NOTES & COMMENTS

CULTIVATING THE BENEFIT OF § 501(r)(3): § 501(r)(3) REQUIREMENTS FOR NONPROFIT HOSPITALS

by
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Hospitals may qualify for nonprofit status for purposes of federal tax exemption by providing community benefit. Historically, however, lax reporting requirements and the resulting paucity of data resulted in a disconnect between hospital conduct and tax exemption. The enactment of the Affordable Care Act and the addition of §501(r) to the tax code introduced new guidelines and reporting obligations that nonprofit hospitals must satisfy to qualify for federal tax exemption. The newly implemented Community Health Needs Assessment (CHNA) obligation represents an attempt to enforce the ongoing requirement that hospitals redirect money saved via tax exemption towards addressing specific health needs of the community.

Although the CHNA obligation seeks to instill a firmer framework to justify tax-exempt status, the regulations give hospitals too much discretion for the assessment to be a complete solution. For example, hospitals must merely "solicit" input from the community, not collect it, resulting in a lack of ongoing community input at some stages of the process. Additionally, no standard exists for incorporating such input

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The authors wish to thank their families, friends, and professional colleagues for their support and comments on earlier drafts of this Paper. The authors would also like to acknowledge Kelsey Benedick and the Lewis & Clark Law Review staff for their ardent refinements. All errors and omissions are the authors' own.

into the CHNA. These shortcomings prevent the CHNA process alone from strengthening the community benefit standard.

Despite the shortfalls of the CHNA process, secondary benefits of the requirements have the potential to encourage meaningful change. Widespread compliance with the reporting requirements will improve overall data transparency in the healthcare sector, permitting collaborative efforts among advocates and experts to comprehensively define a community's needs. Greater data transparency will also promote media advocacy and strengthen the public's influence on hospitals. These secondary effects have the capacity to ensure nonprofit hospitals are meeting their duty to serve their communities.

I. INTRODUCTION

Consider your nearest nonprofit hospital. Do you know how much revenue it brings in and what it is doing for your community in return for its nonprofit status? What if the hospital reported net income of three times the amount it spent on community benefits?[1] Or devoted only

[1] *See, e.g.*, LEGACY MERIDIAN PARK HOSPITAL, 2013 I.R.S. FORM 990, http://www.

2.86% of its total expenses to financial assistance of patients and community benefits?[2] Reports show that hospitals spend less than 10% of their revenue on community benefit activities on average, mostly on uncompensated care.[3] Some might question whether these hospitals meet requirements to be tax-exempt at all. Yet there is no federal requirement to quantify a return in exchange for tax exemption. The public may not realize the extent of this tax savings. A 2011 study estimated that hospitals received a $24.6 billion tax exemption benefit, marking a sizable increase from the $12.6 billion estimated benefit in 2002.[4]

Now consider your community. Do you know the health needs of its residents? What services do you and your neighbors need most? Historically, data on whether your nearest nonprofit hospital addressed community needs was difficult to obtain. A hospital decided on its own which health needs to address and how to meet them without worrying much about tax exemption.[5] If you were at all aware of the services a hospital provided, it was often through the self-promotion of the hospital's marketing department.

The disconnect between hospital conduct and tax exemption led many critics to call for change.[6] That change came with the enactment of the Affordable Care Act (ACA).[7] Included in the ACA's expansive scope

guidestar.org/FinDocuments/2014/930/618/2014-930618975-0b2bdb11-9.pdf (Part I Line 19 Revenue less Expenses: $30.98M; Schedule H Part I Line 7k Net Community Benefit Expense: $10.82M); SAINT THOMAS WEST HOSPITAL, 2013 I.R.S. FORM 990, http://www.guidestar.org/FinDocuments/2014/620/347/2014-620347580-0b901ebb-9.pdf (Part I Line 19 Revenue less Expenses: $67.82M; Schedule H Part I Line 7k Net Community Benefit Expense: $21.17M).

[2] As measured by the IRS. *See, e.g.*, MERCY MEDICAL CENTER – CLINTON INC, 2013 I.R.S. FORM 990, http://www.guidestar.org/FinDocuments/2014/421/336/2014-421336618-0b8ce417-9.pdf (Schedule H Part I Line 7k Column f).

[3] *See infra* Part II.B.

[4] Sara Rosenbaum et al., *The Value Of The Nonprofit Hospital Tax Exemption Was $24.6 Billion in 2011*, 34 HEALTH AFF. 1225, 1228 (2015). The 2002 estimate is reportedly from the Joint Committee on Taxation. *See* CONG. BUDGET OFFICE, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS 3 (2006).

[5] *See* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-08-880, NONPROFIT HOSPITALS: VARIATION IN STANDARDS AND GUIDANCE LIMITS COMPARISON OF HOW HOSPITALS MEET COMMUNITY BENEFIT REQUIREMENTS 7 (2008); John D. Colombo, *Federal and State Tax Exemption Policy, Medical Debt and Healthcare for the Poor*, 51 ST. LOUIS U. L.J. 433, 447 (2007) ("The current federal community benefit test provides essentially zero accountability in operational behavior.").

[6] *See* Susannah Camic Tahk, *Tax-Exempt Hospitals and Their Communities*, 6 COLUM. J. TAX L. 33, 40–43 (2014) (summarizing criticism from scholars and lawmakers).

