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Proposed Regulations Released Regarding the Community Health Needs Assessment Requirement for Tax-Exempt Hospitals

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On April 5, the Internal Revenue Service ("**IRS**") and the Treasury Department published proposed regulations addressing the community health needs assessment ("**CHNA**") required of 501(c)(3) tax-exempt hospitals pursuant to the Affordable Care Act.[1] Section 501(r)(3) of the Internal Revenue Code ("**Section 501(r)(3)**") requires a hospital organization to conduct a CHNA at least once every three years for taxable years beginning after March 23, 2012 and to adopt an implementation strategy to meet the community health needs identified. Previous guidance on the topic was issued by the IRS in Notice 2011-52. The proposed regulations are largely consistent with Notice 2011-52, but offer further clarification on some aspects of the CHNA requirements and also make some modifications in response to comments received regarding Notice 2011-52 (certain of those differences are discussed below). The key provisions of the proposed regulations are summarized below.

The statutory effective date for the CHNA requirements was March 23, 2012, and the IRS and Treasury Department have stated that a hospital facility may rely on these proposed regulations until six months after temporary or final regulations are published. Because hospital facilities must comply with the CHNA statutory requirements, and these proposed regulations provide guidance on implementation of those statutory requirements, hospital facilities should seriously consider complying with these proposed regulations as they conduct CHNAs and adopt implementation strategies pursuant to Section 501(r)(3).

Comments and requests for a public hearing are being accepted on the proposed regulations through July 5, 2013. Providers that require further clarification or have concerns about certain aspects of the proposed regulations should consider taking this opportunity to submit comments to the IRS.

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[1] *See* http://www.gpo.gov/fdsys/pkg/FR-2013-04-05/pdf/2013-07959.pdf

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Conducting a CHNA

Section 501(r)(3) provides that a CHNA must take "into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise in public health," and must be "made widely available to the public." The proposed regulations describe in detail what steps would be required to meet these requirements.

Community Served by the Hospital Facility

The proposed regulations provide that a hospital facility has flexibility to take into account all the relevant facts and circumstances when defining its community, including the geographic area served, target populations served, and principal functions (such as a focus on a specific disease or specialty area). However, a hospital facility could not define its community in such a way as to exclude medically underserved, low-income, or minority populations where such populations would otherwise be part of the patient population.

Assessing Community Health Needs

Pursuant to the proposed regulations, a hospital facility would be required to identify significant health needs of the community, prioritize those health needs, and identify potential measures and resources available to address the health needs. A hospital facility has flexibility to prioritize the identified health needs. The proposed regulations provide examples of criteria that a hospital facility could consider when prioritizing such health needs, including: (i) the burden, scope, severity or urgency of the health need; (ii) the feasibility and effectiveness of possible interventions; (iv) the health disparities associated with the need; and (v) the importance the community places on addressing the health need.

Persons Representing the Broad Interests of the Community

The proposed regulations provide that a hospital facility would be required to, at a minimum, consider input from the following three sources. First, a hospital facility would be required to consider input from at least one state, local, tribal or regional (but not federal) governmental public health department, or an equivalent department, with relevant knowledge, information or experience. Second, a hospital facility would be required to consider input from members of medically underserved, low-income, and minority populations in the community, or individuals or organizations that represent the interests of such populations. The proposed regulations clarify that a hospital facility can seek input directly from population members, such as through focus groups or surveys, or seek input from representative individuals or organizations. Third, a hospital facility would be required to consider any written comments received on the hospital facility's most recently conducted CHNA and adopted implementation strategy.

Documentation of a CHNA

A hospital facility would be required to document its CHNA in a CHNA report that is adopted by an authorized body. The CHNA report would need to include five elements: (i) definition of the community served and a description of how that community was determined; (ii) description of the process used to conduct the CHNA; (iii) description of how the hospital facility took into account input from persons who represent the broad interests of the community; (iv)

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prioritized description of the significant health needs identified, along with a description of the process and criteria used; and (v) description of potential measures and resources identified to address the identified health needs. When describing the process and methods used for the CHNA, the proposed regulations would require the CHNA report to describe the data used in the CHNA, as well as the methods of collecting and analyzing the data. If the hospital facility collaborated with any parties to conduct the CHNA, those parties must also be identified. However, the scope of this requirement and what parties would be covered is not entirely clear. Although the proposed regulations do not specify whether a hospital facility must identify consultants that it uses to conduct a CHNA pursuant to this requirement, as a conservative approach, hospital facilities should consider identifying any consultants used in the CHNA process to ensure compliance with this requirement.

