

Client Alert

August 2011

IRS Issues Interim Guidance Concerning Community Health Needs Assessment Requirements Applicable to Tax-Exempt Hospitals

Overview of Section 501(r)

For decades, nonprofit hospitals described in section 501(c)(3) of the Internal Revenue Code have had to satisfy one of two operational tests to obtain or maintain federal income-tax-exempt status. One is to provide free or below-cost care “to the extent of their financial ability” under the relief of poverty test in Revenue Ruling 56-185. The other is to satisfy the “community benefit” test set forth in Revenue Ruling 69-545. The community benefit test requires section 501(c)(3) hospitals to operate an open emergency room (in most cases) but otherwise allows them to treat people who are able to pay, have insurance, participate in the federal Medicare program or participate in the federal-state Medicaid program.

As part of the Patient Protection and Affordable Care Act enacted on March 23, 2010, section 501(r) was added to the Code. Section 501(r) imposes four additional operational requirements on tax-exempt hospitals: conduct a community health needs assessment (“CHNA”) every three years; have a written financial assistance policy that meets several specific requirements; limit amounts charged for emergency or other medically necessary care provided to individuals eligible for financial assistance; and refrain from “extraordinary” collection actions before the hospital has made reasonable efforts to determine whether an individual is eligible for financial assistance.

The penalty for failure to meet any one or all of the four new operational requirements is draconian: loss of exempt status at the entity level, if the organization operates one hospital, or loss of exemption at the facility level, if the organization operates more than one hospital. In addition, failure to satisfy the CHNA requirement will result in the imposition of a \$50,000 penalty excise tax on each noncompliant hospital pursuant to section 4959 of the Code.

On July 7, 2011, the Treasury Department and the Internal Revenue Service issued Notice 2011-52 to provide guidance concerning the CHNA requirements and to clarify the types of tax-exempt hospitals that are subject to section 501(r)'s requirements. Interestingly, the Notice focuses on the one requirement that is not already applicable to section 501(c)(3) hospitals — the CHNA requirement — and fails to address the issues and ambiguities inherent in the three other requirements that became applicable to section 501(c)(3) hospitals for their fiscal years beginning after March 23, 2010.

The only guidance in the Notice of immediate impact is the clarification that section 501(r) applies to every hospital that has been recognized or seeks recognition as an organization described in section 501(c)(3), *including governmental hospitals*. Resolving this question early will allow hospital districts, hospital authorities, public university hospitals and other types of governmental hospitals operated by those and similar organizations that have received section 501(c)(3) exemption to ensure they are in compliance with the three requirements already in effect.

Hospitals Required To Meet the CHNA Requirements

Section 501(r) applies to a “hospital organization,” defined as an operator of one or more state-licensed, registered or similarly recognized facilities (state-licensed hospitals). Notice 2011-52 confirms that Treasury and the IRS do not intend at the present time to use their statutory authority to expand the application of section 501(r) to organizations that provide hospital care as their primary purpose or function, leaving open the possibility they may do so in the future. For example, section 170(b)(1)(A)(iii) defines the term “hospital” for public charity status purposes very broadly to include an organization whose principal purpose is the provision of hospital or medical care, and Treasury and the IRS have interpreted that definition for decades to include outpatient facilities such as ambulatory surgery and imaging centers as well as community clinics and FQHCs. On the other hand, the Notice makes it clear that section 501(r) applies to hospitals operated by pass-through entities such as partnerships and limited liability companies that have a tax-exempt organization as a partner or member.

Finally, the Notice clarifies that hospitals located outside the 50 United States and the District of Columbia, including hospitals in Puerto Rico and Guam, will not be considered state-licensed hospitals for purposes of section 501(r).

Documenting the CHNA

The CHNA must take the form of a *written* report that includes five components.

