Tax-Exempt Hospitals, Community Health Needs and Addressing Disparities

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INTRODUCTION

Assessing the impact of the Patient Protection and Affordable Care Act (the "Act" or "ACA") on the health and well-being of vulnerable populations is an ambitious and gargantuan enterprise. A comprehensive assessment would require the consideration of the implications of one of the most complex, detailed, and multi-faceted pieces of legislation in modern U.S. history, for one of the most complex and seemingly intractable problems facing health policy makers.

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Health disparities based on race and ethnicity, as well as disability, gender, and socio-economic status, are numerous, pervasive, and tenacious. Researchers are still striving mightily to understand and document the complex and interacting factors that produce and perpetuate the differences in health status and health outcomes, so that steps can be taken to diminish and eliminate those instances of inequality.

Of course, addressing disparities is not the central or most commonly known concern of the Affordable Care Act, which may be most widely known for its provisions reforming markets for health insurance and requiring that individuals have health insurance coverage. The drafters of the legislation, however, were by no means oblivious to the problem of disparities, and indeed one goal expressly stated in the ACA is to reduce health disparities across populations. Embedded throughout the Act are numerous provisions that explicitly seek to diminish disparities, whether by addressing access to health care for persons with disabilities or by taking steps to increase the diversity of the health care workforce and to enhance workers' cultural competency. Moreover, to the extent that the Act is eventually effective in providing health coverage to most of the Americans who are currently uninsured (a disproportionate percentage of whom are non-white), it will predictably lessen existing disparities in rates of health insurance coverage, which may translate into a salutary effect on the disparities

2. § 3011. The Act also calls for the Secretary of Health and Human Services to ensure that federally supported health programs collect and report “data on race, ethnicity, sex, primary language, and disability status for applicants, recipients or participants.” § 4302.


5. For example, the ACA’s expansion of Medicaid eligibility is likely to increase the percentage of minority populations that have health insurance coverage. According to the Kaiser Commission on Medicaid and the Uninsured, in 2009, 27% of black Americans and Hispanic Americans (a total of 23 million people) were covered by Medicaid, in contrast to 11% of non-Hispanic white Americans. The Commission estimates that the ACA’s expansion of Medicaid will extend eligibility to nearly 4 million black Americans and nearly 8 million Hispanic Americans. See Kaiser Comm’n on Medicaid and the Uninsured, “Medicaid’s Role for Black Americans” (May 2011), available at http://www.kff.org/medicaid/8188.cfm; Kaiser Comm’n on Medicaid and the Uninsured, “Medicaid’s Role for Hispanic Americans” (May 2011), available at http://www.kff.org/medicaid/8189.cfm. Because the Medicaid program is administered by the
in health outcomes and health status experienced by members of racial and ethnic minorities.\textsuperscript{6}

Beyond the statutory sections that explicitly seek to address disparities, and those that predictably may have some effect on disparities, are the large bulk of the Act’s provisions, which are apparently entirely unconcerned with disparities. This Essay focuses on a section that falls into the latter group—a provision establishing new requirements for federally tax-exempt hospitals\textsuperscript{7}—that has the potential to play a meaningful role in addressing disparities. In particular, I will consider the possibility that the new requirement that hospitals engage in regular community health needs assessments might be used as a mechanism for both gaining a better understanding of concrete and particular instances of disparities and developing approaches to responding to those disparities.

This Essay suggests that the community health needs assessment (CHNA) requirement could be implemented in such a way that it would function as a valuable addition to the existing toolkit for addressing disparities. After providing a brief background on hospital tax exemption and a description of the new requirement imposed by the ACA in Parts I and II, respectively, in Parts III and IV I will sketch out several ways in which the CHNA may add value. Of particular note is the potential that the community-orientation inherent in the CHNA may encourage hospitals’ use of a wider-angled lens and the incorporation of public health expertise in examining and responding to disparities. Realizing this potential value, however, is by no means assured, for several significant barriers exist to a thoughtful, coordinated, disparities-sensitive application of the CHNA requirement. Part V highlights several of these potential barriers, and Part VI concludes by suggesting some steps to increase the likelihood that this new requirement might help diminish the disparities that exist in

\textsuperscript{6} Cf. Calvin B. Johnson, \textit{Health Care Reform, the Law, and Eliminating Disparities}, 82 \textit{TEMPLE L. REV.} 1137, 1137 (2010) ("[S]ome of the enacted changes have clear implications for impacting health disparities. Perhaps the most recognizable example with measurable impact is the effect of broader insurance coverage on disparities in access to care.").

communities across the country and add to our collective understanding of what interventions are effective in reducing disparities.