When describing the input from persons representing the broad interests of the community, a CHNA report would be considered sufficient if it: (i) summarizes the input in general terms, along with how and over what time period it was provided; (ii) provides the names of the organizations providing input and summarizes that input received; and (iii) describes the medically underserved, low-income or minority populations being represented by organizations or individuals providing input. Notice 2011-52 provided that the CHNA report would need to identify not only the organization providing input, but also the name and title of at least one individual within the organization that was consulted. Due to privacy concerns, the proposed regulations have relaxed this requirement, and a hospital facility would not need to name or otherwise individually identify individuals in the CHNA report.

Making the CHNA Report Widely Available to the Public

The proposed regulations are generally consistent with Notice 2011-52, in that the proposed regulations would require a hospital facility to post its CHNA report on its website, or if it does not have its own website separate from the hospital organization, on the hospital organization's website. Alternatively, the CHNA report can be posted on the website of another entity as long as the hospital facility provides a link to the other entity's website. Individuals must be able to access, download, view and print the CHNA report without purchasing special computer hardware or software or paying a fee. A hospital facility must provide the direct website address of the page where the report is posted to individuals who ask how to access a copy online.

However, the proposed regulations also expand the Notice 2011-52 requirements, in response to comments received requesting that the IRS increase the transparency of a hospital facility's CHNA. The proposed regulations make the following proposed modifications to the Notice 2011-52 requirements: (i) the CHNA report must now be posted "conspicuously" on a website; (ii) the CHNA report must remain on a website until two subsequent CHNA reports have been posted; (iii) a hospital facility cannot require an individual to create an account or otherwise provide personally identifiable information to access the CHNA report online; and (iv) a paper copy of the CHNA report must be available for public inspection, without charge, until the hospital facility has made paper copies of two subsequent CHNA reports available for public inspection.

The proposed regulations provide that these requirements also apply to financial assistance policies required pursuant to Section 501(r)(4) of the Internal Revenue Code.

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Implementation Strategy

Pursuant to the proposed regulations, a hospital facility must adopt an implementation strategy that describes how the hospital facility plans to address each identified significant health need in its CHNA. A hospital facility would be required describe the anticipated impact of the actions and the plan to evaluate such impact, and identify programs and resources that the hospital facility plans to commit to address the identified health need. A hospital facility would also be required to identify any collaboration that is planned to address the significant health need. A hospital facility would be required to take into account any written comments received on its most recently adopted implementation strategy.

For any significant health need that a hospital facility does not plan to address, a brief explanation of the reasons why it does not intend to address the health need would be considered sufficient. Examples of reasons for not addressing a health need could include resource constraints, relative lack of experience or competency, a lack of identified effective interventions, the fact that the need is addressed by other organizations in the community, or the fact that the hospital facility assigned the health need a relatively low priority.

Consistent with the timeframe provided in Notice 2011-52, the proposed regulations provide that the implementation strategy should be adopted by the end of the same taxable year in which the hospital facility conducts its CHNA. Because the CHNA and implementation strategy are required only once every three years, the IRS explained that hospital facilities will have "ample time" to complete a CHNA earlier in the third year and adopt an implementation strategy by the end of the same year.

However, the proposed regulations do provide some transition relief, by providing a longer timeframe to adopt an implementation strategy for a hospital facility that conducts a CHNA in a taxable year prior to March 23, 2012 or that conducts a CHNA in its first taxable year after March 23, 2012. For a hospital facility that conducts a CHNA in a taxable year prior to March 23, 2012 (the effective date of Section 501(r)(3)), the hospital facility would have until the 15th day of the fifth calendar month following the close of its first taxable year beginning after March 23, 2012 to adopt an implementation strategy. For a hospital facility that conducts a CHNA in its first taxable year beginning after March 23, 2012, it would have satisfied the Section 501(r)(3) requirements if it adopts an implementation strategy on or before the 15th day of the fifth month following the close of that same taxable year.