Community Served. The CHNA must describe the community served by the hospital (or each hospital, if more than one) and explain how it was determined. The Notice indicates that Treasury and the IRS will use the all-too-familiar “facts and circumstances” approach instead of prescribing a one-size-fits-all definition of *community served*. The Notice indicates that a typical hospital’s “community” will generally be defined by a geographic location such as a particular city, county or metropolitan region. However, where appropriate, a hospital’s community may take into account target populations served, such as children, women or the aged. In addition, a hospital’s community may take into account the hospital’s principal functions, such as its focus on a particular specialty (orthopedics) or targeted disease (cancer, cardiovascular disease, mental or behavioral health).

The Notice cautions against the use of circumvention schemes to define *community* so as to avoid addressing the health needs of targeted populations (e.g., low-income individuals), and it solicits comments regarding the relative merits of different geographically based definitions of *community*, specifically the Metropolitan Statistical Area or Micropolitan Statistical Area in which the hospital is located, or its rural status.

Processes and Methods Used to Conduct the CHNA. The CHNA must describe the process and methods used to conduct the CHNA. The description must include the sources and dates of the data, other information used in the CHNA, and analytical methods used to identify community health needs. The CHNA also must identify data gaps and, if the hospital collaborates with other organizations, identify all organizations with which it collaborated.

Many hospitals (especially smaller hospitals) will outsource some portion or all of this CHNA function to a consulting or other outside firm to obtain access to professional skills or data sets not available internally. If third parties are engaged, the CHNA must disclose their identity and qualifications.

External Input. The CHNA must describe the process used by the hospital to obtain input from persons who represent the broad interests of the community served by the hospital. The Notice indicates that the regulations will be very prescriptive about the level of detail required, as follows:

- The CHNA must describe when and how the hospital consulted with community representatives, including whether the input was obtained through meetings, focus groups, interviews, surveys, written correspondence or other means.

- If the input was obtained from an organization, the CHNA must identify the organization and the name and title of at least one individual with whom the hospital consulted.
- The CHNA must take into account public health needs. The CHNA must identify name, title and affiliation of at least one individual consulted and must provide a brief description of the individual's special knowledge of public health needs.
- The CHNA must take into account input from leaders, representatives or members of medically underserved, low-income and minority populations, as well as populations with chronic disease needs. As part of the required documentation, the CHNA must identify by name any individual who is a "leader" or "representative" of those special needs populations, as well as the nature of the individual's leadership or representative role.

Prioritized Description of Health Needs. The CHNA report must include a prioritized description of health needs indentified through the CHNA process. It must also describe the process and criteria used to prioritize the community health care needs.

Existing Facilities and Resources. The CHNA report must contain a description of the existing health care facilities and other resources within the community available to meet the community health needs identified during the needs assessment process.

The Three-Year CHNA Cycle

Section 501(r) requires that a hospital "conduct" a CHNA every three years or face loss of tax-exempt status and a \$50,000 penalty excise tax. The Notice discusses "when" and "how" a CHNA is or is not considered "conducted" for purposes of this three-year requirement.

First, the CHNA will be considered as being "conducted" in the taxable year that the written CHNA report is made "widely available" to the public. This, effectively, means the taxable year in which the CHNA's written report and implementation plan are finalized, approved and accepted by the hospital's governing body. The Notice requests comments concerning when a hospital organization must conduct a CHNA for a newly acquired hospital or a new hospital placed in service after March 23, 2010.

Second, a CHNA will be considered "conducted" only if it (a) identifies and assesses the health needs of the community served and (b) takes into account input from persons who represent the broad needs of that community.

The key takeaways from these two tests are:

- Treasury and the IRS intend to treat section 501(r), at least with respect to the CHNA requirement, as a strict liability statute similar to the Stark self-referral law. In other words, hospitals must comply with all of its detailed requirements or face loss of exemption and a \$50,000 excise tax.
- Substantial compliance may not be adequate. Treasury and the IRS provided no indication that good faith substantial compliance will serve as reasonable cause for the avoidance of loss of exemption or the \$50,000 excise tax, even though commenters including this author recommended that it do so.
- Reliance on state law community benefit reporting or property tax community benefit reporting requirements will not be adequate to meet the high CHNA standards prescribed in the Notice. The Notice makes it clear that neither the content nor the timing of state-

dictated community needs assessments or measurements will satisfy the federal section 501(r) requirements.

