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Issue Brief

Nonprofit Hospitals and Community Benefit July 2011

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Summary

The majority of hospitals in the United States are recognized as nonprofit organizations by federal, state and local governments. This status provides a number of financial benefits, including exemption from federal and state income tax as well as a variety of state and local taxes. Nonprofits can also receive donations that are tax-deductible to the donor and may benefit from tax-exempt bond financing. The standard hospitals must meet to receive and maintain nonprofit status is ambiguous and not easily amenable to either oversight or enforcement. There is strong evidence that many nonprofit hospitals do not operate in ways that are significantly different from those of hospitals that are operated as profit-generating enterprises.

As a result of increased scrutiny at the federal, state and local level, the IRS in 2008 began requiring that nonprofit hospitals report with more specificity the benefits they provide to the community. The Affordable Care Act (ACA) requires additional transparency from nonprofit hospitals and prohibits some of the more egregious charging and collection activities. The ACA also requires that each nonprofit hospital facility conduct an assessment of the health needs of the people in the community it serves and take steps to address those needs. This assessment must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health. Some states have also enacted laws and regulations that require transparent charity care policies and practices that exceed the federal requirements.

This issue brief begins with a brief overview of nonprofit hospitals and a description of the requirements hospitals must meet to obtain the benefits that flow from nonprofit status. It then discusses problems that have been identified with the current regime and recent legislative and regulatory changes that have been introduced to address them.

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Finally, it suggests opportunities for advocates to use these new tools to advance the health rights of low-income uninsured and under-insured patients.

Background

About 59 percent of hospitals in the United States are recognized by the IRS as nonprofit organizations.² Sixty-eight percent of Medicare beds are located in nonprofit hospitals.³ Not including government-run hospitals, about 77 percent of community hospitals are nonprofits.⁴ Collectively, nonprofit hospitals own 86 percent of private hospital fixed assets.⁵

Nonprofit Hospitals Enjoy Substantial Tax Benefits

Qualified nonprofit organizations—those meeting the requirements of Internal Revenue Code 501(c)(3)—enjoy a number of benefits not available to profit-making corporations and organizations. Chief among these is favorable treatment under the tax code.⁶ Qualified nonprofit organizations are exempt from federal income tax, and donations to them are tax-deductible to the donor.⁷ They may also have the ability to have tax-exempt debt issued for their benefit.⁸ Many nonprofits are also exempt from state and local taxes, including property, income and sales tax.⁹

Favorable tax treatment significantly reduces the cost of capital for nonprofit hospitals compared to similarly situated for-profits.¹⁰ According to the nonpartisan Joint Committee on Taxation (JCT), the income tax exemption and the ability to have tax-exempt bonds issued for their benefit provided nonprofit hospitals with about \$4.3 billion

² See U.S. GOVERNMENT ACCOUNTABILITY OFFICE, GAO-08-880, VARIATION IN STANDARDS AND GUIDANCE LIMITS COMPARISON OF HOW HOSPITALS MEET COMMUNITY BENEFIT REQUIREMENTS 8 (2008) [hereinafter GAO, VARIATION IN STANDARDS AND GUIDANCE] (2002 data).

³ See U.S. CONGRESSIONAL BUDGET OFFICE, PUB. NO. 2707, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS 3 (2006) [hereinafter CBO, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS].

⁴ See U.S. CONGRESSIONAL BUDGET OFFICE, NONPROFIT HOSPITALS AND TAX ARBITRAGE 3 (2006) [hereinafter CBO, TAX ARBITRAGE].

⁵ See CBO, TAX ARBITRAGE, *supra* note 4, at 3. Fixed assets are those that are owned by the hospital and intended to be used long-term, such as buildings, land and machinery.

⁶ These tax benefits are not automatic; organizations incorporated as nonprofits under state law must apply to the IRS and be found to meet the criteria discussed below. See David Nie, *Nonprofit Hospital Billing of Uninsured Patients: Consumer Based Class Actions Move to State Courts*, 4 IND. HEALTH L. REV. 173, 178 (2007).

⁷ See 26 U.S.C. § 170 (2006) (tax deductible donations).

⁸ See 26 U.S.C. § 145 (2006) (qualified 501(c)(3) bonds); 26 U.S.C. § 103(a) (tax-exempt bonds). State and local governments issued about \$9.5 billion in tax-exempt private-activity bonds to nonprofit hospitals in 2002; see *also* CBO, TAX ARBITRAGE, *supra* note 4, at 11.

⁹ See CBO, TAX ARBITRAGE, *supra* note 4, at 3.

¹⁰ See CBO, TAX ARBITRAGE, *supra* note 4, at 5 (nonprofit hospitals have cost of capital of around 10.8 cents per dollar of investment vs. 12.9 cents per dollar of investment for for-profit hospitals).

in savings in 2002.¹¹ JCT estimated that, when state and local tax exemptions are included, nonprofit hospitals received tax benefits of \$12.6 billion.¹² According to information provided by the House Ways and Means Committee, in 2001 nonprofit hospitals made up less than two percent of qualified nonprofit organizations but received 41 percent of the tax benefits.¹³ These sums represent money that would otherwise be available to local, state and federal governments to use for service provision, reduction in taxes paid by other entities and other purposes.¹⁴

The 501(c)(3) Standard for Qualification as a Nonprofit Hospital is Ambiguous and Evolving

Although not specifically recognized in the Internal Revenue Code, hospitals may qualify as exempt nonprofit organizations if they meet certain criteria.¹⁵ Like all qualified nonprofits, they must be “organized and operated exclusively for” an exempt purpose.¹⁶ Hospitals must also meet several other criteria to qualify for the preferential treatment afforded to nonprofits under the federal tax code.¹⁷

These criteria have changed over time. From 1956 through 1969, the IRS required nonprofit hospitals to provide care at no or low cost to those who could not afford it to the extent the hospital was financially able to do so.¹⁸ With the advent of Medicaid and Medicare, hospitals began advocating for a relaxation of this requirement on the grounds that the new legislation would eliminate or greatly reduce the demand for

¹¹ See CBO, TAX ARBITRAGE, *supra* note 4, at 4. Technically, nonprofit hospitals may not issue tax-exempt bonds, but they can be issued by a state or local government to benefit a hospital; see also 26 U.S.C. § 103 (2006).