I. BRIEF BACKGROUND REGARDING FEDERAL TAX-EXEMPTION STANDARDS FOR HOSPITALS

The historical evolution of the standards applicable to nonprofit hospitals seeking the benefit of federal tax exemption has been thoroughly detailed elsewhere, and need not be repeated at any length here. Several aspects of that history merit noting, however, as providing important context for understanding the new CHNA requirement. First, most nonprofit hospitals achieve their tax-exempt status through reliance on Section 501(c)(3) of the Internal Revenue Code as institutions that are "organized and operated exclusively for charitable . . . purposes," but the regulatory approach to how hospitals demonstrate such operation has changed over the decades. Prior to 1969, the Internal Revenue Service ("IRS") test asked whether a hospital operated "to the extent of its financial ability for those not able to pay." The IRS largely abandoned this explicit focus on providing free care as the quid pro quo for the benefits of tax exemption in 1969, after the creation of the Medicare and Medicaid programs left hospitals concerned that there would no longer be a robust need for charity care. That year the IRS promulgated the "community benefit" standard for judging hospitals' entitlement to tax-exempt status, a standard that has endured for over four decades. The Revenue Ruling establishing the community benefit standard articulated a series of fairly general, non-quantitative factors deemed relevant to judging how hospitals serve their communities.

11. See Berg, supra note 8, at 381.
12. Id.
14. These factors include whether a hospital: (1) operates an emergency room open to all persons needing emergency treatment; (2) provides care to all persons able to pay directly or through insurance; (3) serves a public rather than private interest; (4) maintains a medical staff available to all qualified physicians in the area; and (5) uses surplus revenues to improve the quality of patient care, facilities, medical training, education, and research. Id.
whether a hospital is providing sufficient community benefit, leaving to hospitals a significant degree of latitude in how exactly they provided the community benefits.

In general, tax-exempt hospitals' accountability for providing quantifiable community benefits has been quite limited for most of the time since the standard was adopted. Over the past few decades, however, the attention of policy makers, and even at times the public, has focused sporadically on what kinds of benefits communities actually receive from the operation of tax-exempt hospitals and whether those benefits justify the substantial tax revenue forgone as a result of that tax exemption. That attention has been magnified as the for-profit segment of the hospital industry has grown (raising questions as to whether the conduct of tax-exempt hospitals provides benefits distinct from those provided by for-profit hospitals) and as news accounts of hospitals treating patients unable to pay for care in a distinctly uncharitable fashion and paying their executives handsome sums have suggested that some hospitals place a higher value on revenue generation and private benefit than on caring for fitting subjects of charity. In recent years, the IRS has beefed up hospitals' reporting requirements with respect to what they do to satisfy the community benefit requirement and has systematically inquired into


16. Reliable and up-to-date estimates of the aggregate value of hospitals' tax-exemption are hard to come by. As of a decade ago, the estimated value of the federal tax-exempt status enjoyed by hospitals in the United States was $6,100,000,000. Cong. Budget Office, Nonprofit Hospitals and the Provision of Community Benefits 3, 5 (2006), available at http://www.cbo.gov/publication/18256. This figure, which does not include the value of exemption from state and local taxes such as property taxes and sales taxes, includes hospitals' forgone federal income tax liability, their ability to receive tax-deductible donations, and their ability to issue tax-exempt bonds.


20. See Doyle, supra note 15.
hospitals' community benefit activities. At the same time, members of Congress voiced growing concerns about the lack of accountability and clear standards for tax-exempt hospitals. In short, the years preceding the ACA's enactment saw the growth of a vigorous discussion among both policy makers and scholars on whether and how to make the test for hospital tax exemption more exacting.