Making a CHNA Widely Available to the Public

The hospital must make its CHNA report “widely available” to the public. The Notice indicates that Treasury and the IRS will follow the suggestion of commenters and pattern the rules for making the CHNA widely available to the public after the rules for making Form 990 series returns widely available.

There are several means by which a hospital can make its CHNA widely available to the public in compliance with section 501(r):

- Post the CHNA report on its own website or on the website of the organization that operates the hospital. For example, if a university owns and operates an academic medical center, the CHNA report can be posted on either the medical center’s website or the university’s website.
- Post the CHNA report on the website established and maintained by another organization as long as either (a) the hospital’s website provides a link to the website on which the CHNA report is posted, with clear instructions for accessing the report on that website, or (b) if the hospital or its operators don’t have a website, any individual requesting a copy of the CHNA report must be given the direct website address, or URL, where the report can be accessed.

The Notice indicates that four additional requirements must be met in order to consider the CHNA report to be made widely available to the public.

- The website on which the CHNA report is posted must clearly inform readers that the document is available and must provide instructions for downloading it;
- The document must be posted in a format that, when accessed, downloaded, viewed and printed in hard copy, exactly reproduces the image of the CHNA report;
- No special hardware or software must be required for the format, other than software readily available to the public for free, such as Adobe® Reader®;
- Neither the hospital nor any other organization maintaining the website may charge for access to viewing, downloading or copying from the website; and

It is important to note that the Notice does not mirror the Form 990 disclosure requirements in two key respects. First, unlike the Form 990 disclosure requirements, section 501(r) simply defaults to the widely available option, so posting notices of availability of hard copies of the CHNA in the hospital will not satisfy the widely available option. Second, the entire report must be posted and available to download and print. Thus, it appears that confidential information in the CHNA report (e.g., market data) must be included in the widely available CHNA report in order to be treated as an exact reproduction and cannot be redacted, unlike contributor information reported on Schedule B to the Form 990, which need not be disclosed.

The key point here is that if the widely available requirements are not completely met, there is no “substantial compliance” protection and the CHNA report will not be treated as having been “conducted.”

Implementation Strategy

In addition to preparing the CHNA report and making it widely available to the public, the hospital must adopt an “implementation strategy” to meet the community health needs identified in the CHNA report.

The Notice confirms that each hospital facility operated by an organization must have a hospital-specific strategy, even if the health system of which it is a part does its regular planning on a regional or other basis. Moreover, the implementation strategy must be a written plan that addresses *each* of the community health needs identified through the CHNA report for that facility.

The Notice indicates Treasury and the IRS will require a written explanation of how the hospital plans to meet the specific health need identified in the CHNA report or why it does not intend to do so.

This particular requirement begs the question of how a health care need is identified and the degree of particularity required. For example, mental health care is an unmet need in broad terms for most communities and is typically identified in health needs assessments today. However, it is unclear under what circumstances the identification of such a broad need and an implementation plan to address it will be adequate to comply with this requirement. For example, will such need have to be broken down into inpatient, outpatient, substance or alcohol abuse, or adult or pediatric care? One can be sure, however, that an IRS examining agent will have no ability to assess objectively compliance with this requirement.

The Notice approaches the implementation plan requirement the same way it approaches all of the other requirements — by requiring detailed information and data. For example, the implementation strategy must tailor the description of the facility plan to the particular hospital, by taking into account its specific resources, programs and priorities and by identifying the programs and resources the hospital plans to commit to meeting the health need and the anticipated impact of those programs and resources on the health need.

The Notice also contemplates that an implementation strategy for a particular hospital facility can describe any planned collaboration with other governmental and nongovernmental entities, including for-profit organizations. If the hospital intends to collaborate with other organizations in developing an implementation strategy, the Notice indicates that all of the other organizations should be identified.

