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June 27, 2013

Submitted electronically to www.regulations.gov
(IRS REG—106499—12)

Department of the Treasury
Internal Revenue Service
Washington, DC 20004

Re: REG—106499—12 Community Health Needs Assessments for Charitable Hospitals

To Whom It May Concern:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, the American Hospital Association (AHA) appreciates the opportunity to provide comments on the proposed regulations issued on April 5 by the Department of the Treasury and the Internal Revenue Service (collectively the "Treasury") to implement amendments to Section 501(r) of the Internal Revenue Code (Code) enacted by the *Patient Protection and Affordable Care Act of 2010* (ACA). Specifically, Section 501(r)(3) requires a hospital to conduct a community health needs assessment (CHNA) at least once every three years and to adopt an implementation strategy to meet the needs identified through the CHNA; in addition, Section 6033(b)(15) requires a hospital organization to report on its annual information return how it is meeting the needs identified through the CHNA. The proposed regulations also address the consequences for a hospital failing to satisfy any of the Section 501(r) requirements.

The AHA and its members support the goals of Section 501(r), and hospitals are committed to meeting the requirements of the statute. We appreciate the important improvements the proposed regulations make to the 2011 guidance from Treasury regarding CHNAs and other modifications that will help minimize unnecessary burden for hospitals. We also welcome the long-awaited guidance on the consequences for failing to meet the 501(r) requirements and support the "three-tiered" approach, which recognizes that loss of exemption should occur only in extreme circumstances. Our comments recommend modifications and clarifications to the proposed regulations to further reduce unnecessary burden under the CHNA requirements and to provide greater certainty regarding enforcement of the statute.

CHNA AND IMPLEMENTATION STRATEGY

At the core of the CHNA requirements are transparency and engagement with the community served by the hospital in identifying its health needs. These are expectations hospitals not only endorse, but are embedding in the fabric of their organizations. Hospital concerns with implementation of Section 501(r) continue to be focused on staying true to the intent of Congress, while avoiding detailed or prescriptive requirements that create unnecessary burden and limit appropriate flexibility for the means to achieve the statutory requirements.

Congress did not, and had no need to, prescribe how to do a "needs assessment;" it is a longstanding fixture in the world of health planning. The essential components are to identify needs and develop a strategy to address priorities within available resources. The 2011 guidance and the current proposed guidance both attempt to establish a regimen for how to do this. They also create significant documentation requirements that add no discernible value to this process.

The proposed regulations make several welcome improvements to the 2011 guidance. First, hospitals that collaborate in conducting a CHNA also will be able to develop one joint CHNA report. Similarly, collaborating hospitals may develop a joint implementation strategy. While the prior guidance encouraged collaboration, each hospital was required to document in a separate report and implementation strategy the results of the collaborative effort, even though the purpose of collaboration was to make most effective use of resources in assessing community needs and mapping out strategies to address them. Another improvement is the clarification that the intended focus of an assessment and a strategy is "significant" health needs of the community, rather than "all" of the health needs a community might have. The proposed regulations also remove some of the detail previously required to document the "who, what, where" of interactions with the community.

However, even with all of these improvements, the size, scope and cost of CHNAs to meet the detail of the proposed regulations can be significant. In Treasury's submission to the Office of Management and Budget for clearance under the *Paperwork Reduction Act* to require the "collection of information" necessitated by the proposed regulations, the estimated burden was 80 hours. Input from AHA members indicates the amount of time required to comply with the request for information will greatly exceed this estimate. Based on estimates and experience, satisfying the requirements of the proposed regulations may involve thousands of hours and the expenditure of tens of thousands of dollars or more. A close look at the detail of what is required demonstrates why. A chart is attached summarizing the procedures each hospital will have to establish and implement.

