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An Evolution of the IRS Regulations Governing Nonprofit Hospitals' Community Health Needs Assessments

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Introduction

It has long been the case that nonprofit hospitals established as 501(c)(3) charitable organizations qualify for tax exemption in exchange for the requirement that they invest in the health of the communities they serve. These investments, known as “community benefit” obligations, have existed for decades. They evolved from exclusively the provision of charity care (free or reduced cost care traditionally provided to low-income, uninsured patients) to include such activities as education, research and programs that improve community health.¹ In recent years, the federal government has grown increasingly interested in imposing standards that require 501(c)(3) nonprofit hospitals to justify their tax-exempt status. In 2002 alone, it was estimated that nonprofit hospitals saved a total of \$12.6 billion that would have been owed in federal, state, and local taxes.²

The Department of Treasury and the Internal Revenue Service (IRS) are responsible for issuing regulations that govern 501(c)(3) nonprofit organizations, including hospitals. In 2008, the IRS introduced Schedule H, a tax form that nonprofit hospital facilities and systems must file along

¹ SARA ROSENBAUM, MAUREEN BYRNES & NIKKI HURT, COMMUNITY BENEFIT AND THE ACA: A BRIEF HISTORY AND UPDATE 1–2, *available at* http://www.nchh.org/Portals/0/Contents/HCF_CBACA%20overview.pdf.

² CONG. BUDGET OFFICE, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS 3 (Dec. 2006), *available at* <http://www.cbo.gov/publication/18256>.

with their Form 990 tax filings.³ This tax form, which has undergone several iterations since its 2009 introduction, gives guidance on how hospitals should define and report community benefit spending in relation to other costs they incur.⁴ The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 brought further changes to the Schedule H form and increased transparency and IRS oversight for any hospital claiming tax-exemption as a 501(c)(3) charitable organization.⁵

Section 9007 of the ACA amends the Internal Revenue Code by creating subsection 501(r) titled “Additional requirements for certain hospitals.” This new code section establishes new requirements that aim to improve the relationship between community health needs and community benefit investments made by nonprofit hospitals as a condition of tax exemption. The ACA requires each nonprofit hospital facility to undergo a formal “community health needs assessment” (CHNA) process every three years. During the needs assessment process, hospitals must take into account input from members of the community—including individuals who have expertise in public health. Hospital facilities must also make their CHNAs widely available to the public by posting them on their websites. In addition to the CHNA, hospitals must also write and adopt a formal Implementation Strategy. The Implementation Strategy outlines how the hospital’s community benefit programs will address community health needs identified and prioritized through the CHNA process. The Implementation Strategy need not be made widely available but must be filed along with the hospital’s Form 990 tax filings. Each nonprofit hospital facility had to complete its first CHNA by the last day of its first taxable year beginning after March 23, 2012.

Following the passage of the ACA in 2010, the IRS provided guidance to nonprofit hospitals on the new CHNA and Implementation Strategy requirements through a series of proposed rules. The IRS invited public comments on these rules from any interested parties. In July 2011, the IRS issued the first in this series of proposed rules, titled *2011 Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-exempt Hospitals* (“2011 Notice”).⁶ The 2011 Notice could be relied upon by any hospital conducting a CHNA prior to October 5, 2013.⁷ The IRS issued new proposed rules in 2013 in response to comments received from the 2011 Notice (“2013 Proposed Rules”).⁸ Taking into account the comments received following the 2013 Proposed Rules, the final IRS regulations governing

³ IRS. Instructions for Schedule H (2008). <http://www.irs.gov/pub/irs-prior/i990sh--2008.pdf>. See also Davis C. Nonprofit hospitals and community benefit. National Health Law Program; July 2011.

⁴ Rosenbaum, *supra* note 1, at 2.

⁵ 26 U.S.C. 501(r) (2011).

⁶ Notice and Request for Comments Regarding the Community Health Needs Assessment Requirement for Tax-exempt Hospitals, Notice 2011-52 (proposed July 25, 2011) (to be codified at 26 C.F.R. pts. 1, 53) [hereinafter “2011 Notice”].

