The Internal Revenue Service (IRS) on April 3 released a proposed rule on the community health needs assessment (CHNA) requirement for tax-exempt hospitals created by the Patient Protection and Affordable Care Act (Section 501(r) of the Internal Revenue Code). In addition, the proposed rule provides guidance on the consequences if a hospital facility fails to satisfy the requirements of Section 501(r), including the CHNA, financial assistance policy, limitation on charges, and billing and collection provisions.

The CHNA proposed rule largely tracks the guidance that was issued by IRS in 2011 (Notice 2011-52). Several of the modifications respond to concerns raised by hospitals. Importantly, the guidance on how IRS will respond to noncompliance recognizes, as AHA has urged, that not all infractions are of the same significance and takes a calibrated approach.

Highlights of the IRS rule are detailed below.

**CHNA Provisions**

**Identifying community health needs.** In contrast to the 2011 IRS Notice that required all health needs be identified and prioritized, the proposed regulation clarifies that a CHNA may focus only on significant health needs. Similarly, the implementation strategy may address only a few of the significant health needs identified in the CHNA as long as it explains why it does not address the other significant health needs.

**Community input.** The proposed regulation trims back some of the detailed documentation that the Notice required regarding who was consulted and the input received. Summaries, in general terms, of the input will be sufficient, and no names of individuals contacted will be required. The proposed rule adds a requirement to consider input received regarding a CHNA or implementation strategy that has been adopted. Going forward, a hospital would be required to consider input on its existing CHNA or implementation strategy as part of conducting its next required assessment.

**Joint CHNA and joint implementation strategy.** While the Notice focused on hospital facility-specific CHNA reports and implementation strategies, the proposed rule explicitly allows hospitals that collaborate to share joint reports and strategies under certain conditions. Among other conditions, the joint CHNA report must clearly identify each hospital facility to
which it applies, and the authorized body of each facility must adopt the joint report as its own. A joint strategy must include a summary or other tool that helps the reader easily locate those portions of the joint implementation strategy that relate to each hospital facility.

Making the CHNA widely available. While the proposed rule continues to allow use of the web to meet this requirement, it includes additional requirements. A complete version of the CHNA must be “conspicuously” posted; the report must remain on the web until two subsequent CHNA reports have been posted; an individual must not be required to create an account or provide personally identifiable information in order to access the report; a paper copy must be available for public inspection without charge.

Implementation strategy. In addition to describing the actions intended to address significant health needs, the proposed rule adds several requirements. The anticipated impact of these actions must be included as well as a plan to evaluate the impact. In addition to attaching the strategy to the Form 990, annual updates should be included on the Form 990 describing the actions taken during that tax year to address the needs identified in the strategy or, if no action was taken, the reasons why no action occurred.

Timing for adoption of strategy. The proposed rule includes the requirement from the Notice that the strategy be adopted in the same tax year as the hospital facility finishes conducting the CHNA (typically, by making the report widely available to the public). Recognizing the difficulty this will present for some hospitals in completing their first CHNA, it creates transition relief allowing for later adoption in connection with a hospital facility’s first CHNA under certain conditions.

**CONSEQUENCES OF NONCOMPLIANCE WITH SECTION 501 (R) REQUIREMENTS**

The proposed regulations make a distinction between errors and omissions and noncompliance that is willful and egregious.

Excused noncompliance. Under the proposed regulations, noncompliance may be excused in two circumstances: (1) when it is minor, inadvertent and due to reasonable cause, and the hospital facility corrects the error or omission as promptly as is reasonable given the nature of the noncompliance; and (2) when noncompliance rises above the level of minor and inadvertent, but is neither willful nor egregious, and the hospital facility corrects and discloses the noncompliance to the government.

Willful and egregious noncompliance. If, however, failure to meet Section 501(r) requirements is willful and egregious, it would result in revocation of tax-exempt status. (“Willful” would include gross negligence, reckless disregard or willful neglect.) The IRS would evaluate all facts and circumstances in making its determination, including the relative size, scope, nature, recurrence and significance of the failure, as well as the reasons for the failure and whether it was corrected.
If the offending hospital facility is part of a multi-facility organization, the organization would maintain its tax exemption. Instead, the organization would be subject to unrelated business income tax on the activities of the noncompliant hospital facility for the entire year in which the facility willfully and egregiously failed to meet one or more Section 501(r) requirements.

**Next Steps**

The IRS proposed rule was published in the April 5 *Federal Register*. Comments will be accepted until July 5. Watch for an *AHA Regulatory Advisory* with further details in the coming weeks.