We urge the following changes and clarifications to the requirements for the CHNA and implementation strategy to minimize unnecessary burden and facilitate collaboration among hospitals:

- **Remove the requirement that a CHNA include "potential measures and resources" to address the significant health needs identified.** This duplicates documentation

requirements for the implementation strategy and requires more information than is necessary. The implementation strategy is the place to discuss the means to address health needs. In it, the hospital will identify the significant health needs it will address and then describe the programs and resources it will commit to addressing those needs.

- **Modify the requirement that a CHNA describe the "data and information used" and the "method for collecting and analyzing" the data to permit referencing publicly available source material that is relied on (e.g., public health agency data) and including a summary or highlights of key information.**

- **Clarify that the requirement for an implementation strategy to include a "plan to evaluate the impact" of its efforts to address a need can be accomplished through the process of conducting its next needs assessment.**

- **Eliminate the requirement that the implementation strategy be adopted in the same tax year as the CHNA was conducted.** Requiring that both be completed in the same "tax year" will unnecessarily limit needed flexibility for hospitals. This is especially the case when hospitals are collaborating with others or when collaborating with a public health agency. Many public health departments are required to conduct needs assessments on cycles different than the hospital's three-year cycle. Also, collaborating hospitals may start their tax years in different months (e.g., January and July). The effect of the proposed regulations would be that one of them would arbitrarily have only six months within which to complete its implementation strategy.

The final regulations also should recognize equivalent state-law requirements and permit hospitals in those states to satisfy the 501(r) requirements by demonstrating compliance with the state's requirements. A number of states have laws addressing one or more of the requirements in Section 501(r). Requiring compliance with the specifics of the 501(r) regulations without regard to what hospitals are already required to do under state law creates unnecessary duplication of effort and administrative burden. The Schedule H can be used for the hospital to identify the state law that applies and describe how satisfying the state requirements provides an alternative means to meet the goals of the CHNA requirements in the statute.

SANCTIONS

The proposed regulations responded to the concerns of hospitals and others that revocation of exemption is an extraordinary remedy that could adversely affect hospitals, patients and the community. The regulations adopt a calibrated approach that excuses certain levels of infractions and reserves loss of exemption for extreme circumstances.

Excused Noncompliance. Infractions that are minor, inadvertent and due to reasonable cause will be excused, provided they are corrected as promptly after discovery as is reasonable given the nature of the infraction. A second tier of noncompliance that also will be excused involves infractions that are more than minor and inadvertent but are not willful and egregious. These

will be excused only if the hospital corrects and discloses the noncompliance pursuant to future guidance that will be issued separately from the final regulations. The proposed regulations caution, however, that correction and disclosure does not create a presumption that the failure was neither willful nor egregious.

We recommend that the final regulations create a rebuttable presumption that infractions encompassed in the second tier of noncompliance are neither willful nor egregious once a hospital corrects and discloses it in accordance with IRS guidance. The proposed regulations create an unreasonable uncertainty for hospitals regarding their status. As proposed, even after reasonably prompt discovery, correction and disclosure of the noncompliance, a hospital organization may be subject to the burden of computing the facility-level tax or even to loss of exemption. This could occur many years after the original infraction. The preamble stresses that transparency is an important objective of Section 501(r). Correcting and disclosing noncompliance achieves the goal of transparency and serves the best interests of the hospital and its community. Once a hospital meets the objective of Section 501(r) by rectifying noncompliance and disclosing it, a hospital should not be subject to future repercussions.

The IRS may rebut the presumption based on all the facts and circumstances, including those enumerated in the proposed regulations for determining whether continued exemption is merited. For hospitals that do not comply with the proposed future guidance regarding correction and disclosure, the rebuttable presumption would not apply. Their noncompliance would be evaluated using the facts and circumstances enumerated in the proposed regulations to determine appropriate sanctions.

