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Submitted electronically via www.regulations.gov

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Commissioner
Internal Revenue Service
1111 Constitution Avenue, N.W.
Washington, DC 20224

William M. Paul
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Re: Notice 2017-28, Executive Order (EO) 13765, EO 13771 and EO 13777

Dear Acting Assistant Secretary West, Commissioner Koskinen and Acting Chief Counsel Paul:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) is writing to request that the department's 2017-2018 Priority Guidance Plan include two areas of needed guidance: the community benefit achieved when hospitals address social determinants of health, and the participation of tax-exempt hospitals in an accountable care organization (ACO) that is partially or entirely outside of the Medicare Shared Savings Program (MSSP).

These additions would positively impact thousands of tax-exempt hospitals by providing clear authoritative guidance that addressing social determinants is community benefit. It would replace the subjective determinations made by Internal Revenue Service (IRS) officials who embedded a view of community benefit in Schedule H that has no basis in law. Congress, the public and the IRS would continue to get robust information on community benefit activities, and the information would be clearer and more accurate. Guidance on participation in ACOs would allow nonprofit hospitals to be certain they are complying with tax exemption requirements when integrating with physician practices and other health care providers, as they must, to improve health outcomes and control costs.



COMMUNITY BENEFIT GUIDANCE

Activities that Address Social Determinants of Health Should be Recognized as Community Benefit. Existing IRS guidance does not clearly recognize activities that address the social determinants of health as community benefit. **Guidance should clarify that hospitals are promoting health for the benefit of the community as a whole when they address housing, nutrition, transportation, and other social determinants of health.** A substantial body of research demonstrates that providing a clean, safe place to live, regular nutritious meals or more job opportunities has a profound and positive effect on health. Nonprofit tax-exempt hospitals across the country are committed to improving health in their communities and are devoting more attention and resources to social determinants of health. For low-income communities in particular, these services and supports can be as important as providing free medical care.

The Schedule H that all tax-exempt hospitals must complete each year arbitrarily distinguishes between community benefit activities and what IRS calls “community building.” Hospitals are denied credit for the expenditures they make to improve the health of individuals in the community. The form instructions continue to be contradictory. More importantly, the existence of “community building” as a distinct category implies that activities shuttled into that category do not support exemption under the community benefit standard the IRS has long applied.

The AHA, in conjunction with other hospital associations, raised our concern previously with the IRS, specifically with respect to housing activities, but to no avail. For convenience, a copy of the bibliography of research demonstrating the linkage between housing and health that we provided IRS is attached. Significant research also is available demonstrating the linkage between other social determinants and health. We urge issuance of formal guidance recognizing what the research demonstrates – that promoting health goes beyond providing medical care. It also would eliminate the inconsistency and burden that the lack of guidance and the form have created.

We also recommend updating the Schedule H of Form 990 to reflect the guidance on social determinants and to reduce the unnecessary burden created by duplicative reporting of information as well as to accurately report the full value of community benefit activities.

Complementary Recommended Changes to Schedule H

- Fold Part II (Community Building Activities) into Part I, line 7 (Financial Assistance and Certain Other Community Benefits At Cost).

For nearly 50 years, the IRS has taken the position that a hospital furthers charitable purposes under section 501(c)(3) if it promotes health for the benefit of the community as a whole. As discussed above, addressing key social factors that impact health has been shown to have an important impact on health in a community comparable to the provision of health care services. However, in 2007, when the IRS redesigned Form 990 and created Schedule H, the staff and executives responsible for the form did not recognize that linkage. They made an arbitrary

decision to categorize those activities as “community building activities” and locate them in a separate part of the form.

The form instructions include the confusing statement, “Some community building activities may also meet the definition of community benefit,” but create substantial confusion by directing that items that clearly benefit community health be reported as community building. As a result, those activities are not included in the data the IRS uses for reporting to Congress on costs incurred by hospitals for community benefit activities as required under section 9007(e)(1)(B).

The IRS has compounded the problem by refusing to revise the form or the form instructions to correct the recent contradictory directions about the treatment of those activities, even after the AHA identified the problem. There is no basis in statute, regulation, case law or, as importantly, in fact, for treating hospital expenditures on affordable housing, economic development, violence prevention, public health emergency prevention, workforce development and the like as anything other than community benefit expenditures. **Part II of Schedule H should be eliminated. Expenditures for the full range of community benefit activities, including anything that the current form instructions suggest or require be reported in Part II, should be reported in Part I.**

- Eliminate duplicative questions on financial assistance policy and community health needs assessment.

Under section 501(r)(4) of the Code, enacted as part of the Affordable Care Act, tax-exempt hospitals are required to have a written financial assistance policy widely available on a website and to perform and make publicly available a community health needs assessment at least once every three years. Hospitals are committed to meeting these requirements so the public has clear consistent information available on financial assistance and community health status. However, the changes to Schedule H since enactment of the section 501(r) have resulted in needless additional burden with duplicative questions in different parts of the form as well as multiple questions that ask the hospital to repeat information that is contained in their financial assistance policies.

In particular, Schedule H Part I, lines 1 – 6 and Part V, lines 1 – 16 cover the same material. For the public, a more useful source of information is the hospital’s financial assistance policy itself and the community health needs assessment. Both are available on a website and the web addresses are reported on Schedule H. A plain language summary of the financial assistance policy must also be available, which should ensure the contents of the policy will be understandable to a general audience. For the IRS when monitoring compliance, the focus should be the financial assistance policy itself rather than duplicative questions on the form. **The duplication on Parts I and V should be eliminated so that Schedule H can be streamlined with an emphasis on access to and the substance of the financial assistance policy and community health needs assessment.**

- Recognize the full value of community benefit activities funded by grants.