[7] The term "Affordable Care Act" is commonly used to refer to two separate pieces of legislation—the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) [hereinafter PPACA] (codified in scattered sections of the U.S. Code), and a reconciliation bill—the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (codified in

is an effort to add much-needed structure to the regulation of nonprofit hospitals. By adding I.R.C. § 501(r) to the tax code, the ACA introduced new guidelines and reporting obligations that nonprofit hospitals must satisfy to qualify for federal tax exemption.[8]

This Paper focuses on the Internal Revenue Service's (IRS) final regulations for nonprofit hospitals under § 501(r).[9] Analysis specifically pertains to § 501(r)(3); its purpose is intended to bring focus to the vital health needs of the community by requiring hospitals to undertake and implement a Community Health Needs Assessment (CHNA). The money saved via tax exemption is supposed to be redirected towards providing community benefit, and the newly implemented CHNA obligation represents an attempt to enforce this ongoing requirement. Now that the final regulations for § 501(r) have been released,[10] we will have the opportunity to scrutinize whether the statute is likely to increase transparency of nonprofit hospital activities and bring sufficient progress toward improving the IRS's community benefit standard.

This Paper proceeds in three parts to provide a framework for the external forces leading to § 501(r)(3), the legislative meaning and subsequent implementation concerns, and how the CHNA can improve community benefits if properly cultivated. Part I of this Paper reviews the evolution of the community benefit standard used by the IRS and the courts to determine whether a hospital qualifies for federal tax exemption under § 501(c)(3). It highlights the insufficiency of the current standard to deliver benefits to the community commensurate with the forgone tax revenue, and explains early congressional efforts to remedy these shortfalls. Finally, it explains the obligations and penalties introduced under § 501(r)(3).

Part II guides the reader through a comprehensive inquiry into the sufficiency of § 501(r)(3) and questions whether the discretion afforded to hospitals in satisfying the regulations causes the statute to fall short of making meaningful progress towards strengthening the community benefit standard. It explores potential loopholes that extremely flexible regulations create and illustrates the negative effects that may occur. Although the CHNA obligations seek to instill a firmer framework to justify tax-exempt status, the regulations give hospitals too much discretion for the assessments to be a complete solution. The discretion is partially a result of inconsistent operation of § 501(r)(3) on hospital entities due to aggregation and collaboration during the CHNA process. As a result, loopholes exist in the process of identifying a hospital's "community." Discretion also appears in the manner in which hospitals gather input

scattered sections of the U.S. Code).

[8] PPACA § 9007(a) (codified as I.R.C. § 501(r) (2012)).

[9] Treas. Reg. § 1.501(r) (2015).

[10] *Id.*

from stakeholders. The absence of ongoing community input at some stages of the process is of fundamental concern—input is not required to be *collected*, but merely to be "solicited." Further, no standard exists by which hospitals must incorporate input into the CHNA or implementation strategy. Ultimately, these concerns prevent the CHNA process from making meaningful progress toward strengthening the community benefit standard.

In Part III we recover from this initial cynicism to highlight secondary benefits of the requirements that hold the potential to inspire meaningful change. Nonprofit hospitals comprise the majority of the hospital sector in the United States. Widespread compliance with the reporting requirements will improve overall data transparency in the healthcare sector. Benefits will develop from the collaborative efforts among advocates and experts to acquire data to define a community's needs comprehensively. The disclosures also bring new opportunities for public health advocates. Greater transparency of health information and a hospital's intended activities to provide for its community permits public influence. In the time of WikiLeaks and Twitter feeds, the power of the media to apply pressure to corporate decision-makers may even transcend the power of the IRS and Congress to drive change.

II. THE NEED TO EXPAND TAX EXEMPTION REQUIREMENTS BEYOND THE COMMUNITY BENEFIT STANDARD

The charitable nature of providing for community members in need and a nonprofit's purpose *to provide for a community* are concepts not clearly defined or qualified by the IRS. The "community benefit" standard evolved into a judicially crafted term as case law expounded upon the meaning and requirement of providing a community benefit.[11] This evolution reflects the fluidity of the legal landscape governing nonprofit hospitals. The essence of a nonprofit hospital is to fulfill its charitable purpose—a requisite of receiving nonprofit status.

Nonetheless, once the IRS makes its final determination and grants the hospital § 501(c)(3) status, the only way a hospital is held accountable for its ongoing community benefit activities is by completing the annual reporting requirements via the Form 990.[12] Hospitals are required to report spending using only broad categories[13] and there is no in-depth analysis after initial qualification. Rather, only surface measurements are

[11] *See, e.g.*, IHC Health Plans, Inc. v. Comm'r, 325 F.3d 1188, 1195 (10th Cir. 2003); Geisinger Health Plan v. Comm'r, 985 F.2d 1210, 1216 (3d Cir. 1993).

[12] I.R.S., Form 990 Return of Organization Exempt from Income Tax (2015), http://www.irs.gov/pub/irs-pdf/f990.pdf.

