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VIA ELECTRONIC SUBMISSION

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Attn: CC:PA:LPD:PR (REG–106499–12)

RE: CC:PA:LPD:PR (REG–106499–12)

Proposed Rule: Community Health Needs Assessments for Charitable Hospitals

The National Health Law Program (NHeLP) protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates, and litigates at the federal and state levels. NHeLP provides technical support to direct legal services programs, community-based organizations, the private bar, and providers and individuals who work to preserve a health care safety net for the millions of uninsured or underinsured low-income people.

It is critical not only that that low-income and underserved individuals have access to emergency and medically necessary care at charitable hospitals, but also that those hospitals work with health departments and other community partners to fully understand the needs of the communities they serve and address structural and other determinants of health. The requirements contained in ACA § 9007 are a much-needed step to ensure that the health needs of low-income and underserved individuals are being met and to encourage covered hospitals to meaningfully engage with community members and organizations to help meet those needs. We appreciate the opportunity to provide comments on the proposed regulations implementing those statutory requirements. Our suggestions are based on our long experience advocating for the health rights of low-income and underserved people and aim to strengthen the proposed regulations to promote accountability, transparency, and collaboration.

We commend IRS for drafting a proposed rule that makes great strides in encouraging (and in some cases requiring) nonprofit hospitals to collaborate with relevant stakeholders to ensure the needs of low-income and underserved people are addressed. In general, we support the standards outlined in the proposed rule. However, we have several

specific suggestions to make the rules more meaningful for low-income and underserved individuals.

§ 1.501(r)–1: Definitions

We commend IRS for adding § 1.501(r)–1(c), additional definitions, which provide important insight into several previously undefined terms. We generally support the proposed definitions. However, we have several suggestions that we believe will provide additional clarity and better align these definitions with those proposed in the companion NPRM of June 26, 2012.[1]

§ 1.501(r)–1(b)(16): Hospital Organization

We support the addition of the second sentence of the proposed definition, which clarifies that hospital organizations will continue to be covered by § 4959 for the remainder of the taxable year in the event that their 501(c)(3) status is revoked. However, we recommend that the definition of hospital organization be modified to include the language from I.R.C. *§* 501(r)(2)(A)(ii) that a hospital organization also includes any organization that the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption under § 501(c)(3). This will clarify the definition and prevent confusion as to which definition was intended to apply.

RECOMMENDATION: We propose amending § 1.501(r)–1(b)(16) as follows:

> *Hospital organization* means an organization recognized (or seeking to be recognized) as described in section 501(c)(3) that operates one or more hospital facilities ***and any organization that the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption under section 501(c)(3).*** If the section 501(c)(3) status of such an organization is revoked, the organization will, for purposes of section 4959, continue to be treated as a hospital organization during the taxable year in which such revocation becomes effective.

§ 1.501(r)–1(c)(2): Operating a Hospital Facility

We strongly support the addition of 1.501(r)–1(c)(2), which clarifies that a covered organization will be deemed to operate a hospital facility regardless of whether it does so directly or through a management corporation, disregarded entity, partnership, or similar arrangement. We believe that this definition will increase fairness and transparency by ensuring that all hospital organizations are treated similarly, regardless of their organizational structure.

§ 1.501(r)–1(c)(4): Widely Available on a Web Site

We commend IRS for clarifying the manner in which documents must be made widely available on a web site and for requiring that documents be available without special computer hardware or software, without payment of a fee, and without creating an account or providing personally identifiable information. We further recommend that IRS work with HHS to post CHNA reports and implementation strategies, or links to such documents, on a national, searchable website, such as www.healthcare.gov.

[1] Additional Requirements for Charitable Hospitals, 77 Fed. Reg. 38,148 (June 26, 2012), *available at* http://www.gpo.gov/fdsys/pkg/FR-2012-06-26/pdf/2012-15537.pdf.

§ 1.501(r)–2: Failure to Satisfy Section 501(r)

We generally support the proposed regulations regarding consequences for failing to satisfy the requirements of § 501(r) contained in § 501(r)-2(a). However, we question the addition of § 501(r)-2(b), under which certain failures to comply with the law will not be "considered" failures, so long as they meet certain requirements. Section 501(r)-2(a) provides the Commissioner with wide latitude in revoking the status of nonconforming hospitals and requires the Commissioner to take into account "the size, scope, nature and significance of the organization's failure(s)." While we agree that not all failures should result in revocation of a hospital's 501(c)(3) status, we see no reason *not* to call errors and omissions occurring under 2(b) what they are: failures to comply with the law. If 501(r)-2(b) is to remain, we strongly recommend that the regulations clarify that hospitals are required to disclose any errors made under 2(b) and to make such disclosures widely available to the public.