⁷ I.R.B. 2013-21, May 20, 2013.

⁸ Community Health Needs Assessments for Charitable Hospitals, 78 Fed. Reg. 66 (proposed Apr. 5, 2013) (to be codified at 26 C.F.R. pts. 1, 53) [hereinafter, “2013 Proposed Rules”].

CHNAs and Implementation Strategies were released on December 31, 2014 (“2014 Final Regulations”).⁹

This paper summarizes the IRS’s rules contained in the 2011 Notice and the changes made to these rules in both the 2013 Proposed Rules and the 2014 Final Regulations. This discussion is divided into eight sections that reflect the new CHNA requirements for hospitals: (I) defining the community served; (II) assessing community needs; (III) community input; (IV) documentation of the CHNA; (V) collaboration; (VI) availability to the public; (VII) Implementation Strategy; (VIII) failure to satisfy the requirements. The analysis will show that, while the 2013 Proposed Rules added significant clarification and detail to the requirements for charitable hospitals, some of the regulations were watered down in the resulting 2014 Final Regulations.

Analysis

I. Defining the Community Served

The 2011 Notice required that each hospital define its community served in the CHNA and describe how it reached this conclusion.¹⁰ The 2013 Proposed Rules expanded on this general requirement, explaining that the definition of the community served could include populations in addition to the hospital’s patient populations or geographic areas outside of those in which its patient populations reside.^{11,12} Regardless of how the hospital facility chose to define its community, the 2013 Proposed Rules prohibited the facility from defining community in a way that excluded medically underserved, low income, or minority populations who are a part of the hospital’s patient population.¹³ If the hospital facility chose to take into account its patient population in defining the community served, the facility was required to treat all individuals who received care from the hospital facility as patients, regardless of who paid their bill or whether they were eligible for financial assistance.¹⁴

After reviewing the comments submitted in response to the 2013 Proposed Rules, the 2014 Final Regulations took away some of the language that allowed for flexibility in defining the community served. Specifically, the 2014 Final Regulations deleted language suggesting that a hospital facility could define its community to include populations in addition to its patient population and geographic areas outside of those in which its patient population resides. The 2014 Final Regulations do, however, continue to give hospital facilities leeway in defining the communities they serve or intend to serve, taking into account all relevant facts and

⁹ Additional Requirements for Charitable Hospitals: Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return, 79 Fed. Reg. 78954 (Dec. 31, 2014) (codified at 26 C.F.R. pts. 1, 53, 602 (2014)) [hereinafter 2014 Final Regulations].

¹⁰ 2011 Notice at 13.

¹¹ 2013 Proposed Rules, 78 Fed. Reg. at 20528–29.

¹² *Id.* at 20529.

¹³ *Id.*

¹⁴ *Id.*

circumstances, provided that they do not exclude medically underserved, low-income, or minority populations. The 2014 Final Regulations also add that hospital facilities may not exclude low-income or minority populations living “in the geographic areas from which the hospital facility draws its patients,” even if these populations are not currently receiving care from the facility.¹⁵ Outside of these amendments and additions, the 2014 Final Regulations adopt the 2013 Proposed Rules with regard to defining the community served.

The expanded guidelines in the 2013 Proposed Rules for defining a hospital facility’s “community served” encouraged hospitals to include populations outside of the hospital’s traditional service-seeking patient population. Unfortunately, after reviewing the comments submitted in response to the 2013 Proposed Rules, the 2014 Final Regulations took away some of the language that encouraged nonprofit hospitals to think broadly when defining the community served.¹⁶ Specifically, the 2014 Final Regulations eliminated much of the detail that encouraged hospitals to include potentially outlying medically underserved areas for purposes of assessing community health needs.¹⁷ The IRS explained that the deletion aims to “avoid potential confusion” expressed by commenters who felt that the language that encouraged charitable hospitals to look outside of their patient population and geographic area “could create confusion among both hospital organizations and the public, as it implies that the community that is defined for CHNA purposes may not actually be the community served by the hospital facility.”¹⁸

