The Internal Revenue Service's Final Rule:
Charitable Hospitals & Community Health Needs Assessments

I. Introduction

On December 31, 2014, the Internal Revenue Service (IRS) published final rules for the Affordable Care Act's (ACA's) community health needs assessment (CHNA) requirement.[1] The IRS allows charitable hospitals to rely on both the 2012 and 2013 proposed rules until the hospital's first tax year after December 29, 2015. The final rules address various regulatory issues, including definitional changes, health needs assessments under expanded regulations, implementation strategies, Financial Assistance Policies (FAPs), and preemption.

II. Definitional Changes — § 501(r)-1

The final rules include new definitions for several important terms. The final rules redefined a single "hospital facility" to include those hospital organizations with multiple buildings that operate under a single state license.[2] This applies regardless if the hospital organization's multiple buildings are located in various communities. The preamble explains that using this new fixed definition provides consistency and certainty in tax administration.

Not included in the definition of a single "hospital facility" are hospital facilities within single buildings that operate under multiple state licenses; the final rules consider these as multiple hospital facilities. Thus each state-licensed entity must produce its own FAP, CHNA, and implementation strategy. The final rules, however, allow such entities to have identical and joint FAPs, CHNAs, and implementation strategies to reduce administrative burdens.[3] Such collaboration is also allowed for Accountable Care Organizations (ACOs), where various hospital facilities are operating under a collective agreement.[4]

The final rules also expand on the definition of "operating" a hospital facility. A hospital organization operates a hospital facility if it owns, directly or indirectly, a capital or profits interest in one or more lower-tier entities that the federal government treats as a partnership for tax purposes.[5]

III. Community Health Needs Assessments — § 501(r)-3

CHNAs consist of two main elements: a health needs assessment and an implementation strategy. Each element has different requirements that hospital facilities must meet to remain in compliance with the IRS' final rules.

A. Health Needs Assessments — § 501(r)-3(b)

The process of conducting a CHNA requires a hospital facility to define the community it serves and assess the community's health needs. When assessing the community's health needs, the hospital

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[1] *See* Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirements of a Section 4959 Excise Tax Return and Time for Filing the Return; Final Rule, 79 Fed. Reg. 78954, 78956 (Dec. 31, 2014) (to be codified at 26 C.F.R. pts. 1, 53, and 602), *available at* http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf [hereinafter Final Rule].
[2] *See* 26 C.F.R. § 1.501(r)-1(b)(17).
[3] *See* Final Rule at 78957.
[4] *See id.,* at 78958.
[5] *Id.,* at 78958-9; *see* 26 C.F.R. § 1.501(r)-1(b)(22).

facility must solicit and take into account the input received from individuals representing the broad interests of the community. The hospital facility must also document the approved report and make it widely available to the public.[6]

1. Health Needs Assessments and Expanded Health Needs – § 501(r)-3(b)(4)

The final rules expand the examples of health needs that hospital facilities may include in their CHNAs. The 2013 proposed rules specified that improving the health statuses of a community requires improving access to care by removing financial and other barriers. The final rules, however, expand beyond access to care to include other public health objectives, such as the need to "prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community."[7] These health needs are only examples, and a hospital facility does not have to identify all of those health needs in its CHNA. Hospital facilities only have to identify those health needs determined to be *significant* in the community.[8]

2. Input from Broad Interests of the Community – § 501(r)-3(b)(5)

When receiving input from individuals representing the broad interests of the community, hospital facilities must meet specific requirements. Hospital facilities must, at a minimum, solicit input from (1) a "governmental public health department . . . with knowledge, information, or expertise relevant to the health needs of the community;" (2) "members of medically underserved, low-income, and minority populations;" and (3) "written comments received on the hospital facility's most recently conducted CHNA and adopted implementation strategy."[9] While the final rules require hospital facilities to solicit input from these three categories, hospital facilities only have to include received responses.[10]

The preamble discusses the term "governmental public health department," which is defined as a local, state, tribal, or regional government with jurisdiction over and expertise in public health.[11] The final rules allow a hospital facility to choose which level of governmental public health department to solicit as a means of providing flexibility to hospital facilities.[12] The preamble states that this flexibility is necessary because a hospital facility's jurisdiction may span several local health departments, and a hospital facility may reasonably decide that one public health department jurisdictional level is more appropriate than another when receiving input for its CHNA.[13]

The final rules also encourage, but do not require, collaboration between hospital facilities and public health departments, as well as among other hospital facilities, during the creation of a CHNA. All joint CHNA reports must contain the same essential information that an individual CHNA report must contain.[14] When collaborating with public health departments, hospital facilities may include identical information found in a public health department's CHNA for those portions that address the hospital facility's community.[15]

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[6] *See* Final Rule at 78962; *see also* 26 C.F.R. § 1.501(r)-3(b)(1)(i)-(v).
[7] Final Rule at 78963; 26 C.F.R. § 1.501(r)-3(b)(4).
[8] *See* Final Rule at 78963; *see also* 26 C.F.R. § 1.501(r)-3(b)(4).
[9] Final Rule at 78963; *see also* 26 C.F.R. § 1.501(r)-3(b)(5)(i)(A)-(C).
[10] *See* Final Rule at 78963; *see also* 26 C.F.R. § 1.501(r)-3(b)(5)(i).
[11] *See* Final Rule at 78964.
[12] *See id.*
[13] *See id*.
[14] *See* Final Rule at 78967; *see also* 26 C.F.R. § 1.501(r)-3(b)(6)(v).
[15] *See* Final Rule at 78967; *see also* 26 C.F.R. § 1.501(r)-3(b)(6)(v)(1).

