Client Alert

April 2013

Community Health Needs Assessment: IRS Issues Interim Guidance to Tax-Exempt Hospitals

*by **Ofer Lion** and **Douglas M. Mancino***

New proposed regulations provide detailed interim guidance to charitable hospitals as to how to undertake, document and publicize the community health needs assessment (CHNA) and implementation strategy required by section 501(r) of the Internal Revenue Code. The new regulations also cover CHNA Form 990 reporting requirements and application of the excise tax for failure to meet the CHNA requirements.

In addition, the new regulations clarify that charitable hospital organizations will not lose their tax-exempt status for failure to meet the requirements of section 501(r) if the failure is not willful or egregious and the hospital facility makes reasonable and appropriate corrections and disclosures. These and other issues are addressed in our related client alert, "*Foot Faults Don't Kill: New Proposed Regulations Provide Helpful 501(r) Guidance to Nonprofit Hospitals*" (April 2013), available at the Hunton & Williams website: www.hunton.com.

The proposed regulations and this client alert help to answer the following frequently asked questions about the application of section 501(r), including the:

- basic requirements for conducting a CHNA;
- scope of the "community served" by a hospital facility;
- assessment of the community's needs;
- input required from representatives of the "broad interests of the community";
- CHNA documentation requirements;
- option to collaborate with other hospital facilities on CHNAs;
- development and execution of independent or joint implementation strategies;
- Form 990 reporting requirements; and
- excise taxes for failure to meet the CHNA requirements.

Conducting a CHNA

What are the basic CHNA requirements?

Each hospital facility must conduct and document an assessment of its "community health needs" at least once every three years.

The CHNA must take into account input from persons "representing the broad interests of the community served by the hospital facility," including those with special knowledge of or expertise in public health.

An "authorized body" of the hospital facility, by the end of the tax year in which the hospital facility conducts the CHNA, must adopt an "implementation strategy" to meet the community health needs identified by the CHNA.

The CHNA report must be made "widely available to the public."

This could take a while. When is our CHNA deemed conducted?

A CHNA must be prepared once every three years. Typically, a completed CHNA will be considered "conducted" on the date a complete CHNA (rather than a draft, expressly marked as such) is posted on the hospital facility's website.

What "community" is served by our hospital facility?

The test is flexible, and all relevant facts and circumstances should be taken into account. These may include the geographic area served (e.g., all or a portion of its Metropolitan or Micropolitan Statistical Area), target populations served (e.g., women, children or the elderly) and principal hospital functions (e.g., those with a particular disease).

The "community served" may not be defined in a way that excludes medically underserved, low-income or minority populations. Medically underserved populations include those experiencing health disparities (e.g., gaps in the quality of health across racial/ethnic and socioeconomic groups), those at risk of inadequate medical care because they are underinsured and otherwise cannot afford it, and those at risk of inadequate medical care due to geographic, linguistic or other barriers.

If a hospital facility's patient population is taken into account, all patients must be included regardless of their ability to pay.

How do we "assess" and prioritize the health needs of the community?

A hospital facility must (i) identify and prioritize its community's significant health needs based on all of the relevant facts and circumstances present in the community and (ii) identify potential measures and resources available to address the significant needs identified.

Prioritization criteria may include "the burden, scope, severity, or urgency of the health need; the estimated feasibility and effectiveness of possible interventions; the health disparities associated with the need; or the importance the community places on addressing the need."[1]

Who are the "persons representing the broad interests of the community" whose "input" the CHNA is supposed to take into account?

At a minimum, the CHNA must take into account input, including but not limited to financial and other barriers to health care access in the community, from:

i. at least one state, local, tribal or regional governmental public health department (or its equivalent) with knowledge, information or expertise relevant to the community's health needs;

ii. individuals or organizations serving or representing, or members of, medically underserved, low-income and minority populations in the community; and

iii. written comments received on the hospital facility's prior CHNA and most recently adopted implementation strategy, which is intended to establish a continual feedback loop.

[1] Prop. Reg. § 1.501(r)-3(b)(4).

"In addition, a hospital facility may take into account input from a broad range of persons located in or serving its community, including, but not limited to, health care consumers and consumer advocates, nonprofit and community-based organizations, academic experts, local government officials, local school districts, health care providers and community health centers, health insurance and managed care organizations, private businesses, and labor and workforce representatives."[2] Such input could be garnered from public comments to the prior CHNA or to a posted draft CHNA.

Who needs to sign off on the CHNA?

An "authorized body" of the hospital facility must adopt the CHNA report. Typically, that will be the hospital organization's board of trustees or an authorized committee of the board having fiduciary authority. Under certain circumstances, the separate governing board (or a committee thereof) of a hospital facility, rather than the board of the hospital organization, may be able to adopt the CHNA.

CHNA Reports: Documenting, Collaborating and Publication

What needs to be documented in our CHNA?