Further, we express great concern regarding proposed 501(r)-2(c), which purports, in contravention of statute, to excuse failures that are not willful or egregious so long as the hospital facility corrects the failure and "makes disclosure in accordance with the rules set forth in the guidance" – guidance which does not yet exist. While we support the transparency and increased accountability that comes with full disclosure, we do not believe that correction and disclosure should be sufficient to excuse a failure to follow the law. We understand that IRS may believe that its options to address failures to comply with 501(r) are limited by statute to revocation of the hospital's 501(c)(3) status and imposition of a fine in the amount of $50,000, and we agree that those penalties may in some cases be inappropriate for minor failures. However, we do not believe that is a reason to excuse such failures, nor do we believe such an excusal is permitted by 26 U.S.C. § 4959. We strongly recommend that § 501(r)-2(c) be struck in its entirety. If 2(c) remains, we recommend at a minimum that the regulations clarify that hospitals must disclose failures under 2(c) to the public.

We support 2(d)(3), which prohibits a hospital organization from aggregating non-exempt income. A hospital organization should not be permitted to use losses from one noncompliant hospital to offset taxes on unrelated business taxable income or gains at another noncompliant hospital.

RECOMMENDATION: As noted above, we recommend that 1.501(r)–2(b) and(c) be struck in their entirety. If they are to remain, we propose amending § 1.501(r)–2(b) and (c) as follows:

> (b) *Minor and inadvertent omissions and errors.* A hospital facility's omission of required information from a policy or report described in § 1.501(r)–3 or § 1.501(r)–4, or error with respect to the implementation or operational requirements described in § 1.501(r)–3 through § 1.501(r)–6, will not be considered a failure to meet a requirement of section 501(r) if— (1) Such omission or error was minor, inadvertent, and due to reasonable cause; ~~***and***~~ (2) The hospital facility corrects such omission or error as promptly after discovery as is reasonable given the nature of the omission or error~~.~~***; and (3)The hospital facility promptly and fully discloses the error or omission and makes such disclosure widely available to the public on its website as described in § 1.501r–1(c)(4).***
>
> (c) *Excusing certain failures if hospital facility corrects and discloses.* Pursuant to guidance set forth by revenue procedure, notice, or other guidance published in the Internal Revenue Bulletin, a hospital facility's failure to meet one or more of the requirements described in § 1.501(r)–3 through § 1.501(r)–6 that is neither willful nor egregious shall be excused for purposes of this section if the hospital facility corrects ***the failure*** and ***promptly and fully***

discloses the failure, making such disclosure widely available to the public on its website as described in § 1.501r–1(c)(4) ~~***makes disclosure in accordance with the rules set forth in the guidance***~~. If a hospital facility's failure was willful or egregious, the failure will not be excused, even if the hospital facility corrects and makes disclosure in accordance with the guidance, and no presumption will be created by a hospital facility's correction and disclosure that the failure was neither willful nor egregious. For purposes of this paragraph (c), willful is to be interpreted consistent with the meaning of that term in the context of civil penalties, which would include a failure due to gross negligence, reckless disregard, or willful neglect. Furthermore, notwithstanding a hospital facility's compliance with such future guidance, a hospital facility may, in the discretion of the IRS, be subject to an excise tax under section 4959 for failures to meet the requirements of section 501(r)(3).

§ 1.501(r)–3(b): Conducting a CHNA

§ 1.501(r)–3(b)(3): Community Served by the Hospital Facility

We commend IRS for recognizing that geographical area is only one component in determining the community served by a hospital facility. We support the proposed regulation's caution that "a hospital facility may not define its community to exclude medically underserved, low income, or minority populations who are part of its patient populations, live in geographic areas in which its patient populations reside (unless they are not part of the hospital facility's target populations or affected by its principal functions), or otherwise should be included based on the method the hospital facility uses to define its community." However, we recommend adding individuals with limited English proficiency (LEP) to that list. It is critical that the hospital facility assess the language needs of the population eligible to use their facilities in addition to the needs of the population that actually uses the hospital. This concept is outlined in HHS' Office for Civil Rights' "LEP Guidance," which requires that a hospital receiving federal financial assistance take reasonable steps to provide meaningful access to LEP individuals.[2]

We also recommend that a hospital be required to consult persons representing the broad interests of the community, defined in § 1.501(r)–3(b)(5), in defining the community served.

