹ The American Institute of Certified Public Accountants also suggested that where a local public health agency conducts a CHNA, the hospitals in the area “could jointly fund or participate.”⁵² The Association of State and Territorial Health Officers (ASTHO), in written comments to the IRS, suggested that public health agencies be included in the required CHNAs.⁵³

The IRS took these recommendations into account in Announcement 2011-52, which states that the IRS intends “to allow a hospital organization to conduct a CHNA in collaboration with other organizations, including state and local agencies, such as public health departments.”⁵⁴ The Announcement also clarifies that hospitals will be permitted to develop implementation strategies in collaboration with other organizations, including public health departments.⁵⁵ The IRS is accepting comments on the Announcement through September 23, 2011.⁵⁶

The clients served by HDs would likely benefit from a collaborative CHNA process. HDs are uniquely situated to provide evidence-based insight on matters of local public health. Since many of the statutory CHNA requirements are vague, health department input will likely be very useful in ensuring that hospitals interpret terms in a way that most benefits community partners and clients, particularly underserved members of the community.

Such collaborations may prove helpful to HDs as well. As of August 2010, at least 12 states required hospitals to assess community needs and develop implementation strategies.⁵⁷ The new Public Health Accreditation Board (PHAB) draft standards require public health agency applicants to have conducted a community health assessment and have a community health improvement plan in place to gain accreditation.⁵⁸ Sharing the task of completing these assessments with a local nonprofit hospital might increase the quality of the assessment and reduce the overall cost to both parties. Collaboration may also lead to shared accountability for outcomes and increased trust and relationship-building between hospitals and LHDs, with mutually beneficial outcomes.⁵⁹

Both HDs and hospitals are currently planning for the CHNA process. In February 2011 the National Association of County and City Health Officials (NACCHO) held a meeting to discuss how national associations such as NACCHO can support community health assessment and planning.⁶⁰ The group noted as opportunities presented by a joint process the shared goal of improving community health, the fact that collaboration may head off “engagement fatigue” from partners in the community, and that the sharing of frameworks and datasets can lead to both improved results and reduced costs.⁶¹

The IRS has asked the Centers for Disease Control and Prevention (CDC) for advice on implementing the CHNA requirements. In response, CDC held a [meeting](#) in July 2011 to discuss best practices for conducting CHNAs.⁶² The meeting included 13 expert panels with 34 panelists from a wide variety of fields. A number of issues were discussed, including community engagement, priority setting, ownership and data integrity. Based in part on this meeting, CDC plans to develop an outline of best practices and publish it in the Morbidity and Mortality Weekly Report (MMWR), and to advise the IRS.

The Network Can Help

The Network for Public Health Law realizes that, in the face of severely declining resources, many local health departments are striving to save costs and improve efficiencies by sharing expertise, resources and service delivery, both with HDs from neighboring jurisdictions and with other local health care providers, such as federally qualified health

centers (FQHCs) and nonprofit community hospitals. In addition, some public health leaders are concerned about the potential impact of local “umbrella agency” reorganizations, in which a HD is merged into a consolidated county umbrella agency along with other health and human service programs such as Medicaid, social services, mental health and child protection, among others. All of these new collaborative arrangements raise questions about data sharing, privacy protection and other legal issues.

To help health departments address these concerns, the Network has launched an initiative to provide timely, accurate technical assistance to HDs and other public health professionals and organizations facing change, including issues surrounding CHNAs. All assistance is provided at no charge to the requestor. The Network can be reached via the internet at <http://www.networkforphl.org>.

SUPPORTERS



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¹ See U.S. Government Accountability Office, GAO-08-880, Variation in Standards and Guidance Limits Comparison of How hospitals Meet Community Benefit Requirements 8 (2008) [hereinafter GAO, Variation in Standards and Guidance] (2002 data).

² See U.S. Congressional Budget Office, Pub. No. 2707, Nonprofit Hospitals and the Provision of Community Benefits 3 (2006) [hereinafter CBO, Nonprofit Hospitals and the Provision of Community Benefits].

³ See U.S. Congressional Budget Office, Nonprofit Hospitals and Tax Arbitrage 3 (2006) [hereinafter CBO, Tax Arbitrage].