II. THE ACA'S NEW REQUIREMENTS FOR TAX-EXEMPT HOSPITALS

So what does all of this talk about hospital tax exemption have to do with health care reform? One of the less publicized provisions of the massive ACA creates a new § 501(r) of the Internal Revenue Code, detailing new requirements for hospitals wishing to obtain or retain federal tax-exempt status. Under this new Code provision, hospitals must do the following:

1. establish written policies regarding patient eligibility for financial assistance and the provision of emergency care;
2. limit the amount charged to patients eligible for financial assistance for emergency or medically necessary care to the amount generally billed for insured patients;
3. refrain from pursuing “extraordinary collection actions” without first inquiring whether a patient is eligible for financial assistance; and
4. at least once every three years, conduct a “community health needs assessment” and adopt an “implementation strategy” to respond to the needs identified by the assessment.

This provision of the ACA was co-authored by Senator Charles Grassley, one of the most vocal critics of hospitals' lack of accountability to demonstrate quantifiable community benefits in return for

22. Id. at 374-76.
23. See, e.g., Berg, supra note 8, at 377-78 (advocating for a population health oriented approach to the community benefit standard).
25. Id.
their tax exemption and the egregious practices some hospitals engaged in with respect to uninsured patients. The first three requirements listed above respond directly to concerns about these practices and, more generally, hospitals' lack of transparency regarding indigent care. They stop well short, however, of requiring hospitals to provide any particular quantum of free care to patients unable to pay.

The final element of section 501(r)(3), requiring hospitals to perform periodic “community health needs assessments,” takes a different tack in establishing a seemingly novel—at least from the perspective of federal tax policy—requirement for tax-exempt hospitals. The CHNA requirement actually entails a bundle of requirements. First, a hospital must conduct a CHNA at least once every three years, taking 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.” Once the CHNA has been completed, the hospital must make the assessment “widely available to the public.” Then the hospital must adopt an “implementation strategy to meet the community health needs identified through such assessment,” and, finally, it must report to the IRS “how the organization is addressing the needs identified” and “a description of any such needs that are not being addressed together with the reasons why such needs are not being addressed.” By establishing this multi-step process, the ACA seeks to ensure that tax-exempt hospitals are in fact providing community benefits by requiring them first to assess what specific health needs their communities have, then to take steps to meet those needs, and, finally, to report what they are doing to the IRS. A tax-exempt hospital that fails to comply with these requirements will be subject to a $50,000 excise tax.


28. As one commentator notes, these requirements do not affirmatively require hospitals to act charitably; instead, they focus on “stopping manifestly uncharitable behavior.... To refrain from behaving badly is not, or should not be, equated to behaving well.” Roger Colinvaux, Charity in the 21st Century: Trending Toward Decay, 11 FLA. TAX REV. 1, 51 (2011).


32. PPACA § 9007(d), 124 Stat. 119, 858 (to be codified at 26 U.S.C. § 6033(b)(15)(A)).

33. See supra notes 29-32.


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Although an obligation to conduct CHNAs in order to retain tax-exempt status represents an entirely new and daunting requirement for most hospitals, hospitals in a dozen states have been subject to similar requirements for some time. These states have each adopted some kind of requirement that hospitals seeking tax exemption at the state level must have some kind of process for assessing and responding to the health needs of their communities.

To give hospitals subject to the ACA’s new requirements a more complete sense of exactly what they will need to do to satisfy the CHNA requirement, in July 2011, the IRS issued a Notice and Request for Comments specifically on this requirement, describing provisions that the Treasury Department and the IRS anticipate will appear in proposed regulations. The Notice addresses a number of specific issues, ranging from how hospital organizations with multiple facilities must comply, to how the community served by a hospital should be defined, to how a hospital should document the CHNA it conducts. The regulatory guidance, however, does not specifically address how the CHNA requirement might have some bearing on health care disparities or vulnerable populations, and it remains to be seen whether any final regulatory action by the Treasury and the IRS will do so. The balance of this Essay will suggest that the new CHNA requirement presents a valuable opportunity to engage hospitals, with their central and at least potentially coordinating role in the health care delivery system, in addressing why vulnerable populations bear a dis-