In addition, we recommend that IRS explicitly define the community served by the hospital facility in a way that leads to an accurate representation both of individuals who use the hospital facility and individuals who live within the hospital facility's service community but may not use the facility because the hospital lacks adequate language access or reproductive health services or for other reasons, such as cost, lack of transportation, and stigma, or because they had not previously required hospital care. For example, many people who do not currently access hospital facilities because of inability to pay may become eligible for Medicaid or other insurance coverage in 2014. This is a population of millions of people who may not be currently served by the hospital but who should be included in the "community served" by it. We also recommend the regulations clarify that a hospital may not exclude individuals from the community served because they need services to which the hospital has a moral or religious objection.

Finally, we suggest modifications to the proposal that a hospital facility "may define its community to include populations in addition to its patient populations and geographic areas

[2] Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47,311 (Aug. 8, 2003), *available at* http://www.gpo.gov/fdsys/pkg/FR-2003-08-08/pdf/03-20179.pdf**.**

outside of those in which its patient populations reside." The preamble indicates that this language was included so that a hospital collaborating with other hospitals in a geographic area "may define its community as the entire [area] in which all of the collaborating hospital facilities are located, even if the hospital facility itself only generally serves and draws its patients from a portion of that [area]."[3] While we strongly support such collaboration, particularly where it involves governmental and non-governmental organizations in addition to collaborating hospital facilities, we are concerned that this provision could create confusion among both hospital organizations and the public if the "community served" for CHNA purposes is not actually the community served by the hospital. While we support the flexibility given to hospitals to collaborate in carrying out the needs assessments, we believe that it is important that each hospital facility understand and clearly state the community served by that facility. As we note in our comments to § 1.501(r)–3(b)(7)(v) and § 1.501(r)–3(c)(4), *infra,* we strongly recommend that "community served by the hospital facility" not be defined as other than the community served, or in a position to be served, by the hospital facility conducting the CHNA.

RECOMMENDATION: We propose amending § 1.501(r)–3(b)(3) as follows:

> *(3) Community served by the hospital facility.* In defining the community it serves for purposes of paragraph (b)(1)(i) of this section, a hospital facility ***must take into account input from the sources listed in § 1.501(r)–3(b)(5) and*** may take into account all of the relevant facts and circumstances, including the geographic area served by the hospital facility, target populations served (for example, children, women, or the aged), and principal functions (for example, focus on a particular specialty area or targeted disease). A hospital facility may ~~***define its community to include populations in addition to its patient populations and geographic areas outside of those in which its patient populations reside. However, a hospital facility may***~~ not define its community to exclude medically underserved, low income, ***limited English proficient,*** or minority populations who are part of its patient populations, live in geographic areas in which its patient populations reside (unless they are not part of the hospital facility's target populations or affected by its principal functions), or otherwise should be included based on the method the hospital facility uses to define its community. In addition, if a hospital facility's method of defining its community takes into account patient populations, the hospital facility must treat as patients all individuals who receive care ***or are within the geographical area served by the hospital but not currently receiving care*** from the hospital facility, without regard to whether (or how much) they or their insurers pay for the care received***,*** ~~***or***~~ whether they are eligible for assistance under the hospital facility's financial assistance policy***, or whether they are in need of services to which the hospital has a moral or religious objection***.

§ 1.501(r)–3(b)(4): Assessing Community Health Needs

We recommend that the proposed regulations be revised to explicitly require hospital facilities to consult with persons representing the broad interests of the community, defined in § 1.501(r)–3(b)(5), in identifying the significant health needs of the community, prioritizing those health needs, and identifying potential measures and resources available to address those health needs. Working with community partners in this process will help hospitals more effectively determine and prioritize the health needs of the community, including vulnerable and medically underserved community members. It will also provide the community with a meaningful opportunity to provide input in the CHNA process.

[3] Community Health Needs Assessments for Charitable Hospitals, 66 Fed. Reg. 20,523, 20,529 (Apr. 5, 2013), *available at* http://www.gpo.gov/fdsys/pkg/FR-2013-04-05/pdf/2013-07959.pdf.