⁴ See CBO, Tax Arbitrage, *supra* note 4, at 3. Fixed assets are those that are owned by the hospital and intended to be used long-term, such as buildings, land and machinery.

⁵ These tax benefits are not automatic; organizations incorporated as nonprofits under state law must apply to the IRS and be found to meet the criteria discussed below. See David Nie, *Nonprofit Hospital Billing of Uninsured Patients: Consumer Based Class Actions Move to State Courts*, 4 Ind. Health L. Rev. 173, 178 (2007).

⁶ See 26 U.S.C. § 170 (2006) (tax deductible donations).

⁷ See 26 U.S.C. § 145 (2006) (qualified 501(c)(3) bonds); 26 U.S.C. § 103(a) (tax-exempt bonds). State and local governments issued about \$9.5 billion in tax-exempt private-activity bonds to nonprofit hospitals in 2002; see also CBO, Tax Arbitrage, *supra* note 4, at 11.

⁸ See CBO, Tax Arbitrage, *supra* note 4, at 3.

⁹ See CBO, Tax Arbitrage, *supra* note 4, at 5 (nonprofit hospitals have cost of capital of around 10.8 cents per dollar of investment vs. 12.9 cents per dollar of investment for for-profit hospitals).

¹⁰ See CBO, Tax Arbitrage, *supra* note 4, at 4. Technically, nonprofit hospitals may not issue tax-exempt bonds, but they can be issued by a state or local government to benefit a hospital; see also 26 U.S.C. § 103 (2006).

¹¹ *Id.* at note 6.