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39. In addressing what a hospital must do in order to satisfy the ACA’s requirement that a CHNA must take into account input from persons who represent the broad interests of the community, the Notice does state that a CHNA must at least take into account input from, among others, “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.” ROSENBAUM, supra note 38, at 3. The Notice further states that hospitals may also seek input from other persons, including, among others, “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.” NOTICE 2011-52, supra note 37, § 3.06.
III. THE CHNA REQUIREMENT AND EFFORTS TO ADDRESS DISPARITIES

How does the ACA's requirement that tax-exempt hospitals begin conducting and responding to community health needs assessments relate to the impact of health care reform on vulnerable communities? A brief examination of one example of the kinds of community health needs that an assessment called for by the ACA might identify quickly reveals the CHNA's potential relevance to addressing health disparities and vulnerable populations.

In October 2011, the New York Times published an article titled "Tackling Infant Mortality Rates Among Blacks," describing a particularly alarming disparity in infant mortality rates between black babies and white babies in Pittsburgh, Pennsylvania. As the New York Times article reports, while the overall infant mortality rate in the U.S. (at 6.7 deaths per 1,000 live births) is among the highest in the industrialized world, the infant mortality rates for African Americans (at 13.3) is nearly double that. In Allegheny County, where Pittsburgh is located, the infant mortality rate for African American babies was a whopping 20.7 in 2009, compared to a rate of 4.0 for white babies. A starker racial disparity with respect to a central measure of health status may be hard to find.

The New York Times article goes on to highlight some of the possible reasons behind this disparity, which include a laundry list ranging from some "usual suspects" like the county's privatization of health care services for pregnant women and inequitable access to health care to the possibility that stress may be a factor or that black women may have shorter birth canals. Although the primary causes for the growing gap between black and white infant mortality rates remain a puzzle, it seems that the fact that one in fifty black babies in Alle-

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41. Id.
42. Id.
43. Id.

Recent studies have shown that poverty, education, access to prenatal care, smoking and even low birth weight do not alone explain the racial gap in infant mortality, and that even black women with graduate degrees are more likely to lose a child in its first year than are white women who did not finish high school.

Id.

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gheny County dies before its first birthday would likely be a “community health need” that at least some tax-exempt hospitals in the county might identify as a result of their CHNA. And once the need is identified, under the ACA, the hospital has some accountability for either developing a strategy for addressing that need or explaining to the IRS why it chooses not to address an identified need in its plan.44

Given the number and variety of disparities in health access, status, and outcomes already documented in the health services literature, one can imagine that when tax-exempt hospitals across the country go through the process of assessing the health needs in their communities, many will find needs that reflect the disproportionate burden of morbidity and mortality borne by vulnerable populations—at least if those assessments are conducted with some degree of attentiveness towards finding and understanding disparities. And if a hospital’s CHNA identifies health needs that include disparities, then we might hope that the hospital’s strategies for responding to those needs might actually work both to diminish some disparities existing in a particular community and to produce a better understanding of what interventions are and are not successful in reducing disparities so that successes can be replicated in other communities.

Several aspects of the ACA’s requirement that tax-exempt hospitals seek to identify and respond to health needs existing in their communities suggest that this requirement has the potential to be a valuable addition to the existing “toolkit” for addressing disparities.45 The next section of this Essay will sketch out some of those aspects.

IV. LEVERAGING THE NEW CHNA REQUIREMENT TO ADDRESS DISPARITIES

The ACA explicitly calls for tax-exempt hospitals, when assessing community health needs, to gather and take into account “input from persons who represent the broad interests of the community served . . . , including those with special knowledge of or expertise in public health.”46 This provision is central to the potential that hosp-

44. See supra notes 31-32.
45. See LEIYU SHI & GREGORY D. STEVENS, VULNERABLE POPULATIONS IN THE UNITED STATES 185-98 (2010) (describing programs seeking to eliminate racial and ethnic disparities). The Federal Government has identified eliminating disparities as one of the four overarching goals of its Healthy People 2020 initiative and in 2011, the Federal Department of Health and Human Services released its first comprehensive Action Plan to Reduce Racial and Ethnic Health Disparities. See Koh et al., supra note 4, at 1822.
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tals, as they engage in CHNAs, may offer for addressing disparities. Obliging tax-exempt hospitals to give voice to local community members and to incorporate public health perspectives in their assessment of needs makes it more likely that the CHNA process might contribute to producing a community benefit by addressing disparities.