We also recommend that a hospital not be permitted to use "any" criteria in prioritizing significant health needs; this is no different than having no rule at all. Rather, we suggest removing the term "any" and providing the proposed criteria as a non-exclusive list. We also believe it is important that hospitals not be permitted to exclude or assign a lower priority to health needs based on the hospital's moral or religious beliefs.

RECOMMENDATION: We propose amending § 1.501(r)–3(b)(4) as follows:

> *(4) Assessing community health needs.* To assess the health needs of the community it serves for purposes of paragraph (b)(1)(ii) of this section, a hospital facility must identify significant health needs of the community, prioritize those health needs, and identify potential measures and resources (such as programs, organizations, and facilities in the community) available to address the health needs. For these purposes, the health needs of a community include requisites for the improvement or maintenance of health status in both the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities). ***In completing the requirements of this subsection, a hospital facility must take into account input from the sources listed in § 1.501(r)–3(b)(5).*** A hospital facility may determine whether a health need is significant based on all of the facts and circumstances present in the community it serves. ***When prioritizing health needs, ~~In addition,~~*** a hospital facility may use ***~~any~~*** criteria ***~~to prioritize the significant health needs it identifies,~~*** including, but not limited to, the burden, scope, severity, or urgency of the health need; the estimated feasibility and effectiveness of possible interventions; the health disparities associated with the need; ***~~or~~ and*** the importance the community places on addressing the need. ***A hospital may not exclude or assign a lower priority to a health need based on the hospital's moral or religious objection to the services required to address the health need.***

§ 1.501(r)–3(b)(5): Persons Representing the Broad Interests of the Community

We commend IRS for requiring hospital facilities to seek input from state, local, tribal, or regional governmental public health departments. Many health departments now conduct community health assessments of their own, and this requirement may provide an additional opportunity for collaboration between health departments and nonprofit hospitals, resulting in reduced costs and increased benefits for all participants.

Additionally, we strongly support the requirement that hospitals consult with members or representatives of medically underserved, low-income, and minority populations regarding issues including but not limited to financial and other barriers to access to care in the community. However, we recommend that § 1.501(r)–3(b)(5)(ii) be revised to clarify that hospital facilities must consult a member or representative of *each* medically underserved, low income, or minority population identified in its community served. One person or organization may represent multiple populations, but all populations should be represented. Finally, we strongly support the requirement that hospitals take into account written comments received on the hospital's most recently conducted CHNA and most recently adopted implementation strategy. Since the proposed rule does not require hospitals to formally evaluate the effect of the CHNA and implementation strategy on community health, such comments may provide extremely valuable information to guide future assessments and implementation plans.

RECOMMENDATION: We propose amending § 1.501(r)–3(b)(5)(ii) as follows:

> (ii) ***At least one ~~M~~members~~s~~*** of ***each*** medically underserved, low income, ***and*** minority population***s identified*** in the community served by the hospital facility, or individuals or organizations serving or representing the interests of such populations; and

§ 1.501(r)–3(b)(6): Medically Underserved Populations

In determining the health needs of medically underserved populations, we recommend that the regulations guide hospitals to give particular thought to the needs of women and children as well as the needs of individuals with language barriers and individuals with chronic conditions.

RECOMMENDATION: We propose amending § 1.501(r)–3(b)(6) as follows:

> (6) *Medically underserved populations.* For purposes of this paragraph (b), medically underserved populations include populations experiencing health disparities or at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers. ***Hospital facilities should pay particular attention to the health needs of women, children, individuals with limited English proficiency, and individuals with chronic conditions within medically underserved populations.***

§ 1.501(r)–3(b)(7): Documentation of a CHNA

We strongly support the inclusion of the 3(b)(7) documentation requirements, as we believe that they will increase transparency and therefore community support and willingness to meaningfully participate in the CHNA process. We particularly support the requirement in 3(b)(7)(i)(D) that the hospital facility describe the process and criteria used to identify and prioritize significant community health needs, which will increase transparency. We also support the decision reflected in these rules to require that hospitals list the names of organizations consulted, but not to require that the names and titles of individuals in the organizations be listed in the publicly available CHNA report.

§ 1.501(r)–3(b)(7)(iv) Separate CHNA Reports

We strongly support the requirement in (b)(7)(iv) that each hospital facility document the information required in (b)(7) in a separate CHNA report. While we cautiously support the proposed rule's statement that a hospital facility that collaborates with other organizations in conducting the CHNA may produce a CHNA that is "substantively identical to portions of a CHNA report of a collaborating hospital," we recommend that the final rule make clear that, to the extent that the communities served differ (please see our comments regarding § 1.501(r)–3(b)(3), *supra*) the CHNA must reflect the unique needs of the community served by the hospital facility submitting the CHNA, which may be different in important ways from the needs of the communities served by collaborating organizations.