- 12 Press Release, Subcomm. on Oversight, H. Comm. on Ways & Means, Houghton Announces First Hearing in a Series on Tax-exemption: Pricing Practices of Hospitals (June 15, 2004) [hereinafter Subcomm. on Oversight, H. Comm. on Ways & Means], available at <http://www.gpo.gov/fdsys/pkg/CHRG-108hrg99670/pdf/CHRG-108hrg99670.pdf>.
- 13 See 26 U.S.C. § 501(c)(3) (2006) (“referring to organizations “organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster national or international amateur sports competition (but only if no part of its activities involve the provision of athletic facilities or equipment), or for the prevention of cruelty to children or animals”).
- 14 They are also prohibited from participating in any campaign activity for or against political candidates and engaging substantially in attempting to influence legislation, and none of their earnings may inure to the benefit of a private shareholder or individual. See *id.*
- 15 As with all entities seeking an exemption, the burden of proof falls on the hospital. See *Living Faith, Inc. v. Commissioner*, 950 F.2d 365, 370 (7th Cir.1991) (citing cases).
- 16 See Rev. Rul. 56-185, 1956-1 C.B. 202. This was known as the “financial ability” standard; this free or low-cost care is often termed “charity care”. The provision of free care to the poor was, in fact, the reason for which hospitals were first created. The well-off could afford to have physicians come to their homes. See generally Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books 1989).
- 17 See Minority Staff of S. Finance Committee, Tax Exempt Hospitals: Discussion Draft 5 (2007) [hereinafter S. Finance Committee, Tax Exempt Hospitals], available at <http://grassley.senate.gov/releases/2007/07182007.pdf> (noting that, “The new guidance in Rev Rul. 69-545 was based on what turned out to be an inaccurate expectation.”).
- 18 See Rev. Rul. 69-545, 1969-2 C.B. 117. The 1969 “community benefit” ruling set out five non-conclusive factors that would be examined to determine qualification for the nonprofit exemption: (1) the operation of an emergency room available to all community members; (2) a governance board composed of community members; (3) the use of surplus revenue for facilities improvement, patient care, and medical training, education, and research; (4) the provision of inpatient hospital care for all able to pay without discrimination based on payor; and (5) a requirement that all physicians who meet the hospital’s requirements be permitted hospital privileges. *Id.* Hospitals may qualify even if they fail to meet one of these standards. See Rev. Rul. 83-157 (hospital may qualify even when it does not operate an emergency room).
- 19 See *Geisinger Health Plan v. Comm’r*, 985 F.2d 1210, 1217 (3rd Cir. 1993) (examining the state of the law and concluding, “no clear test has emerged to apply to nonprofit hospitals seeking tax exemptions”).
- 20 GAO, Variation in Standards and Guidance, *supra* note 2, at 19 (reporting that “[v]ariations in the activities nonprofit hospitals define as community benefit lead to substantial differences in the amount of community benefits they report”); *Id.* at 41 (“We believe that because the [community benefit] standard affords considerable discretion to hospitals in both the determination and measurement of activities that demonstrate community benefit . . . the IRS standard allows nonprofit hospitals broad latitude to determine community benefit.”)
- 21 See, e.g., Catholic Health Association of the United States, et al. Community Benefit Reporting Guidelines and Standard Definitions for the Community Benefit Inventory for Social Accountability, available at <https://www.vhafoundation.org/documents/benefitreporting.pdf> (providing the somewhat ambiguous definition of community benefit as “a planned, managed, organized, and measured approach to a health care organization’s participation in meeting identified community health needs [that] implies collaboration with a ‘community’ to ‘benefit’ its residents—particularly the poor, minorities, and other underserved groups—by improving health status and quality of life”).
- 22 See GAO, Variation in Standards and Guidance, *supra* note 2, at 16-19 (documenting that, in 2005, 36 states had no community benefit requirements and that requirements varied in states that did have them); see also Community Catalyst, Free Care Compendium: National Snapshot, http://www.communitycatalyst.org/projects/hap/free_care/pages?id=0003 (reporting that a minority of states mandate free and reduced cost care, and how such care is treated for purposes of tax treatment under state law); Hilltop Institute, Hospital Community Benefits After the ACA: Building on State Experience at 7-10 (2011) [hereinafter Hilltop Institute (2011)] (collecting state laws regarding the income level at which patients become eligible for charity care, state approaches to billing and collection practices, state law regarding publicizing hospital financial assistance policies and community benefit reporting requirements); see also *Hosp. Utilization Project v. Commonwealth*, 487 A.2d 1306,1317 (Pa. 1985) (holding that, to obtain tax benefits under state law, nonprofit organizations must (a) advance a charitable purpose; (b) donate or render gratuitously a substantial portion of its services; (c) benefit a substantial and indefinite class of persons who are legitimate subjects of charity; (d) relieve the government of some of its burden; and (e) operate entirely free from private profit motive). Some states have also adopted voluntary community benefit standards. See Massachusetts Attorney General, Community Benefits, available at <http://www.cbsys.ago.state.ma.us/cbpublic/public/hccbindex.aspx>.
- 23 GAO, GAO-05-743T, Nonprofit, For-Profit, and Government Hospitals: Uncompensated Care and Other Community Benefits at 19 (2005) (reporting on hospitals in five states) [hereinafter GAO, Nonprofit, For-Profit, and Government Hospitals].
- 24 See *id.*
- 25 *A Review of the Tax-Exempt Health Care Sector, Hearing Before the Committee on Ways and Means*, 109th Cong. 2, 7, (May 26, 2005) (written statement of Mark W. Everson, Commissioner of Internal Revenue) [hereinafter *A Review of the Tax-Exempt Health Care Sector*], available at http://www.irs.gov/pub/irs-tege/5-26-05_hospital_sector_testimony.pdf. (noting that changes in the hospital system since 1969 have left “certain factors specifically discussed in Rev. Rul. 69-54... less relevant in distinguishing tax-exempt hospitals from their for-profit counterparts.”).