Hospitals often receive grants to support the charitable activities they conduct. Community needs drive hospitals' community benefit activities and grant funds help support the related expenses. As part of hospitals' stewardship of charitable resources, they seek appropriate and available funding to perform needed services. The IRS currently takes the position that activities supported with grants intended for those purposes do not count as community benefit on Schedule H. This is a reversal of the position the IRS initially took, and has no basis in law or published guidance.

The IRS unwisely and incorrectly treats grants for types of charitable activities as the equivalent of payment for services rendered (i.e., revenue generated by a program or activity that must be "netted out"). Reporting on Schedule H Part 1 emphasizes the dollar value of community benefit activities. Hospitals receive these grants because they have talent and infrastructure to conduct needed activities, and in the case of research, an activity that no one else can perform. The value of the research to the community is the gain in knowledge from the overall project. **The IRS's position results in a form that inaccurately understates the contribution hospitals make to their communities.**

GUIDANCE ON PARTICIPATION IN ACOS

The AHA once again requests that guidance on tax-exempt hospitals' participation in ACOS outside of the MSSP be a priority. The focus of health care has shifted from delivering services after patients have developed health problems to improving health status and outcomes by increasing preventive services, encouraging healthy behaviors and coordinating care among physicians and providers. ACOS are a primary vehicle through which this transformational shift is accomplished. Regardless of how MSSPs may evolve, the clinical integration model is firmly in place and increasingly relied on by private payers. The IRS should recognize this welcome paradigm shift with clear and effective guidance permitting tax-exempt hospitals to participate in all ACOS that serve their community.

ACOs, whether formed as corporations, partnerships or limited liability companies (LLCs), are designed to promote better health and better care at a lower cost for a defined population of people. ACOs pursue that goal by offering financial incentives to physicians, hospitals and other health care providers to coordinate and improve care for patients and avoid unnecessary hospitalizations. The ACO puts the incentives in place to implement contracts with payers. For MSSP ACOs, the payer is Medicare. For non-MSSP ACOs, the payers are private insurers and self-insured plans. Regardless of the specific payer, the ACO makes the providers accountable for the care they provide. ACOs succeed when individuals stay healthier. When the ACOs manage costs, the shared savings are available to fund the financial incentives.

Tax-exempt hospitals continue to face significant challenges in structuring ACOs because IRS guidance is limited to MSSP. The only other written statement – a nonprecedential redacted denial letter issued to a single organization that applied for a determination of exemption – sent a message that participation outside of an MSSP ACO placed a hospital's exemption at risk.

The AHA requests that the IRS make it a priority to issue guidance clarifying that participation in an ACO that is partially or entirely engaged with private payers is consistent with the requirements for exemption when hospitals integrate with physicians and other providers to reward coordinated patient care. A copy of the request for guidance we sent to the IRS last year, including a technical appendix, is attached. Further, we commend the American Bar Association's detailed analysis of this issue and its call for guidance that was submitted to the IRS in response to Notice 2011-20.

CRITERIA FOR EVALUATING GUIDANCE PROJECTS

The AHA's requests meet the criteria for guidance projects and are consistent with the objectives of Executive Orders 13765, 13771 and 13777.

Broad Impact and Burden Reduction. Guidance on the community benefit achieved by addressing social determinants of health would positively impact thousands of tax-exempt hospitals by providing clear authoritative guidance to replace the subjective determinations made by a few IRS officials who designed Schedule H to reflect views that have no basis in law. Implementing the guidance through complementary changes to Schedule H also would provide clearer and more direct information to the millions of people who may need financial assistance with the cost of health care while giving policy makers a more accurate picture of the benefits that hospitals generate for their communities, which can and should include efforts to address housing, nutrition, transportation, poverty and other social determinants of health. Guidance on ACOs would give hospitals clarity and certainty about their ability to enter into arrangements that are critical to addressing the problems in our health care system.

Minimizing Economic Burden of Affordable Care Act, Regulatory Reform Agenda. Guidance on how addressing the social determinants of health promotes health for the benefit of the community as a whole and making the complementary streamlining changes to Schedule H would reduce the burden tax-exempt hospitals experience in complying with section 501(r), a provision enacted as part of the Affordable Care Act. Congress, the public and the IRS would continue to get robust information on community benefit activities, and the information would be clearer and more accurate. The guidance can be provided through one or more revenue rulings without the need to add to the inventory of regulations or identify two regulations to be rescinded in place of the guidance. The complementary changes to Schedule H would remove a burden that is providing zero benefit to the public and the IRS.

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Thank you for your consideration. The AHA would welcome the opportunity to meet with you to discuss our concerns. Please feel free to contact me with any questions or comments at mhatton@aha.org or (202) 626-2336.

Sincerely,

/s/

Melinda Reid Hatton
General Counsel

Attachments

- July 14, 2015 Letter to Sunita Lough, Tamara Ripperda
- May 16, 2016, Letter to John Koskinen, Mark Mazur



July 14, 2015

Via electronic mail

Sunita Lough
Commissioner
Tax Exempt and
Government Entities Division
Internal Revenue Service

Tamara Ripperda
Director, Exempt Organizations
Internal Revenue Service

Dear Sunita and Tammy:

Thank you very much for meeting with representatives of the American Hospital Association, the Catholic Health Association of the United States and the Association of American Medical Colleges. We very much appreciated the opportunity to speak with you and your colleagues about the important issue of including housing as a “Community Benefit” in Part I of the Form 990, Schedule H.

As we discussed, when the Schedule H was first introduced, it was contemplated that some of the activities initially listed as “Community Building” might later be reclassified as “Community Benefit.” In fact, an IRS release, dated December 20, 2007, stated:

“While the IRS believes that certain of these community building activities might constitute community benefit or other exempt purpose activities, more data and study is required.”