II. Assessing Community Needs

The 2011 Notice required that the CHNA identify the health needs of the community, prioritize those health needs, and identify potential measures and resources available to address the health needs.¹⁹ The 2013 Proposed Rules clarified that the hospital’s CHNA need only identify and prioritize *significant* health needs.²⁰ In prioritizing these needs, the hospital was permitted to use any criteria it deemed appropriate, including, but not limited to: burden, scope, severity, urgency, feasibility and effectiveness of interventions, associated health disparities, and the importance to the community.²¹

The 2014 Final Regulations explain in more detail what a hospital facility should consider in assessing community needs.²² The requirement that the CHNA identify potential measures that might be taken to address health needs was deleted, and instead the 2014 Final Regulations require only that a hospital facility identify *resources* potentially available to address the

¹⁵ 2014 Final Regulations, 79 Fed. Reg. at 78962.

¹⁶ See 2014 Final Regulations, 79 Fed. Reg. at 78962.

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ 2011 Notice at 11.

²⁰ 2013 Proposed Rules, 78 Fed. Reg. at 20529.

²¹ *Id.*

²² 2014 Final Regulations, 79 Fed. Reg. at 78962–63.

community's significant health needs.²³ The term "resources" includes programs, organizations, and facilities available to community members, including those of the hospital itself.²⁴

The 2014 Final Regulations also expand on the examples of "health needs" that a hospital may consider in its CHNA, including not only the need to address financial and other barriers to care, but also the need to prevent illness, ensure adequate nutrition, or address social, behavioral, and environmental factors that influence health in the community.²⁵ The expanded list of examples encourages hospitals to think outside of the box and consider focusing their resources on upstream factors that impact community health.

III. Community Input

The 2011 Notice required that hospitals gather input from members of the community for use in the CHNA.²⁶ In order to have adequately gathered input, the 2011 Notice required that each hospital, at minimum, collect input from persons with special knowledge of or expertise in public health; federal, tribal, regional, State, or local health departments with data or information relevant to the health needs of the community served; and leaders, representatives, or members of medically underserved, low-income and minority populations, as well as populations with chronic disease needs, in the community served.²⁷ The 2011 Notice allowed hospital facilities to take into account the input of any additional community members as well.²⁸

The 2013 Proposed Rules eliminated the portion of the regulations allowing hospitals to take into account the input of federal health departments, so as to ensure that input was coming from public health in the relevant community.²⁹ The 2013 Proposed Rules also eliminated the portion allowing hospitals to consult with leaders and representatives of underserved, low-income, and minority populations.³⁰ Instead, the 2013 Proposed Rules stated that input should be gathered from members or individuals, or organizations representing the interests of those populations.³¹ With respect to collecting input from members of populations with chronic disease needs, the 2013 Proposed Rules clarified that no particular chronic disease needs to be addressed – instead, the focus should be on disparities in coverage, access, and other barriers to care for persons with health needs that may include, but are not limited to, chronic diseases.³² The 2013 Proposed Rules also added that a hospital facility must accept community

²³ *Id.* at 78963.

²⁴ *Id.*

²⁵ *Id.*

²⁶ 2011 Notice 15–16.

²⁷ *Id.*

²⁸ *Id.* at 16.

²⁹ 2013 Proposed Rules, 78 Fed. Reg. at 20530.

³⁰ *Id.*

³¹ *Id.*

³² *Id.*

feedback after the publication of the CHNA and must establish an “ongoing feedback mechanism” for each three-year cycle.³³ Finally, the 2013 Proposed Rules added that the input collected *must* include input on any financial and other barriers to access to care in the community.³⁴

Georgia Watch was pleased to see that the 2014 Final Regulations adopt the community input provisions of the 2013 Proposed Rules, which ensure that input is thoroughly gathered from necessary parties and public health departments within a hospital’s defined community. However, in order to address the concern that a hospital facility, despite its best efforts, might not be able to secure input from a required party, the 2014 Final Regulations clarify that a facility must only *solicit* input and take into account the input received.³⁵ Hospitals are required to document their “reasonable” efforts to obtain such input.³⁶ While gathering input may be difficult for hospitals that do not have a history of strong community engagement, changing the obligatory language of the rules from *gather* to *solicit* may provide hospitals with an excuse not to establish stronger community relationships.