- 26 CBO, Tax Arbitrage, *supra* note 4, at 16 (estimating that 31 percent of nonprofit hospitals were engaged in full arbitrage and 59.1% engaged in partial arbitrage). See also William M. Gentry, *Debt Investment and Endowment Accumulation: The Case of Not-for-Profit Hospitals*, 21 J. Health Econ. 845 (2002) (reporting similar results from 1996 data); CBO, Nonprofit Hospitals and the Provision of Community Benefits, *supra* note 3, at 16, 18.
- 27 See Subcomm. On Oversight, H. Comm. on Ways & Means, *supra* note 13; A Review of the Tax-Exempt Health Care Sector, *supra* note 28.
- 28 Press Release, U.S. Senate Committee on Finance: Grassley Asks Non-Profit Hospitals to Account for Activities Related to their Tax-Exempt Status (2005), available at <http://www.ahp.org/Resource/advocacy/us/giftstaxesIRS/taxexemptstatus/Documents/prg052505.pdf>; ²⁸ *Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals: Hearing Before the Senate Finance Committee*, 109th Cong. (2006), available at <http://finance.senate.gov/hearings/hearing/?id=e6a6e518-bc40-78f7-ee63-a9993d182e5c> (collecting testimony). The report also recommended that the community benefit standard be replaced with a requirement that nonprofit hospitals that do not meet certain requirements register under a separate section of the tax code, under which they would be unable to issue tax-exempt bonds or receive tax-deductible contributions. *Id.*
- 29 See S. Finance Committee, Tax Exempt Hospitals, *supra* note 17. (suggesting, among other things, that certain nonprofit hospitals that do not meet specified requirements regarding charity care and other issues register as 501(c)(4) entities); Press Release, Grassley's Provisions for Tax-exempt Hospital Accountability Included in New Health Care Law (March 24, 2010), available at http://grassley.senate.gov/news/Article.cfm?customel_dataPageID_1502=25912.
- 30 See Beverly Cohen, *The Controversy Over Hospital Charges to the Uninsured – No Villians, No Heroes*, 51 Vill. L. Rev. 95, 127-38 (2006) (discussing the initial ruling on the federal claims in the charity care class actions).
- 31 See Valerie McWilliams & Alan A. Alop, *The Dearth of Charity Care: Do Nonprofit Hospitals Deserve Their Tax Exemptions?*, 44 J. Poverty Law & Policy 110, 115-18 (July-Aug. 2010); *Provena Covenant Med. Ctr. v. Dept. of Revenue*, 236 N.E.2d 1131, 1146 (Ill. 2010).
- 32 See, e.g., 210 Ill. Comp. Stat. Ann. 88/15, 88/20 (requiring hospitals to inform patients about charity care and limiting collection activities); 210 Ill. Comp. Stat. Ann. 89/10 (requiring hospitals to discount cost of care provided to low income people); Texas Health & Safety Code Ann. §§ 311.043-311.047 (requiring nonprofit hospitals to provide certain community benefits); Catholic Health Association, Survey of State Laws/Oversight Related to Community Health Needs Assessments and Implementation Strategies, at 2 (August 1, 2010) (collecting state laws).
- 33 CA, CT, IL, IN, ME, MD, MA, MN, NH, NJ, NY, OH, PA, RI, SC, TN, TX, UT, WA, and WV. See Hilltop Institute (2011), *supra* note 25, at 7.
- 34 MD, MA, MI, MO, NH, NM, OH, OR, PA, RI, SC, TX, WA, WV, and WI. See *id.* at 8.
- 35 See, e.g., Press Release, Agreement Between Attorney General and Minnesota Hospitals Will Provide Fair Pricing to Uninsured Patients, Establish Code of Conduct for Debt Collection Practices (May 5, 2005), available at http://www.mnhospitals.org/inc/data/pdfs/AG_agreement_press.pdf.
- 36 Internal Revenue Service, *Draft Form 990 redesign project – Schedule H instructions*, at 1, (June 2007) available at http://www.irs.gov/pub/irstege/drafform990redesign_sch_h_instr.pdf. See also Instructions for Schedule H (2008), <http://www.irs.gov/pub/irs-prior/i990sh--2008.pdf>.
- 37 These requirements apply to hospital organizations that operate a facility “required by a State to be licensed, registered or similarly recognized as a hospital” or that the “Secretary determines has the provision of hospital care as its principal function.” Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119, 855-858 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (2010) § 9007(a) [hereinafter ACA] (adding new section 26 U.S.C. § 501(r)). These requirements apply to hospitals organizations on a facility-by-facility basis.
- 38 Previously, the only remedy available to the IRS was revocation of an hospital's tax-exempt status. See A Review of the Tax-Exempt Health Care Sector, *supra* note 28, at 12.
- 39 ACA § 9007(a) (amending 26 U.S.C. § 501(r)(4)).
- 40 ACA § 9007(a) (amending 26 U.S.C. § 501(r)(5)). Gross charges are undefined in the ACA, but generally refer to the undiscounted cost of services sometimes charged to self-pay patients. See S. Finance Committee, Tax Exempt Hospitals, *supra* note 19, at 12.
- 41 ACA § 9007(a) (amending 26 U.S.C. § 501(r)(6)). Neither “extraordinary collection actions” nor “reasonable efforts” are defined in the statute.
- 42 ACA § 9007(a) (amending 26 U.S.C. § 501(r)(4)). This requirement is limited to the provision to emergency care covered by EMTALA, 42 U.S.C. 1395dd, which nearly all covered hospitals are already required to provide.
- 43 ACA § 9007(a).
- 44 ACA § 9007(b)(1) (codified at 26 U.S.C. § 4959).
- 45 ACA § 9007(f). This means that the planning and implementation must begin well before then.

