



July 2, 2013

Internal Revenue Service  
CC:PA:LPD:PR (REG-106499-12), Room 5203  
P.O. Box 7604  
Ben Franklin Station  
Washington, DC 20044

RE: The Kansas Hospital Association Comment Letter on Community Health Needs Assessments for Charitable Hospitals

U.S. Department of Treasury and IRS Officials:

The Kansas Hospital Association and its members appreciate the opportunity to comment on the Proposed Rules for Community Health Needs Assessments for Charitable Hospitals. KHA agrees with many of the recommendations and comments offered by the U.S. Department of Treasury and the Internal Revenue Service in the proposed rule. We believe the development and completion of a Community Health Needs Assessment is a valuable exercise to better understand the health care needs within a community.

In Kansas, we continue to collaborate on a number of statewide initiatives with local health departments and other stakeholders to support Community Health Needs Assessments and Improvement Plans. In order for communities to obtain meaningful information through the CHNA, we are requesting that the final rule provide sufficient flexibility to allow 501(c)3 hospitals ample opportunity to meet the identified needs of their communities.

It appears the proposed rule largely tracks the guidance that was issued in the Notice 2011-52 and we are pleased that several of the modifications made respond to hospital concerns that were raised in KHA's comment letter sent Sept. 22, 2011. Please consider the following comments on the proposed rule:

**[Page 20525]**

The Treasury Department and the IRS request comments regarding whether (and under what circumstances) a hospital organization should be able to treat multiple buildings under a single state license as separate hospital facilities for purposes of the CHNA and other section 501(r) requirements and, if so, how certainty and consistency in the designation of hospital facilities can be achieved.

We agree with the amendment made in these proposed regulations that define multiple buildings operated by a hospital organization under a single state license "are" (rather than "may be") considered a single hospital facility. We have a hospital in a large metropolitan area with more than one building under a single state license. This is one hospital, just in two buildings serving one community and should only be required to do one CHNA and Implementation Strategy.

**[Page 20532]**

The Treasury Department and the IRS request comments regarding whether these proposed rules provide for sufficient disclosure regarding the community input into a CHNA report, or whether the CHNA report should be required to provide any other information regarding input provided, in order to ensure transparency in the CHNA process.

We feel these proposed rules provide for sufficient disclosure regarding the community input into a CHNA report. Identifying organizations and providing summaries of input is sufficient and we agree that names and titles do not add value and raises privacy concerns and make the report more cumbersome.

**[Page 20535]**

The Treasury Department and the IRS seek comments on whether this rule will materially inhibit the ability of hospital facilities with different taxable years to collaborate with each other or otherwise burden hospital facilities unnecessarily.

Hospitals in the same community that want to collaborate on CHNA yet have different tax years are at a disadvantage. Collaboration can be obstructed by the strict time constraints. KHA would suggest as much flexibility as possible to allow for collaboration.

In addition, as part of the requirements of accreditation for public health departments from the Public Health Accreditation Board, health departments will need to conduct community health needs assessments and improvement plans. The proposed rules require hospitals to work with public health departments. We feel the Treasury and IRS should encourage collaboration by instituting the same time parameters (every 5 years, not every 3 years.)

By allowing government hospital to conduct an assessment every five years instead of every three years, it would encourage continued collaboration with public health departments and put them on the same schedule. KHA feels this suggestion has merit for all 501(c)3 hospitals (not just governmental) and would recommend the IRS and Treasury consider adopting a 5-year period (as the PHAB has done) vs. a 3-year period.

**[Page 20536]**

The Treasury Department and the IRS request comments regarding whether hospital organizations whose financial statements are included in consolidated financial statements should be able to redact financial information about any taxable organizations that are members of the consolidated group.

Yes, we agree that hospitals should be able to redact financial information about any taxable organizations that are members of the consolidated group.

**[Page 20537]**

The Treasury Department and the IRS invite comments on whether, and what type of, additional transitional relief may be necessary.

Additional transitional relief (especially in this first round) would be appreciated for hospitals working to collaborate on CHNA with another hospital (with a different tax year) or with a public health department that is working on accreditation.

The cost of conducting a CHNA and developing an implementation strategy is costly (thousands of dollars) and timely (hundreds of hours). Efficiencies on multiple levels would be possible (for hospitals and health departments) if the period was extended from 3 years to 5 years. Annual updates could still be provided to show progress in a 5 year period.

## [Additional Comments]

KHA commends the revisions provided in the proposed rule that clarify that the CHNA and the implementation strategy may address only significant health needs versus all identified health needs.

KHA seeks clarification in what form hospitals will be required to submit the input received (from the community at large) on existing CHNA and implantation strategies. Will there be a section on the Form 990 to complete, or will an attachment be required?

KHA also commends the Treasury Department and the IRS for the language in the proposed rule that encourages collaboration and efficiency, such as allowing hospitals to collaborate and share joint reports and strategies.

Hospitals will need to spend addition hours to complete the new requirements for the implementation strategy, specifically related to the new language requiring hospitals to detail the anticipated impact of actions, as well as a plan to evaluate the impact. Hospitals also will need to dedicate resources to reporting and documenting their work EACH year versus every three years, with the newly required annual updates. KHA would request that format of the annul updates be something hospitals can complete with expensing significant costs and resources.

Lastly, we agree with the recommendations of the American Hospital Association to 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.**

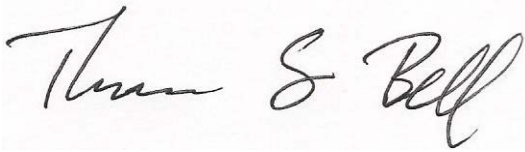
**Clarify that the requirement for an implementation strategy to include a “plan to evaluate the impact” of its efforts to address a need can be accomplished through the process of conducting its next needs assessment.**

**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.

**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.

Thank you for your consideration of our comments. If you should have any questions, please contact me or Cindy Samuelson, vice president of member services and public relations, at (785) 233-7436 or [csamuelson@kha-net.org](mailto:csamuelson@kha-net.org).

Sincerely,

A handwritten signature in black ink that reads "Tom S. Bell". The signature is written in a cursive style with a large, stylized "T" and "B".

Tom Bell  
President and CEO  
Kansas Hospital Association