¹² *Id.* at note 6.

¹³ Press Release, Subcomm. On Oversight, H. Comm. on Ways & Means, Houghton Announces First Hearing in a Series on Tax-exemption: Pricing Practices of Hospitals (June 15, 2004) [hereinafter Subcomm. on Oversight, H. Comm. on Ways & Means], available at <http://www.gpo.gov/fdsys/pkg/CHRG-108hhr99670/pdf/CHRG-108hhr99670.pdf>.

¹⁴ It is likely that actual government revenue would be slightly less, as taxable hospitals engage in a variety of activities to lower their tax burden. See CBO, TAX ARBITRAGE, *supra* note 4, at note 2.

¹⁵ See 26 U.S.C. § 501(c)(3) (2006) (“referring to organizations “organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster national or international amateur sports competition (but only if no part of its activities involve the provision of athletic facilities or equipment), or for the prevention of cruelty to children or animals”).

¹⁶ They are also prohibited from participating in any campaign activity for or against political candidates and engaging substantially in attempting to influence legislation, and none of their earnings may inure to the benefit of a private shareholder or individual. See *id.*

¹⁷ As with all entities seeking an exemption, the burden of proof falls on the hospital. See *Living Faith, Inc. v. Commissioner*, 950 F.2d 365, 370 (7th Cir.1991) (citing cases).

¹⁸ See Rev. Rul. 56-185, 1956-1 C.B. 202. This was known as the “financial ability” standard; this free or low-cost care is often termed “charity care”. The provision of free care to the poor was, in fact, the reason for which hospitals were first created. The well-off could afford to have physicians come to their homes. See *generally* ROSEMARY STEVENS, IN SICKNESS AND IN WEALTH: AMERICAN HOSPITALS IN THE TWENTIETH CENTURY (New York: Basic Books 1989).

charity care.¹⁹ This advocacy effort bore fruit in 1969, when the IRS removed the charity care requirement in favor of a broad standard that required only that hospitals provide benefits to the community.²⁰ This ambiguous “community benefit” requirement remained generally unchanged from 1969 to 2008.²¹

Without clear guidelines in law or regulation, hospitals have usually been left to determine for themselves what activities qualify as community benefits. Not surprisingly, these activities vary across hospitals and hospital organizations, and even where similar benefits are recognized they are often measured inconsistently.²² Some private efforts have been made to standardize and quantify the benefits that nonprofit hospitals provide to the community, but they are largely voluntary and unenforceable.²³ The standards by which states decide if hospitals qualify for preferential treatment under state law also vary considerably.²⁴

¹⁹ See MINORITY STAFF OF S. FINANCE COMMITTEE, TAX EXEMPT HOSPITALS: DISCUSSION DRAFT 5 (2007) [hereinafter S. FINANCE COMMITTEE, TAX EXEMPT HOSPITALS], *available at* <http://grassley.senate.gov/releases/2007/07182007.pdf> (noting that, “The new guidance in Rev. Rul. 69-545 was based on what turned out to be an inaccurate expectation.”).

²⁰ See Rev. Rul. 69-545, 1969-2 C.B. 117. The 1969 “community benefit” ruling set out five non-conclusive factors that would be examined to determine qualification for the nonprofit exemption: (1) the operation of an emergency room available to all community members; (2) a governance board composed of community members; (3) the use of surplus revenue for facilities improvement, patient care, and medical training, education, and research; (4) the provision of inpatient hospital care for all able to pay without discrimination based on payor; and (5) a requirement that all physicians who meet the hospital’s requirements be permitted hospital privileges. *Id.* Hospitals may qualify even if they fail to meet one of these standards. See Rev. Rul. 83-157 (hospital may qualify even when it does not operate an emergency room).

²¹ See *Geisinger Health Plan v. Comm’r*, 985 F.2d 1210, 1217 (3rd Cir. 1993) (examining the state of the law and concluding, “no clear test has emerged to apply to nonprofit hospitals seeking tax exemptions”).

²² GAO, VARIATION IN STANDARDS AND GUIDANCE, *supra* note 2, at 19 (reporting that “[v]ariations in the activities nonprofit hospitals define as community benefit lead to substantial differences in the amount of community benefits they report”); *Id.* at 41 (“We believe that because the [community benefit] standard affords considerable discretion to hospitals in both the determination and measurement of activities that demonstrate community benefit . . . the IRS standard allows nonprofit hospitals broad latitude to determine community benefit.”)

²³ See, e.g., CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, ET AL. COMMUNITY BENEFIT REPORTING GUIDELINES AND STANDARD DEFINITIONS FOR THE COMMUNITY BENEFIT INVENTORY FOR SOCIAL ACCOUNTABILITY, *available at* <https://www.vhafoundation.org/documents/benefitreporting.pdf> (providing the somewhat ambiguous definition of community benefit as “a planned, managed, organized, and measured approach to a health care organization’s participation in meeting identified community health needs [that] implies collaboration with a ‘community’ to ‘benefit’ its residents—particularly the poor, minorities, and other underserved groups—by improving health status and quality of life”).

²⁴ See GAO, VARIATION IN STANDARDS AND GUIDANCE, *supra* note 2, at 16-19 (documenting that in 2005 36 states had no community benefit requirements, and that requirements varied in states that did have them); see also Community Catalyst, Free Care Compendium: National Snapshot, http://www.communitycatalyst.org/projects/hap/free_care/pages?id=0003 (reporting that a minority of states mandate free and reduced cost care, and how such care is treated for

The Nonprofit Hospital Tax Exemption and Its Discontents

In the mid 2000s, a number of federal agencies and officials began questioning whether this voluntary and seemingly arbitrary system was in need of reform. The key problem these officials identified was a lack of standards, accountability and transparency that made it difficult to distinguish hospitals that were providing substantial community benefits from those that were not. The Comptroller General of the United States, testifying before Congress, was blunt: “[C]urrent tax policy lacks specific criteria with respect to tax exemptions for charitable entities, including not-for profit hospitals, in particular. If these criteria are articulated in accordance with desired public policy goals, standards could be established that would allow not-for-profit hospitals to be held accountable for providing services and benefits to the public commensurate with their favored tax status.”²⁵

