July 1, 2013

Mr. Steven T. Miller
Deputy Commissioner for Services and Enforcement
Internal Revenue Service
CC:PA:LPD PR (REG-106499-12)
Room 5203
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Submitted electronically via www.Regulations.gov

RE: Notice of proposed rulemaking, Community Health Needs Assessments for Charitable Hospitals

Dear Deputy Commissioner Miller:

On behalf of the American Heart Association (AHA), including its American Stroke Association (ASA) division, and more than 22 million volunteers and supporters, we appreciate this opportunity to submit comments on the Internal Revenue Service (IRS) proposed rule, Community Health Needs Assessments (CHNA) for Charitable Hospitals, which provides guidance on specific components of the CHNA and financial and reporting obligations of non-profit hospitals.

The CHNA and the corresponding required implementation strategy and the annual description of action can play an important role in assuring that charitable hospitals identify and address significant health needs of the communities they serve, including individuals with heart disease and stroke. We believe these regulations have the potential to strengthen these hospitals' relationships with community providers and organizations, consumers, and health departments and to facilitate the creation of shared goals and initiatives to improve and maintain the health of our communities.

Our comments below focus on a number of specific issues that we believe can help to make the CHNA requirements more effective, and we appreciate your taking these comments into consideration when finalizing the CHNA rules.

§1.501(r)-3-(b)(3) -- Community served by the hospital facility.

In conducting a CHNA, a hospital must first define the community it serves. In this proposed rule, IRS says the definition used by the hospital facility may incorporate a number of generally recognized factors, such as geographic area served and target populations served. The definition gives hospitals tremendous flexibility to define its community.

We applaud the IRS for prohibiting hospitals from excluding medically underserved, low income or minority populations from its definition of community, if these groups otherwise live in and are served by the hospital. This requirement is critical for ensuring that the needs of these populations are not overlooked during the CHNA process. However, we recommend expanding the definition of "medically underserved populations" to expressly include individuals with disabilities to assure that this population is taken into consideration in the development of the CHNA.

We are also very concerned that populations with chronic disease served by the hospital are not required to be included in the definition of community served by the hospital. As originally proposed by the IRS in Notice 2011-52, the definition of community included "populations with chronic disease needs, in the community served by the hospital facility," but IRS dropped this reference to chronic disease in this proposed rule. The association recommends that the reference to chronic disease be restored in the final regulation or at a minimum, that the definition of target population be expanded to include "*populations with the most prevalent diseases*" to assure that conditions like heart disease and stroke that are likely to have a significant impact in the community are considered during the needs assessment process.

IRS indicated in the preamble to the proposed rule that it dropped the inclusion of chronic disease because it could be too burdensome to require input related to every chronic disease in a community. We believe it would be a mistake to not include at least the most prevalent chronic diseases. Collectively, cardiovascular disease (including stroke), cancer, and diabetes account for approximately two-thirds of all deaths in the United States and about $700 billion in direct and indirect economic costs each year. A concerted effort to increase the application of public health and clinical interventions of known efficacy to reduce prevalence of tobacco use, poor diet, and insufficient physical activity—the major, shared risk factors for these diseases—and to increase utilization of screening tests for their early detection could substantially reduce the human and economic cost of these diseases.

§1.501(r)-3-(b)(4) -- Assessing community health needs.

To assess the health needs of the community, the hospital must identify significant health needs of the community, prioritize those health needs, and identify potential measures and resources to address those needs.

The proposed rule explicitly states that the concept of "health needs of a community" includes "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)". We interpret this language to mean that health needs go beyond the need for health care services and encompass interventions needed to improve or maintain health. This concept is critical to moving our nation's health care system from one that focuses largely on treating illness to one that also emphasizes maintaining health and wellness, and we applaud IRS for including this specific language. This language is also consistent with the underlying, long-standing concept of community benefit, which includes investments in community health improvement, not just health care itself.