Importantly, the Notice recognizes that it is appropriate for the hospital to collaborate with related organizations. Thus, separately incorporated hospitals within a multi-hospital system can collaborate. However, the Notice provides no guidance on how a multi-hospital system should budget for program development, implementation and finances in a manner that will comply with the implementation requirement. Moreover, the Notice underscores the requirement that an implementation strategy is required for each hospital in the multi-hospital system, from the large 500-bed tertiary care teaching hospital to the 15-bed critical access hospital serving an entirely different type of community and in an entirely different manner. In fact, the Notice expects each hospital to present its implementation strategy in a “clearly presented and easily accessible” manner, but it is unclear what that phrase means.

How and When an Implementation Strategy is Adopted

Approval Requirement. An implementation strategy will not be considered adopted until it is approved by an authorized governing body. The Notice provides three examples of what constitutes an authorized governing body for this purpose.

First, the Notice states that an authorized governing body is the board of directors, board of trustees or equivalent controlling body of the hospital. This definition implies that, to be a governing body for this purpose, the board must have fiduciary and not merely advisory responsibilities with respect to the facility. Thus, local governing bodies of hospitals in multi-hospital systems that may be “governing bodies” for licensing or accreditation purposes may not be considered governing bodies for section 501(r) purposes. In addition, in a multi-hospital system in which hospitals are housed in separate corporations, care must

be used to review each separately incorporated hospital's bylaws and system policies and procedures to confirm whether the fiduciary board of the separate corporation, in fact, has the legal authority to approve an implementation plan or whether that action is covered by a power reserved to the corporate parent.

Second, a committee of the governing body can approve an implementation plan — as long as state law permits the committee to act on behalf of the fiduciary board. Again, each hospital's bylaws and committee charters must be reviewed to determine whether a committee, such as an executive committee, can legally act for the full board or whether the committee is merely advisory, as many often are, and cannot act for the full board.

Finally, other parties may be authorized by the fiduciary board to act on its behalf and serve as the governing body for purposes of approving an implementation plan for a hospital. However, the Notice also states that the other party must "follow[...] procedures specified by the [fiduciary] governing body in approving an implementation strategy." Thus, the term *governing body* should cover management companies and the general partners or boards of managers of separate pass-through entities that operate joint-ventured hospitals. However, at a minimum, management contracts, partnerships agreements and operating agreements should be reviewed to determine whether the requisite authority has been delegated to the third party to approve an implementation strategy.

Timing Requirements. The implementation strategy must be approved in the same taxable year that the CHNA report is completed. Thus, hospitals will have to complete the CHNA report early enough in the year to allow adequate time for the governing board to adopt a corresponding implementation strategy.

In light of this timing requirement, and the absence of any reasonable cause excuse for failure to comply, section 501(r) compliance must be a high priority for every section 501(c)(3) hospital, whether freestanding or part of a larger health system.

Loss of Exemption and the \$50,000 Excise Tax

Failure to satisfy any one of the four section 501(r) requirements will serve as a basis, in itself, to revoke the tax-exempt status of the noncompliant hospital. Until Treasury and the IRS indicate otherwise, hospitals should assume that failure to comply with any of the three requirements currently in force will result in loss of exemption for the year in which the failure occurs. The CHNA requirement, in contrast, is tied to the end of a hospital's taxable year. Thus, if a hospital fails to satisfy the CHNA requirement by the end of the third year in the three-year cycle, the tax-exempt status of a one-hospital organization at the entity level or a multi-hospital organization at the facility level will be revoked at the close of such taxable year.

The \$50,000 excise tax will be imposed in the third year of the three-year period in which the requirement had to be satisfied. Then another \$50,000 excise will be imposed in the following year if the hospital fails to correct and comply with the CHNA requirements in the following year. The Notice does not address how the \$50,000 excise tax will be coordinated with the revocation of a tax-exempt hospital's exemption either at the entity or at the facility level.

Because the CHNA requirements apply separately with respect to each hospital facility, the \$50,000 excise tax will apply to each noncompliant hospital operated by an organization. Thus, more than one \$50,000 penalty may be imposed on an organization that operates more than one hospital.

