Law and the Public's Health

This issue of *Law and the Public's Health* reviews new requirements applicable to nonprofit hospitals under the Patient Protection and Affordable Care Act, with a particular focus on responsibilities related to community public health planning, and assesses their implications for public health policy and practice.

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TAX-EXEMPT HOSPITALS AND THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: IMPLICATIONS FOR PUBLIC HEALTH POLICY AND PRACTICE

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This installment of *Law and the Public's Health* takes a closer look at how the Patient Protection and Affordable Care Act (hereafter, ACA) alters the duties of not-for-profit hospitals that seek federal tax-exempt status under the Internal Revenue Code, and considers the implications of these reforms for public health policy and practice. The article examines the key elements of the ACA and the Internal Revenue Service's (IRS's) initial implementation steps in the wake of the Act.[1]

BACKGROUND

Approximately 2,900 nonprofit hospitals furnish health care in the U.S., representing half of all U.S. hospitals.[2] Under Section 501(c)(3) of the Internal Revenue Code, nonprofit hospitals may qualify for tax-exempt status if they meet certain federal requirements. The estimated value of hospitals' tax-exempt status in terms of federal, state, and local tax revenues foregone amounted to $12.6 billion in 2002.[3] Of course, hospitals' tax-exempt status is worth far more than the value of the tax exemption to the business enterprise, as tax exemption allows hospitals to raise billions of dollars annually in charitable contributions. The total estimated worth of these charitable contributions stood at $5.3 billion in 2010 alone.[4]

Prior to 1969, the IRS specified that to maintain tax-exempt status, hospitals were required to provide charity care. While facilities were given latitude to define the amount of care required, the obligation was defined under the law. In 1969, however, the IRS replaced this relatively defined obligation with a more ambiguous standard; Revenue Ruling 69-545[5] eliminated the obligation to furnish care on an uncompensated basis. Since 1969, a far broader community benefit standard has prevailed; this standard turns on the facts and circumstances of the case[6] and generally takes a broad community benefit[7] approach to hospitals' obligation. A legal challenge to this shift in policy failed in the mid-1970s;[8] thus, the standard was successfully diluted to the point of non-enforceability.

As with the "financial ability test" for exemption that existed prior to 1969, the community benefit standard is also sufficiently vague as to make measurement and enforcement difficult.[9] Although certain states have taken a more aggressive stance over the years and have refused to recognize tax-exempt status in the absence of measurable performance,[10] the federal government has not taken similar direct enforcement action. In recent years, however, nonprofit hospitals have come under increasing congressional[11] and IRS[6] scrutiny. Similarly, widespread evidence has mounted regarding the dearth of measurable charitable activities, confusion over what might constitute a charitable activity to begin with, and actual evidence of conduct that is decidedly uncharitable (e.g., refusal to discount or forgive bills in the case of indigent people or imposition of the highest possible charges on uninsured and underinsured patients accompanied by aggressive collection actions). A 2009 report by the IRS found "considerable diversity" in hospitals' community benefit activities; similarly, a 2008 U.S. Government Accountability Office report[3] valued the federal tax exemption alone at nearly $13 billion in 2002 (a figure that does not include the total value of the exemption to hospitals when state tax laws also are considered), and concluded that the vagueness of federal requirements precluded effective enforcement. As a result, community benefit activities

have, until the passage of the ACA, remained largely a matter of individual hospital discretion, state law requirements, and informal IRS guidance.

In recent years, nonprofit hospitals have been the subject of more than 45 class-action lawsuits challenging their tax-exempt status on the basis of their billing practices and treatment of low-income uninsured individuals.[9] However, these lawsuits have confronted the vagaries of the community benefit standard, which essentially has required nothing on the part of hospitals.

At the same time, early signs of significant change began to emerge. In 2009, nonprofit hospitals were required to file supplemental information with the IRS to illuminate their community benefit-related spending.[12] However, given the limited nature of the supplemental data collection, and the difficulties inherent in attempting to measure expenditures against so amorphous a notion of community benefit,[13] the debate continued.

THE AFFORDABLE CARE ACT

The ACA (§9007) amends the Internal Revenue Code by adding a new §501(r) entitled "Additional Requirements for Charitable Hospitals."[14] The provision conditions hospital organizations' eligibility for tax-exempt status on their ability to meet four basic requirements: (*1*) community health needs assessment and implementation strategy; (*2*) financial assistance policies, including adherence to the hospital's Emergency Medical Treatment and Active Labor Act emergency care obligations (which are expressly identified in the statute); (*3*) policies related to hospital charges; and (*4*) policies related to billing and collections.

A hospital organization is defined as "a facility which is required by a State to be licensed, registered, or similarly recognized as a hospital," and "any other organization which the Secretary determines has the provision of hospital care as its principal function or purpose." In cases in which a hospital organization operates more than one facility, the provisions apply to each facility.[15] Except for the community health needs assessment requirement, which has a longer phase-in time period, the changes are effective in the first taxable year beginning after the date of enactment.