[13] I.R.S., Form 1023 Application for Recognition of Exemption Under Section 501(c)(3) of Internal Revenue Code (2013), https://www.irs.gov/pub/irs-pdf/f1023.pdf.

taken from financial expenditures.[14] Unfortunately, short of revocation of tax-exempt status, there are extremely limited enforcement measures that the IRS can take and no existing intermediate monetary sanctions.[15] The hospital is shielded, in effect, from the IRS's revoking the status because revocation might result in the hospital's closure. If closure occurs, the community loses all benefit. As a result, some hospitals continue to operate tax-exempt even when they neglect to meet the charitable purpose of § 501(c)(3) organizations.[16]

This Part reviews the current community benefit standard that places operational obligations on nonprofit hospitals. It then highlights the problems with the standard—namely, the lack of meaningful correlation between the value of the benefit provided to the community by the hospital and the tax impact from its exempt status. We describe how the obligations under § 501(r)(3) resulted from years of congressional efforts to expand on the standard.[17] Finally, we provide an overview of the obligations and summary of the penalties associated with noncompliance.

A. The Current Community Benefit Standard

We begin with a review of the current community benefit standard. The legal framework governing nonprofit hospitals is shaped by three primary developments: (1) a revenue ruling that requires charitable purpose to be a benefit to the whole community, (2) the extension of charitable purpose as a benefit to a broad class, and (3) judicial interpretation structuring the necessary elements of the community benefit standard.

First, the foundation for the community benefit standard stems from Revenue Ruling 69-545, where the IRS determined whether two nonprofit hospitals would qualify as § 501(c)(3) tax-exempt hospitals, based on various hospital features.[18] The IRS indicated that a hospital's tax-exempt qualification hinges on its charitable nature, attributable to its organization and operation in support of a charitable purpose exclusively, and

[14] *See* U.S. Gov't Accountability Office, GAO-08-880, Nonprofit Hospitals: Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements 40–41 (2008).

[15] *See* Joint Comm. on Taxation, JCX-18-10, Technical Explanation of the Revenue Provisions of the "Reconciliation Act Of 2010," as Amended, in Combination with the "Patient Protection And Affordable Care Act" 79 (2010).

[16] David M. Studdert, Michelle M. Mello, Christopher M. Jedrey & Troyen A. Brennan, *Regulatory and Judicial Oversight of Nonprofit Hospitals*, 356 New Eng. J. Med. 625, 625 (2007) ("Recent litigation illuminates the identity crisis of nonprofit hospitals . . . . The plaintiffs allege that the hospitals have broken their covenant with the community and morphed into profit-seeking businesses. Similar claims have been made by the Internal Revenue Service (IRS) and state attorneys general.").

[17] *See infra* Part II.C.

[18] Rev. Rul. 69-545, 1969-2 C.B. 117.

not reflective of any private interest.[19] Specifically, the IRS clarified that "[t]he promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole . . . ."[20]

Second, the IRS issued Revenue Ruling 83-157,[21] further distinguishing the scope of what it means for a hospital to operate for a charitable purpose for a broad class of persons. This ruling clearly indicated that a hospital could fulfill the need to provide for a broad class and meet the community benefit standard by satisfying significant factors, such as "a board of directors drawn from the community, an open medical staff policy, treatment of persons paying their bills with the aid of public programs like medicare and medicaid, and the application of any surplus to improving . . . patient care, and medical training, education, and research . . . ."[22] These explicitly identified factors have become the minimum requirements to which a nonprofit hospital must adhere.

Third, taking into consideration the IRS's interpretation of providing a public benefit, the courts formulated factors required to meet the community benefit standard to refine this guidance. In 2003, the Tenth Circuit defined "community benefit" while determining the charitable nature of a health maintenance organization in *IHC Health Plans, Inc. v. Commissioner*.[23] Ultimately, the *IHC Health Plans* court held that charitable status depends on "whether the taxpayer operates *primarily for the benefit of the community*."[24] The Court employed a "totality of circumstances" test[25] and further crafted a fundamental set of factors to be considered when determining whether the community benefit had been taken into consideration.

With regards to the notion that it is insufficient to solely provide access to healthcare, the court looked to the following factors: "(1) size of the class eligible to benefit; (2) free or below-cost products or services; (3) treatment of persons participating in governmental programs such as Medicare or Medicaid; (4) use of surplus funds for research or educational programs; and (5) composition of the board of trustees."[26] These

[19] *Id.* at 117–18 ("To qualify for exemption from Federal income tax under section 501(c)(3) of the Code, a nonprofit hospital must be organized and operated exclusively in furtherance of some purpose considered 'charitable' in the generally accepted legal sense of that term, and the hospital may not be operated, directly or indirectly, for the benefit of private interests.").

[20] *Id.* at 118.

[21] Rev. Rul. 83-157, 1983-2 C.B. 94–95.

[22] *Id.* at 95.

[23] 325 F.3d 1188, 1197–98 (10th Cir. 2003).

[24] *Id.* at 1197 (emphasis added).

[25] *Id.* at 1198 (citing Geisinger Health Plan v. Comm'r, 985 F.2d 1210, 1219 (3d Cir. 1993)); *see infra* note 28.