In 2005, the Government Accountability Office (GAO) reported that on one criterion that is measured relatively consistently across hospitals, the amount of uncompensated care provided to those that cannot afford to pay their hospitals bills, nonprofit hospitals scored only slightly better than for-profits.²⁶ As to other possible benefits, the GAO “was not able to discern a clear distinction among the government, nonprofit and for-profit hospital groups.”²⁷ That same year, the IRS Commissioner testified before a Senate committee that “abuse is increasingly present in the tax-exempt [hospital] sector” and that dramatic changes in the hospital system since 1969 have left “certain factors specifically discussed in Rev. Rul. 69-54... less relevant in distinguishing tax-exempt hospitals from their for-profit counterparts.”²⁸

purposes of tax treatment under state law); HILLTOP INSTITUTE, HOSPITAL COMMUNITY BENEFITS AFTER THE ACA: BUILDING ON STATE EXPERIENCE at 7-10 (2011) [hereinafter HILLTOP INSTITUTE (2011)] (collecting state laws regarding the income level at which patients become eligible for charity care, state approaches to billing and collection practices, state law regarding publicizing hospital financial assistance policies and community benefit reporting requirements); see also *Hosp. Utilization Project v. Commonwealth*, 487 A.2d 1306,1317 (Pa. 1985) (holding that, to obtain tax benefits under state law, nonprofit organizations must (a) advance a charitable purpose; (b) donate or render gratuitously a substantial portion of its services; (c) benefit a substantial and indefinite class of persons who are legitimate subjects of charity; (d) relieve the government of some of its burden; and (e) operate entirely free from private profit motive). Some states have also adopted voluntary community benefit standards. See Massachusetts Attorney General, Community Benefits, *available at* <http://www.cbsys.ago.state.ma.us/cbpublic/public/hccbindex.aspx>.

²⁵ GAO, GAO-05-743T, NONPROFIT, FOR-PROFIT, AND GOVERNMENT HOSPITALS: UNCOMPENSATED CARE AND OTHER COMMUNITY BENEFITS at 19 (2005) (reporting on hospitals in five states) [hereinafter GAO, NONPROFIT, FOR-PROFIT, AND GOVERNMENT HOSPITALS].

²⁶ See *id.* This is, remember, the original justification for hospitals’ nonprofit status. See Stevens, *supra* note 19.

²⁷ *Id.* at 19. The GAO also found that uncompensated care costs were spread unevenly across nonprofit hospitals, with some providing much more than others. *Id.* at 14.

²⁸ *A Review of the Tax-Exempt Health Care Sector, Hearing Before the Committee on Ways and Means*, 109th Cong. 2, 7, (May 26, 2005) (written statement of Mark W. Everson, Commissioner of Internal Revenue) [hereinafter *A Review of the Tax-Exempt Health Care*

The nonpartisan Congressional Budget Office (CBO) reported in 2006 that many nonprofit hospitals issued tax-exempt bonds to finance capital investment even when the hospital held assets sufficient to cover the costs for which the bonds were issued.²⁹ A separate CBO report found that, far from serving those most in need, the average nonprofit hospital operated in an area with higher average incomes, lower poverty rates and lower rates of uninsurance than for-profit hospitals.³⁰ It also found that, while nonprofit hospitals provided slightly more uncompensated care, on average, than for-profit hospitals (about 0.6 percentage points), they also provided care to fewer Medicaid patients as a share of their total patient population than did for-profit hospitals.³¹

Congress took note. The House Committee on Ways and Means held hearings in 2005 at which the IRS Commissioner testified about problems with the current system.³² Senator Grassley (R-Iowa), then ranking member of the Senate Finance Committee, also questioned the nonprofit status of some hospitals in a series of well-publicized hearings.³³ That Committee subsequently proposed a number of reforms, including some that would later appear in the Affordable Care Act.³⁴

Sector], *available at* http://www.irs.gov/pub/irs-tege/5-26-05_hospital_sector_testimony.pdf. The IRS Commissioner also expressed concern that “certain [nonprofit hospital executive] compensation arrangements” may be “excessive” and that the agency may lack the “proper range of tools to enforce compliance in a measured way.” *Id.* at 12. The IRS reported in 2009 that average compensation of executives at a sample of nonprofit hospitals was \$490,431 per year, with a number of top executives drawing more than one million dollars in yearly compensation. IRS, Exempt Organizations Hospital Study Final Report at 124 (2009). Executives in a subgroup of 20 high-compensation hospitals received average compensation of \$1.4 million. *Id.* at 10.

²⁹ CBO, TAX ARBITRAGE, *supra* note 4, at 16 (estimating that 31 percent of nonprofit hospitals were engaged in full arbitrage and 59.1% engaged in partial arbitrage). *See also* William M. Gentry, *Debt Investment and Endowment Accumulation: The Case of Not-for-Profit Hospitals*, 21 J. HEALTH ECON. 845 (2002) (reporting similar results from 1996 data).

³⁰ CBO, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS, *supra* note 3, at 16, 18.

³¹ *Id.* at 15. CBO did find that nonprofit hospitals were significantly more likely to provide a number of generally unprofitable specialized services than were for-profit hospitals. *Id.* at 20. A large number of studies have examined differences in the quality of care and health outcomes between for-profit and nonprofit hospitals but have not generally identified any consistent patterns. *Id.* at 9 (collecting studies).

³² *See* Subcomm. on Oversight, H. Comm. on Ways & Means, *supra* note 13; A Review of the Tax-Exempt Health Care Sector, *supra* note 28.