A core public health requirement: the community health needs assessment and implementation strategies

Section 501(r)(3), as added by ACA §9007, provides as follows:

> (3) Community health needs assessment
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> (A) In general—an organization meets the requirements of this paragraph with respect to any taxable year only if the organization—(*i*) has conducted a community health needs assessment that meets the requirements of subparagraph (B) in such taxable year or in either of the two taxable years immediately preceding such taxable year, and (*ii*) has adopted an implementation strategy to meet the community health needs identified through such assessment.
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> (B) Community health needs assessment—a community health needs assessment meets the requirements of this paragraph if such community health needs assessment—(*i*) takes into account input from people who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and (*ii*) is made widely available to the public.

The community health needs assessment provision does not address the relationship between the hospital's needs assessment/implementation planning obligations and its other obligations under the law. For example, nothing in the statute itself requires the assessment to specifically address the needs of the low-income and uninsured population living in its service area or the amount of free care that will be furnished and the manner in which uncompensated care needs will be met. Similarly, the statutory text leaves to agency interpretation the responsibility for defining key terms. At the same time, the law creates a powerful platform for an implementation strategy that ultimately yields a national system of community health needs assessments and implementation strategies that in scope parallels the law's broad concept of community health transformation.

Under §501(r):

- The hospital must undertake an activity that qualifies as a "community health needs assessment." (The law does not define the term but presumably the IRS, in implementing the law, will set parameters on its meaning to limit hospital discretion to declare that any activity an organization may elect to undertake qualifies as an assessment).
- The assessment and implementation strategy must be carried out on a recurring basis, suggesting an ongoing need for updating and modification as the service area or other conditions change.
- The assessment must "take into account" "input" from people who "represent" the "broad interest" of the "community served by the hospital facility." (The statute does not define these terms,

but the text suggests that each hospital facility in a multifacility corporation presumably would have to show that its assessment was carried out in relation to people who represented the community served by that facility.)

- The assessment must include "those" people (potentially people in the community and potentially people outside the community) with "special knowledge or expertise in public health," suggesting a link to public health not only in terms of the content of information collected through the assessment, but also the assessment process itself. That is, the assessment process—as well as its structure and content—potentially must reflect knowledge and public health expertise. The legislative history indicates that hospitals may use existing public health information and may work with other organizations.[16] But the text also suggests that the process include more than just compiled public health information and must also include information gleaned from "those" with special knowledge and public health expertise.
- The assessment must be made "widely available" to the "public." The term "public" could denote the general public or public within the service area. The term "available" is not defined, but given its overall goal of community health needs assessment, the text suggests not only geographic availability, but also, potentially, availability in a cultural and linguistic sense, or in a manner that comports with the hospital's other duties under other federal laws, such as Title VI of the 1964 Civil Rights Act, §504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act, and other relevant laws.
- The hospital must have "adopted" an "implementation strategy." The term "adopted" is not defined, nor is the term "implementation strategy." The term "adopted" suggests, in the context of hospital organizations, a formal activity, while the term "implementation strategy" may or may not mean the actual implementation of the plan or, more simply, a strategy for implementing the plan.

Implementation

The Treasury Department is the lead agency for implementation and oversight of the law and the agency already has issued a "Request for Comments Regarding Additional Requirements for Tax-Exempt Hospitals."[1] Key to the implementation of this needs assessment and implementation obligation will be interpretive rules and guidelines that strike a balance between giving hospitals appropriate latitude to plan and implement, while at the same time producing a meaningful result. By meaningful, one might mean a planning document and implementation strategy that

- has been designed and conducted in a manner that produces relevant, valid, reliable, and current evidence of community health need;
- has been carried out using recognized input and development processes from the vast world of community health planning;
- is reflective of community needs and public health knowledge and expertise; and
- is structured in such a way that it is even possible to establish an implementation strategy.

The question is whether the Treasury Department will create flexible yet objective and clear regulatory standards that set the parameters for an acceptable assessment, an acceptable assessment process, and an acceptable implementation strategy. In its request for comments earlier in 2010, Treasury left open the door for public health agencies and officials to guide the agency in creating guidance for hospitals and for offering suggestions regarding objective measures of needs assessment and implementation strategy activities, including the essential elements of a needs assessment and a consultation process, the potential for joint planning with other hospitals serving a community, and the elements of an implementation strategy. A sample of more than 100 comments can now be viewed online.[17]

IMPLICATIONS FOR PUBLIC HEALTH POLICY AND PRACTICE

The community health needs assessment standard potentially opens the door to greater collaboration between state and local health agencies and hospitals serving the region. Public health agencies might wish to closely monitor Treasury's implementation guidance for further clarification of the community health needs assessment obligation. In the mean time, consultation with area hospitals would appear to be a key step to determine how the assessment process might be used to further the achievement of measurable and critical population health improvement goals, such as reaching all communities with preventive services, achieving better management of chronic illnesses and conditions, raising community health literacy levels, generating support for community health providers and programs

of proven effectiveness, and attaining goals related to population health and health literacy.

Hospitals invest in their communities in multiple ways. The needs assessment process opens the door to a more rational and coordinated investment approach that is evidence based and that rests on an inclusive consultation process involving both communities and public health expertise to address area-wide goals.

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