A similar approach was adopted in the intermediate sanctions regulations (Treas. Reg. § 53.4958-6) regarding "excess benefit transactions." A rebuttable presumption was created that certain transactions will not be treated as excess benefit transactions if specified conditions are satisfied. The IRS may rebut the presumption by relying on contemporaneous facts and circumstances. **We urge the IRS to adopt the rebuttable presumption approach for the second tier of noncompliance for those hospitals that self-monitor, self-correct and disclose their infractions consistent with the objectives of Section 501(r).**

Additional Modifications. We urge additional modifications and clarifications to advise hospitals more clearly how the statute will be enforced:

- **The final regulations (§501(r)-2(a)) should state that tax-exempt status will be lost only when, based on all the facts and circumstances, the violation amounts to an egregious and willful failure to meet Section 501(r) requirements**. While the preamble to the proposed regulations notes that the "Treasury Department and the IRS expect that the application of these facts and circumstances will ordinarily result in revocation of the section 501(c)(3) status of the hospital organization if the organization's failures to meet the requirements of section 501(r) are willful and egregious," this expectation is not embedded in the text of the proposed regulation.

- **The terms "egregious" and "civil penalty" should be defined and/or clarified**. The term "egregious," one of the two benchmarks for revocation of exemption, is not defined in the proposed regulations nor is a definition found in any other part of the Code or Treasury regulations. Additionally, the discussion of what "willful" means alludes to interpretations of the term in the context of unidentified "civil penalties." Hospitals should be fully informed of how the Treasury will interpret the two most consequential terms for maintaining tax-exempt status.

- **The final regulations should include examples to illustrate the various types of noncompliance, as well as when and how such noncompliance should be remedied to avoid sanctions**. It is critical for hospitals to understand when noncompliance with Section 501(r) requirements may be excused or sanctioned. The proposed regulations do not provide any guidance or descriptions regarding the types of failures that would qualify as minor and inadvertent or as more than minor and inadvertent. It is common for Treasury regulations to provide examples that clarify the content of the regulations. For instance, there are multiple examples that illustrate, based on a facts and circumstances analysis, when tax-exempt status may be revoked in situations where intermediate sanctions have been imposed (Treas. Reg. § 1.501(c)(3)-1(f)(2)(iv)). Similar examples can be provided in the final regulations to illustrate various infractions, as well as how the facts and circumstances analysis in the proposed regulations (Treas. Reg. § 1.501(r)-2(a)) will be applied.

- **The final regulations also should clarify that activities of facilities subject to the facility-level tax will not constitute unrelated trade or business of the hospital organization.** Tax-exempt bond rules generally require bond-financed hospital facilities to be owned by a 501(c)(3) hospital organization and to be used in activities that do not constitute an unrelated trade or business of the hospital organization. **Final regulations should make clear that if a hospital organization is subject to a facility-level tax, the activities of the noncompliant facility will not be treated as an unrelated trade or business of the hospital organization for purposes of tax-exempt bonds issued to finance the noncompliant facility**.

EFFECTIVE DATE OF FINAL REGULATIONS

Treasury has announced its intention to issue one consolidated set of final 501(r) regulations. As proposed, all would take effect on the date they are published in the *Federal Register*. Treasury acknowledges that a transition period is currently only provided for the CHNA and that it is considering transition relief for the other three 501(r) requirements. **The final regulations should include a transition period for hospitals to come into compliance with the finalized financial assistance policy, limitation on charges, and billing and collection requirements commensurate with the extent to which hospital policies, procedures and information systems will need to be changed.**

As described in AHA's September 24, 2012 comment letter, meeting the proposed Section 501(r)(4)-(6) regulations would require extensive changes to hospitals' information systems and administrative procedures, as well as an investment of significant time and financial resources. **We continue to believe that the detailed requirements, especially the "reasonable effort" requirements, are unwarranted to meet the goals of the statute, and urge that the final regulations make significant modifications to what was proposed.** Only when the content of the final regulations is known can we make a reasonable assessment of how much time will be needed for transition relief. In the absence of significant changes, however, it is clear that significantly more transition relief will be required than the four-and-a-half month period for the CHNA requirements.