RECOMMENDATION: We propose amending § 1.501(r)–3(b)(7)(iv) as follows:

> (iv) *Separate CHNA reports.* While a hospital facility may conduct its CHNA in collaboration with other organizations and facilities (including, but not limited to, related and unrelated hospital organizations and facilities, for profit and government hospitals, governmental departments, and nonprofit organizations), every hospital facility must document the

information described in this paragraph (b)(7) in separate CHNA report to satisfy paragraph (b)(1)(iv) of this section unless it is eligible to adopt a joint CHNA report as described in paragraph (b)(7)(v) of this section. However, if a hospital facility is collaborating with other facilities and organizations in conducting its CHNA or if another organization has conducted a CHNA for all or part of the hospital facility's community, portions of the hospital facility's CHNA report may be substantively identical to portions of a CHNA report of a collaborating hospital facility or the other organization conducting a CHNA, if appropriate under the facts and circumstances. For example, if a hospital facility conducts a survey of the health needs of residents of homeless shelters located in the community in collaboration with other hospital facilities, the description of that survey in the hospital facility's CHNA report may be identical to the description contained in the CHNA reports for the other collaborating hospital facilities. Similarly, if the state or local public health department with jurisdiction over the community served by the hospital facility conducts an inventory of community health improvement resources available in that community, the hospital facility may include that inventory in its CHNA report. ***However, to the extent the communities served by collaborating hospital facilities or organizations differ, a hospital facility's CHNA report must reflect the unique needs of the community served by that hospital facility.***

§ 1.501(r)–3(b)(7)(v) Joint CHNA reports

As noted in our comments to § 1.501(r)–3(b)(3), *supra*, we believe it is extremely important that the "community served by the hospital facility" represent the actual community served (or eligible to be served) by the hospital facility conducting the CHNA. While we support collaboration between hospital facilities, health departments, and community organizations in conducting CHNAs, we strongly encourage IRS to require that each facility prepare and submit a CHNA report that is specific to the needs and characteristics of the actual community served by that facility. We recognize the benefits of assessing the health needs of an area that might be larger than the community served by a single hospital facility, but we strongly believe that joint reports covering large areas (such as an MSA) do not provide the community served by a hospital facility with the opportunity for meaningful input and cannot provide the specificity needed to enable that community to determine which facility bears responsibility for responding to its needs and whether that facility has taken its input into account. Under Office of Management and Budget rules, an MSA must contain at least one urban core area of at least 50,000 people.[4] Such a large area does not fit any reasonable definition of community, and we cannot fathom how a report covering such a large area could possibly take seriously the needs of the people served by a hospital facility.[5] We strongly recommend that organizations be permitted to collaborate in the CHNA process, but that the CHNA report (and corresponding implementation strategy) be tailored to each hospital facility.

RECOMMENDATION: We propose amending § 1.501(r)–3(b)(7)(v) as follows:

(v) *Joint CHNA reports*—(A) *In general.* A hospital facility that collaborates with other hospital facilities in conducting its CHNA will satisfy paragraph (b)(1)(iv) of this section if an authorized body of the hospital facility adopts for the hospital facility a joint CHNA report

[4] *Definitions*, U.S. CENSUS BUREAU, http://www.census.gov/econ/susb/definitions.html (last revised Apr. 3, 2013).

[5] The New York-Newark-Jersey City, NY-NJ-PA MSA, for example, contains over 19 *million* people. *Annual Estimates of the Population of Metropolitan and Micropolitan Statistical Areas: April 1, 2010 to July 1, 2012*, U.S. CENSUS BUREAU, http://www.census.gov/popest/data/metro/totals/2012/index.html (last revised Mar. 13, 2013).

produced for all of the collaborating hospital facilities, as long as ~~**all of**~~ the collaborating hospital facilities ~~***define their community to be the same and***~~ conduct a joint CHNA process, ~~***and***~~ the joint CHNA report is clearly identified as applying to the hospital facility, ***and the CHNA report for each facility is tailored to the particular community served by the hospital facility.***

(B) *Example.* The following example illustrates this paragraph (b)(7)(v):