In the more than 7 years since that statement was written, numerous studies and research in the public health area have clearly established that “housing is health care.” It is indisputable that healthcare is no longer being provided only within the four walls of hospital buildings. In addition, viewing healthcare delivery in traditional silos prevents us from addressing health needs in more innovative and effective ways. According to an article in the New England Journal of Medicine: “For many patients, a prescription for housing or food is the most powerful one that a physician could write, with health effects far exceeding those of most medications.”¹

¹ <http://www.nejm.org/doi/full/10.1056/NEJMp1310121>

As you requested, we have attached a list of links to many important studies on housing and health as well as a summary of the research on the social determinants of health, including housing. These resources strongly support our position that housing, an essential component of the infrastructure needed to promote and sustain good health, should be counted as a Community Benefit activity in Part I when undertaken by tax-exempt hospitals. This research also confirms that many other government agencies, including the CDC, HUD, EPA and USDA, view access to safe housing as an important contributor to the health of American families. In addition, we have attached a brief summary of the other types of community building activities revealed by a review of CHNAs and Schedule H's of 32 hospitals.

During our call, you asked why it is so important for this change to be made to the Schedule H. Under Rev. Rul. 69-545, hospitals desiring tax-exempt status under Section 501(c)(3) are required to demonstrate that they are promoting health within the community. Schedule H was intended to provide the IRS, legislators and the public with a snapshot of the activities that a hospital has undertaken to meet this requirement. In particular, Part 1, Line 7 is the section that the IRS has designated as "community benefit." Given the growing recognition that improving the health of a community requires a broad, multi-disciplinary approach, it is both reasonable and necessary for hospitals to focus attention and dollars to address housing and other social determinants of health. It has been demonstrated that providing access to safe, quality and affordable housing can have a greater impact on the health of a community than more traditional clinical modalities. Moving the reporting of housing activities to Schedule H, Part I not only will align the incentives with population health findings and the efforts of other federal agencies, but also will provide a clearer picture of how hospitals are contributing to the health of their communities.

Once you have reviewed these materials, please let us know if there is further information that you would need to consider our request.

Again, many thanks for your attention to this matter.

Sincerely,

Lisa Gilden
VP, General Counsel/Compliance Officer
The Catholic Health Association
Of the United States

Melinda Reid Hatton
Senior Vice President & General Counsel
American Hospital Association

Janis M. Orlowski, MD, MACP
Chief Health Care Officer
Association of American Medical Colleges

Attachments

cc: Melaney Partner
TE/GE Communications & Liaison – Operations
melanie.partner@irs.gov

ATTACHMENT 1

The Public Health Case on the Connection between Housing and Health

The American Hospital Association (AHA), the Association of American Medical Colleges (AAMC) and the Catholic Health Association of the United States (CHA) are pleased to submit to the Internal Revenue Service supplemental information on why actions related to housing should be reportable as community health improvement activities.

As recently as June 26 of this year, the Department of Health and Human Services' Centers for Medicare and Medicaid Services issued a bulletin for states describing housing-related activities that could be eligible for Medicaid reimbursement.¹

And in April of 2015, the National Housing Conference and Center for Housing Policy compiled a wide body of evidence that found a strong relationship between health and housing. The report concluded, "Overall, the research supports the critical link between stable, decent, and affordable housing and positive health outcomes."² This affirms the statement in the National Housing Standard, developed by the American Public Health Association and the National Center for Healthy Housing that "housing is one of the best known and documented determinants of health."³

These research findings are driving government agencies and national organizations committed to improving public health to support initiatives to address poor and inadequate housing. In 2013, the Department of Housing and Urban Development (HUD) issued *Advancing Healthy Housing: A Strategy for Action* that stated,

"Poor housing conditions, such as a dilapidated structure; roofing problems; heating, plumbing, and electrical deficiencies; water leaks and intrusion; pests; damaged paint; and radon gas are associated with a wide range of health conditions, including unintentional injuries, respiratory illness, asthma, lead poisoning, and cancer, respectively."⁴

The HUD report went on to note broad agreement among several federal agencies in support of healthy housing as a means of preventing diseases and injury:

"Interagency collaboration culminated in the planning and delivery of two federal Healthy Homes Conferences, the first held in September 2008 and the second in June 2011, both sponsored by HUD, CDC, EPA, and USDA. These conferences served as an incubator for the exchange of ideas, and helped to focus national attention on the importance of safe, healthy, efficient, and affordable homes for America's families."⁴

In 2013 the American Public Health Association's (APHA) annual meeting featured a general session on housing with representatives from HUD and the Environmental Protection Administration titled, "Landscape of Healthy Housing: Strategies, Policies, and Initiatives." The relationship between health and housing has been a continuing topic of interest to the APHA. Its May 2002 journal was devoted to the topic. The lead article, "Housing and Health: Time Again for Public Health Action," by James Krieger, MD, MPH, and Donna L. Higgins, Ph.D., included a bibliography of 154 scientific papers and other resources, concluding:

“Poor housing conditions are associated with a wide range of health conditions, including respiratory infections, asthma, lead poisoning, injuries, and mental health. Addressing housing issues offers public health practitioners an opportunity to address an important social determinant of health.”⁵

The Robert Wood Johnson Foundation, a widely respected philanthropic organization focused on improving the health of all Americans, produced an issue brief on housing and health in 2011 as part of its Commission to Build a Healthier America.⁶ This document, which included 47 references, stated:

“Good health depends on having homes that are safe and free from physical hazards. When adequate housing protects individuals and families from harmful exposures and provides them with a sense of privacy, security, stability and control, it can make important contributions to health. In contrast, poor quality and inadequate housing contributes to health problems such as infectious and chronic diseases, injuries and poor childhood development.”⁶