In closing, we urge that the final regulations explicitly address whether and, if so, how, the CHNA and other requirements apply to government hospitals with 501(c)(3) status. Applying those requirements represents a major change in how these hospitals are treated in the Code. While the 2011 guidance requested input on how the CHNA requirement might be adapted for government hospitals with (c)(3) status, the proposed regulations do not acknowledge that request or discuss the comments received. These hospitals and their governing bodies continue to raise questions about their status under the regulations and the final regulations should provide clear direction to them.

The AHA welcomes an opportunity to meet with Treasury representatives to discuss our comments as the 501(r) regulations are finalized. Please feel free to contact me with any questions or comments at mhatton@aha.org or (202) 626-2336.

Sincerely,

/s/

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Attachment

PROCEDURES REQUIRED TO COMPLY WITH THE PROPOSED REGULATIONS UNDER SECTION 501(r)(3) AND OTHER REPORTING REQUIREMENTS

Community Health Needs Assessment (CHNA)
Tasks
Conduct a CHNA and prepare a CHNA report every three years. • Define the community served by the hospital and describe how the community was determined

• Assess the needs of the community
  ○ Identify which health needs are significant
  ▪ Describe the process and criteria used to identify which needs were significant
  ○ Prioritize the significant health needs
  ▪ Describe the process and criteria used to prioritize the significant health needs
  ○ Identify and describe potential measures and resources to address the significant health needs

• Take into account input from persons representing the broad interests of the community served by the hospital
  ○ Consult with a public health department
  ○ Consult with members of the medically underserved population or organizations that serve or representative them
  ○ Consult with members of the low-income population or organizations that serve or represent them
  ○ Consult with members of minority populations or organizations that serve or represent them

• Describe how the hospital took into account input from those representing the broad interests of the community served
  ○ Summarize, in general terms, how and over what time period input was provided (for example, whether through meetings, surveys, or written comments and between what dates)
  ○ Provide the names of organizations providing input and summarize the nature and extent of the organization's input
  ○ Describe the medically underserved, low-income, or minority populations being represented by organizations or individuals that provided input

- Describe the process and methods used to conduct the CHNA
    - Data and other information used in the assessment
    - Methods of collecting and analyzing the data and information
    - Any parties with whom the hospital collaborated
    - Any party with whom the hospital contracted for assistance

- Adoption of the CHNA by an authorized body of the hospital

- Widely publicize the CHNA
    - Conspicuously post the CHNA report on the hospital website or link to another site where it is posted
    - Make a paper copy available for public inspection at the hospital

Implementation Strategy

Tasks

Develop a written Implementation Strategy every three years.

- For each significant health need identified through the CHNA
    - Describe the actions the hospital facility intends to take to address the health need
    - Describe the anticipated impact of these actions
    - Develop a plan to evaluate such impact
    - Identify the programs and resources the hospital facility plans to commit to address the health need
    - Describe any planned collaboration between the hospital facility and other facilities or organizations in addressing the health needs – OR,
        - For any health need the hospital does not plan to address, provide a brief description of the reason

- Adoption of the implementation strategy by an authorized body of the hospital

- Attach the Implementation strategy to the hospital's Form 990 –OR,
    - Make it widely available on a website and include the address (URL) for the site where the strategy is located

• Report on the hospital's Form 990 for each of the subsequent two years, a description of the actions taken during the taxable year to address the significant health needs identified through its most recently conducted CHNA, or, if no actions were taken with respect to one or more of these health needs, the reasons why no actions were taken
Failure to Satisfy Section 501(r) Requirements
Tasks
• Report on the hospital's Form 990 the amount of an excise tax imposed for failure to meet the CHNA requirements during the taxable year • Disclose (pursuant to future guidance to be issued separately) failure to comply with a requirement that is more than minor or inadvertent and not willful or egregious • Calculate (pursuant to detailed instructions) and report on the organization's Form 990-T the tax due for any willful or egregious noncompliance of a hospital facility within a multi-hospital organization