[26] *Id.* at 1197 n.16.

factors are derived from the court's construal of previous IRS Revenue Rulings, with particular attention to 69-545 and 83-157.[27] Combining IRS and judicial interpretations, a hospital's exempt status under the community benefit standard is determined based on related facts and circumstances.[28]

B. The Problem with the Current Standard

Undeniably, the healthcare industry as a whole is a profitable marketplace;[29] nevertheless, financial success or assets gained should not be the primary concern of nonprofit hospitals. However, critics put forth the notion that hospitals are reaping the benefits of state and federal tax exemption,[30] yet allocating an inadequate amount of funds to serve their community. As noted *supra*, the community benefit standard fails to require any correlation between the value of the benefit provided to the community and the tax dollars saved by the hospital in exchange.

One of the principal needs for reform stemmed from hospitals' increasing profit-centric movement. In a 2009 project, the IRS found that "79% of the [participating] hospitals reported excess revenues."[31] The aggregate data represented 4.6% excess revenue after expenses[32] and overall, "[t]he aggregate annual revenues reported on Form 990 by the 488 hospitals [surveyed] was $87.5 billion."[33]

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[27] *Id.* at 1197.

[28] I.R.S., IRS EXEMPT ORGANIZATIONS HOSPITAL STUDY, EXECUTIVE SUMMARY OF FINAL REPORT, 1 (2009) (on file with Lewis & Clark Law Review) ("The community benefit standard is the legal standard for determining whether a nonprofit hospital is exempt . . . . This standard uses a facts and circumstances approach to assess whether a hospital is exempt or taxable."); *see, e.g.*, *IHC Health Plans, Inc.*, 325 F.3d at 1199; *Geisinger Health Plan*, 985 F.2d at 1216.

[29] *See* Gary J. Young et al., *Provision of Community Benefits by Tax-Exempt U.S. Hospitals*, 368 NEW ENG. J. MED. 1519, 1520 (2013) ("[C]ongressional hearings have been held to address the issue of whether tax-exempt hospitals are sufficiently accountable for providing community benefits at levels that justify the value of their federal income-tax exemption, which, according to the Government Accountability Office [], is approximately $13 billion annually." (internal footnotes omitted)).

[30] *See, e.g.*, Nancy M. Kane, *Tax-Exempt Hospitals: What Is Their Charitable Responsibility and How Should It Be Defined and Reported?*, 51 ST. LOUIS U. L.J. 459, 465–68 (2007) (discussing the lack of demonstrable value for tax exemption); Daniel B. Rubin, Simone Rauscher Singh & Peter D. Jacobson, *Evaluating Hospitals' Provision of Community Benefit: An Argument for an Outcome-Based Approach to Nonprofit Hospital Tax Exemption*, 103 AM. J. PUB. HEALTH 612, 612 (2013) ("Policymakers have recently started to question the adequacy of the community-benefit activities that nonprofit hospitals provide in exchange for their substantial tax exemptions.").

[31] I.R.S., IRS EXEMPT ORGANIZATIONS (TE/GE) HOSPITAL COMPLIANCE PROJECT FINAL REPORT, 9 (2009), (on file with Lewis & Clark Law Review).

[32] *Id.* at 4.

[33] *Id.* at 23.

Despite having the financial means to do so, because of the loosely defined scope of community benefit and convoluted benchmarks to guide hospitals, there appears to be a growing trend of hospitals moving away from charitable spending.[34] Even before § 501(r)(3), hospitals were required to complete a hospital-specific Schedule H in addition to filing a Form 990 with the IRS.[35] However, there are insufficient requirements as to how expenditures are allocated and to what degree funds are attributed. Reports show that hospitals have spent less than 10% of their total revenue on community benefit-related purposes.[36]

Revenue has instead been apportioned to general expenses, which often lack a direct relationship to the charitable purpose of providing for a hospital's surrounding community. Of the limited percentage of funds spent on community benefits, uncompensated care tends to account for the greatest expenditure dedicated to a charitable purpose.[37] Aside from uncompensated care, only minimal amounts are disbursed toward medical education and training, research, and community focused programs.[38] Nonprofit hospitals have lost sight of their § 501(c)(3) objective and have possibly focused their spending on, for example, compensation of staff[39]

[34] *See, e.g.*, Jessica Berg, *Putting the Community Back into the "Community Benefit" Standard*, 44 GA. L. REV. 375, 377 (2010) ("Congress, state legislatures, and courts have all begun to scrutinize hospital charity care"); Jack Hanson, *Are We Getting Our Money's Worth? Charity Care, Community Benefits, and Tax Exemption at Nonprofit Hospitals*, 17 LOY. CONSUMER L. REV. 395, 399 (2005) (describing "growing concern" that hospitals might not provide sufficient social benefits to justify tax exemption); James R. King & Keith W. Hearle, *Documenting the Quid Pro Quo of Community Benefit*, 18 TAX'N EXEMPTS 29, 29 (2006) (describing "increasing pressure[s]" for tax-exempt providers to demonstrate quid pro quo); Studdert et al., *supra* note 16, at 625 ("[R]ecent litigation illuminates the identity crisis . . . . The plaintiffs allege that the hospitals have broken their covenant with the community and morphed into profit-seeking businesses.").

[35] I.R.S., *supra* note 12, at 4.

[36] I.R.S., *supra* note 28, at 2 ("The average and median percentages of total revenues reported as spent on community benefit expenditures were 9% and 6%, respectively [for the overall group]."). *Cf.* Young et al., *supra* note 29, at 1519 ("Tax-exempt hospitals spent 7.5% of their operating expenses on community benefits during fiscal year 2009."); Tahk, *supra* note 6, at 73 (finding that hospitals spent an average of 8.5% of their total expenses on community benefits in 2012).