Consequences for Failing to Satisfy the Requirements of Section 501(r)(3) – (r)(6)

Revocation of 501(c)(3) Status

The IRS may revoke the 501(c)(3) status of a hospital organization that fails to meet Section 501(r) requirements, and, pursuant to the proposed regulations, in making such a decision will consider the relevant facts and circumstances. The proposed regulations list nine specific facts and circumstances that the IRS will consider, including the relative size, scope, nature, and significance of the failure to meet the requirements, the reasons for the failure, and whether the same types of failures have previously occurred. In addition, the IRS will consider whether the hospital

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organization has previously established practices and procedures designed to promote compliance with Section 501(r), and whether the practices and procedures were routinely followed and the failure occurred through an oversight or mistake in application. Since two of the nine enumerated factors address practices and procedures, hospital organizations should consider implementing formal policies and procedures to address 501(r) compliance, in addition to the creation of a financial assistance policy as required by Section 501(r)(4), and hospital organizations should take care to document implementation of the policies and procedures along with any training provided to staff regarding the policies and procedures.

If the hospital organization's failures are willful or egregious, the IRS and Treasury Department expect that consideration of the facts and circumstances will ordinarily result in revocation of 501(c)(3) status.

Taxation of Noncompliant Hospital Facilities

The proposed regulations address the situation where a hospital organization operates multiple hospital facilities, and one of its hospital facilities fails to comply with Section 501(r). The proposed regulations provide that the particular hospital facility would cease to be exempt from taxation, assuming its failure would trigger revocation under the facts and circumstances described above and its failure is not otherwise excusable. However, the hospital organization as a whole would retain its tax-exempt status. The proposed regulations describe in detail how the noncompliant hospital facility would be taxed in such a situation.

Excise Tax for Failure to Comply with Section 501(r)(3)

Internal Revenue Code Section 4959 imposes a $50,000 excise tax on a hospital organization that fails to meet the requirements of Section 501(r)(3) with respect to any taxable year. The proposed regulations provide that the excise tax applies to any three year period, so that the excess tax could apply in sequential years. As an example, the commentary to the proposed regulations provides that a hospital organization could be subject to a $50,000 excise tax in 2013 because it failed to conduct a CHNA in 2011-2013. If the hospital organization again fails to conduct a CHNA in 2014, it could be subject to another $50,000 excise tax in 2014 for failure to conduct a CHNA in 2012-2014. In addition, hospital organizations with multiple facilities could face a separate excise tax for each hospital facility that is out of compliance. As a result, hospital organizations could potentially face excise taxes significantly higher than $50,000, depending on the circumstances. The proposed regulations specify that the excise tax may be imposed in addition to taxation of a particular noncompliant facility and in addition to revocation of a hospital organization's 501(c)(3) status.

Certain Failures Excused

An omission of required information in a report required pursuant to Section 501(r)(3) or a financial assistance policy pursuant to Section 501(r)(4), or an error in implementing the other requirements of Section 501(r)(3)-(6), would not be considered a failure to meet the Section 501(r) requirements if: (i) the omission or error is minor, inadvertent, and due to reasonable cause; and (ii) the hospital facility corrects the omission or error as promptly after discovery as is reasonable given the nature of the omission or error.

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For failures to comply with Section 501(r) that rise beyond the minor and inadvertent, the IRS will excuse such errors under certain conditions, as an incentive for hospital facilities to correct and disclose such errors when they occur. The IRS and the Treasury Department plan to issue future guidance to address the conditions under which such failures will be excused. If a hospital facility corrects and provides disclosure of its failure to meet the Section 501(r) requirements pursuant to the future guidance, and such failures are neither willful or egregious, the failures will be excused.

