PUBLICATION

IRS Proposes Regulations Regarding Community Health Needs Assessments for Charitable Hospitals [Ober|Kaler]

May 10, 2013

The IRS has released its proposed regulations [PDF] detailing the requirements for conducting and reporting Community Health Needs Assessments (CHNAs) under section 501(r)(3) of the Internal Revenue Code, which were established by the Affordable Care Act (ACA).

Charitable hospitals that do not comply with the relevant provisions are subject to sanctions, including a $50,000 excise tax and loss of 501(c)(3) status. The excise tax would be assessed on a per facility, as opposed to organization-wide, basis. The proposed rule is largely based on the previously published IRS Notice 2011-52, which established the IRS's anticipated regulations and solicited comments from the public. Comments on the proposed rule are due by July 5, 2013, 90 days after its April 5, 2013, publication date.

Purpose of a CHNA

The ACA imposed certain additional requirements that charitable hospitals must meet in order to retain their tax-exempt status. Among those is the requirement to conduct a CHNA at least once every three years and to adopt an implementation strategy to meet the community needs identified through the CHNA. The purpose of these requirements is to hold charitable hospitals more accountable for understanding the status of the health of their respective communities and to adopt a plan that is responsive to those identified needs. This reflects a resolution by the IRS to have a more identifiable return or benefit from its granting charitable hospitals tax exempt status.

Conducting a CHNA

The proposed rule identifies three components of a CHNA, which the hospital facility must complete to discharge its obligations under section 501(r)(3). The facility must: (1) assess the health needs of the community it serves by collecting and reviewing input from persons who represent the broad interests of its community, including those with special knowledge or expertise in public health; (2) document the CHNA in a written report that is adopted for the hospital facility by an authorized body; and (3) make the written report widely available to the public.

Assessing Community Health Needs

Preliminary to assessing the needs of its community, a hospital facility must define the community that it serves. Rather than establish specific criteria for defining a facility's community, the proposed regulations grant facilities significant flexibility to take into account all of the relevant facts and circumstances in defining the communities they serve. Examples of criteria that would be appropriate for the determination include the geographic area served by the hospital, target populations served, and principal functions of the hospital. A facility may not deliberately exclude medically underserved, low-income, or minority populations from its definition of the community it serves, except where such populations are not part of the facility's target population or affected by its principal functions.

Unlike the requirement in IRS Notice 2011-52 that all of the health needs of a community be identified and prioritized, the proposed rule states that the assessment of the health needs of a community is limited to the *significant* health needs of the community. Facilities are granted discretion in determining whether a particular health need is significant, based on all of the facts and circumstances present in the communities they serve. Assessment of a community's health needs requires a facility to: (1) identify the significant health needs; (2) prioritize such needs; and (3) identify potential measures and resources available to address the needs. Example criteria for facilities to use when prioritizing health needs include:

- Burden, scope, severity or urgency of the health need;
- Estimated feasibility and effectiveness of possible interventions;
- Health disparities associated with the need;
- Importance placed by the community on addressing the need.

In assessing the health needs of its community, a facility is required to consult with persons representing the broad interests of the community. The proposed regulations would require, at a minimum, that a facility obtain input from (1) a government health department with knowledge or expertise regarding the health needs of the community; (2) members of medically underserved, low income and minority populations (or representatives of organizations that serve their needs); and (3) written comments that the facility receives pursuant to the publication of its CHNA and implementation plan. Input from medically underserved, low income and minority communities may be obtained directly from members of such communities (via public meetings, focus groups, surveys, etc.) or via meetings with representatives of organizations that serve or advocate for the interested populations. The government health department may be at any jurisdictional level, with the exception of federal. In addition to input from the mandatory sources, a facility may consider input from a broad range of persons who may have expertise in public health, such as consumer advocates, health insurance and managed care organizations, or academic experts. Finally, in addition to addressing the source of input on community health needs, the proposed rules provide that a relevant subject matter for such input is the existence of any financial or other barriers to access to care in the community.