[37] I.R.S., *supra* note 28, at 2.

[38] *See id.* at 2–3 ("After uncompensated care [56%], the next largest categories of community benefit expenditures, ranked as a percentage of total community benefit expenditures, were medical education and training (23%), research (15%), and community programs (6%).").

[39] *See, e.g.*, I.R.S., *supra* note 31, at 10 ("The average and median compensation amounts paid to the top management official as reported on the questionnaire were $490,000 and $377,000, respectively. Compensation amounts varied across demographics, but generally increased as the hospital's revenue size increased.").

and equipment, thereby neglecting to provide a substantial community benefit.[40]

C. Congressional Effort to Improve the Standard

Congress has been crafting a policy solution for nearly ten years. It began confronting the problem in a 2006 report shedding light on the "tax arbitrage" advantage granted to nonprofit hospitals.[41] The chairman of the Committee on Ways and Means requested the Congressional Budget Office to discover "the costs associated with providing the federal tax preferences . . . [and] how much the costs might be reduced if policymakers were to impose a particular type of restriction on hospitals' use of tax-exempt financing."[42] In 2008, the Government Accountability Office drafted a report in response to a request by Senator Charles E. Grassley, following his 2007 congressional inquiries examining prospective reforms.[43] The 2008 report found that the "IRS's community benefit standard allows nonprofit hospitals broad latitude to determine the services and activities that constitute community benefit."[44] Additionally, the report addressed concerns that the "[v]ariations in the activities nonprofit hospitals define as community benefit lead[ing] to substantial differences in the amount of community benefits [hospitals] report."[45]

A new policy solution came from a subsection of the ACA.[46] Subsection 9007 represents the joint effort of the Senate Finance Committee and the Senate Health, Education, Labor, and Pensions Committee, made while merging proposed legislation to create the ACA. The inclusion of § 501(r) largely derived from Senator Grassley's initiatives to address the underwhelming action of nonprofit hospitals providing a community benefit, from both a financial and expenditures perspective, in addition to charitable services provided.[47] Senator Max Baucus, Finance

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[40] *See* Rubin et al., *supra* note 30, at 612.

[41] CONG. BUDGET OFFICE, NONPROFIT HOSPITALS AND TAX ARBITRAGE 1–2 (2006).

[42] *Id.* at 4.

[43] U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-08-880, NONPROFIT HOSPITALS: VARIATION IN STANDARDS AND GUIDANCE LIMITS COMPARISON OF HOW HOSPITALS MEET COMMUNITY BENEFIT REQUIREMENTS 4 (2008).

[44] *Id.* at 7.

[45] *Id.*

[46] PPACA § 9007.

[47] *See* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-08-880, *supra* note 43 (report requested by Senator Grassley studying the community benefit standard). The report refers to a 2007 discussion draft that Senator Grassley distributed containing proposals for reform; *see also Tax-Exempt Hospitals: Discussion Draft,* U.S. SENATE COMM. ON FIN.—MINORITY (July 19, 2007); Amanda W. Thai, Note, *Is Senator Grassley Our Savior?: The Crusade Against "Charitable" Hospitals Attacking Patients for Unpaid Bills*, 96 IOWA L. REV. 761, 772, 772 n.68 (2011).

Committee Chair, first introduced the concept of a CHNA in his September 2009 proposal of the America's Healthy Future Act.[48] Specifically referring to nonprofit hospitals in a Senate news release, Senator Baucus emphasized that "[t]his proposal would establish new requirements applicable to nonprofit hospitals beginning in 2010. The requirements would include a periodic community needs assessment."[49] The America's Healthy Future Act of 2009 outlines details regarding the additional requirements for nonprofit hospitals, including the CHNA requirement.[50] The committee bill largely resembled the final requirements introduced in the ACA, such as conducting the assessment once every three years and developing an implementation strategy.[51] The collaborative efforts of the Senate, particularly the work of the Finance Committee, eventually included these requirements in the ACA, creating § 501(r) in the tax code.[52]

D. Overview of § 501(r)(3) Requirements

In addition to satisfying the community benefit standard, § 501(r) requires nonprofit hospital organizations to meet four new obligations in order to qualify for tax-exempt status under § 501(c)(3). Specifically, a hospital must meet: (1) the CHNA requirements;[53] (2) the financial assistance policy requirements;[54] (3) requirements on limitation of service

[48] America's Healthy Future Act of 2009, S. 1796, 111th Cong. § 6007(a) (2009).

[49] *Baucus Introduces Landmark Plan to Lower Health Care Costs, Provide Quality, Affordable Coverage,* U.S. SENATE COMM. ON FIN.: CHAIRMAN'S NEWS 18 (Sept. 16, 2009), http://www.finance.senate.gov/chairmans-news/baucus-introduces-landmark-plan-to-lower-health-care-costs-provide-quality-affordable-coverage.

[50] S. 1796 § 6007(a).

[51] S. REP. NO. 111-89, at 338 (2009). Senator Baucus submitted the report which provided that community health needs assessments should include: (1) implementation strategies at least once every three years, (2) collection of information from public health agencies and other like kind organizations, (3) input from a broad spectrum of community stakeholders, (4) annual disclosure addressing recognized community needs, (5) publically availing assessments, and (6) enforcement of an inaction penalty up to $50,000 for failing to meet assessment requirements. *Id.* at 338–39.