Example. P is one of ***two*** ~~***ten***~~ hospital facilities located in and serving the populations of a particular ***neighborhood*** ~~***Metropolitan Statistical Area (MSA)***~~. P and the other ~~***nine***~~ facilit~~***iesy***~~ in the ***neighborhood*** ~~***MSA, some of***~~ which ***is*** ~~***are***~~ unrelated to P, decide to collaborate in conducting a CHNA for the ***neighborhood*** ~~***MSA***~~ and to each define their community as constituting the entire ***neighborhood*** ~~***MSA***~~. The ***two*** ~~***ten***~~ hospital facilities work together with the state and local health departments of jurisdictions in the ***neighborhood*** ~~***MSA***~~ to assess the health needs of the ***neighborhood*** ~~***MSA***~~ and collaborate in conducting surveys and holding public forums to receive input from the ***neighborhood's*** ~~***MSA's***~~ residents, including its medically underserved, low-income, and minority populations. The hospital facilities then work together to prepare a joint CHNA report documenting this joint CHNA process that contains all of the elements described in paragraph (b)(7)(i) of this section. The joint CHNA report identifies ***both*** ~~***all of the***~~ collaborating hospital facilities~~***, including P,***~~ by name, both within the report itself and on the cover page. ***P's version of the joint report also includes how P's particular community served differs from the entire neighborhood and identifies the unique needs of P's community served.*** The board of directors of the hospital organization operating P adopts the joint CHNA report for P. P has complied with the requirements of this paragraph (b)(7)(v) and, accordingly, has satisfied paragraph (b)(1)(iv) of this section.

§ 1.501(r)–3(b)(8): Making the CHNA Report Widely Available to the Public

We commend IRS for including regulations to facilitate hospitals in releasing draft CHNA reports for public comment. However, we recommend that the regulations encourage hospitals to release draft CHNA reports and implementation strategies prior to finalization to foster collaboration and transparency. We support the requirement that the hospital facility maintain at least three CHNA reports on its website, since this will result in negligible additional burden on the facility but will better enable the community to view changes over time. We also support the requirement that the facility make the CHNA report available in paper form for those individuals who do not have reliable or convenient internet access.

In addition, we recommend that, if any population with LEP constitutes more than 5% of a hospital's community served or 500 individuals within a hospital's community served, the hospital be required to translate the CHNA report and implementation strategy into the primary language of that population. One of the primary reasons for the CHNA report and implementation strategy is to increase the transparency of actions hospitals take to improve the health of the community. That purpose is not served if the community cannot read the documents.

RECOMMENDATION: We propose amending § 1.501(r)–3(b)(8) as follows:

(8) *Making the CHNA report widely available to the public*—(i) *In general.* For purposes of paragraph (b)(1)(v) of this section, a hospital facility's CHNA report is made widely available to the public only if the hospital facility— (A) Makes the CHNA report widely available on a Web site, as defined in § 1.501(r)-1(c)(4), at least until the date the hospital facility has made widely available on a Web site its two subsequent CHNA reports; and (B) Makes a

paper copy of the CHNA report available for public inspection without charge at the hospital facility at least until the date the hospital facility has made available for public inspection without charge a paper copy of its two subsequent CHNA reports.

(ii) *Making draft CHNA reports widely available*. Notwithstanding paragraph (b)(8)(i) of this section, if a hospital facility makes widely available on a Web site (and/or for public inspection) a version of the CHNA report that is expressly marked as a draft on which the public may comment, the hospital facility will not be considered to have made the CHNA report widely available to the public for purposes of determining the date on which the hospital facility has conducted a CHNA under paragraph (a) of this section. ***Hospital facilities are encouraged to make draft CHNA reports widely available to increase the opportunity for community comment and to incorporate such comments into the final report.***

(iii) Translating CHNA reports. If any population with limited English proficiency constitutes more than 5 percent of the community served by a hospital facility or more than 500 individuals within the community served by a hospital facility, the hospital facility must translate the CHNA report into the population's primary language and make the translated report widely available, as described in paragraph (b)(8)(i) of this section.

§ 1.501(r)–3(c): Implementation Strategy

§ 1.501(r)–3(c)(1): In General

The preamble states that "[t]he Treasury Department and the IRS recognize that conducting a CHNA and developing an implementation strategy are part of one fluid process, with no definite point at which the CHNA ends and the implementation strategy begins."[6] We strongly support this description and believe that, due to the fluidity of the process, there should not be different publication requirements for the CHNA report and the implementation strategy.