The importance of requiring hospitals that are assessing needs to listen to individuals with public health expertise lies in the potential to shift hospitals' traditional institutional focus on individual health to a perspective that incorporates some level of commitment to a broader conception of community health. Hospitals' traditional focus on individual patient welfare is a product of their historical evolution during the twentieth century as so-called "physicians' workshops," providing a venue for physicians to care for patients too ill to be cared for in their homes. As such, hospitals have usually been understood as part of the "health care system" or "medical care system," and not as actors within the "public health system." Gostin and his co-authors describe the common understanding of these systems as being distinct:

The health care system is devoted primarily to improving individual health outcomes, focusing on "financing, organizing, and delivering . . . personal medical services." The public health system is devoted primarily to "safeguarding and improving health outcomes in the population," focusing on community-wide interventions to reduce morbidity and premature mortality. Thus, health care is concerned with the individual's care and treatment, while public health is concerned with the health and well-being of populations.

This potential broadening of a hospital's understanding of its role with respect to its community, if it in fact occurs, could be significant and beneficial. Even though, prior to the passage of the ACA, the IRS standard for determining hospitals' tax-exempt status centered on whether the hospital provided a "community benefit," discussions of how to measure community benefit regularly focused on a hospital's provision of charity care—essentially, whether the hospital provided individual-oriented, uncompensated medical care to enough persons in the community. By contrast, the inclusion of public health input as part of health reform's CHNA requirement signals that hospitals should understand the quid pro quo for the value of their tax exemption to be benefits flowing to the community as a population, and not

48. Gostin et al., supra note 18, at 1783 (citations omitted).
49. See id. at 1790.
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simply to individuals within the community. Some scholars have praised the CHNA provision of the ACA for this reason, suggesting that it illustrates a desirable "emerging integration" between the health care and public health systems.50

Those advocating more generally for greater attentiveness to public health expertise and research in health policy debates emphasize that many of our society's health problems—of which disparities are but one group—are better understood as collective problems, rather than simply individual problems (or even the aggregation of individual problems).51 As a result, the inclusion of public health thinking—with its appreciation for social determinants of health—may permit interventions to address problems most effectively on a structural, rather than individual, level.52 Recognizing the potential contribution of a structural approach to remedying disparities, as contrasted with an approach focusing on individual dynamics, parallels the growing recognition in other areas of inequality law (e.g., employment discrimination law) that structural approaches may prove more effective in improving outcomes than the traditional focus on individuals' intent and actions.53 So understood, the ACA's call for tax-exempt hospitals to perform CHNAs that include public health perspectives can be seen as stimulating structural responses to racial and ethnic disparities in local communities.54

Another important aspect of the strategies that hospitals are called to devise to respond to the health needs identified in their communities is that these strategies will be local in nature. As noted, the new Section 501(r) calls for hospitals to consider input from persons broadly representing the range of interests in the communities served.55 This input should help the hospital identify and understand

50. Id. at 1787.
52. See Burris, supra note 51, at 1657-62 (discussing structural versus individual interventions to promote health). This idea is not entirely novel. Jessica Berg, writing prior to the passage of the ACA, advocated for an interpretation of the "community benefit" standard that would require hospitals to provide "population health care benefits." See Berg, supra note 8, at 395-402.
54. Along the same lines, Elizabeth Pendo has suggested that the health care reform law may provide "a new ... complementary ... systems reform approach that could benefit people with disabilities." Pendo, supra note 3, at 1083.
the particular health needs experienced by the community that it serves.\textsuperscript{56} Public health literature highlights the importance of local community input and engagement to implementing initiatives that seek to change the dynamics producing negative health outcomes.\textsuperscript{57} Moreover, one recent study suggests that national data regarding health disparities may mask the role of particular social environments in explaining disparities and thus underscores the potential value of a local focus in developing policies to address disparities.\textsuperscript{58} The local focus demanded by the CHNA requirement, if applied with an eye to identifying and understanding racial and ethnic disparities, may help us determine whether in fact we should say that “all disparities are local” (to borrow from a saying often attributed to former House Speaker Tip O’Neill).\textsuperscript{59}