A CHNA report must:

i. define the "community" served and how it was determined;

ii. describe the "process and methods" used;

iii. describe how it took into account input from persons representing the broad interests of the community;

iv. prioritize the "significant" health needs identified;

v. describe the process and criteria used to (a) identify health needs as "significant" and (b) prioritize those needs; and

vi. describe the potential measures and resources identified through the CHNA to address those significant health needs.

How much detail is required to describe our CHNA's "process and methods"?

There is no single method necessary to fulfill the requirement, but a CHNA report "will be considered to describe the process and methods" if it:

i. describes the data and other information used;

ii. describes the methods of collecting and analyzing this data and information; and

iii. identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance.

How do we describe how we took into account "input from persons who represent the broad interests of the community"?

Again, there is no single prescription to fulfill this requirement. A CHNA report "will be considered to describe" how it took such input into account if it:

i. describes the medically underserved, low-income or minority populations being represented by those persons providing input;

[2] Prop. Reg. § 1.501(r)-3(b)(5).

ii. summarizes, in general terms, the input provided by such persons;

iii. summarizes, in general terms, "how and over what time period such input was provided (for example, whether through meetings, focus groups, interviews, surveys, or written comments and between what dates),"[3] but a detailed description of each instance of feedback is not required, specific meeting dates are not required and meeting minutes are not required; and

iv. provides the names of organizations providing input and summarizes the nature and extent of the organization's input, although the CHNA report need not include the names or titles of any individuals within the organization.

In all cases, the CHNA report need not identify the names or roles of any individuals providing input for the CHNA, including individuals participating in community forums, focus groups, survey samples or similar groups.

Preparing a CHNA report is quite the undertaking. Can we collaborate with other organizations or hospital facilities? Can we issue a joint CHNA report?

Yes. There is no restriction on the types of organizations and facilities with which a hospital facility may collaborate in conducting its CHNA (e.g., related and unrelated hospital organizations and facilities, for-profit and government hospitals, governmental authorities, nonprofits, etc.).

Nonetheless, except for those eligible to adopt a joint CHNA as described below, each hospital facility must produce its own CHNA report. However, if appropriate, portions of a CHNA report may be substantively identical to portions of the CHNA report of a collaborating hospital facility (e.g., the same survey of the health needs of local homeless shelter residents or inventory of community health improvement resources may be used in multiple CHNAs).

With respect to joint CHNA reports, a hospital facility that collaborates with other hospital facilities in conducting its CHNA can issue a joint CHNA report if:

i. an authorized body of the hospital facility adopts the joint CHNA;

ii. all the collaborating hospital facilities define their community to be the same;

iii. all the collaborating hospital facilities conduct a joint CHNA process; and

iv. the joint CHNA report is clearly identified as applying to the hospital facility.

The proposed regulations include the following example illustrating compliance with the joint CHNA requirements:

> P is one of ten hospital facilities located in and serving the populations of a particular Metropolitan Statistical Area (MSA). P and the other nine facilities in the MSA, some of which are unrelated to P, decide to collaborate in conducting a CHNA for the MSA and to each define their community as constituting the entire MSA. The ten hospital facilities work together with the state and local health departments of jurisdictions in the MSA to assess the health needs of the MSA and collaborate in conducting surveys and holding public forums to receive input from the MSA's residents, including its medically underserved, low-income, and minority populations. The hospital facilities then work together to prepare a joint CHNA report documenting this joint CHNA process that contains all of the [required elements, as described above]. The joint CHNA report identifies all of the collaborating hospital facilities, including P, by name, both within the report itself and on

[3] Prop. Reg. § 1.501(r)-3(b)(7)(iii).

> the cover page. The board of directors of the hospital organization operating P adopts the joint CHNA report for P.[4]

Does posting the CHNA report on our website make it "widely available to the public"?

Yes, but a hospital facility must keep each CHNA report, in full, conspicuously posted on its website and make a paper copy available for public inspection without charge at the hospital facility until two subsequent CHNA reports are added. In other words, both the current and the immediate prior CHNA reports must be posted on a website and a hard copy made available at the hospital facility.

The online CHNA report must be accessible to view, download or print without requiring a fee, special software that isn't publicly available for free or the creation of an account or other requirements to identify the user. If someone asks how to access a copy online, the hospital facility must provide the direct website address.

Implementation Strategy Reports

What goes into an "implementation strategy to meet the community health needs identified" in our CHNA?

The implementation strategy, with respect to each significant health need identified, must either describe how the hospital facility intends to address the need, or explain why the hospital facility does not intend to address it. Note that an implementation strategy may describe planned activities to address health needs other than those significant health needs identified in the CHNA report.

How should our implementation strategy describe how we plan to address a significant health need identified in the CHNA?

First, describe the actions the hospital facility intends to take to address the health need, the anticipated impact of the actions and a plan to evaluate such impact. Second, identify the programs and resources the hospital facility plans to commit to address the health need. Finally, describe any planned collaboration between the hospital facility and other facilities or organizations in addressing the health need.