New Hospital Facilities

The proposed regulations address when a hospital facility that is newly acquired or placed into service, or that becomes newly subject to the requirements of section 501(r) because it is newly recognized as a 501(c)(3) entity, would be required to conduct its first CHNA. Such a hospital facility would have until the last day of the second taxable year beginning after the date, respectively, that the hospital facility is acquired, recognized by the state as a hospital (such as through licensure), or newly subject to Section 501(r) as a result of being recognized as described in section 501(c)(3).

The proposed regulations do not address whether compliance with Section 501(r) requirements is required for purposes of submitting the Form 1023, Application for Recognition of Exemption Under Section 501(c)(3) of the Internal Revenue Code. However, Rev. Proc. 2013-9, which addresses the procedures for requesting recognition of tax exempt status, provides under the "Form 1023" heading that "[i]n the case of an organization that is a hospital and is seeking exemption under §501(c)(3), see §501(r)," which implies that a new hospital facility should at least address how it plans to meet the Section 501(r) requirements. In our experience, the IRS requires that a new hospital facility do so as part of its Form 1023 submission.

Operating a Hospital Facility Through a Partnership

Notice 2011-52 provided that the intention of the IRS was to define a hospital organization to include any 501(c)(3) organization that operates a hospital facility through a joint venture, limited liability company, or other entity treated as a partnership for federal tax purposes. Notice 2011-52 also requested comments regarding under what circumstances such an organization would not be considered to operate a hospital facility for purposes of Section 501(r).

The proposed regulations provide that, as a general rule, a hospital organization is considered to operate a hospital facility if it is a partner in a joint venture, limited liability company, or other entity treated as a partnership, and that partnership operates the hospital facility.

The proposed regulations then provide two exceptions to this general rule. First, if a tax-exempt partner of a partnership operating a hospital facility does not have sufficient control to ensure that the operation is furthering an exempt purpose under 501(c)(3), and thus treats the operation of the hospital facility as an unrelated trade or business, it would not be considered to be operating a hospital facility pursuant to Section 501(r). Second, the proposed regulations provide a grandfather rule. Under that rule, a hospital organization would not be considered to be operating a hospital facility pursuant to Section 501(r) if the organization: (i) has, at all times since March 23, 2010, been organized and operated primarily for educational or scientific purposes, not for the operation of a hospital facility; (ii) pursuant to a partnership agreement entered into prior to March 23, 2010, the

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organization does not own over 35 percent of the capital or profits interest, does not own a general partner or similar interest, and does not have sufficient control to ensure that the hospital facility is operated in compliance with Section 501(r).

Other Key Topics Addressed

In addition to the topics addressed above, the proposed regulations address a broad range of other topics, including the ability to collaborate on CHNA reports and implementation strategies, the CHNA reporting requirements on the Form 990, whether the requirements apply to tribal hospital facilities, and the treatment of multiple buildings under a single hospital license as a single hospital facility.

Important Dates

The statutory effective date for Section 501(r)(3) was March 23, 2012, and the statutory effective date for other Section 501(r) requirements was March 23, 2010.

The Treasury Department and IRS intend to finalize these proposed regulations in conjunction with the proposed regulations issued in 2012, which addressed Section 501(r)(4)-(6). These proposed regulations are effective on the date that they are published as temporary or final regulations in the Federal Register. Hospital organizations may continue to rely on Notice 2011-52 until October 5, 2013 (six months after publication of these proposed regulations). After October 5, 2013, Notice 2011-52 will be considered obsolete. Hospital organizations may rely on these proposed regulations up to six months after these proposed regulations are published as temporary or final regulations, at which point hospital organizations could then rely only on the subsequent temporary or final regulations.

Comments will be accepted on the proposed regulations through July 5, 2013.

For further information, please contact Amy Joseph, David Hatch, or Todd Swanson in our Los Angeles office at 310.551.8111, Paul Smith or Steve Lipton in our San Francisco office at 415.875.8500, Stephen Treadgold or Mary Norvell in our San Diego office at 619.744.7300, or Robert Roth in our Washington D.C. office at 202.580.7700.

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