However, we are concerned that hospitals are not required to use any particular criteria to prioritize the significant health needs it identifies. As proposed, the hospital facility "*may* use *any* criteria" to prioritize the community's health needs. The regulation goes on to list potential criteria a hospital may use, including, but not limited to, "the burden, scope, severity, or urgency

of the health need." This is commonly used criteria in health care measurement and program evaluation. We recommend revising the rule to require the use of this accepted health planning and program evaluation criteria.

§1.501(r)-3-(b)(5) -- Persons representing the broad interests of the community.

The association strongly supports the requirement that hospitals must take into account input from persons who represent the broad interests of the community served by the hospital as well specifically at least 1 state, local, tribal, or regional governmental health department and members of medically-underserved, low-income, and minority populations or organizations serving their interests when developing the CHNA. In addition, the proposed rule says that hospitals *may* take into account input from "a broad range of persons located in or serving its community, including health care consumers and consumer advocates, and nonprofit and community-based organizations." We recommend that hospitals be required, not just permitted, to obtain input from patient and health care consumer organizations located in or serving its community. Again, this will help to ensure that the needs of patients will be addressed in the needs assessment and implementation strategy.

We are also concerned that the proposed rule does not require a draft copy of the CHNA to be made publicly available for comment prior to being finalized, although the IRS says that if a hospital wants to do that, publishing the draft CHNA on its website would not trigger the start of its next 3-year CHNA cycle. The justification for not requiring opportunity to comment on the draft CHNA prior to finalizing it is the complexity of the additional timeframes and procedures such a process would require. We believe a mandatory public comment period, even if it is brief (i.e. 30 days) should be required early in each CHNA cycle to notify organizations representing the broad interests of the community or interested individuals about the process and timeframes that the hospital will use to complete or update its CHNA and subsequent implementation strategy and to request written comments on the health needs of the community and its most recently conducted CHNA and implementation strategy plan. Without a mandatory public comment opportunity, interested individuals and organizations may not be aware that a hospital is conducting its CHNA until it is complete.

§1.501(r)-3-(b)(8) -- Making the CHNA report widely available to the public

As proposed, there is no requirement that the hospital's implementation strategy be made widely available to the public. In general, the implementation strategy has to be adopted by the hospital by the last day of the taxable year in which the hospital adopts its CHNA and it must be provided each year to the IRS along with the annual description of action when the hospital files its Form 990. We recommend that the implementation strategy and annual description of action be subject to the same public disclosure requirements as the CHNA and be widely available to the public on the hospital's website and for viewing in person. While we recognize that non-profit hospitals have a separate obligation to make their Form 990 available, these forms are often difficult to find and difficult to read. IRS should require that the implementation plan and annual description of action be made widely available to the public by posting it conspicuously on the facility's website, along with the CHNA. The implementation plan and action steps should be available in an easy to understand format that may increase the community's understanding of and participation in the CHNA and implementation strategy process.

There is also no threshold proposed in the rules for IRS to evaluate whether a hospital has credible or legitimate reasons for not addressing a significant health need. For instance, under

the example in the proposed rule, a hospital could simply say on its Form 990 that it's not addressing a significant health need in the community because of resource constraints or a low priority placed on the need, and the IRS would not evaluate that. While we recognize that IRS may not feel it has the expertise or resources to evaluate the hospital's CHNA, implementation plan or actions taken to determine whether a charitable hospital is adequately meeting the obligations of its not-for-profit status, making these documents widely available to the public will help to provide some degree of public accountability. This approach allows community stakeholders to hold the hospital accountable through greater transparency and can help to assure that the community receives the intended charitable benefits.

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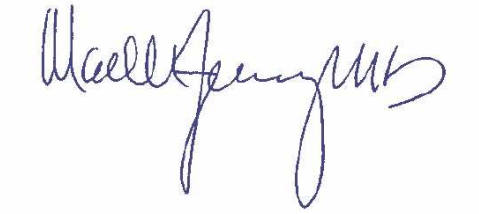
Thank you again for the opportunity to share our comments on issues related to required community health needs assessments for charitable hospitals. If you have any questions, please feel free to contact Stephanie Mohl, Senior Government Relations Advisor, at Stephanie.Mohl@heart.org or 202-785-7909.

Sincerely,



Mariell Jessup, MD, FAHA
President