IV. Documentation of the CHNA

As mentioned in the above sections, the 2011 Notice outlined several areas that had to be documented in a hospital’s CHNA, including, but not limited to:

- Describe the community served, and how the hospital determined the community served.³⁷
- Describe the methods and processes used in conducting the CHNA, including a description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs.³⁸ The CHNA should also describe information gaps that impact the ability to assess the health needs of the community.³⁹ Also, if the hospital collaborates with other organizations in conducting the CHNA, the report should identify these collaborative efforts and partnerships and identify at least one person from each collaborative organization by name, title and affiliation and provide a brief description of that person’s specialized knowledge.⁴⁰
- Describe when and how the hospital organization consulted with persons who represent the broad interests of the community served by the hospital (whether through meetings, focus groups, interviews, surveys, written correspondence, etc.).⁴¹ If the

³³ *Id.* at 20534.

³⁴ *Id.* at 20531.

³⁵ 2014 Final Regulations, 79 Fed. Reg. at 78963.

³⁶ *Id.* at 78963–64.

³⁷ 2011 Notice at 9.

³⁸ *Id.* at 9–10.

³⁹ *Id.* at 10.

⁴⁰ *Id.*

⁴¹ *Id.*

hospital consulted with persons in conducting its CHNA, the report should identify by name, title, and affiliation any individuals with special knowledge or expertise in public health who were consulted.⁴²

- Contain a prioritized description of the community health needs and the prioritization methods used for the needs identified.⁴³
- Describe other resources and healthcare facilities in the community, which are addressing or capable of addressing needs identified in the CHNA.⁴⁴

In order to further clarify what it meant to “document” the items listed above, the 2013 Proposed Rules clarified that CHNAs should summarize, in general terms, input that was provided and how and over what time such input was provided.⁴⁵ The 2013 Proposed Rules made this documentation slightly less demanding by eliminating the requirement that the names of individuals providing input be listed – instead, the CHNA was only required to list the names of the organizations that provided input, and summarize the nature and extent of the organization’s input.⁴⁶ If input came from a vulnerable population in the community served, the assessment had to include a description of that vulnerable population when identifying groups that provided input.⁴⁷

In response to comments (likely submitted by hospitals), the 2014 Final Regulations note that a hospital facility may rely on data collected or created by others in conducting its CHNA. In such cases, hospitals may cite the data sources rather than describe the “methods of collecting” the data.⁴⁸ Otherwise, the 2014 Final Regulations retain the same language as the 2013 Proposed Rules, with respect to documentation of the CHNA.⁴⁹

Overall, the changes made to the documentation requirements in the later versions of the regulations do not require the level of transparency that Georgia Watch would like to see. By allowing hospitals to summarize “in general terms” input provided, the IRS gives hospitals much flexibility to decide how much detail to include.⁵⁰ By eliminating the data collection reporting requirements, the 2014 Final Regulations allow hospitals to avoid some public accountability for their CHNA process. The number of individuals in the community solicited for input, the means of solicitation, the response rate, and the names of the individuals providing input are all necessary elements to assess the quality and thoroughness of each CHNA. Georgia Watch encourages advocates to examine hospital CHNAs carefully for these details.

⁴² 2011 Notice at 10.

⁴³ *Id.* at 11.

⁴⁴ *Id.*

⁴⁵ 2013 Proposed Rules, 78 Fed. Reg. at 20531.

⁴⁶ *Id.*

⁴⁷ *Id.* at 20532.

⁴⁸ 2014 Final Regulations, 79 Fed. Reg. at 78966.

⁴⁹ *See id.* at 78966–67 (describing the 2014 Final Regulations with respect to “Documentation of a CHNA”).

⁵⁰ *Id.* at 78967.