Finally, it is important to note that state charities officials will be notified by the IRS if the IRS imposes a section 4959 excise tax on a hospital, because section 4959 is part of Chapter 42 of the Code. Thus, the state charities officials may seek to surcharge the hospital's governing body for such excise taxes, as they have in other Chapter 42 excise tax cases. This is yet one more reason why compliance with section 501(r)'s requirements is a compliance matter that rises to the level of the governing board of the hospital or health system.

Reporting Requirements Applicable to CHNA

Section 501(c)(3) hospitals that are required to file a Form 990 (i.e., other than governmental section 501(c)(3) hospitals) currently must answer several section 501(r) compliance questions on Schedule H, *Hospitals*, and the IRS may add new questions in the future. In addition, the most recently adopted implementation strategy will have to be attached to the annual Form 990. Lastly, a hospital will be required to report the amount of the \$50,000 excise tax imposed on the organization under section 4959.

Section 501(c)(3) governmental hospitals are relieved from the Form 990 filing requirement. Thus, they are relieved from the section 501(r) reporting requirements associated with the Form 990. Treasury and the IRS will have to identify alternative methods to obtain the information required by section 501(r) in order to complete accurately their required reports to Congress.

Effective Dates

The Notice makes clear that Treasury and the IRS intend to apply section 501(r)'s requirements to all section 501(c)(3) hospitals, including governmental hospitals. As a consequence, Treasury and the IRS have placed governmental hospitals on notice that they are currently subject to the three section 501(r) requirements that became effective for taxable years starting after March 23, 2010.

The CHNA requirements are effective for taxable years beginning after March 23, 2012. Accordingly, the Notice states that Treasury and the IRS will require hospitals to conduct a CHNA and adopt an implementation strategy for each hospital by the last day of the first taxable year beginning after March 23, 2012.

The Notice confirms that a *compliant* CHNA and implementation strategy conducted in the taxable year beginning after March 23, 2012, or in the preceding two years, will satisfy the requirement. However, the key is "compliant."

Planning Considerations

Section 501(c)(3) hospitals, their boards and management, and their advisors should take the numerous messages conveyed in Notice 2011-52 seriously and adopt compliance practices as soon as practicable for several reasons:

- **Strict Liability.** The Notice makes clear that Treasury and the IRS view section 501(r) as a strict liability statute — comply or lose exemption, plain and simple.
- **Tax-Exempt Financing.** Effective immediately, compliance with section 501(r)'s requirements will be part of all tax-exempt financing due diligence. Underwriter's counsel, issuer's counsel, disclosure counsel and others will place a high level of attention on section 501(r) compliance and the adequacy of the hospital's internal compliance process and procedures. Assessing compliance will be important from both a tax point of view and a securities law disclosure point of view.
- **Collaboration.** The Notice approves collaboration for the purpose of developing implementation plans for CHNA reports. However, care must be used when collaborating with competitors or intermediaries. Price fixing, division of markets and other antitrust compliance issues must be addressed in advance of such collaboration.
- **Reliance on Opinions.** Hospitals will routinely utilize consultants to assist in developing CHNA reports and implementation plans. However, while these consultants are or should be competent to assist a hospital with those tasks, they are not tax experts. The opinion on whether a hospital is section 501(r) compliant requires a legal conclusion that cannot

be properly rendered by a non-legal expert. Knowledgeable tax professionals should be involved in the CHNA process to assure compliance with section 501(r)'s legal requirements.

- **Role of Examining Agents.** One of the stated reasons for publishing Revenue Ruling 69-545 was to provide a more administrable standard than the "extent of financial ability" test of exemption in Revenue Ruling 56-185. The Notice is a signal that Treasury and the IRS are approaching the application of section 501(r) to section 501(c)(3) hospitals in the prescriptive, detail-rich manner similar to that applied to consumer credit counseling organizations. This will give examining agents and their managers great power over the fate of a nonprofit hospital's continued tax-exempt status.

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