[52] *Health Care Reform from Conception to Final Passage: Timeline of the Finance Committee's Work to Reform America's Health Care System*, U.S. SENATE COMM. ON FIN., http://www.finance.senate.gov/imo/media/doc/Health%20Care%20Reform%20Timeline.pdf. The entry from Nov. 19, 2009 states, "Baucus worked with his colleagues to merge the Finance Committee health care reform bill [the America's Healthy Future Act] with the bill passed by the Health Education Labor and Pension (HELP) Committee, and together the two committees brought one bill, the Patient Protection and Affordable Care Act, to the Senate floor for debate." *Id.*

[53] I.R.C. § 501(r)(1)(A) (2012); *see also* I.R.C. § 501(r)(3).

[54] I.R.C. § 501(r)(1)(B); *see also* I.R.C. § 501(r)(4).

charges;[55] and (4) billing and collection requirements.[56] This Paper discusses only the first obligation—performance of a CHNA along with associated reporting obligations and penalties under § 501(r)(3).[57]

Every three years, a charitable hospital is now required to perform a health needs assessment focused on the community it resides in.[58] Health needs can include expansive categories, such as social, behavioral, and environmental factors, in addition to basic needs such as addressing financial barriers to accessing care.[59] At the conclusion of the assessment, the hospital must produce a written report of the findings for adoption by an authorized body.[60] This Paper uses the term "CHNA" to refer to both the process of performing the needs assessment and to the CHNA written report. Though the focal point of the final CHNA report is a full description of the identified significant health needs of the community,[61] the report must also include a description of how the report was created,[62] how the facility defined community,[63] and how the hospital took input from persons who represent "broad interests" in the community.[64] These factors are elaborated throughout the remainder of this Paper, as they resemble the underpinnings of the community benefit standard.

It may have been Congress's intention that this exercise would in part help ensure that hospitals "act charitably."[65] Directing a needs-

[55] I.R.C. § 501(r)(1)(C); *see also* I.R.C. § 501(r)(5).

[56] I.R.C. § 501(r)(1)(D)*; see also* I.R.C. § 501(r)(6).

[57] For discussion regarding the other 501(r) obligations see King & Hearle, *supra* note 34, at 31; Tahk, *supra* note 6, at 46–48. *See generally* 1–4 TAXATION OF HOSPITALS & HEALTH CARE ORGANIZATIONS § 4.03[2][c], Lexis (2015).

[58] Treas. Reg. § 1.501(r)-3(a)(1)(2015).

[59] Treas. Reg. § 1.501(r)-3(b)(4). The IRS provides little to no guidance on the process or methods for diagnosing these needs.

[60] Treas. Reg. § 1.501(r)-3(a)(2). This is usually a board of directors or board of trustees. See examples provided in Treas. Reg. § 1.501(r)-1(b)(4)(i). Once approved, the report must be made widely available to the public. I.R.C. § 501(r)(3)(B)(ii); Treas. Reg. § 1.501(r)-3(b)(1)(v).

[61] Treas. Reg. § 1.501(r)-3(b)(6)(i) (D)–(F) describes four aspects relating to the full description: 1) the process and criteria used in identification; 2) a prioritized description of the needs identified; 3) a description of potential resources identified to address each need; and 4) an evaluation of any action taken to address the needs identified in the hospital's immediately preceding CHNA. Of course, input from the fourth category is only applicable beginning with a hospital's second CHNA, likely conducted in 2015 or 2016.

[62] Treas. Reg. § 1.501(r)-3(b)(6)(i)(B).

[63] Treas. Reg. § 1.501(r)-3(b)(6)(i)(A).

[64] Treas. Reg. § 1.501(r)-3(b)(6)(i)(C). The requirement to "take into account" input from persons who represent "broad interests" was a mandate from Congress. I.R.C. § 501(r)(3)(B)(i); *see also* Treas. Reg. § 1.501(r)-3(b)(1)(iii).

[65] *See* Memorandum from Senator Chuck Grassley, *Grassley's Provisions for Tax-exempt Hospital Accountability Included in New Health Care Law* (Mar. 24 2010), http://www.grassley.senate.gov/news/news-releases/grassley's-provisions-tax-exempt-

identification assessment would ultimately influence policy and strategic planning for the hospital and enable the public to ensure the provision of programs that would benefit the community. Thus, the obligations move beyond performing a simple assessment and go further in an attempt to ensure a beneficial outcome by also requiring an action plan to address the needs the assessment uncovered. Leaders of a hospital facility must determine whether each health need identified is "significant" in the community that it serves.[66] All significant needs must be prioritized for intervention and compiled into "a written plan"[67] that is required to be filed with the hospital's annual tax returns.[68] This Paper uses the term "implementation strategy" to refer to this written plan, the same term employed by the IRS in the regulations.[69]

The first round of CHNAs and each corresponding implementation strategy were due for taxable years beginning after March 23, 2012.[70] Most hospitals likely adopted their first CHNA in 2013, and included an implementation strategy with their 2013 tax filings.[71] The IRS allowed hospitals to rely on anticipated regulatory provisions made available in an early Notice while preparing these inaugural reports.[72] Proposed rules for future CHNAs were published in 2012 and 2013.[73] The IRS issued final

hospital-accountability-included-new-health-care.