V. Collaboration

The 2011 Notice allowed hospital organizations to conduct CHNAs in collaboration with other organizations.⁵¹ However, each hospital facility was required to document its CHNA in a separate written report.⁵² In response to commenters who questioned the efficiency of submitting essentially identical CHNAs separately, the 2013 Proposed Rules clarified that, if a hospital facility was collaborating with other organizations, portions of the CHNA could be substantively identical, if appropriate under the facts and circumstances.⁵³ However, each hospital was still required to separately document its own written CHNA.⁵⁴ The one exception to this rule, outlined in the 2013 Proposed Rules, was if a hospital facility collaborated with other hospital facilities in conducting its CHNA.⁵⁵ In that situation, all of the collaborating hospital facilities could produce a joint CHNA report as long as all of the facilities defined their community to be the same and conducted a joint CHNA process.⁵⁶

The 2014 Final Regulations clarify that joint CHNA reports must contain all of the same basic information that separate CHNA reports must contain.⁵⁷ In response to commenters, the 2014 Final Regulations note that collaborating hospitals are not required to publish their CHNAs on the same day – although collaborating hospitals are still individually responsible for making their CHNA widely available.⁵⁸ The 2014 Final Regulations also add that the same collaboration rules that apply to collaborating hospitals also apply to a hospital facility that chooses to collaborate with a local public health department.⁵⁹

The requirements for collaboration did not change much between the 2011 Notice and the 2014 Final Regulations, although the later versions do clarify some of the confusion associated with collaboration. Broadly speaking, the guidelines governing collaboration encourage hospitals to collaborate locally and regionally with each other or with public health departments that may also be conducting needs assessments as part of their accreditation processes. Georgia Watch was pleased to see that the 2014 Final Regulations encourage collaboration but do not allow exceptions for collaborating hospitals that could reduce CHNA quality.

VI. Availability to the Public

⁵¹ 2011 Notice at 12–13.

⁵² *Id.* at 13.

⁵³ 2013 Proposed Rules, 78 Fed. Reg. at 20532.

⁵⁴ *Id.*

⁵⁵ *Id.* at 20532–33.

⁵⁶ *Id.* at 20532–33.

⁵⁷ 2014 Final Regulations, 79 Fed. Reg. at 78967.

⁵⁸ *Id.*

⁵⁹ *Id.* at 78968.

The 2011 Notice required that hospitals make their CHNAs “widely available” to the public.⁶⁰ Hospitals were required to post their CHNAs online for easy retrieval by all who had access to a computer; hospitals could not require specific software for download or viewing.⁶¹ The report could be made available on a hospital’s website, on the organization that operates a hospital’s website, or on another website, depending on what options were available to the hospital.⁶² The CHNA had to remain widely available until the next CHNA was published.⁶³

For purposes of clarification, the 2013 Proposed Rules added that (1) the CHNA report must be posted “conspicuously” on the website; (2) the CHNA report must remain on the website until two subsequent CHNA reports have been posted; (3) an individual must not be required to create an account or otherwise be required to provide identifying information in order to access the CHNA report on a website; and (4) a hospital facility must make a paper copy of its CHNA report available for public inspection, without charge, at the hospital facility until the date that two subsequent CHNAs are available in paper copy in the hospital facility, also without charge.⁶⁴ The 2013 Proposed Rules also added that, to facilitate the sharing of draft versions of CHNA reports for comment, a hospital facility could post a draft CHNA report for public review and comment without starting its next three-year CHNA cycle.⁶⁵

The 2014 Final Regulations amend the 2013 Proposed Rules to say that a paper copy of a hospital’s CHNA report need only be made available upon request.⁶⁶ Otherwise, the 2014 Final Regulations retain the language of the 2013 Proposed Rules,⁶⁷ enabling community members to have easy access to a hospital’s CHNA.

VII. Implementation Strategy

The 2011 Notice required that each hospital organization produce an Implementation Strategy that identified what needs each hospital facility would address or would not address and why.⁶⁸ If the hospital organization’s Strategy covered more than one hospital facility, the Strategy was required to be separately documented for each hospital facility.⁶⁹ If the hospital collaborated with other hospitals or organizations in producing its Implementation Strategy, these other hospitals or organizations had to be identified in the report.⁷⁰ Finally, the 2011 Notice required that the Implementation Strategy be adopted by the hospital’s governing body in the same taxable year that the CHNA was conducted.⁷¹

⁶⁰ 2011 Notice at 17.