³³ Press Release, U.S. Senate Committee on Finance: Grassley Asks Non-Profit Hospitals to Account for Activities Related to their Tax-Exempt Status (2005), *available at* <http://www.ahp.org/Resource/advocacy/us/giftstaxesIRS/taxexemptstatus/Documents/prg052505.pdf>; ³³ *Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals: Hearing Before the Senate Finance Committee*, 109th Cong. (2006), *available at* <http://finance.senate.gov/hearings/hearing/?id=e6a6e518-bc40-78f7-ee63-a9993d182e5c> (collecting testimony). The report also recommended that the community benefit standard be replaced with a requirement that nonprofit hospitals that do not meet certain requirements register under a separate section of the tax code, under which they would be unable to issue tax-exempt bonds or receive tax-deductible contributions. *Id.*

Beginning in the summer of 2004, uninsured patients across the United States commenced a number of class action lawsuits alleging that certain hospitals were violating their obligations as tax-exempt charitable institutions by overcharging uninsured patients, failing to inform them of the availability of charity care, and aggressively pursuing them for collection.³⁵ Within a few months more than 70 lawsuits had been filed in federal courts in more than 40 states, with more than 600 hospitals named as defendants.³⁶ The complaints alleged a variety of state contract and fraud claims as well as violations under the Fair Debt Collection Practices Act and the Emergency Medical Treatment and Active Labor Act (EMTALA).³⁷

Federal district court judges uniformly rejected plaintiffs' attempt to use § 501(c)(3) to recognize plaintiffs' contract claims and refused to find that federal tax law gave patients an enforceable right to affordable medical care, but most dismissed state claims without prejudice.³⁸ State cases, based largely on consumer-fraud statutes, were more successful.³⁹ For example, an Illinois state court refused to dismiss plaintiffs' claims for breach of contract and violation of the Illinois Consumer Fraud Act.⁴⁰ As a result,

³⁴ See S. FINANCE COMMITTEE, TAX EXEMPT HOSPITALS, *supra* note 19. (suggesting, among other things, that certain nonprofit hospitals that do not meet specified requirements regarding charity care and other issues register as 501(c)(4) entities); Press Release, Grassley's Provisions for Tax-exempt Hospital Accountability Included in New Health Care Law (March 24, 2010), *available at*

http://grassley.senate.gov/news/Article.cfm?customel_dataPageID_1502=25912.

³⁵ See Beverly Cohen, *The Controversy Over Hospital Charges to the Uninsured – No Villians, No Heroes*, 51 VILL. L. REV. 95, 127-38 (2006) (discussing the initial ruling on the federal claims in the charity care class actions).

³⁶ See *Nonprofit Hospital Charity Care Litigation*, HEALTH L. REP., Nov., 22, 2004, <http://healthcenter.bna.com/pic2/hc.nsf/id/BNAP-674MLV>.

³⁷ See, e.g., *Kizzire v. Baptist Health System, Inc.*, 441 F.3d 1306 (11th Cir. 2006) (dismissing contract and EMTALA claims); *Jellison v. Fla. Hosp. Healthcare Sys. Inc.*, No. 6:04-cv-1021-Orl-28KRS (M.D. Fla. 2005) (ruling that there is no language in 501(c)(3) demonstrating that plaintiffs were the intended beneficiaries of the hospital's tax-exempt status); see also Cohen, *supra* note 35, at 129-33 (discussing plaintiffs' claims in the district courts).

³⁸ See, e.g., *Ferguson v. Centura Health Corp.*, 358 F. Supp. 2d 1014, 1016 (D. Colo. 2004) (stating that the legal premise underlying claims was "patently untenable" and that "formulating federal health care policy is not a proper function of a [federal] court"); *Kolari v. N.Y. Presbyterian Hosp.*, 382 F. Supp. 2d 562, 565-66 (S.D.N.Y. 2005) ("[P]laintiffs have lost their way; they need to consult a map or a compass or a Constitution because plaintiffs have come to the judicial branch for relief that may only be granted by the legislative branch."); *Burton v. William Beaumont Hosp.*, 373 F. Supp. 2d 707 (E.D. Mich. 2005); *Quinn v. BJC Health Sys.*, 364 F. Supp. 2d 1046 (E.D. Mo. 2005).

³⁹ See Kelly Dermody, *Exerting Their Patients*, ABA JOURNAL, May 1, 2009, *available at* http://www.abajournal.com/magazine/article/exerting_their_patients/.

⁴⁰ See *Servedio v. Our Lady of the Resurrection Med. Ctr.*, No. 04 L 3381 (Ill. Cir. Ct. Cook County Jan. 6, 2005) (finding plaintiffs adequately pled state law claims alleging consumer fraud, unfair practices, and breach of contract); *Christiani v. Advocate Health Sys. Care Network, Inc.*, No. 03L14635 (Ill. Cir. Ct. Cook Co., Jan. 27, 2006) (finding a 50% cost reduction for uninsured patients "could constitute a violation of the Consumer Fraud Act"). *But see*

several Illinois hospitals entered into settlement agreements.⁴¹ Similarly, in California two of the largest nonprofit hospital systems in the state, Catholic Healthcare West and Sutter Health, settled class-action lawsuits.⁴² These settlements provided for both prospective and retrospective relief, including refunds for past medical bills and agreements to implement more comprehensive charity care policies.

Suits in other states fared worse. In Connecticut, the state court refused to certify a class of uninsured patients, finding that common issues of law and fact did not predominate.⁴³ Georgia courts dismissed claims alleging unjust enrichment, breach of fiduciary duty, breach of an implied duty of good faith and violations of the state's Uniform Deceptive Trade Practice Act.⁴⁴

State and local officials also challenged hospital charitable behavior and tax-exempt status. For example, in 2004 the Champaign County Board of Review recommended revocation of property tax exemption for Provena-Covenant hospital in Urbana, Illinois.⁴⁵ The Board of Review found that the hospital failed to meet its charity care obligations by billing all patients, including the uninsured poor, for services and then aggressively pursuing debt collection against them. The recommendation was accepted by the State Department of Revenue. The Illinois Supreme Court recently upheld the decision on the grounds that the hospital failed to show that it dispensed charity care "to all who needed it and applied for it."⁴⁶ Revocation of the state property tax means a loss of more than \$1.1 million in savings for Provena.⁴⁷

In addition to challenging hospitals' tax-exempt status, several state legislatures have enacted laws requiring hospitals to implement community benefits practices.⁴⁸ Twenty

Schmitt v. St. Elizabeth's Hosp. Sisters of the Third Order of St. Francis, No. 05L0186 (Ill. Cir. Ct. St. Clair Co., Dec. 16, 2005) ("Plaintiff has failed to allege that he has paid any amount to St. Elizabeth's, or even offered to pay any amount, or that St. Elizabeth's, or even offered to pay any amount, or that St. Elizabeth's has undertaken any collection activities against him, he has no actual damages, and thus cannot state a claim under the Consumer Fraud Act.").