> For example, a CHNA may identify as significant health needs financial or other barriers to care in the community, such as high rates of financial need or large numbers of uninsured individuals and families. Its implementation strategy could describe a program to decrease the impact of these barriers, such as by expanding its financial assistance program or helping uninsured individuals and families learn about and enroll in sources of insurance such as Medicare, Medicaid, Children's Health Insurance Program (CHIP), and the new Health Insurance Marketplaces (also known as the Exchanges); state how it anticipates its program will reduce these barriers to care; and identify the data sources it will use to track the program's impact on the barriers.[5]

What if we do not intend to address an identified health need?

Provide a brief explanation, which could include a description of resource constraints, other facilities or organizations in the community addressing the need, a relative lack of expertise or competencies to effectively address the need, a relatively low priority assigned to the need and/or a lack of identified effective interventions to address the need.

[4] Prop. Reg. § 1.501(r)-3(b)(7)(v)(B).

[5] Notice of Proposed Rulemaking, Community Health Needs Assessments for Charitable Hospitals, Fed. Reg., Vol. 78, No. 66, p. 20534 (April 5, 2013).

Can we develop a joint implementation strategy with other facilities and organizations?

Yes. The hospital facility must still document its implementation strategy in a separate written plan specifically tailored to it, taking into account its specific programs and resources. However, a hospital facility that adopts a joint CHNA report, as discussed above, may also adopt a joint implementation strategy, as long as the joint implementation strategy:

i. is clearly identified as applying to the hospital facility;

ii. clearly identifies the hospital facility's particular role and responsibilities in taking the actions described in the implementation strategy and the programs and resources the hospital facility plans to commit to such actions; and

iii. includes a summary or other tool that helps the reader easily locate those portions of the joint implementation strategy that relate to the hospital facility.

How soon after we post the CHNA report must we adopt an implementation strategy?

By the end of that tax year.

However, transition relief may extend the initial deadline. As a reminder, the statutory effective date of section 501(r)'s CHNA requirement is a hospital organization's first taxable year beginning after March 23, 2012.

A hospital facility that conducted a CHNA in either its first taxable year beginning after March 23, 2010, or March 23, 2011, does not need to meet the CHNA requirements again until the third following taxable year, provided that the hospital facility adopted an implementation strategy on or before the 15th day of the fifth calendar month following the close of its first taxable year beginning after March 23, 2012.

A hospital facility that conducts a CHNA in its first taxable year beginning after March 23, 2012, will be deemed to satisfy the implementation strategy requirement during that taxable year if it is adopted on or before the 15th day of the fifth calendar month following the close of that year.

Reporting Requirements and Excise Taxes

As a hospital organization, do we need to file our audited financial statements with Form 990?

Yes.

Are there any CHNA-related Form 990 reporting requirements?

Yes. Hospital organizations must either attach a copy or provide the website address of the most recently adopted implementation strategy for each hospital facility it operates.

While the implementation strategy may be dated by its second or third year in effect, hospital organizations must describe the actions taken during the taxable year to address the significant health needs identified through its most recent CHNA for each hospital facility it operates or, if no actions were taken with respect to one or more of these health needs, the reason or reasons why.

How much will it cost if we don't meet the CHNA requirements?

There is a $50,000 excise tax per hospital facility, per taxable year of noncompliance with the CHNA requirements. The excise tax must be reported on Form 990.

Additionally, the hospital facility may be subject to taxation and/or the hospital organization could lose its tax-exempt status, as described in our related client alert, "*Foot Faults Don't Kill: New Proposed*

Regulations Provide Helpful 501(r) Guidance to Nonprofit Hospitals" (April 2013), available at the Hunton & Williams website: www.hunton.com.

When will these new proposed regulations become effective?

The proposed regulations covering the CHNA and discussed herein may be relied on for any CHNA completed, or implementation strategy adopted, on or before the date that is six months after the date temporary or final regulations are published. Hospital organizations may not rely on other proposed 501(r) regulations until they are published as final or temporary regulations.

In any case, while the proposed regulations have little if any precedential value, they provide a clear indication of how Treasury and the IRS interpret the provisions of section 501(r).

If you have any questions about this alert, these "frequently asked questions," CHNAs or section 501(r) generally, please contact any of the Hunton & Williams lawyers listed below.

Contacts

Douglas M. Mancino
dmancino@hunton.com

Matthew D. Jenkins
mjenkins@hunton.com

Mark S. Hedberg
mhedberg@hunton.com

Andrew R. Kintzinger
akintzinger@hunton.com

J. William Gray, Jr.
billgray@hunton.com

Ofer Lion
olion@hunton.com

William H. McBride
wmcbride@hunton.com

Robert Dean Pope
rpope@hunton.com

Caryl Greenberg Smith
carylsmith@hunton.com