Documenting the CHNA

The proposed rule requires a facility's CHNA to be documented in a CHNA report that is adopted by an authorized body of the hospital facility. The CHNA report would need to include the following:

- Definition of the community served by the facility and an explanation of the criteria used to determine that community;
- Processes and methods used to conduct the CHNA, including a description of the data used in the assessment and any parties that collaborated or contracted with the facility in conducting the CHNA;
- Description of the community input, including a general description of its sources and general timeframe it was gathered; names of organizations providing input, with a summary of the nature and extent of such input; and a description of the medically underserved, low-income, or minority populations being represented by individuals or organization providing input;
- Prioritized list of significant community health needs, including the process and criteria used to identify such needs;
- Description of potential resources and measures identified through the CHNA to address the significant community health needs.

Making the CHNA Report Widely Available to the Public

The proposed rule anticipates that the default method for making the CHNA report widely available to the public would be to publish the CHNA report on a hospital facility's website. In the event that the facility is part of a larger organization and does not have an individual website, the report could be published on the organization's website. The report may alternatively be published on the site of another host, as long as the

hospital facility or organization website has a link to the host website, along with clear instructions on how to access the report. The proposed rule would require the report to be posted conspicuously, and to be accessible without requiring parties to set up an account or divulge personal information. In addition, the proposed rule would require the facility to maintain a paper copy of the report for inspection. Both the internet and paper copies would need to be available for inspection at the hospital facility, without charge, until at least two subsequent CHNA reports have been published.

Implementation Strategies

In collaboration with their CHNA reports, facilities must prepare and publish implementation strategies that address the significant health needs identified in the CHNA. This does not mean that a strategy must be developed for each significant health need identified in the CHNA. Rather, the strategies should describe how the facility will address each identified significant health need or identify the health need as one the facility does not intend to address and explain why any such health need is not being addressed. In addition to describing how the facility will meet the identified health needs, it must also describe the anticipated impact of these actions, the plan to evaluate such impact and the programs and resources the facility plans to commit to address each health need. The proposed rules would require the strategies to be published at the end of the same taxable year as the CHNA completion.

Collaboration on CHNA Reports and Implementation Plans

Collaboration on CHNAs would be allowed under the proposed regulations, and multiple facilities would be allowed to produce and publish a joint CHNA report and implementation plan in some instances. While each facility would generally be required to publish its own CHNA report, portions of the report may be substantially identical to a collaborating facility's CHNA report. If multiple facilities serve the same community (e.g., several facilities define their community solely by reference to the same geographical area), a joint CHNA report would be acceptable.

Multiple facilities would be allowed to collaborate on their respective implementation strategies under the proposed rule, but facilities would generally be required to document their implementation strategies in separate written plans. Where a joint CHNA report is appropriate, a single implementation strategy would also be acceptable. If multiple facilities produce a joint implementation strategy, the strategy would have additional requirements. First, the joint implementation strategy would have to clearly state that it applies to each hospital facility. Second, each facility's specific roles and responsibilities would have to be clearly delineated in the strategy. Finally, the joint implementation strategy would have to include a summary that helps the reader to identify the portions of the joint implementation strategy that apply to each particular facility.

Transition Rules and Rules for Hospitals Newly Subject to Section 501(r)

The proposed rule would recognize any CHNAs that were performed by hospital facilities after the adoption of the ACA. Any facility that performed a CHNA in either of its first two taxable years beginning after March 23, 2010, would not need to produce a new CHNA and implementation strategy immediately, but would need to do so by the third taxable year after the taxable year in which the facility performed its last CHNA. To qualify for this exception, the hospital facility would have to adopt an implementation strategy by the fifteenth calendar day of the fifth calendar month following the close of its first taxable year beginning on or after March 23, 2012 (i.e., May 15, 2014, for facilities that report on a calendar year basis).

Hospitals that are newly opened, acquired or that are operated by an organization that is newly recognized under section 501(c)(3) would not immediately need to conduct a CHNA. In order to provide a transition for

such hospitals, the proposed rule would require the CHNA and implementation strategy to be adopted and published by the last day of the second taxable year beginning after the date of the hospital being acquired, placed into service or otherwise newly subject to section 501(r).

Reporting Requirements

The proposed rule would require facilities to regularly report information related to the CHNA and its implementation strategy. Each organization operating a hospital facility would be required to attach its implementation strategy (or a URL where the implementation strategy is made available on a website) to the Form 990. In addition, the proposed rule would require organizations to annually provide on the Form 990 a description of the actions taken during the taxable year to address each significant health need identified in the CHNA. If no actions were taken to address a particular health need, the organization would be required to include an explanation of why no actions were taken.