⁴⁶ IRS, Notice 2011-52, *Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-Exempt Hospitals*, available at <http://www.irs.gov/pub/irs-drop/n-11-52.pdf>. Although future guidance is likely, the Announcement notes that hospital organizations may rely on the Announcement “on or before the date that is six months after the date further guidance regarding the CHNA requirements is issued.”

⁴⁷ *Id.*

⁴⁸ *Id.* at 15.

⁴⁹ *Id.* at 10.

⁵⁰ Joint Committee on Taxation, Technical Explanation of the Revenue Provisions of the “Reconciliation Act of 2010, as amended, in combination with the Patient Protection and Affordable Care Act (JCX-18-10 (2010), at 81.

⁵¹ American Hospital Association et al, Letter to Douglas Shulman, Commissioner of Internal Revenue 4 (2010).

⁵² American Institute of Certified Public Accountants, Letter to Douglas Shulman, Commissioner of Internal Revenue 4 (2010).

⁵³ Association of State and Territorial Health Officers (ASTHO). (2010). Letter to IRS and Dept. of Treasury RE Notice 2010-39, available at www.sitemason.com/files/i4IRb2/ASTHO%20Paul%20Jarris.pdf (2010)

⁵⁴ IRS, Notice 2011-52, at 12-13.

⁵⁵ *Id.* at 20.

⁵⁶ Comments should be sent to: Internal Revenue Service, CC:PA:LPD:PR (Notice 2011-52), Room 5203,P.O. Box 7604, Ben Franklin Station, Washington, DC 20044 or via email to Comments@irs.counsel.treas.gov.

With Notice 2011-52 in the subject line.

⁵⁷ Catholic Health Association, Survey of State Laws/Oversight Related to Community Health Needs Assessments and Implementation Strategies, at 2 (collecting laws).

⁵⁸ See PHAB, Proposed State Standards and Measures, available at <http://www.phaboard.org/assets/documents/PHABStateJuly2009-finaleditforbeta.pdf>; PHAB, Proposed Local Standards and Measures, available at <http://www.phaboard.org/assets/documents/PHABLocalJuly2009-finaleditforbeta.pdf>.

⁵⁹ Several good health assessment and planning tools already exist. In a recent NACCHO survey,

seventy nine percent of LHDs that had completed a community assessment had used Healthy People 2010, fifty three percent had used the Operational Definition of a Local Health Department, and thirty three percent had used Mobilizing for Action through Planning and Partnerships (MAPP).

NACCHO, National Profile of Local Health Departments, 2008, at 68, available at http://www.naccho.org/topics/infrastructure/profile/resources/2008report/upload/NACCHO_2008_ProfileReport_post-to-website-2.pdf.

⁶⁰ See National Association of County and City Health Officials, A National Conversation of Community Health Assessments: Convened by NACCHO on Feb. 10, 2011 (2011), available at <http://oce.sph.unc.edu/acawebinar/naccho1.pdf>

⁶¹ *Id.*

⁶² See Kevin Barnett, *Best Practices for Community Health Needs Assessment and Implementation Strategy Development: A Review of Scientific Methods, Current Practices and Future Potential*, available at <http://www.naccho.org/topics/infrastructure/mapp/loader.cfm?csModule=security/getfile&pageid=200625>.