



*A Passionate Voice for Compassionate Care*

July 2, 2013

Michael D. Julianelle, Acting Commissioner  
Tax Exempt and Government Entities Division  
Internal Revenue Service  
P.O. Box 7604  
Ben Franklin Station  
Washington, DC 20044

Subject: IRS Notice of Proposed Rulemaking: Community Health Needs Assessments for Charitable Hospitals  
26CFR Parts 1 and 53 (REG-106499-12)

Dear Commissioner:

The Catholic Health Association of the United States (CHA), representing Catholic sponsored hospitals and other health care facilities, their sponsoring organizations and health care systems, is pleased to provide comments on the Internal Revenue Service Notice of Proposed Rulemaking concerning the Affordable Care Act (ACA) requirements on community health needs assessments (CHNAs) for charitable hospitals.

For over 20 years, CHA has been a leader in the field of community benefit, providing education and resources on how tax-exempt health care organizations plan and report their community benefit contributions. Since 1989, CHA materials have included guidelines and resources for assessing community health needs and developing plans to address those needs. Working with our members, experts in public health and consumer advocates, CHA has developed a new resource *Assessing and Addressing Community Health Needs*. ([Assessing and Addressing Community Health Needs](#)) to help charitable hospitals comply with the new ACA requirements around CHNAs and implementation strategies and to strengthen their processes around needs assessments and community benefit planning.

CHA was pleased to see that comments submitted on the earlier notice of intent (Notice 2011-52) were incorporated into this NPRM. Our comments below include some of these earlier comments and other issues of concern to our membership.

### **1.501 (r) – 2 Issue: Failure to satisfy requirements**

CHA agrees that minor and inadvertent omissions and errors should not be considered failure to meet the requirement if the hospital facility corrects the omission or error promptly after discovery.

CHA also agrees that the failure of one facility within a multi-facility hospital organization should not cause the entire organization to lose its tax-exemption.

However, CHA is concerned about the ambiguity of the term “egregious”. Therefore, we urge the IRS, when issuing guidance on what types of conduct would be considered egregious to reserve this for actions that are of the utmost seriousness and that would undermine the intent of Section 501(r) as a whole.

### **1.501 (r) –2 (d)(4) Issue: Taxation of noncompliant hospital facilities and tax-exempt bonds**

The regulations state that a hospital organization operating a noncompliant hospital facility subject to taxation will continue to be treated as a Section 501(c)(3) for all purposes of the Code. The example given in the NPRM is that imposition of the tax on the noncompliant hospital will not, by itself, affect the status of tax-exempt bonds issued to finance the noncompliant facility. For purposes of clarification, we request that the final regulations specifically provide that imposition of the tax on a noncompliant facility will not cause its activities to be treated as an unrelated trade or business. This will help eliminate confusion about the application of other Sections of the Code, such as Section 145, to this situation.

### **1.501 (r) – 3 (b) (2) and (c)(5) Issue: Timing of the CHNA and implementation strategy**

It may be impractical for the CHNA and the implementation strategy to be conducted within the same tax year, especially if the hospital facility is working collaboratively with other hospitals and/or other community organizations that have different timetables for their assessments and community health improvement plans.

CHA recommends that 1.501 (r) – 3 (a) (2) be reworded to:

“An authorized body of the hospital facility has adopted an implementation strategy to meet the community health needs identified through the CHNA....~~by the end of the taxable~~ within twelve months from the date in which the hospital facility conducts the CHNA.”

#### **1.501 (r) – 3 (b) (4) Issue: Significant needs**

CHA appreciates, here and elsewhere, the use of the term “significant health needs” as opposed to directing hospitals to address all health needs identified in the CHNA. We believe that hospitals will be able to determine which needs are significant, as described in the proposed rule.

#### **1.501 (r) – 3 (b) (5) Issue: Persons representing the broad interests of the community**

CHA agrees that public health expertise should come from “at least one state, local, tribal or regional government public health department (or equivalent department or agency with knowledge, information or expertise relevant to the health needs of that community.” We believe this requirement meets the intent of the legislation.

#### **1.501 (r) – 3 (b) (7) (i) (E) Issue: Measures for addressing needs**

CHA recommends deleting, “(E) A description of the potential measures and resources identified through the CHNA to address the significant health needs.” This information should be in the implementation strategy, not in the assessment.

#### **1.501 (r) – 3 (b) (7) (iii) Issue: Input from persons who represent the broad interests of the community**

CHA agrees that documentation of input received is sufficient if “the CHNA report summarizes, in general terms, the input provided by such persons and how and over what time period such input was provided...” This provision gives direction while allowing flexibility.

#### **1.501 (r) – 3 (b) (7) (iv) and (v) Issue: Separate CHNA reports and joint reports**

CHA appreciates the clarification that portions of hospitals’ CHNA reports may be identical if those hospitals are collaborating on the CHNA and that in some circumstances joint reports are permissible.

#### **1.501 (r) – 3 (b) (8) (ii) Issue: Draft reports**

CHA agrees that draft reports made publicly available should not be considered final. This will allow hospitals to solicit comment on their CHNAs without “starting the clock” for the implementation strategy and the next cycle of assessment.

### **1.501 (r) -7 Effective/applicability dates**

This NPRM addresses the effective date of the hospital financial assistance and billing rules as well as for CHNAs. We believe, given the extensive nature of the former, that hospitals will need considerable time to gear up for implementation. Therefore, we recommend that adequate time be allowed for hospitals to make needed changes in personnel, policies and electronic records that the new rules will necessitate.

### **State law equivalence**

Finally, CHA recommends, as we did in our earlier comments on Notice 2011-52, that final rules recognize equivalent state-law requirements regarding CHNAs and implementation strategies. Hospitals in those states should be considered to satisfy the requirements of Section 501 (r) when they meet their states' requirements.

The Catholic Health Association welcomes an opportunity to discuss these comments. Please contact Michael Rodgers at [mrodgers@chausa.org](mailto:mrodgers@chausa.org) or 202-296-3993 for any questions or comments.

Sincerely,

A handwritten signature in black ink that reads "Sr. Carol Keehan". The signature is written in a cursive, flowing style.

Sr. Carol Keehan, DC  
President and Chief Executive Officer