[66] Treas. Reg. § 1.501(r)-3(b)(4). A hospital may make this determination based on all of the facts and circumstances present. *Id.*

[67] Treas. Reg. § 1.501(r)-3(c)(1).

[68] I.R.C. § 6033(b)(15)(A) (2012); Treas. Reg. § 1.6033-2(a)(2)(ii)(l)(2) (2015).

[69] Treas. Reg. § 1.501(r)-3(a)(2); Treas. Reg. § 1.501(r)-3(c).

[70] I.R.S. Notice 2011-52, 2011-30 I.R.B. 60, 66. Since many PPACA requirements became effective the first taxable year after enactment, the IRS revised Form 990 Schedule H for 2010 tax year filings. I.R.S., INSTRUCTIONS FOR SCHEDULE H (FORM 990) (2010), http://www.irs.gov/pub/irs-prior/i990sh–2010.pdf. However, CHNA requirements did not take effect until "taxable years beginning after the date which is 2 years after the date of the enactment of this Act." PPACA § 9007(f). Therefore, reporting on the CHNA and implementation strategy was optional for charitable hospitals prior to March 23, 2012. I.R.S. Notice 2011-52, 2011-30 I.R.B. 60, 66; *see also* I.R.S. Announcement 2011-37, 2011-27 I.R.B. 37.

[71] Sixty percent of hospitals have a fiscal year-end date of either June or December. AM. HOSP. DIRECTORY, INC., *Frequently Asked Questions*, http://www.ahd.com/faq.html. Hospitals having either a June or a December fiscal year end would have been required to complete their first CHNA in 2013.

[72] I.R.S. Notice 2011-52, 2011-30 I.R.B. 60, 66. Hospitals may rely on this guidance for adoption of any report that occurs no later than six months after future guidance is issued. *Id.* Final regulations take effect for taxable years beginning after December 29, 2015. Treas. Reg. § 1.501(r)-7(a). Hospitals may rely on a reasonable, good-faith interpretation of section 501(r) that complies with either the proposed or final regulations for CHNA's conducted or adopted prior to this date. Treas. Reg. § 1.501(r)-7(b).

[73] The most significant are Prop. Treas. Reg. § 1.501(r), 77 Fed. Reg. 38,148, 38,148 (June 26, 2012) and Prop. Treas. Reg. § 1.501(r), 78 Fed. Reg. 20,523, 20,523 (Apr. 5, 2013) (the "2013 proposed regulations").

regulations near the close of 2014,[74] which will take effect for taxable years beginning after December 29, 2015.[75]

E. Penalties for Noncompliance

Prior to the ACA's passage, no sanctions short of revocation of tax-exempt status were available to the IRS if it wanted to take action against hospitals that failed to satisfy the community benefit standard.[76] Revocation is an extreme measure that the IRS has rarely pursued.[77] The IRS has reported only a handful of revocations for hospitals or medical centers since February 2005.[78]

While performing a CHNA and adopting an implementation strategy does not prove that a hospital is meeting the community benefit standard, it is the closest proxy measurement available. Consequently, hospitals that fail to satisfy the requirements may face what could be classified as intermediate sanctions: monetary penalties or temporary suspension of tax-exempt status at the facility level.

Section 4959 imposes a $50,000 monetary penalty on a hospital organization that fails to meet the CHNA requirements for any taxable year.[79] If a hospital organization operates multiple facilities that do not comply, each noncompliant facility is assessed a separate penalty.[80] A hospital organization must self-disclose a violation by reporting on its annual-information return the amount of any penalty imposed.[81] This sanction is not levied for omissions or errors that are minor or inadvertent if they are promptly corrected in accordance with the regulations.[82]

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[74] T.D. 9708, 2015-5 I.R.B. 337.

[75] Treas. Reg. § 1.501(r)-7(a).

[76] Joint Comm. on Taxation, JCX-18-10, Technical Explanation of the Revenue Provisions of the "Reconciliation Act Of 2010," as Amended, in Combination with the "Patient Protection And Affordable Care Act" 79 (2010).

[77] Lawrence E. Singer, *Leveraging Tax-Exempt Status of Hospitals*, 29 J. Legal Med. 41, 49–50 (2008); Studdert et al., *supra* note 16, at 626; *see* Martha H. Somerville, Laura Seeff, Daniel Hale & Daniel J. O'Brien, *Hospitals, Collaboration, and Community Health Improvement*, 43 J.L. Med. & Ethics (Special Supplement 1) 56, 58 (2015).

[78] I.R.S., *Revocations of 501(c)(3) Determinations - I.R.B. 2005-09 to Present, I.R.S.*, https://www.irs.gov/pub/irs-tege/c3Revocations_2005Forward.pdf.

[79] PPACA § 9007(b) (relating to all of the § 501(r) obligations, not just the CHNA obligations); I.R.C. § 4959 (2012). This is the same amount originally proposed in America's Healthy Future Act. of 2009, S. 1796, 111th Cong. § 6007(b).

[80] Treas. Reg. § 53.4959-1(a) (2015). As discussed *infra* notes 92–93 and accompanying text, obligations under § 501(r) apply separately to each individual facility.