As recently as last month, the Yale Global Health Leadership Institute released, “Leveraging the Social Determinants of Health: What Works” with 95 scientific references.⁷ The document stated:

“The evidence supporting the direct relationship between housing interventions and health outcomes within low-income or otherwise vulnerable populations is expansive. Whether enabling access to housing, creating a supportive housing environment, or simply expanding the availability of affordable housing to families in lower-poverty neighborhoods, the evidence suggests housing is critical to the health of vulnerable individuals.”⁷

These various reports tell a compelling story about how housing impacts health. To summarize, they tell us:

- Lead poisoning affects brain and nervous system development and can lead to lower intelligence and reading disabilities. The primary source of lead exposure comes from lead-based paint in older homes.
- Exposures to very high or very low indoor temperatures are associated with poor health and mortality.
- Poor housing conditions can lead to exposure to carcinogenic air pollutants including radon, environmental tobacco smoke, heating and cooking gases, and asbestos.
- Housing problems such as water leaks, poor ventilation, dirty carpets and pest infestation can lead to mold and other allergens that can cause or complicate respiratory problems such as asthma.
- Crowding in homes has been linked to infectious diseases such as tuberculosis and psychological distress.

The United States Surgeon General’s “Call to Action to Promote Healthy Homes”⁸ and “Healthy Home Checklist,”⁹ and the Centers for Disease Control and Prevention Healthy Homes website¹⁰ suggest many ways that homes can be healthier. Some of these include:

- Removing allergens that cause asthma attacks and allergic reactions.
- Testing for and ameliorating lead paint.
- Controlling moisture and mold
- Installing and maintaining smoke and other alarms.
- Getting rid of pests, including cockroaches and mice.

- Ensuring safe drinking water.
- Keeping homes free from hazards that could lead to falls and other accidents.
- Ensuring properly functioning heating and air conditioning.

In addition to upgrading and repairing existing housing, developing new, safe and affordable housing for low-income and high-risk individuals and families can be an effective strategy for improving health. It can protect people from the dangers encountered in substandard housing and offer other significant benefits: The April 2015 report of the National Housing Conference and Center for Housing Policy, “The Impacts of Affordable Housing on Health: A Research Summary” states:

“Affordable housing alleviates crowding and makes more household resources available to pay for health care and healthy food, which leads to better health outcomes. High quality housing limits exposure to environmental toxins that impact health. Stable and affordable housing also supports mental health by limiting stressors related to financial burden or frequent moves, or by offering an escape from an abusive home environment. Affordable homeownership can have mental health benefits by offering homeowners control over their environment. Affordable housing can also serve as a platform for providing supportive services to improve the health of vulnerable populations, including the elderly, people with disabilities, and homeless individuals and families. Safe, decent, and affordable housing in neighborhoods of opportunity can also offer health benefits to low income households.”²

Further, according to an article in the Annual Review of Public Health, titled “Housing and Public Health,”

“Investment in housing can be more than an investment in bricks and mortar: It can also form a foundation for the future health and well-being of the population. Addressing poor-quality housing and detrimental neighborhoods, in the broadest sense, is thus a task that should be grasped with vigor and determination by all those involved in public health.”¹¹

In conclusion, AHA, AAMC and CHA urge the Internal Revenue Service to recognize the involvement of community benefit programs in improving housing in their communities as a strategy for improving health by specifically noting that this involvement can be reported in Part I of the IRS Form 990, Schedule H. This would be consistent and supportive of the work of other federal agencies and would acknowledge the growing body of public health research on the impact of safe, affordable housing on health.

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ATTACHMENT 2

Research on the Social Determinants of Health

The idea that health care needing a wider definition than the traditional inclusion of strictly “clinical care” has been studied extensively over the past few decades. Over a decade ago, the World Health Organization (WHO) began to shift its focus to improving public health through upstream intervention and released a publication, *The Social Determinants of Health: The Solid Facts*, examining several social determinants of health (SDH). The publication reflected the need and demand for scientific guidance in health policy-making areas outside what had been traditionally defined as medicine.

The Social Determinants of Health: The Solid Facts
Marmot, M., Wilkinson, R. (2003). *The Social Determinants of Health: The Solid Facts* ed. 2.
World Health Organization (WHO).
http://www.euro.who.int/data/assets/pdf_file/0005/98438/e81384.pdf

This edition compiles new evidence on the impact of SDH, including those from stress, early life experiences, work and unemployment, social cohesion, addiction, food, and transportation.

The WHO found a complex relationship between transportation and health, with topics such as physical activity, injury and trauma from traffic accidents, social cohesion, air pollution, and access to basic needs such as health care. For example, reducing reliance on cars “can play a key role in combating sedentary lifestyles... [because] regular exercise protects against heart disease and, by limiting obesity, reduces the onset of diabetes. It promotes a sense of well-being and protects older people from depression.”

In another follow-up publication, the WHO compiled their studies on SDH in *The Economics of Social Determinants of Health and Health Inequalities: A Resource Book*.

The Economics of Social Determinants of Health and Health Inequalities: A Resource Book
World Health Organization (WHO). (2013). *The Economics of Social Determinants of Health and Health Inequalities: A Resource book*.
http://apps.who.int/iris/bitstream/10665/84213/1/9789241548625_eng.pdf

On the intersection between transportation and health policy, the WHO stated: “The physical environment where people live can have relevant impacts on their well-being, and particularly on health. There is growing consensus today on the implications of the urban environment, including transport, infrastructure provision and basic services, for people’s health and healthy behaviours, and therefore for health inequities. Factors such as overcrowding, dampness, area reputation, neighbourliness, fear of crime and area satisfaction appear to be important predictors of self-reported health.”