For that reason, we recommend adding a requirement that implementation strategies be made widely available to the public in the same manner as CHNA reports, as described in § 1.501(r)–3(b)(8). Neither transparency nor accountability is served by limiting the availability of implementation strategies to Form 990 submissions. In addition, making the implementation strategy widely available will raise awareness of new programs and resources being developed in support of the strategy, create opportunities for comment and collaboration, and allow the community to monitor the hospital's progress and aid in its efforts.

RECOMMENDATION: We propose amending § 1.501(r)–3(c)(1) as follows:

(1) *In general.* For purposes of paragraph (a)(2) of this section, a hospital facility's implementation strategy to meet the community health needs identified through the hospital facility's CHNA is a written plan that ***is made widely available to the public as described in § 1.501(r)–3(b)(8) and*** that, with respect to each significant health need identified through the CHNA, either—(i) Describes how the hospital facility plans to address the health need; or (ii) Identifies the health need as one the hospital facility does not intend to address and explains why the hospital facility does not intend to address the health need.

[6] Community Health Needs Assessments for Charitable Hospitals, 66 Fed. Reg. at 20,532.

§ 1.501(r)–3(c)(2): Description of How the Hospital Facility Plans to Address a Significant Health Need

We support the changes to § 1.501(r)–3(c)(2) requiring that the implementation strategy include the anticipated impact of actions taken by the hospital to address health needs and a plan to evaluate such impact. In particular, we strongly support the explicit recognition that the implementation strategy may include collaboration between the hospital facility and other facilities or organizations. However, we recommend that the regulations be amended to require that the hospital perform the planned evaluation and publish the results of the evaluation in its subsequent CHNA report. This will encourage reflection and offer an opportunity for continuous quality improvement.

We also recommend that hospital facilities be required to consult with persons representing the broad interests of the community, defined in § 1.501(r)–3(b)(5), in developing and carrying out implementation strategies.

RECOMMENDATION: We propose amending § 1.501(r)–3(c)(2) as follows:

> (2) *Description of how the hospital facility plans to address a significant health need.* In describing how a hospital facility plans to address a significant health need identified through a CHNA for purposes of paragraph (c)(1)(i) of this section, the implementation strategy must describe the actions the hospital facility intends to take to address the health need, the anticipated impact of these actions, and a plan to evaluate such impact. The implementation strategy must also identify the programs and resources the hospital facility plans to commit to address the health need~~. ***Finally, the implementation strategy must and*** describe any planned collaboration between the hospital facility and other facilities or organizations in addressing the health need. ***In developing and executing the implementation strategy, the hospital facility must also take into account input from the sources listed in § 1.501(r)–3(b)(5) and describe how the hospital facility took into account such input in accordance with § 1.501(r)–3(b)(7)(iii). Finally, the hospital facility must conduct the planned evaluation and report the results of the evaluation in its next CHNA report.***

§ 1.501(r)–3(c)(3): Description of Why a Hospital Facility is Not Addressing a Significant Health Need

§ 1.501(r)–3(c)(3) lists several reasons a hospital might choose not to address a significant health need in its implementation strategy. We disagree that "resource constraints" and "relative lack of expertise or competencies to effectively address the need" should serve as reasons for failing to address an identified need. In those circumstances, to the extent possible, hospitals should identify individuals and organizations with the required expertise, competency, or resources and partner with them to determine how to address the need. CHNAs provide an opportunity for hospitals to move *beyond* clinical care in addressing the health needs of the community, to utilize innovative and evidence-based practices, and to partner with health departments and other organizations in doing so. Implementation strategies are an opportunity for further collaboration between hospital facilities, health departments, and community organizations. If the CHNA identifies a health need as a priority, the hospital facility should work with community partners to address (or begin addressing) that need. Sustained, cross-disciplinary approaches will be required to address many community health needs. Hospitals cannot and should not be expected to address them alone, and important community health

needs should not be ignored because they cannot be addressed by a hospital facility working alone.

RECOMMENDATION: We propose amending § 1.501(r)–3(c)(3) as follows:

> *(3) Description of why a hospital facility is not addressing a significant health need.* In explaining why it does not intend to address a significant health need for purposes of paragraph (c)(1)(ii) of this section, a hospital facility may provide a brief explanation of its reason for not addressing the health need, including, but not limited to, ~~***resource constraints,***~~ other facilities or organizations in the community addressing the need, ~~***relative lack of expertise or competencies to effectively address the need,***~~ a relatively low priority assigned to the need, and/or a lack of identified effective interventions to address the need.