B. Implementation Strategies — § 501(r)-3(c)

A hospital facility's implementation strategy must address each significant health need identified through the needs assessment and explain whether or not the hospital facility plans to address the health need.[16] While the implementation strategy must discuss all of the health needs identified in the needs assessment, hospital facilities may also include additional health needs that the hospital facility identified through other means.[17] Hospital facilities may include interventions designed to prevent illness or address social, behavioral, and environmental factors within an implementation strategy.[18]

The 2013 proposed rules required hospital facilities to describe the actions they intended to take to address the health needs, the expected impact of the actions, and the plan to evaluate the impact.[19] The final rules, however, alter this requirement. Instead of describing *the plan* to evaluate the impact, hospital facilities' implementation plans must include "*the evaluation* of the impact of any actions that were taken since the hospital facility finished conducting its immediately preceding CHNA to address the significant health needs identified in the hospital facility's prior CHNA(s)."[20]

While the health needs assessment must take into consideration input from individuals representing the broad interests of the community, this requirement does not apply to implementation strategies.[21] A hospital facility must, however, consider "comments received on the previously adopted implementation strategy when the hospital facility is conducting the subsequent CHNA."[22] The final rules also encourage, but do not require, collaboration between hospital facilities and public health departments, as well as among other hospital facilities, when creating an implementation strategy.

Hospital facilities now have an additional four and a half months to adopt the implementation strategy to meet the health needs identified through the CHNA, which is the 15th day of the fifth month after the taxable year in which the hospital facility completes the CHNA.[23]

IV. Financial Assistance Policies — § 501(r)-4

The final rules require all hospital organizations to establish FAPs as a means of providing financial assistance to patients using medical services. Hospital organizations satisfy this requirement if the hospital organization establishes for its hospital facility a written FAP that applies to emergency and other medically necessary care provided in the hospital facility. The FAP must list the providers, other than the hospital facility, delivering emergency and other medically necessary care and which of those providers the FAP covers.[24] The final rules allow hospital facilities the flexibility to create their own definition of "medically necessary" because providers can reasonably disagree as to what is medically necessary in a particular situation.[25]

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[16] *See* Final Rule at 78969; *see also* 26 C.F.R. § 1.501(r)-3(c)(1)(i)-(ii).
[17] *See* Final Rule at 78969.
[18] *See id.,* at 78970.
[19] *See id.,* at 78969.
[20] *Id* (emphasis added).
[21] Section 501(r)-(3)(b) only applies the requirement of community input to CHNAs, not implementation strategies. And only § 501(r)-(3)(A)(i), related solely to CHNAs, cross-references the requirements of community input. *See* Final Rule at 78969.
[22] Final Rule at 78969; *see* 26 C.F.R. § 1.501(r)-3(b)(5)(i)(C).
[23] *See* Final Rule at 78970; *see also* 26 C.F.R. § 1.501(r)-3(c)(5)(i).
[24] *See* Final Rule at 78971; *see also* 26 C.F.R. § 1.501(r)-4(b)(1)(iii)(F).
[25] *See* Final Rule at 78980' *see also* 26 C.F.R. § 1.501(r)-4(b)(8).

The FAPs must also state the eligibility criteria for financial assistance and the basic elements of the program. Hospital facilities may provide financial assistance outside of its FAP, but hospital facilities cannot report such assistance on their Schedule H Form 990s. Also, the IRS will not consider such assistance as ACA community benefit activities or for purposes of determining whether the hospital organization meets the requirements in section 501(c)(3).[26] Hospital facilities must widely publicize their FAPs to reach residents of the community served.[27]

V. Section 501(r) and State Law

The preamble addressed some commenters' concerns that the final rules are conflicting or inconsistent with relevant state law requirements. Commenters suggested two differing solutions: (1) that a hospital facility's compliance with state law when relevant should satisfy the final rules, or (2) that the final rules do not preempt state law from containing additional or stricter requirements. The preamble states that the final rules do not make it impossible for a hospital facility to comply with both federal and state requirements. Because the final rules do not equate compliance of applicable state law with satisfying the final rules, the preamble explains that the final rules do not preempt state law or regulations. Thus any additional or stricter state laws or regulations will continue to apply to hospital facilities licensed in the state.[28] Therefore, a state may enact stricter, more stringent CHNA requirements that hospital facilities must meet.

[26] Final Rule at 78971.

[27] *See id.,* at 78974; *see also* 26 C.F.R. § 1.501(r)-4(b)(5).

[28] *See* Final Rule at 78994.