The WHO further analyzed the impacts of interventions in infrastructure on health in several countries, and have found positive results in all. Specifically in the U.S., a variety of infrastructure improvement policies have reported a significant improvement in health. Traffic calming interventions such as speed limit regulations and red-light camera usage have reduced road fatalities. Furthermore, research conducted in several different countries have found that transportation and physical activity have closely tied links, as “each additional hour spent in a car

per day has been associated with a 6% increase in the likelihood of obesity in the United States...[and that] a review of interventions in Germany, the Netherlands, Norway, the United Kingdom and the United States found that overall, commuter subsidies and alternative provision (for example a new train station) had the strongest impact on modal shift (1% and 5% respectively).”

The Centers for Disease Control and Prevention (CDC) followed suit by conducting its own studies and establishing various task forces and initiatives to begin addressing social determinants of health as well. In 2010, Thomas R. Frieden, the director of the CDC, wrote an article titled “A Framework for Public Health Action: The Health Impact Pyramid” explaining five different levels of public health intervention: socioeconomic factors, promotion of health behaviors, long-term protective interventions, clinical interventions, and counseling and education, from most upstream factors to least.

A Framework for Public Health Action: The Health Impact Pyramid
Frieden, T. R. (2010). A Framework for Public Health Action: The Health Impact Pyramid. *American Journal of Public Health*, 100(4), 590–595. doi:10.2105/AJPH.2009.185652
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836340/>

“Interventions at the top tiers [such as direct clinical care and counseling] are designed to help individuals rather than entire populations...even the best programs at the pyramid’s higher levels achieve limited public health impact, largely because of their dependence on long-term individual behavior change...The bottom tier of the health impact pyramid represents changes in socioeconomic factors...often referred to as social determinants of health, that form the basic foundation of a society.”

Focusing on upstream intervention, Frieden argues, will have a greater population health impact with less effort than focusing on individual, downstream intervention. He concludes, “Interventions that address social determinants of health have the greatest potential public health benefit. Action on these issues needs the support of government and civil society if it is to be successful. The biggest obstacle to making fundamental societal changes is often not shortage of funds but lack of political will; the health sector is well positioned to build the support and develop the partnerships required for change.”

The U.S. Public Health Service also conducted its own research on SDH published in its journal *Public Health Reports*. The most recent article there on SDH titled, “The Social Determinants of Health: It’s Time to Consider the Causes of the Causes” in 2014 compiles accumulated knowledge to assess the strength of the causal role of social factors on population health. Note: The article uses the term “medical care” for clinical services, not to be confused with “health care.”

The Social Determinants of Health: It’s Time to Consider the Causes of the Causes
Braveman, P., & Gottlieb, L. (2014). The Social Determinants of Health: It’s Time to Consider the Causes of the Causes. *Public Health Reports*, 129(Suppl 2), 19–31.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863696/>

Medical care only has a limited outreach, and though undeniably important, fall under the shadow the power of social factors, according to multiple studies, observational examples, quasi-experiments, and natural experiments assessing the impact of social determinants of health.

There are multiple layers of socioeconomic factors that are both directly and indirectly influence population health. Some are relatively simple to study, such as the negative health impacts of lead ingestion, pollution, and allergens in poor housing situations or the perpetuation of risky health behaviors among youths who are more easily swayed by social norms. Others, such as tobacco use and poor food choices common in lower socioeconomic neighborhoods, have impacts that only emerge later in life in the form of chronic disease. New biological explanations are also being explored, including the physical consequences of long-term stress and the influence of the environment on epigenetics (the regulation of gene expression).

Further exploration into quantifying the limits of medical care have been catalogued by the Agency for Healthcare Research and Quality (AHRQ) under the U.S. Department of Health and Human Services.

2014 National Healthcare Quality and Disparities Report
U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2015). 2014 National Healthcare Quality and Disparities Report.
<http://www.ahrq.gov/research/findings/nhqdr/nhqdr14/2014nhqdr.pdf>

In 2015, the AHRQ came out with its annual National Healthcare Quality and Disparities Report based on data collected in 2014. One of its key findings point to the startling realization that health disparities have actually widened over the last few years despite improved access to care through health reform and the Affordable Care Act. According to the report, very few disparities, with the exception for childhood immunization rates, were eliminated, and others, such as chronic disease management and hospice care, actually grew larger.

The CDC in particular has been a leader in population health, which has come to define 21st century health care in the United States. The CDC's "Healthy People in Healthy Places" mission tackles with promoting health and safety through improving "the places where people live, work, learn and play." (<http://www.cdc.gov/healthyplaces/>) The Built Environment and Health Initiative is a collaboration between the CDC and the National Center of Environmental Health to oversee community reinvestments by providing "Health Impact Assessment to Foster Healthy Community Design" (HIA) grants. There are currently six grantees working to improve public health through improving the community: <http://www.cdc.gov/healthyplaces/stories/default.htm>.

Healthy Community Design Topics also address (but are not limited to) the following areas:

Transportation: Former Transportation Secretary Ray LaHood states, "Streets where walkers and bikers are protected from motor vehicles encourage people to get more exercise as part of their daily routines. Increasing the transportation options available in a community helps reduce congestion and air pollution even as it ensures that communities have access to necessary services like full-service grocery stores and doctors' offices."
<http://www.cdc.gov/healthyplaces/healthtopics/transportation/default.htm>

Accessibility: “Poorly designed communities can make it difficult for people with mobility impairments or other disabling conditions to move about their environment; consequently, people with a disability often are more vulnerable to environmental barriers.”

<http://www.cdc.gov/healthyplaces/healthtopics/accessibility.htm>

Parks and Trails: “In a well-designed community, homes, parks, stores, and schools are connected by safe walking and biking routes. Such routes allow all members of the community a chance to enjoy the outdoors and get physical and mental health benefits.”