Any excise tax imposed on the organization for failures to meet the requirements of section 501(r) would be required to be disclosed with the Form 990. The proposed rule would also require audited financial statements to be filed with the Form 990. In the case of organizations that produce consolidated financial statements, the IRS has solicited comments regarding whether any taxable organization included in the consolidated financial statement should be allowed to have its information redacted prior to filing.

Government hospitals would be exempt from the filing and annual reporting requirements under the proposed rule.

Consequences for Noncompliance

Two categories of noncompliance may be excused. The first is noncompliance that is minor, inadvertent and due to reasonable cause, where the facility corrects the error or omission as quickly as reasonably possible given the nature of the noncompliance. The second is noncompliance that rises above the level of minor and inadvertent, but is neither willful nor egregious, and which the facility corrects and discloses to the government in accordance with guidance to be published by the IRS in the future. However, for noncompliance in this second category, even though the facility is excused from a potential sanction of loss of exempt status and, notwithstanding a facility's compliance with future guidance from the IRS, a facility may still be subject, at the discretion of the IRS, to an excise tax of $50,000 pursuant to section 4959.

If the noncompliance is a result of willful and egregious conduct, then the facility will be subject to the revocation of its tax-exempt status. In making this determination, the IRS will consider all of the applicable facts and circumstances, including prior violations of section 501(r), the size and scope of the failure to comply, the reason for such failure, the existence, or lack thereof, of compliance practices and procedures designed to promote compliance with section 501(r), safeguards implemented against future failures and whether the failure was corrected. The revocation of exempt status for failure to comply with one or more requirements of section 501(r) would not result in the loss of exempt status for interest that accrues on tax-exempt bonds issued by that facility. If the failure was by a single facility in a multi-facility organization, the organization would not lose its exempt status. Rather, the offending facility would be subject to unrelated business income tax for the year in which it failed to meet the section 501(r) obligations.

New Definitions

The proposed rule would amend the definitions of *hospital facility* and *hospital organization* that were set forth in a prior proposed rule, and would add a definition of operating a *hospital facility* for purposes of applying

section 501(r). The definition of hospital facility would establish that the term includes multiple buildings operated under a single state license. The prior proposed rule merely stated that such a collection of buildings "may be" considered a hospital facility. The definition of *hospital facility* would expressly exclude tribal facilities that are not required to obtain a state license, and an organization would not be considered a *hospital organization* solely by virtue of operating such a facility. If a facility is not required to be licensed as a hospital in the state where it operates, section 501(r) would not be applied to such facility.

As a general rule, the proposed rule would establish that any organization *operates* a hospital facility if it is a partner in a joint venture, LLC, or other entity treated as a partnership for income tax purposes. Exceptions to the general rule would apply when an organization does not exercise sufficient control over the facility to ensure compliance with 501(r), as well as for certain grandfathered arrangements. A hospital organization will not be deemed to operate a hospital facility if: (1) the arrangement was entered into prior to March 23, 2010; (2) the hospital organization has been organized primarily for scientific or educational purposes since that date, and not engaged primarily in the operation of one or more hospital facilities; and (3) the hospital organization owns no more than 35 percent interest in the facility and does not exercise sufficient control over the facility to ensure compliance with section 501(r).

Ober|Kaler's Comments

The requirements for charitable hospitals under section 501(r) should be of great concern to counsel and governing bodies for these hospitals. The requirements and deliverables of the law are essentially laid at the feet of the governing body. This will require an education effort for the governing body by the CEO and his or her staff, including counsel. On a continuing basis, these requirements should be incorporated into the hospital's compliance plan so that there is an existing external check on the operations staff who would normally be charged with getting the CHNA and implementation strategy done.

The potential loss of exempt status for certain violations of section 501(r) is a clear warning regarding how seriously the IRS views this issue. As previously noted, we view this as an action by the government to hold charitable hospitals accountable for the value of the exempt status that they are afforded. Recent years have brought a lot of noise, and some action at the state level, regarding potential restrictions or additional requirements on organizations to justify their exempt status. Hospitals would be well-advised to outperform the section 501(r) requirements in an effort to proactively demonstrate the value that they are providing to their communities in exchange for their exempt status.

** Mark A. Stanley is a former member of Ober|Kaler's Health Law Group.*