⁴¹ See Settlement Agreement, *Niewinski v. Resurrection Health Care Corp.*, No. 04 CH 15187 (Ill Cir Ct. Cook Cnty. Sept. 9, 2008). Settlement was also reached in *Servedio v. Our Lady of the Resurrection Medical Center*, but terms of the settlement are confidential. See Cohen, *supra* note 35, at fn308.

⁴² See David M. Studdert, et al., *Regulatory and Judicial Oversight of Nonprofit Hospitals*, 356 NEW ENG. J. MED 625, 629 (Feb. 8, 2007), available at http://www.hsph.harvard.edu/faculty/michelle-mello/files/Charity_Care_PDF.pdf.

⁴³ *Ahmad v. Yale-New Haven Hosp., Inc.*, 933 A.2d 1208 (Conn. App. 2007) (finding common issues do not predominate as required for class certification).

⁴⁴ See *Cox v. Athens Regional Med. Ctr.*, 631 S.E. 2d 792 (Ga. Ct. App. 2006); *Pitts v. Phoebe Health Sys., Inc.*, No. 04CV1991-3 (Super. Ct. Dougherty County, Ga. June 27, 2005).

⁴⁵ See Valerie McWilliams & Alan A. Alop, *The Dearth of Charity Care: Do Nonprofit Hospitals Deserve Their Tax Exemptions?*, 44 J. POVERTY LAW & POLICY 110, 115-18 (July-Aug. 2010).

⁴⁶ *Provena Covenant Med. Ctr. v. Dept. of Revenue*, 236 N.E.2d 1131, 1146 (Ill. 2010).

⁴⁷ See *id.* at 1140.

⁴⁸ See, e.g., 210 Ill. Comp. Stat. Ann. 88/15, 88/20 (requiring hospitals to inform patients about charity care and limiting collection activities); 210 Ill. Comp. Stat. Ann. 89/10 (requiring hospitals

states and the District of Columbia now have laws requiring providers to notify patients and the public of available financial assistance programs,⁴⁹ and 15 states have adopted billing and debt collection requirements that apply exclusively to medical debt.⁵⁰ Moreover, several attorneys general have taken investigative action in an effort to ensure that nonprofit hospitals within their states meet their tax-exempt obligations. For example, as a result of the Minnesota Attorney General's investigation of hospitals' charity care policies, the Minnesota Hospital Association and several nonprofit hospitals entered into an agreement to offer uninsured patients a fairer price for services and reform debt collection practices.⁵¹

The IRS Prioritizes Transparency through Additional Reporting Requirements

In 2008 the IRS introduced a new form, Schedule H, in an attempt to “combat the lack of transparency surrounding the activities of tax-exempt organizations that provide hospital or medical care” and “quantify, in an objective manner, the community benefit standard applicable to tax-exempt hospitals”.⁵² Schedule H, which must be filed by nonprofit hospitals each year, requires reporting of community benefit activities, including provision of free or discounted care, as well as other services the hospital may provide to the community such as community health improvement initiatives.⁵³

A recent analysis of the first wave of Schedule H data found that, on average, nonprofit hospitals devoted 2.5 percent of expenses to providing charity care, and approximately 90 percent failed to devote five percent or more of their expenditures to charity care.⁵⁴ It

to discount cost of care provided to low income people); TEXAS HEALTH & SAFETY CODE ANN. §§ 311.043-311.047 (requiring nonprofit hospitals to provide certain community benefits); Jim Dwyer, *Immune to Cuts: Lofty Salaries at Hospitals*, N.Y. TIMES, Mar. 15, 2011, available at <https://www.nytimes.com/2011/03/16/nyregion/16about.html>. (reporting that Assemblywoman Deborah J. Glick, a Democrat from Manhattan, is sponsoring a bill that would limit executive salaries at publicly financed hospitals to \$250,000); CATHOLIC HEALTH ASSOCIATION, SURVEY OF STATE LAWS/OVERSIGHT RELATED TO COMMUNITY HEALTH NEEDS ASSESSMENTS AND IMPLEMENTATION STRATEGIES, at 2 (August 1, 2010) (collecting state laws).

⁴⁹ CA, CT, IL, IN, ME, MD, MA, MN, NH, NJ, NY, OH, PA, RI, SC, TN, TX, UT, WA, and WV. See HILLTOP INSTITUTE (2011), *supra* note 25, at 7.

⁵⁰ MD, MA, MI, MO, NH, NM, OH, OR, PA, RI, SC, TX, WA, WV, and WI. See *id.* at 8.

⁵¹ See Press Release, Agreement Between Attorney General and Minnesota Hospitals Will Provide Fair Pricing to Uninsured Patients, Establish Code of Conduct for Debt Collection Practices (May 5, 2005), available at http://www.mnhospitals.org/inc/data/pdfs/AG_agreement_press.pdf.

⁵² Internal Revenue Service, *Draft Form 990 redesign project – Schedule H instructions*, at 1, (June 2007) available at http://www.irs.gov/pub/irstege/drafftform990redesign_schh_instr.pdf. See also Instructions for Schedule H (2008), <http://www.irs.gov/pub/irs-prior/i990sh--2008.pdf>.

⁵³ These other metrics, including Medicare shortfall, bad debt and community-building activities, are not automatically considered community benefit. See GAO, VARIATION IN STANDARDS AND GUIDANCE, *supra* note 2, at 41.

⁵⁴ Joe Carlson & Melanie Evans, *Short of the mark: A Modern Healthcare analysis of Form 990s shows some very profitable hospitals offering little subsidized care*, CRAIN'S DETROIT BUSINESS, Mar. 21, 2011, available at <http://www.craindetroit.com/article/20110321/FREE/110329997/short-of-the-mark-a-modern->

also found that, while over half of the hospitals analyzed reported that none of their reported bad debt was for patients who were eligible for charity care, a small percentage of hospitals appeared to do a very poor job of identifying and enrolling patients eligible for charity care, as evidenced by the high level of bad attributed to such individuals.⁵⁵

The Affordable Care Act Further Strengthens Transparency and Community Benefit Requirements

The Affordable Care Act (ACA) contains new requirements that nonprofit hospitals must meet as a condition of retaining their tax-exempt status.⁵⁶ In an effort to further increase transparency, the ACA also requires that tax-exempt hospitals report community benefit activities more fully on Schedule H. The ACA also authorizes, for the first time, tax penalties for failing to comply with some (but not all) of the new requirements.⁵⁷ Please see Appendix 1 for a table of the ACA requirements.