A third benefit potentially flowing from the ACA’s imposition of the CHNA requirement on tax-exempt hospitals is the generation of data and knowledge that could prove informative and applicable beyond a hospital’s immediate community. Although the Act does not explicitly call for the collection and dissemination of data regarding tax-exempt hospitals’ efforts to address the health needs of their communities, it lays the foundation for such a process by calling for the inclusion of public health expertise.\textsuperscript{60} A failure by hospitals and the public health experts, with whom they are supposed to work, to collect, analyze, and share data relating to hospitals’ strategies to address community needs would seem a terrible waste of an opportunity to better understand the complexities of how disparities are produced and persist. As a team of researchers from RAND recently concluded regarding the value of a public health focus in addressing disparities: “Approaching disparities through a public health framework can pro-

\textsuperscript{56} Of course, one possible point of contention is how broadly the term “community” should be understood for purposes of the CHNA requirement. See Berg, supra note 8, at 409 (noting possible different interpretations of “community”). In its preliminary guidance, the IRS indicated that the term should be interpreted to focus on the geographic community served by a particular hospital facility, rejecting the idea that a multi-hospital system might define the community from a system-wide perspective. See Notice 2011-52, supra note 37.

\textsuperscript{57} See generally Neil Bracht, Health Promotion at the Community Level: New Advances (2d ed. 1999) (discussing aspects of organizing community-wide health promotion).

\textsuperscript{58} See Thomas LaVeist et al., Place, Not Race: Disparities Dissipate in Southwest Baltimore When Blacks and Whites Live Under Similar Conditions, 30 Health Aff. 1880, 1880 (2011).


\textsuperscript{60} See Starr, supra note 47, at 178.
provide the foundation for developing more robust evidence to inform additional policies for improving access and reducing disparities.\textsuperscript{61}

In light of the fact that the ACA calls on hospitals—if they wish to maintain their federal tax-exempt status—to seek input from community stakeholders and public health experts in identifying and responding to the health needs existing in their communities, the new CHNA requirement seems to offer significant potential to become a valuable addition to the existing “toolkit" for addressing racial and ethnic disparities. If implemented with an eye to maximizing this value, the CHNA requirement could involve hospitals more directly in determining whether disparities exist in their communities and why some vulnerable groups suffer particular problems, and it could motivate hospitals to try to do something about the disparities and vulnerabilities they uncover. If realized, the benefits from this engagement and involvement by hospitals could prove a pretty good \textit{quid pro quo} for the many billions of dollars in value that hospitals nationally receive by virtue of their tax exemption.\textsuperscript{62} Several factors exist, however, that could diminish the likelihood that these benefits will result, and the next section will briefly suggest some of these challenges.

V. BARRIERS TO USING THE CHNA AS A TOOL FOR ADDRESSING DISPARITIES

The previous section sketches out a vision of how the ACA’s new requirement for tax-exempt hospitals could provide a helpful complement to existing efforts to understand and address racial and ethnic disparities in health and health care. Several significant barriers, however, may prevent the CHNA requirement from being implemented in a way that would permit the realization of this vision. These include the primary role that the IRS can be expected to play in enforcing the new requirement and hospitals’ predictable reluctance to embrace a shift in their perspective to incorporate a population-focused, rather than patient-focused, understanding of community benefit.

Because the ACA’s new requirements for hospital tax exemption are incorporated into the Tax Code via the new Section 501(r), the IRS is the agency charged with enforcing the CHNA requirement and

\textsuperscript{61} Kathryn Pitkin Derose et al., \textit{Understanding Disparities In Health Care Access—and Reducing Them—Through a Focus on Public Health}, 30 \textit{HEALTH AFF.} 1844 (2011).