<http://www.cdc.gov/healthyplaces/healthtopics/parks.htm>

Many academic and trade journals have turned to study the implications of SDH. In the *Journal of Public Health Management and Practice*, a 2008 article “Moving Upstream: How Interventions that Address the Social Determinants of Health Can Improve Health and Reduce Disparities” gives examples and results of programs developed to address SDH both inside and outside the health care system.

Moving Upstream: How Interventions that Address the Social Determinants of Health Can Improve Health and Reduce Disparities

Williams, D. R., Costa, M. V., Odunlami, A. O., & Mohammed, S. A. (2008). Moving Upstream: How Interventions that Address the Social Determinants of Health can Improve Health and Reduce Disparities. *Journal of Public Health Management and Practice: JPHMP*, 14(Suppl), S8–17. doi:10.1097/01.PHH.0000338382.36695.42

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3431152/>

Home-visiting programs, which focused on issues such as health literacy, home safety, and healthy behavior, were also noted to improve families’ overall health and quality of life. The article also summarizes the results of community programs developed to improve neighborhood conditions, employment, and early childhood education, all with favorable results. The de-concentration of public housing initiative in Yonkers, NY, for example, provides cogent evidence demonstrating the impact of built environments on health.

Randomly selected by lottery to participate in the de-concentration of public housing initiative, low-income families who had moved to newly built public housing sites reported a few years later that they enjoyed “better overall health, including less substance abuse, less neighborhood disorder, less violence exposure and other health problems compared to those who had stayed in their original neighborhoods. Movers also reported better satisfaction with public transportation, recreation facilities and medical care. In addition, they had higher rates of employment and lower rates of welfare receipt.”

Other successful programs to improve neighborhood conditions mentioned in the article include the Moving to Opportunity (MTO) intervention, the Gautreaux Residential Mobility Program for desegregation in Chicago, and evidence from other countries, including Norway and the United Kingdom.

Non-profit organizations dedicated to health improvement have long focused on addressing health disparities in the U.S. The Robert Wood Johnson Foundation in its Commission to Build a Healthier America, for example, published a series of issues briefs summarizing the impacts of

social determinants of health. Neighborhoods and Health is one of eleven issue briefs that include income, work, housing, economy, early childhood experiences, education, and race and ethnicity.

Neighborhoods and Health

Robert Wood Johnson Foundation Commission to Build a Healthier America. (2011).

Neighborhoods and Health.

<http://dhss.delaware.gov/dhss/dph/mh/files/neighborhoodsandhealth.pdf>

Plentiful studies delineate the effect of physical characteristics of neighborhoods on their inhabitants, including pollution, traffic, crime rates, proximity to basic needs, and physical activity. This issue brief also examines the more indirect relationship between social environments of neighborhoods and health:

“Residents of “close-knit” neighborhoods may be more likely to work together to achieve common goals such as cleaner and safer public spaces healthy behaviors and good schools; to exchange information regarding childcare, jobs and other resources that affect health; and to maintain informal social controls discouraging crime or other undesirable behaviors such as smoking or alcohol use among youths, drunkenness, littering and graffiti... Children in more closely-knit neighborhoods are more likely to receive guidance from multiple adults and less likely to engage in health-damaging behaviors like smoking, drinking, drug use or gang involvement... Conversely, less closely-knit neighborhoods and greater degrees of social disorder have been related to anxiety and depression.”

ATTACHMENT 3

Catalogue of Community Building Activities of 32 – Section 501(c)(3) Hospitals (Description of activity followed by number of hospitals reporting it)

Health education: 23

For children (20)

 General health education (10)

 Safety/Injury and trauma prevention education (7)

 Substance abuse prevention education (8)

For at-risk people/patients (6)

For immigrants (3)

Healthy eating promotion: 18

 Nutrition and smart cooking/shopping classes (9)

 Farmer's Market (8)

 Access to more local fresh produce (e.g., community gardens) (9)

Infrastructure development: 18

 Medical transportation (8)

 Institutional facilities (e.g., development of exercise facilities, walking trails, etc.) (8)

 Housing (e.g., lead poisoning programs, low-income housing, etc.) (8)

Mental health/emotional and social wellbeing programs: 16

 Senior-friendly environment/programs (4)

 Mental health safe places for youths (5)

 Substance abuse cessation support groups/programs (10)

Physical activity programs: 16

For children (5)

For adults (11)

For seniors (3)

Education/workforce development: 9

 Education (e.g., literacy programs, higher education guidance, etc.) (9)

 Workforce development/career guidance (4)

Note: Subcategory numbers may not add up to overall category numbers since a hospital can be involved in developing programs in more than one subcategory.

Prepared by
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June 30, 2015



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Submitted electronically via www.regulations.gov

John Koskinen
Commissioner
Internal Revenue Services
1111 Constitution Ave., N.W.
Washington, DC 20224

Mark J. Mazur
Assistant Secretary (Tax Policy)
Department of the Treasury
1500 Pennsylvania Ave., N.W.
Washington, DC 20220

Re: IRS Notice 2016-26: Priority Guidance Plan 2016-2017; Tax Exemption for Accountable Care Organizations

Dear Commissioner Koskinen and Assistant Secretary Mazur:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) is writing in response to the position taken by the Internal Revenue Service (IRS) in a recent ruling denying tax exemption to an accountable care organization (ACO)¹. We are seriously concerned that the IRS has adopted a ruling position that means non-profit hospitals risk losing their tax exemption if they pursue a modern approach to clinically integrated health care that holds the greatest promise for improving outcomes and reducing costs.