Beginning in tax years after March 23, 2010, nonprofit hospitals are required to have a written financial assistance policy that includes eligibility criteria, whether free or discounted care is available to low income individuals, how charges to patients are calculated and the process for applying for financial assistance. The policy must explain how it will be widely publicized and, if the hospital organization does not have a separate billing and collections policy, explain the actions it may take in the event of nonpayment.⁵⁸ This requirement will help fill an important gap: a recent study conducted by two NGOs found that, among 99 hospitals surveyed, fewer than half provided application forms for charity care, only about a quarter provided information regarding eligibility, and only about one third provided information in a language other than English.⁵⁹

healthcare-analysis-of-form-990s-shows-some-very-profitable-hospitals-offering-little-subsidized-care#.

⁵⁵ *Id.*

⁵⁶ These requirements apply to hospital organizations that operate a facility “required by a State to be licensed, registered or similarly recognized as a hospital” or that the “Secretary determines has the provision of hospital care as its principal function.” Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119, 855-858 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (2010) § 9007(a) [hereinafter ACA] (adding new section 26 U.S.C. § 501(r)). These requirements apply to hospitals organizations on a facility-by-facility basis.

⁵⁷ Previously, the only remedy available to the IRS was revocation of an hospital’s tax-exempt status. See A Review of the Tax-Exempt Health Care Sector, *supra* note 28, at 12.

⁵⁸ ACA § 9007(a) (amending 26 U.S.C. § 501(r)(4)).

⁵⁹ Carol Pryor, *Best Kept Secrets: Are Non-Profit Hospitals Informing Patients About Charity Care Programs?*, (Community Catalyst; The Access Project; May 2010), available at http://www.communitycatalyst.org/doc_store/publications/Best_Kept_Secrets_May_2010.pdf.

Also beginning in 2010, charges to patients who are eligible for financial assistance for emergency or medically necessary care are limited to the “amounts generally billed” to patients who have insurance covering such care, and gross charges are prohibited.⁶⁰ Additionally, nonprofit hospitals are prohibited from engaging in “extraordinary collection actions” unless and until they have made “reasonable efforts” to determine whether the patient is eligible for financial assistance.⁶¹ Nonprofit hospitals must also have a written policy to provide emergency medical care regardless of the patient’s ability to pay.⁶²

The ACA also requires that nonprofit hospitals conduct a community health needs assessment (CHNA) every three tax years. This assessment must reflect input from persons who “represent the broad interests of the community served” by the hospital facility, “including those with special knowledge of or expertise in public health,” and be made “widely available” to the public. The hospital must have an implementation strategy for meeting the needs identified in the assessment, report how they are addressing those needs and describe any needs that are not being addressed together with the reasons they are not being acted on.⁶³ Any nonprofit hospital organization that does not meet these requirements must be assessed a tax of \$50,000 per year per non-compliant facility.⁶⁴ Hospitals must report that they have completed the CHNA requirements beginning in tax years after March 23, 2012.⁶⁵

In July 2011 the IRS released an Announcement (2011-52) that provides guidance on the CHNA requirements.⁶⁶ This Announcement clarifies some of the ambiguities present in the statute, and requests additional comments. The Announcement appears to have

⁶⁰ ACA § 9007(a), 10903 (amending 26 U.S.C. § 501(r)(5)). Gross charges are undefined in the ACA, but generally refer to the undiscounted cost of services sometimes charged to self-pay patients. See S. FINANCE COMMITTEE, TAX EXEMPT HOSPITALS, *supra* note 19, at 12.

⁶¹ ACA § 9007(a) (amending 26 U.S.C. § 501(r)(6)). Neither “extraordinary collection actions” nor “reasonable efforts” are defined in the statute. The JCT’s Technical Explanation defines extraordinary collection actions” to include “lawsuits, liens on residences, arrests, body attachments, or other similar collection processes” and “reasonable efforts” to include “notification by the hospital of its financial assistance policy upon admission and in written and oral communications with the patient regarding the patient’s bill, including invoices and telephone calls, before collection action or reporting to credit rating agencies is initiated.” Joint Committee on Taxation, *Technical Explanation of the Revenue Provisions of the “Reconciliation Act of 2010” As Amended, in Combination with the “Patient Protection and Affordable Care Act,”* JCX-18-10, available at <http://www.jct.gov/publications.html?func=startdown&id=3673>.

⁶² ACA § 9007(a) (amending 26 U.S.C. § 501(r)(4)). This requirement is limited to the provision to emergency care covered by EMTALA, 42 U.S.C. 1395dd, which nearly all covered hospitals are already required to provide.

⁶³ ACA § 9007(a).

⁶⁴ ACA § 9007(b)(1) (codified at 26 U.S.C. § 4959).

⁶⁵ ACA § 9007(f). This means that the planning and implementation must begin well before then.

⁶⁶ IRS, Notice 2011-52, *Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-Exempt Hospitals*, available at <http://www.irs.gov/pub/irs-drop/n-11-52.pdf>. Although future guidance is likely, the Announcement notes that hospital organizations may rely on the Announcement “on or before the date that is six months after the date further guidance regarding the CHNA requirements is issued.”

taken into account previous comments from advocates and consumers. For example, it clarifies that the community to be assessed “may not be defined in a manner that circumvents the requirement to assess the health needs (or consult with persons who represent the broad interests of) the community served by a hospital facility by excluding, for example, medically underserved populations, low-income persons, minority groups, or those with chronic disease needs.”⁶⁷ It also specifies that the CHNA will be expected to take into account input from “[l]eaders, 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,” among others.⁶⁸

Discussion

Hospitals are strongly pushing back against these new requirements. In February 2011 the IRS released a revised Schedule H and announced a three-month automatic extension for hospital organizations that would otherwise be required to file tax returns before August 15, 2011.⁶⁹ In response, the American Hospital Association (AHA) (which opposed the community needs assessment and charity care reporting requirements before the ACA was passed) together with the Healthcare Financial Management Association and a number of state hospital associations wrote to the IRS claiming that the new reporting requirements were “onerous and redundant,” that they “go beyond what the statute requires” and that they were “inconsistent with recommendations submitted . . . by AHA and other associations.”⁷⁰

This lobbying has started to pay off. In June, 2011 the IRS released an Announcement (2011-37) that makes the section of Schedule H where hospitals report compliance with these new requirements optional for the 2010 tax year “to give [hospitals] more time to familiarize [themselves] with the types of information the IRS will be collecting related to compliance with [the new requirements] and to address any ambiguities arising from the extensive revisions to the form and instructions.”⁷¹ This makes it nearly impossible to determine whether hospitals are complying with the new regulations.