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.* at 18.

⁶⁴ 2013 Proposed Rules, 78 Fed. Reg. at 20533.

⁶⁵ *Id.*

⁶⁶ 2014 Final Regulations, 79 Fed. Reg. at 78968.

⁶⁷ *Id.*

⁶⁸ 2011 Notice at 19.

⁶⁹ *Id.* at 21.

⁷⁰ *Id.* at 20–21.

⁷¹ 2011 Notice at 21.

The 2013 Proposed Rules clarified that a brief summary was sufficient to explain why a hospital facility did not intend to address a significant community health need.⁷² For those needs that a hospital did intend to address, the Implementation Strategy had to identify the programs and resources the hospital facility planned to commit, the anticipated impact, and plan to evaluate such impact.⁷³ The 2013 Proposed Rules emphasized that the health needs identified in the CHNA need only be “significant” ones and that the Implementation Strategy need only address community needs identified through the CHNA.⁷⁴ The Implementation Strategy had to be adopted within the same year that the hospital finished conducting its CHNA.⁷⁵ Finally, the 2013 Proposed Rules required that a hospital facility provide annually on its Form 990 Schedule H a description of the actions taken during the taxable year, or reasons why no actions were taken, to address the significant health needs identified in the hospital’s most recent CHNA.⁷⁶

The 2014 Final Regulations almost entirely adopt the 2013 Proposed Rules governing Implementation Strategies; however, they provide each hospital facility with an additional four and a half months to adopt its Implementation Strategy, specifically requiring an authorized body of the hospital facility to adopt the Implementation Strategy on or before the 15th day of the fifth month after the end of the taxable year in which the hospital facility finishes conducting the CHNA.⁷⁷ By adopting the clarifications and additional requirements in the 2013 Proposed Rules, the 2014 Final Regulations help to ensure that Implementation Strategies will be more than simply a list of existing hospital programs or resources, but rather a document that can make hospitals more accountable to their communities for their health improvement plans.

The primary shortcomings of the 2014 Final Regulations, with respect to the requirements governing Implementation Strategies, are that the requirements that CHNAs “be made widely available to the public” and “take into account input from persons who represent the broad interests of the community” do not apply to Implementation Strategies. Commenters requested, for the sake of transparency, that these requirements be applied to Implementation Strategies in the 2014 Final Regulations.⁷⁸ Commenters argued that this addition would “allow communities to monitor, assist, and provide input on hospital facilities’ efforts to address health needs.”⁷⁹ The 2014 Final Regulations do not adopt these suggestions, explaining that Section 501(r)(3)(B) of the ACA only applies these requirements to CHNAs.⁸⁰ The drafters of the 2014 Final Regulations further justify their refusal to expand these regulations to Implementation Strategies by noting that (1) public input is still taken into account in

⁷² 2013 Proposed Rules, 78 Fed. Reg. at 20534.

⁷³ *Id.*

⁷⁴ *Id.* at 20533.

⁷⁵ *Id.* at 20534.

⁷⁶ *Id.* at 20536.

⁷⁷ 2014 Final Regulations, 79 Fed. Reg. at 78970.

⁷⁸ *Id.* at 78969.

⁷⁹ *Id.*

⁸⁰ 2014 Final Regulations, 79 Fed. Reg. at 78969.

Implementation Strategies because hospitals are required to accept comments on the previously adopted Implementation Strategy when the hospital is conducting its subsequent CHNA; and (2) Implementation Strategies are still required to be made widely available because a hospital has to attach its Implementation Strategy to its Form 990 tax filing.⁸¹ These justifications are insufficient. It is unlikely that interested parties would know to look for a hospital's Implementation Strategy on its Form 990 tax filing, making it improbable that valuable feedback on Implementation Strategies would be submitted in response to a hospital's CHNA.