In its recent ruling, IRS denied tax-exempt status to an ACO not participating in the Medicare Shared Savings Program (MSSP), the exact opposite of the result it would have received if it were an MSSP ACO. The IRS concluded that the ACO generated impermissible private benefit to physicians without any discussion of how the community benefits from coordinated care and better management of health care costs.

¹ PLR 201615022



The IRS ruling is in conflict with the direction that the Department of Health and Human Services (HHS) has given to the hospital field. HHS Secretary Burwell has been very clear about the importance of all types of ACOs in furthering our national health policy goals. In January 2015, when she announced the goal of basing 90 percent of Medicare payments on quality and value by 2018 through use of ACOs or alternative payment models, she said:

Whether you are a patient, a provider, a business, a health plan, or a taxpayer, it is in our common interest to build a health care system that delivers better care, spends health care dollars more wisely and results in healthier people. Today's announcement is about improving the quality of care we receive when we are sick, while at the same time spending our health care dollars more wisely. We believe these goals can drive transformative change, help us manage and track progress, and create accountability for measurable improvement.²

ACOs (MSSP and non-MSSP) are among the prime mechanisms for meeting the goals articulated by Secretary Burwell. We respectfully request that IRS recognize that, when hospitals integrate with physicians and other providers in their community to reward coordinated patient care, the hospitals are promoting health for the benefit of the community and, therefore, operating as section 501(c)(3) organizations should. **To make that clear, it is imperative that IRS publish guidance affirming that hospitals may participate in ACOs without generating a tax cost or incurring the catastrophic loss of their tax-exempt status. Such guidance will remove what appears to be a serious obstacle for nonprofit hospitals striving to coordinate care for their communities and make other improvements in delivering population health.**

Nonprofit hospitals and health systems qualify for exemption as section 501(c)(3) organizations based on their promotion of health for the benefit of the communities they serve. Promotion of health is necessarily a dynamic function. Hospitals must respond to medical advances and changing public health needs with new activities, programs and structures. They also must respond to the economic challenges and demands not only of the Medicare and Medicaid programs but also the coordinated care models expected by innovative private payers.

To meet the community's health needs and respond to the economic imperatives, many non-profit hospitals have expanded beyond fee-for-service acute care inpatient facilities to models that integrate inpatient and outpatient care, recruit physicians to meet community needs, and enter into joint ventures with for-profit and nonprofit health care providers with complementary skills. Case law and IRS guidance have recognized that non-profit hospitals pursue these activities in order to promote health for the benefit of the community as a whole. Therefore, as long as the activities and programs have been structured to avoid giving private parties a profit-like interest and to make returns on investment proportional to the resources invested, non-profit hospitals have been able to innovate and adapt in their relationships with other providers while remaining confident that they retain their tax-exempt status.

² Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value, HHS News Release, January 26, 2015.

Our national health care system has shifted the paradigm for promoting community health. Historically, the health care system was built to deliver hands-on care to patients after they became sick or injured. The hands-on approach has, however, become unsustainable. The focus of health care has shifted to improving health status and outcomes by increasing preventive services, encouraging healthy behaviors and coordinating care among providers to improve outcomes and reduce the cost of care. ACOs are an important innovation through which this transformational shift is accomplished.

ACOs, whether formed as corporations, partnerships or LLCs, are designed to promote better health and better care at a lower cost for a defined population of people. ACOs pursue that goal by offering financial incentives to physicians, hospitals and other health care providers to coordinate and improve care for patients and avoid unnecessary hospitalizations. The ACO puts the incentives in place by contracting with payers. For MSSP ACOs, the payer is Medicare. For non-MSSP ACOs, the payers are private insurers and self-insured plans. Some ACOs may blend MSSP and non-MSSP arrangements. Whatever the payment arrangement, the ACO makes the providers accountable for the care they provide. ACOs succeed when individuals stay healthier. When the ACOs manage costs, the shared savings are available to fund the financial incentives.

Unfortunately, the recent IRS denial letter tells non-profit hospitals seeking to form or participate in ACOs outside of the MSSP that they are risking their tax exemption. If they join with physicians in their community – beyond the physicians they employ or accept on their medical staff – to contract with payers or perform the analytics necessary to track where interventions can be made to improve health at lower cost, the ruling says that the ACO would be operating for the benefit of the physicians not the community.

IRS issued guidance making clear that MSSP ACOs are furthering charitable purposes because they are lessening the burdens of government. That is certainly true, but just as important, non-MSSP ACOs are promoting health for the benefit of the community as a whole. What they are doing reflects an evolution in American health care, a fundamental change that, as Secretary Burwell said, is vital to the public interest. We must reward hospitals and physicians for keeping patients healthier and managing costs. To achieve that goal, we must recognize modern health care relies on coordination and cooperation amongst the providers who care for a community, regardless of whether they are all affiliated with the same hospital or health system. The IRS should recognize this welcome paradigm shift with clear and effective guidance permitting tax-exempt hospitals to participate in all ACOs to serve their communities.

John Koskinen and Mark Mazur

May 16, 2016

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Thank you for your consideration. We ask that you make guidance on participation in ACOs by non-profit hospitals an immediate priority. The AHA would welcome the opportunity to meet with you to discuss our concerns. Please feel free to contact me with any questions or comments at mhatton@aha.org or (202) 626-2336.

Sincerely,

/s/

Melinda Reid Hatton
Senior Vice President and General Counsel

CC:

Sunita Lough – Commissioner, Tax Exempt and Government Entities

Tammy Ripperda – Director, Exempt Organizations

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Kyle Brown – Division Counsel, Tax Exempt and Government Entities

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Technical Appendix

The American Bar Association's Section of Taxation and Health Law Section submitted comprehensive detailed comments to the IRS in response to Notice 2011-20 and the specific questions raised in that notice about non-MSSP ACO activities: (1) do these activities further the exempt purpose of the promotion of health; and (2) do these activities comply with the private inurement and private benefit doctrines. We commend these comments for their thorough review of the existing law and explanation of how the answers to these questions follow from the law. We join their call for published guidance.