⁶⁷ *Id.*

⁶⁸ *Id.* at 15.

⁶⁹ See IRS, 2010 Form 990 Schedule H, *available* at <http://www.irs.gov/pub/irs-pdf/f990sh.pdf>; IRS, Announcement 2011-20, Delayed Filing Season for Certain Tax-Exempt Hospitals, *available* at http://www.irs.gov/pub/irs-tege/a2011_20.pdf. It also directed nonprofit hospital organizations to delay filing Form 990 until July 1, 2011, and waived late filing fees that would otherwise apply. *Id.*

⁷⁰ Letter from Melinda Reid Hatton, Senior Vice President & Gen. Counsel, American Hospital Association to Sarah Hall Ingram, Commissioner, Internal Revenue Service, Tax-Exempt & Government Entities Division (Apr. 20, 2011). The letter also refers to Schedule H as “burdensome, carelessly redundant, and . . . developed outside of the normal IRS process for implementing new statutory requirements.” *Id.* at 7.

⁷¹ IRS, Announcement 2011-37, *Portion of Form 990 Schedule H Optional for Tax-Exempt Hospitals for Tax Year 2010*, *available* at <http://www.irs.gov/pub/irs-drop/a-11-37.pdf>.

Some advocates fear that this is only an opening salvo, with a complete rollback of the new ACA requirements the ultimate goal. While some advocates and advocacy organizations are pushing back against this possibility, this issue appears to have been largely lost in the fog of the large number of other ACA implementation issues.⁷² This is a mistake. Even after 2014 millions of people will continue to lack access to health care and will continue to rely on nonprofit hospitals as a final safety net. The ACA changes, while relatively modest, will still likely increase access to care for these vulnerable people. As such, they should be zealously defended.

To help ensure that low-income uninsured and under-insured people are afforded the protections guaranteed by law, advocates should:

1. Form and maintain strong relationships with community groups, nonprofit organizations and local nonprofit hospitals. In some communities, nonprofit hospitals already operate formal or informal partnerships with groups such as the United Way. They may also have relationships with health departments and clinical care providers such as FQHCs. Attempt to work collaboratively with these organizations to ensure that the new requirements are implemented quickly and well.
2. Familiarize themselves with the track record of any relevant litigation in their state. Past state court successes may make the industry more receptive to allowing advocates a “seat at the table” as decisions are made as to how they will put these new requirements into practice. Advocates should also be aware of any “Payment in Lieu of Tax” (PILOT) regulations and voluntary or mandatory agreements (such as settlement agreements) to which local hospitals may be subject.
3. Engage in internal and public education to ensure that staff and clients are aware of the new financial responsibility and transparency requirements. This education could include fact sheets for clients, trainings for the public, advocates and hospital staff, posting information on the organization’s website, and the like. Advocates should reach out to the state Attorney General and revenue departments to determine what steps they are taking to ensure compliance with applicable state law.
4. Be active and involved members of the community health needs assessment process. Contact the non-profit hospitals in your area to determine what their process is for the assessment, and hold a community forum to inform your clients and the community about the process, including the need for the community to be heard. Reach out to nonprofit hospitals and community providers (including health departments) to ensure that the process is collaborative from the beginning. Consider submitting

⁷² This is not to say that these changes are completely under the radar; the decision to make reporting optional was vocally opposed by a number of organizations. See Letter from Community Catalyst et al. to Timothy Geitner, Secretary, U.S. Dep’t of the Treasury, *available at* http://www.communitycatalyst.org/doc_store/publications/Letter_to_Treasury_re_Schedule_H_Optional_July_2011.pdf.

comments regarding the proposed regulations covered in Announcement 2011-52 and further Announcements and draft regulations as they become available.⁷³

Community input, including input from knowledgeable advocates, is necessary to ensure that terms are interpreted in a way that most benefits community partners and clients, particularly underserved members of the community. Many terms and concepts will need to be sorted out. For example, Announcement 2011-52's definition of "community" is good, but does not specifically mention, for example, those unable to access hospital services because of because of cost, transportation, stigma and other issues.⁷⁴ Many other questions, including the meaning of terms such as "extraordinary collection actions" and "reasonable efforts" will also be addressed with input from the public – including hospitals and hospital associations. It is very important that the consumer voice continues to be heard as these terms are defined.

5. Determine if other state laws apply to nonprofit hospitals. Some states have their own community benefit requirements. Understand how these overlap with the federal requirements. See if your state is among the 36 or so states with certificate of need (CON) laws.⁷⁵ These laws typically require regulated entities to establish how proposed projects will benefit the community as a condition of approval for expansion, new services, and the like. Review the non-profit hospitals' recent CON applications and approvals and hold them to any representations they made to benefit the community as part of the CHNA process.

6. Attempt to ascertain if nonprofit hospitals in the area are in compliance with the new requirements. The Secretary of the Treasury is required to review each nonprofit hospital's community benefit activities every three years, but advocates should not wait for these reports.⁷⁶ Nonprofits are required to make their tax forms publicly available, and many hospitals post them on their websites. Advocates can access each hospital's tax forms on [guidestar.org](http://www.guidestar.org). Advocates and community members can also attempt to gauge compliance by adding relevant questions to intake forms and visiting hospitals to

⁷³ Comments on Announcement 2011-52 are due by September 23, 2011. They should be sent to: Internal Revenue Service, CC:PA:LPD:PR (Notice 2011-52), Room 5203, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044 or via email to Comments@irs.counsel.treas.gov with "Notice 2011-52" in the subject line.