Georgia Watch is concerned that the above limitations may cause the CHNA process to fall short of expectations. Without a requirement for community involvement or collaboration in the implementation phase, the CHNA process may fail to have the maximum amount of potential impact on community health. Community involvement in the implementation planning and execution stages can produce creative collaborations and approaches to improving population health that may not be readily identifiable to hospital leadership.

Another major shortcoming of the regulations governing Implementation Strategies is that there is no required infrastructure to hold hospitals accountable for implementing their strategies.⁸² Each hospital may unilaterally construct its strategy for meeting the health needs of its community, and unless it chooses to take into account feedback on the Implementation Strategy provided in the subsequent CHNA cycle, no "check" on the hospital's strategic planning or implementation activities exists.⁸³ Ideally, the 2014 Final Regulations would have required (1) that each hospital implement some method of measuring success in achieving the goals in its Implementation Strategy, and (2) that each hospital employ at least one person responsible for overseeing the CHNA process and implementation of the strategies to address the health needs identified. Either of these "checks" on nonprofit hospitals would have greatly improved the potential for the CHNA process to achieve its purpose. Absent these requirements in the 2014 Final Regulations, advocates and community stakeholders must be proactive in seeking Implementation Strategies and providing input on them in subsequent CHNA processes. Additionally, it will be important for advocates to focus attention in future CHNA cycles on adequately evaluating the success of the regulations governing Implementation Strategies, and if warranted, highlighting the necessity of the additional "checks" discussed.

VIII. Failure to Satisfy the Requirements of Section 501(r)

Section 4959 of the Internal Revenue Code, also added by the ACA, imposes a \$50,000 excise tax for each hospital facility that fails to satisfy the new CHNA requirements.⁸⁴ The 2011 Notice specified that the \$50,000 penalty would be imposed if the hospital's first CHNA was not published at the end of the allowed three-year period.⁸⁵ An additional \$50,000 would then be

⁸¹ *Id.*

⁸² *See id.* at 78969–70.

⁸³ *See id.*

⁸⁴ 2011 Notice at 22.

⁸⁵ *Id.* at 23

assessed for every subsequent taxable year that the hospital failed to conduct its first CHNA.⁸⁶ The 2013 Proposed Rules reiterated that the \$50,000 excise tax applied on a facility-by-facility basis; if a noncompliant hospital organization owns multiple hospital facilities that fail to conduct CHNAs, that organization would be fined \$50,000 per facility.⁸⁷ Additionally, the excise tax may be imposed for failure to meet any requirements of 501(r)(3), including the requirement to adopt an Implementation Strategy.⁸⁸

The 2013 Proposed Rules also discussed the existence of minor and inadvertent omissions and errors, as well as the facts and circumstances considered in determining whether to revoke an organization's 501(c)(3) status for failure to satisfy the Section 501(r) requirements.⁸⁹ The 2013 Proposed Rules provided that a hospital facility's omission of required information from a policy or report, or error in such a policy or report, would not be considered a failure to satisfy the requirements of Section 501(r) if it was minor, inadvertent, or due to reasonable cause, and if the hospital facility corrected the omission or error as promptly after discovery as was reasonable.⁹⁰ Further, if a hospital facility failed to meet one of the requirements of Section 501(r), and the failure was neither willful nor egregious, the facility would be excused if it corrected and provided disclosure in accordance with the rules.⁹¹ "Willful" was defined to include a failure due to gross negligence, reckless disregard, or willful neglect.⁹² The 2013 Proposed Rules also warned that correction and disclosure would not create a presumption that the failure was neither willful nor egregious.⁹³ Rather, the IRS would consider all of the facts and circumstances in determining whether to continue to recognize the section 501(c)(3) status of a hospital organization if the organization failed to meet the requirements of Section 501(r).⁹⁴

The 2014 Final Regulations expand on this discussion. With respect to "minor" omissions, the final regulations clarify that, in the case of multiple omissions or errors, the omissions or errors are considered minor only if they are minor in the aggregate.⁹⁵ With respect to "inadvertent" omissions or errors, the final regulations note that the fact that the same omission or error has occurred and been corrected previously is a factor tending to show that an omission or error is not inadvertent.⁹⁶ With respect to "reasonable cause," the final regulations provide that a hospital facility's establishment of practices or procedures (formal or informal), reasonably designed to promote and facilitate overall compliance with the section 501(r) requirements prior to the occurrence of an omission or error, is a factor tending to show that the omission or

⁸⁶ *Id.*

⁸⁷ 2013 Proposed Rules, 78 Fed. Reg. at 20536–37.