§ 1.501(r)–3(c)(4): Joint Implementation Strategies

As noted in our comments on joint CHNA reports at § 1.501(r)–3(b)(7)(v), *supra*, we support collaboration between hospital facilities, health departments, and community organizations in conducting CHNAs and developing implementation plans. However, we recommend that the regulations require each facility to prepare and adopt a CHNA report that is unique to the actual community served by that facility. This will also limit the number of hospital facilities permitted to develop joint implementation strategies. To the extent that joint implementation strategies are permitted, each hospital should be required to tailor its version of the joint strategy to the needs of community served by that hospital facility.

RECOMMENDATION: We propose amending § 1.501(r)–3(c)(4) as follows:

> (4) *Joint implementation strategies.* A hospital facility may develop an implementation strategy in collaboration with other facilities and organizations, including, but not limited to, related and unrelated hospital organizations and facilities, for-profit and government hospitals, governmental departments, and nonprofit organizations. ~~***In general,***~~ ~~***a***~~ ***A*** hospital facility that collaborates with other facilities and organizations in developing its implementation strategy must still document its implementation strategy in a separate written plan that is tailored to the particular hospital facility, taking into account its specific programs and resources. However, a hospital facility that adopts a joint CHNA report described in paragraph (b)(7)(v) of this section may also adopt a joint implementation strategy that, with respect to each significant health need identified through the joint CHNA, either describes how the collaborating hospital facilities plan to address the health need or identifies the health need as one the hospital facilities do not intend to address and explains why the hospital facilities do not intend to address the health need, as long as the joint implementation strategy ***adopted by each hospital facility***—(i) Is clearly identified as applying to the hospital facility; (ii) Clearly identifies the hospital facility's particular role and responsibilities in taking the actions described in the implementation strategy and the programs and resources the hospital facility plans to commit to such actions; ***(iii) Is tailored to the particular community served by the hospital facility;*** and (***iv***~~***iii***~~) Includes a summary or other tool that helps the reader easily locate those portions of the joint implementation strategy that relate to the hospital facility.

§ 1.6033–2: Returns by Exempt Organizations (taxable years beginning after December 31, 1969) and Returns by Certain Nonexempt Organizations (taxable years beginning after December 31, 1980

We commend IRS for adding provision § 1.6033–2(a)(2)(ii)(I)(3), requiring each hospital facility to include annually on its Form 990, in addition to its implementation strategy, "a description of the actions taken during the taxable year to address the significant health needs identified through its most recently conduct CHNA . . . or, if no actions were taken with respect to one or more of these health needs, the reason(s) why no actions were taken."

However, we do not support the decision to relieve government hospitals excused from filing a Form 990 from the reporting requirements under § 1.6033–2(a)(2)(ii)(I). In the interests of fairness and transparency, every hospital should be required to follow the same rules, including the requirement to make its audited financial statements, implementation strategy, an annual description of its actions, and the amount of excise tax imposed under 4959 during the taxable year publicly available in the same manner as the CHNA reports, as described in § 1.501(r)–3(b)(8). Making these documents widely available to the public will increase transparency and accountability.

RECOMMENDATION: We propose amending § 1.501(r)–3(a) as follows:

> (a) *In general.* With respect to any taxable year, a hospital organization meets the requirements of section 501(r)(3) with respect to a hospital facility it operates only if—(1) The hospital facility has conducted a community health needs assessment (CHNA) that meets the requirements of paragraph (b) of this section in such taxable year or in either of the two taxable years immediately preceding such taxable year; ~~***and***~~ (2) An authorized body of the hospital facility (as defined in § 1.501(r)–1(c)(1)) has adopted an implementation strategy to meet the community health needs identified through the CHNA, as described in paragraph (c) of this section, by the end of the taxable year in which the hospital facility conducts the CHNA~~.~~***; and (3) The hospital facility makes the information described in § 1.6033–2(a)(2)(ii)(l) widely available to the public, as described in § 1.501(r)–3(b)(8), regardless of whether the hospital facility is required to file a Form 990.***

Conclusion

We appreciate the opportunity to comment on these proposed rules and look forward to working with IRS on their implementation. If you have any questions regarding these comments, please contact Corey Davis at (919) 968-6308 or davis@healthlaw.org. Thank you for your consideration.

Sincerely,

Emily Spitzer
Executive Director