We offer these additional technical points to be taken into consideration.

- Participation in the Medicare version of ACOs cannot be essential for the ACO activity to further exclusively charitable purposes. As Rev. Rul. 69-545, 1969-2 C.B. 117, and Rev. Rul. 83-157, 1983-2 C.B. 94, each say, participation in Medicare and Medicaid is a factor but not a requirement for a hospital to be operated in furtherance of exclusively charitable purposes. Non-MSSP ACOs can satisfy the same factors articulated in Notice 2011-20 for establishing an MSSP ACO whose activities further exclusively charitable purposes, with the exception of approval into the MSSP program by CMS. While CMS acceptance of an ACO arrangement may provide a simple safe harbor, the relevant legal question is whether ACO activities further an exclusively charitable purpose.
- The relevant legal standard is whether activities promote health *for the benefit of the community as a whole*. Pointing to cases about health plans and pharmacies for the proposition that not every activity that promotes health necessarily supports exemption (IHC Health Plans, Inc. v. Commissioner, 325 F.3d 1188, 1197 (10th Cir. 2003), and Federation Pharmacy Services, Inc. v. Commissioner, 72 T.C. 687 (1979), *aff'd*, 625 F.2d 804 (8th Cir. 1980)) does not add anything to the analysis. ACOs are not selling health care products or services to individual consumers. ACOs and other forms of clinical integration, by definition, are focused on the health of a population. They function on a system basis to promote the health of the community *as a whole*, and as such, they are charitable.
- The community, for purposes of the community benefit standard, can take many forms beyond geographic ones. For example, children's hospitals serve children, and specialty cancer or eye hospitals serve patients with particular health needs who may live far away from the hospital itself (Cf. Rev. Rul. 83-157, 1983-2 C.B. 94). Both MSSP and non-MSSP ACOs serve communities of thousands of people. These communities are defined by a combination of geography and source of coverage.
- Since 1996, IRS has recognized that hospitals and physicians would create organizations as a vehicle through which they would work together to benefit their community.

Spiraling increases in health care costs have spawned innovative solutions to reduce the price, increase the quality, enhance the efficiency, and

improve the availability of medical services. The integration of hospitals and physicians into single organizations with the common goal of benefiting the community is part of this movement (IRS Training text on integrated delivery systems and health care for exempt organizations personnel, 1996).

ACOs are a contemporary approach to addressing the same concern. In the same way that formation of an integrated delivery system promotes health for the community as a whole, so does an ACO promote health for the community as a whole. IRS recognized that integration furthered the participating hospital's exempt purpose, and focused on the financial terms in evaluating the arrangement. In the context of an ACO, the focus is on metrics for health care improvement and cost containment. The attention to economics is similarly appropriate for an ACO. So long as the metrics for health care improvement and cost containment are sound and evidence-based, payments based on those metrics are necessarily tied to achievement of an exempt purpose. If the use of metrics and standards in the MSSP as a basis for payment is appropriate, then use of other metrics and standards that are backed by substantial research and analysis in ACOs outside of MSSP should similarly be appropriate.

- IRS already recognized that functions performed by an ACO are the promotion of health that merit exemption. In Rev. Rul. 81-276, 1981-2 C.B. 128, IRS recognized that a professional standards review organization is promoting the health of the beneficiaries of governmental health care programs by preventing unnecessary hospitalization and surgery. Similarly, an ACO also promotes health by using evidence-based medicine and population health analytics to achieve improved outcomes for patients and reduce unnecessary health care expenditures.
- If MSSP ACOs serve a charitable purpose through achieving better care and better health for the Medicare beneficiary community as a whole, so too do non-MSSP ACOs serve a charitable purpose through achieving better care and better health for the communities they serve. When MSSP ACOs lessen the burden on government, they do so not just through cost savings but through an improvement and strengthening of health care for Medicare beneficiaries. The same is true outside of the MSSP: the cost savings is one part of a fundamental improvement to the health care system for the community.
- IRS has further recognized that payments based on quality of services using MSSP criteria is incidental private benefit to the physician (Notice 2014-67, 2014-46 I.R.B. 822). IRS allowed private physicians to perform services in tax-exempt, bond-financed facilities and receive payments without engaging in impermissible private use of the facility. This safe harbor acknowledges that meeting the needs of a patient requires both the facilities of the hospital and the care of the physician. Therefore, any private benefit to the physician is incidental to the accomplishment of the hospital's exempt health care purpose. Similarly, hospitals and physicians need to work together in assuming responsibility for the health of the population in their community – improving quality, outcomes, and reducing the cost of health care. The ACO is like the hospital facility. The hospital may have the size and resources to assemble

the network, but the hospital and the physicians both need the ACO to pursue the ultimate goal of promoting health for the benefit of the community.

We urge IRS to issue guidance quickly affirming that non-profit hospitals may participate in ACOs without generating a tax cost or incurring the catastrophic loss of their tax-exempt status. We believe the public policy goals articulated by Congress and the Department of Health and Human Services, and IRS's established precedents properly applied support the following conclusions:

- ACOs organized and operated to promote better health and better care at a lower cost for a defined population of people serve a charitable purpose.
- Any private benefit to the participating physicians or for-profit health care providers can be established as incidental to the furthering of charitable purpose using the same five-factor analysis the IRS has made applicable to MSSP ACOs, in which no particular factor must be satisfied in all circumstances.
- ACO incentives do not result in inurement where they do not give a physician or provider an equity-like interest in the ACO.