\textsuperscript{62} See supra note 16.
providing regulatory guidance to hospitals subject to the new law. As noted above, the IRS and the Treasury Department in July 2011 issued a Notice and Request for Comments on the CHNA requirement. That document, which addressed a variety of technical questions about hospitals’ obligations under Section 501(r), provided few specifics about how hospitals should solicit and incorporate input from community members or public health experts or about the kinds of needs—for example, disparities—that hospitals might now be called upon to address.

The IRS’s failure in the Notice to consider how the ACA’s policy goals, which include addressing health disparities across populations, might be advanced via the new tax-exemption rules for hospitals is not surprising. For decades, the IRS has indirectly made health policy through its enforcement (or lack of enforcement) of the community benefit standard, without professing to bring to bear any particular expertise in the field of health policy. If the IRS follows this pattern, it seems unlikely that any regulatory guidance it provides with respect to compliance with Section 501(r) will incorporate any emphasis on disparities.

And without meaningful prodding by the IRS, most hospitals may be unlikely to do more than the bare minimum identified as needed to satisfy the new requirement, particularly when it comes to the possibility of widening their focus to include not only individual patients but population-level health needs. The administrative staff of hospitals does not typically include individuals with public health expertise, and hospital leadership may have no desire and little incentive to partner with public health experts or community members any more than necessary in conducting the mandated CHNA. Given the

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63. Section 9007(a)(7) of the ACA, which creates the new section 501(r) in the Internal Revenue Code and its CHNA requirement grants “the Secretary” regulatory authority with respect to the provisions of section 9007(a). Later references in section 9007 are to “the Secretary of the Treasury.” PPACA, Pub. L. No. 111-148 § 9007(c), 124 Stat. 119 (2010).
64. See supra note 37.
65. Id.
66. See supra note 2.
68. Cf. Berg, supra note 8, at 407 (“[U]sing the [hospital’s] existing governing board to oversee community benefit is not adequate.”).
many pressures to which non-profit hospitals today are subject, this response can be expected and is not necessarily blameworthy. A real risk exists, however, that many hospitals will not reflect on how the CHNA might provide an opportunity to develop a new level of relationship with their communities, but will instead view the CHNA requirement simply as a new hoop to jump through with the least possible effort expended.\textsuperscript{69}

VI. \textbf{SO SHOULD WE GIVE UP ON THIS IDEA AS "PIE IN THE SKY"?}

Adopting this more cynical perspective, it may seem that any hopes that the new CHNA requirement might be implemented in a way that meaningfully advances our collective understanding of, and response to, racial and ethnic disparities are entirely in vain. The barriers to that implementation this Essay has identified are quite daunting, and there are probably more barriers not yet identified. That said, the potential value that the CHNA requirement offers with respect to addressing disparities should not be lightly discarded on grounds of impracticality, particularly when we consider the scale of the problem of disparities. A 2009 report by a researcher at the Urban Institute estimated that disparities among African Americans, Hispanics, and non-Hispanic whites with respect to preventable health conditions cost the Medicare and Medicaid programs $17 billion.\textsuperscript{70}

This estimate highlights the scale and seriousness of the problem of disparities not just from a moral perspective, but from an economic perspective as well. Given a problem of this scale and intractability, it seems ill advised to ignore a potentially valuable new tool—even one that it may be challenging to apply.

\textsuperscript{69} A comment made by an audience member at a lecture that I attended regarding hospitals' community benefit obligations under the ACA reinforced this perception. The audience member, who identified himself as working within a hospital system, stated that this hospital system had turned the question of how to comply with the CHNA requirement over to the system's marketing department. This approach is consistent with how many hospitals have touted their "community benefit" efforts as part of their marketing initiatives.

\textsuperscript{70} TIMOTHY WAIDMANN, ESTIMATING THE COST OF RACIAL AND ETHNIC DISPARITIES 1 (2009), available at http://www.urban.org/uploadedpdf/411962_health_disparities.pdf. This study examined estimates of excess costs flowing from selected disease disparities (specifically, disparities in diabetes, hypertension, stroke, and renal disease) and disparities in general health status (based on self-reporting of health status as either fair or poor). \textit{Id.} The excess costs were examined by payer, and the author estimated that the health disparities resulted in excess costs of more than $15 billion to the Medicare program and more than $2 billion to the Medicaid program in 2009. \textit{Id.}
What steps might enhance the CHNA requirement's potential for addressing disparities and thus keep that requirement from becoming simply a new—and potentially meaningless—hoop for hospitals to jump through? This Essay will conclude by offering a few ideas regarding responses to this question, in hopes of stimulating further thinking and action.