⁸⁸ *Id.* at 20537.

⁸⁹ See 2013 Proposed Rules, 78 Fed. Reg. at 20526–28 (discussing the regulations governing "Failures To Satisfy the Requirements of Section (r)").

⁹⁰ *Id.* at 20526–27.

⁹¹ *Id.* at 20527.

⁹² *Id.*

⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ 2014 Final Regulations, 79 Fed. Reg. at 78960.

⁹⁶ *Id.*

error was due to reasonable cause.⁹⁷ The 2014 Final Regulations also clarify that the \$50,000 excise tax may be imposed if a hospital fails to meet one or more of the components for satisfying Section 501(r)(3), in addition to the complete failure to conduct a CHNA.⁹⁸

The 2014 Final Regulations also expand the explanation of what facts and circumstances will be considered in determining whether to revoke 501(c)(3) status.⁹⁹ They include the size, scope, nature, and significance of the organization's failure, as well as the reason for the failure and whether the hospital organization had, prior to the failure, established practices/procedures to ensure compliance, whether the procedures were being followed, and whether the mistake was promptly corrected.¹⁰⁰

As an enforcement mechanism, these regulations are instrumental in promoting compliance among charitable hospitals. The changes made to the regulations in later versions add clarification about what will be considered in evaluating the quality of a hospital's CHNA. In addition, the 2014 Final Regulations distinguish between intentional errors and those that are not punishable if adequately corrected. The increased detail in this portion of the regulations helps to ensure that charitable hospitals are conscious of their obligations and are encouraged to fulfill their charitable purpose. However, it is yet to be seen how effective these regulations will be in changing the behavior of hospitals that may conduct their CHNAs poorly or with little effort. Revoking a nonprofit hospital's 501(c)(3) status is an extremely severe, and little exercised, power of the IRS. Georgia Watch is concerned that penalties for nonprofit hospitals that conduct CHNAs with little effort and limited transparency may not be adequately enforced. It will be important to ensure that material omissions and inadequacies are carefully evaluated to prevent hospitals from going unpunished by claiming that their errors were minor and/or inadvertent.

Conclusion

A thorough analysis of how the regulations changed over time shows that the 2011 Notice created some confusion and inconsistency among hospitals that were not sure how to go about conducting a CHNA for the first time. Much of this confusion was alleviated by the 2013 Proposed Rules, which added a significant amount of detail for hospitals to consult in their effort to comply with the CHNA requirements. However, increased detail in the regulations meant more detail required in the CHNAs on the part of hospitals. In response to commenters, the 2014 Final Regulations took away some of this detail. Unfortunately, the less detail that is required from nonprofit hospitals, the less transparency and public accountability can exist in the CHNA process. While advocates would prefer the level of detail that existed in the 2013 Proposed Rules, every community hospital is different. Georgia Watch acknowledges that there are challenges to creating a one-size-fits-all model for how CHNAs should be conducted.

⁹⁷ *Id.*

⁹⁸ *Id.* at 78995.

⁹⁹ *Id.* at 78961.

¹⁰⁰ *Id.*

Enforcement of these regulations is also critical to their efficacy. The Secretary of Treasury is required to review the community benefit activities of nonprofit hospitals every three years, but advocates should remain watchful.¹⁰¹ Individuals outside of hospital administration need to understand what is required of hospitals in conducting CHNAs and must encourage their community hospitals to work cooperatively with public health and community-based organizations in program planning and implementation to improve population health. The responsibility for ensuring the level of transparency in the CHNA process that advocates desire ultimately lies with community members who must remain vigilant in order to keep nonprofit hospitals working to positively impact the health of their communities.

¹⁰¹ ACA § 9007(c). *See also* Davis, *supra* note 76, at 14.