⁷⁴ See, e.g., CATHOLIC HEALTH ASSOCIATION, ASSESSING AND ADDRESSING COMMUNITY HEALTH BENEFITS – DISCUSSION DRAFT: March 2011 at 19-20 (2011), available at <http://www.chausa.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=4294967392> (suggesting that hospitals "consider areas and populations that are beyond the hospital's traditional service boundaries" including "neighborhoods and other geographic areas having at-risk populations").

⁷⁵ For a state-by-state map, please consult the National Conference of State Legislatures, <http://www.ncsl.org/default.aspx?tabid=14373> (last updated May 11, 2011).

⁷⁶ ACA § 9007(c). These reviews have already begun. See Ruth Madrigal, Dept of Treasury, Presentation to American Health Lawyers Association, Boston, Massachusetts (June 28, 2011). In addition, the Secretary of the Treasury in consultation with the Secretary of Health and Human Services must report to certain Congressional committees on amounts of and trends in community benefit activities no later than five years after the enactment of the ACA. ACA § 9007(e).

see if required information regarding financial assistance policies is posted. See Appendix 2 for a checklist that can be used as a starting point for reviewing compliance.

7. If hospitals are found to be out of compliance, advocates should contact the hospital to present evidence and demand compliance. If such compliance is not forthcoming, contact the press, state and local tax boards, federal treasury authorities and, if appropriate, the state attorney general.

Conclusion

Nonprofit hospitals enjoy a number of financial benefits not available to for-profit corporations. Many, however, appear not to be holding up their end of the bargain by failing to provide substantial benefits to the communities that they serve. As a result of a sustained effort by legislators and advocates, hospitals are required to provide, and show that they are providing, certain community benefits. These new requirements, though not as stringent as they might be, provide concrete benefits to patients and community members. However, some hospitals are strongly pushing back against them. Advocates should be aware of these new requirements, and work to ensure that they are being enforced.

Appendix 1: Affordable Care Act Nonprofit Hospital Requirements

Provision	Requirements	Possible Penalty	Effective Date ⁷⁷
Financial assistance (501(r)(4))	<p>Maintain written financial assistance policy that includes:</p> <ul style="list-style-type: none"> • eligibility criteria for financial assistance • whether such assistance includes free or discounted care • the basis for calculating amounts charged to patients • how to apply • if no separate billing and collections policy, the actions the organization may take in the event of nonpayment, including collections action and reporting to credit agencies • measures to widely publicize the policy within the community 	Loss of 501(c)(3) status	March 23, 2010
Emergency care (501(r)(4))	Maintain a written policy to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility for financial assistance	Loss of 501(c)(3) status	March 23, 2010
Limitations on charges (501(r)(5))	<ul style="list-style-type: none"> • Amounts charged for emergency or other medically necessary care provided to individuals eligible for financial assistance is limited to amounts generally charged to individuals who have insurance covering such care • Use of gross charges is prohibited 	Loss of 501(c)(3) status	March 23, 2010
Billing and collection (501(r)(6))	Hospitals prohibited from engaging in extraordinary collection actions before making reasonable efforts to determine whether patient is eligible for financial assistance	Loss of 501(c)(3) status	March 23, 2010
Community health needs assessment (501(r)(3))	<ul style="list-style-type: none"> • Conduct every three years • Adopt implementation strategy • Take into account input from persons who represent the broad interests of the community served by hospital, including those with knowledge or expertise in public health • Make widely available to the public 	\$50,000 tax per year, loss of 501(c)(3) status	March 23, 2012

⁷⁷ The provisions are effective for tax years beginning after the date noted.

Appendix 2: Nonprofit Hospital Requirements – Checklist for Advocates

Requirement	Checklist	☑
Financial assistance policy	Required by ACA	
	Hospital has financial assistance policy?	
	Financial assistance policy is widely publicized?	
	Policy includes eligibility criteria for financial assistance?	
	Policy states whether such assistance includes free or discounted care?	
	Policy states the basis for calculating amounts charged to patients?	
	Policy states how to apply for assistance?	
	Policy states which actions hospital may take in the event of nonpayment?	
	Policy is reported on Schedule H?	
	Policy as reported on Schedule H reflects actual policy?	
	NHeLP Recommendations	
	Is the policy posted in a conspicuous location in the hospital?	
	Is the policy available in languages used in the community?	
	Is the policy written in clear, simple language?	
	Are hospital personnel available to explain policy and answer questions?	
Limitations on charges	Required by ACA	
	Are amounts charged for emergency or other medically necessary care provided to individuals eligible for financial assistance limited to the lowest amounts charged to individuals who have insurance covering such care?	
	Are gross charges prohibited?	
	NHeLP Recommendations	
	Does the hospital provide information necessary to easily determine compliance?	
	Is the policy prominently posted?	
	Is the policy available in languages used in the community?	
Billing and collection	Required by ACA	
	Does the hospital refrain from engaging in extraordinary collection actions before making reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy?	
	NHeLP Recommendations	
	Is the definition of “extraordinary collection actions” used by the hospital reasonable?	
	Is the definition of “reasonable efforts” used by the hospital reasonable?	
	Is the billing and collection policy prominently posted?	
	Is the policy available in languages used in the community?	

Appendix 2: Nonprofit Hospital Requirements – Checklist for Advocates

Requirement	Checklist	☑
Emergency care	Required by ACA	
	Does the hospital maintain a written policy to provide care for emergency medical conditions to individuals regardless of their eligibility for financial assistance?	
	NHeLP Recommendations	
	Is the policy prominently displayed?	
	Is the policy available in the languages used in the community?	
	Is the policy written in clear, simple language?	
	Is the hospital following the policy?	
Community health needs assessment (CHNA)	Required by ACA	
	Has the hospital conducted a CHNA within the past three years?	
	Has the hospital adopted an implementation strategy?	
	Does the CHNA take into account input from persons who represent the broad interests of the community served by hospital?	
	Does the CHNA take into account input from people with expertise in public health?	
	Is the CHNA widely available to the public?	
	NHeLP Recommendations	
	Was the CHNA conducted with input from members (as opposed to “persons who represent the broad interests of”) the community?	
	Was community input incorporated into the assessment?	
	Is the definition of “community” reasonable?	
	Were community organizations involved in conducting the assessment?	
	Were privacy concerns of informants addressed?	
	Were subsequent assessments modified to address issues identified with previous assessments?	