First, policy expertise regarding public health and health disparities should be brought to bear on the regulatory implementation of the CHNA requirement. Doing so would require the IRS to consult with other federal agencies as it develops a regulatory framework, but—while unusual—that is not without precedent. In fact, the Departments of Treasury, Labor, and Health and Human Services already have been working in concert to develop regulations and other administrative guidance with respect to other provisions of the ACA.\(^1\) Even without congressional direction, the Treasury Department could seek to consult with Health and Human Services (particularly its Public Health Service) or the National Institute on Minority Health and Health Disparities as, over time, it provides further regulatory guidance to tax-exempt hospitals on compliance with the CHNA requirement.

Second, as noted above, while hospitals will face the CHNA requirement as a matter of federal law for the first time in 2012, hospitals in some states have been required for some years to perform community needs assessment by state law.\(^2\) According to a report by the Catholic Health Association, of the dozen states legally requiring hospitals to engage in community health needs assessments, five states require hospitals to give priority to public health needs in their assessments and three call for a focus on vulnerable populations.\(^3\) Examining the experience in those states, with respect to both hospitals’ efforts to comply with these requirements and state regulators’ approaches to enforcement, may provide insights on how the challenges identified above might be met and suggest useful models that could be replicated. This work is already underway. For example, the Hilltop Institute, a research center at the University of Maryland Baltimore County, is producing a series of issue briefs on topics relating to the

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71. See, e.g., Summary of Benefits and Coverage and the Uniform Glossary, 76 Fed. Reg. 52,442 (Aug. 22, 2011) (to be codified at 26 C.F.R. pts. 54, 602) (notice issued by Departments of the Treasury, Labor, and Health and Human Services noting that written comments submitted to one Department will be shared with the other Departments).
72. See CATHOLIC HEALTH ASS’N, supra note 35.
73. Id.
implementation of the federal CHNA requirement, including one ex-
aming state innovations in community benefit policy.\textsuperscript{74}

Moreover, while market pressures may cause some hospital lead-
ers to gravitate towards an approach to compliance that avoids as
much as possible the hospital’s commitment of further effort and re-
sources, the market is also likely to produce resources for hospitals
that seek to take advantage of the opportunity to partner with their
communities. Depending on how vigorously and thoughtfully the IRS
signals it will enforce the CHNA requirement, consultants may be
able to fill hospitals’ expertise gap by guiding hospitals’ outreach to
community members and public health experts in assessing and re-
ponding to community needs. Similarly, academic medical centers
may be able to take advantage of public health expertise within their
own universities to develop a more integrated, and disparities-sensi-
tive, approach to fulfilling the CHNA requirement.

CONCLUSION

This Essay’s purpose has been to highlight briefly how a provision
of the ACA establishing new requirements for tax-exempt hospitals
might be employed as a tool in addressing the persistent problem of
racial and ethnic disparities in health status and health care. Hospi-
tals’ new obligation to conduct and respond to community health
needs assessments that take into account community and public health
input could potentially become a potent mechanism for identifying
and addressing disparities in local communities. While significant ob-
stacles to realizing this potential exist, this Essay seeks to set the stage
for further consideration and action regarding how to maximize the
effect of the CHNA requirement in addressing disparities and the
needs of vulnerable communities.

\textsuperscript{74} \textsc{Hilltop Institute}, http://www.hilltopinstitute.org/index.cfm (last visited Mar. 23,
2012). A copy of the April 2011 issue brief titled “Hospital Community Benefits after the ACA:
Building on State Experience” can be found at http://www.hilltopinstitute.org/publication_view.
cfm?publID=289&st=tbl_Publications. The Hilltop Institute’s work in this area is being sup-
ported by the Robert Wood Johnson Foundation and the Kresge Foundation. \textit{Id}. 

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