[81] Treas. Reg. § 53.6011-1(b) (2015).

[82] Treas. Reg. § 1.501(r)-2(b)(1)(ii) (2015). *See* T.D. 9708, 2015-5 I.R.B. 344–45. An omission or error related to the CHNA that is minor or inadvertent is not considered to be a "failure" to meet § 501(r) obligations, therefore penalties under

In addition to monetary penalties, noncompliant facilities will be temporarily required to pay income tax as normally calculated for a corporation or a trust that is not tax-exempt under § 501(c)(3).[83] Again, this sanction will not be levied for omissions or errors that are minor or inadvertent if they are promptly corrected in accordance with the regulations.[84]

These two new sanctions only augment tools available to the IRS—revocation of tax-exempt status remains an option.[85] The Commissioner will consider all relevant facts and circumstances when determining whether to revoke tax-exempt status.[86] There is no evidence the IRS will pursue this option any more frequently than it historically has; therefore, a hospital's good-faith effort to comply is unlikely to result in a sanction as severe as revocation.

III. QUESTIONING THE EFFICACY OF § 501(r)(3)

While the intermediate sanctions represent a significant step towards a heightened scrutiny of hospitals, some commentators allege that the actual § 501(r)(3) obligations fall short of making meaningful reforms to the community benefit standard.[87] The final regulations permit nonprofit

§ 4959 are not appropriate. The IRS also released proposed regulations containing a proposed revenue procedure setting forth procedures for correction and disclosure of failures. I.R.S. Notice 2014-3, 2014-3 I.R.B. 408, 408–10. To provide incentive for hospital facilities to take steps not only to avoid errors but also to correct and provide disclosure when errors occur, the IRS proposed that a hospital facility's failure to meet one or more CHNA requirements that is neither willful nor egregious would be excused. T.D. 9708, 2015-5 I.R.B. 344–45. However, even if a failure is later corrected, penalties are still due (unless they qualify as minor or inadvertent under Treas. Reg. § 1.501(r)-2(b)). T.D. 9708, 2015-5 I.R.B 345.

[83] Treas. Reg. § 1.501(r)-2(d)(1). Calculation for a corporation is performed as explained in I.R.C. § 11 (2012); for a trust, I.R.C. § 1(e) (2012).

[84] Treas. Reg. § 1.501(r)-2(d)(1). The sanction does not apply if paragraph (b) (relating to minor omissions and errors) or paragraph (c) (relating to excuse following correction and disclosure) of this subsection apply.

[85] Treas. Reg. § 1.501(r)-2(a).

[86] *Id.* A list of nine, non-exclusive considerations is provided.

[87] Zachary J. Buxton, Comment, *Community Benefit 501 (R)edux: An Analysis of the Patient Protection and Affordable Care Act's Limitations Under Community Benefit Reform*, 7 ST. LOUIS U.J. HEALTH L. & POL'Y 449, 451–52 (2014) (calling the changes an "adequate start . . . but . . . likely only an intermediate step between the [community benefit] standard's contemporary state and a complete overhaul within the next five to ten years"); Bobby A. Courtney, Note, *Hospital Tax-Exemption and the Community Benefit Standard: Considerations for Future Policymaking*, 8 IND. HEALTH L. REV. 365, 397 (2011) (observing Congress's "reluctance to approach the issue [of community benefit accountability] in an uncompromising manner"); Jeremy J. Schirra, Note, *A Veil of Tax Exemption?: A Proposal for the Continuation of Federal Tax-Exempt Status for "Nonprofit" Hospitals*, 21 HEALTH MATRIX 231, 276 (2011) (acknowledging the usefulness of the CHNA as a tool but noting the § 501(r) changes "do[] little to

hospitals significant discretion with respect to decisions made while conducting a CHNA and while drafting required reports. Strict standards in the new structure created by the CHNA obligations are frequently sidestepped in favor of murky "facts and circumstances" tests.[88] Flexibility is a theme woven throughout the regulations, with hospitals frequently receiving deference at the community's expense. Although the CHNA obligations attempt to expand the nebulous community benefit standard, they permit hospitals too much discretion to be a sufficient solution. This Part identifies the shortcomings of § 501(r)(3).

A. Does § 501(r)(3) Operate Inconsistently by Allowing Aggregation and Collaboration Among Hospitals to Obfuscate True Needs?

Section 501(r) creates qualifications which, when met, subject a hospital to § 501(r)(3). Recall that § 501(r) only applies to hospital facilities treated as tax-exempt under § 501(c)(3).[89] The final regulations define a hospital facility as "a facility that is required by a state to be licensed, registered, or similarly recognized as a hospital."[90] Hospital organizations that operate multiple hospitals under separate state licenses must satisfy the § 501(r) obligations for each facility on an independent basis.[91]

The 2012 proposed regulations included an allowance that hospital systems operating in multiple buildings yet under a single state license "may" be recognized as one hospital facility.[92] However, this flexibility was removed from the final regulations and such an entity is categorically recognized as one facility under § 501(r).[93] This definition may make

actually change hospital behavior or provide incentives for fundamental changes"). Others advocate for a broader-population health approach. *See* Mary Crossley, *Tax-Exempt Hospitals, Community Health Needs and Addressing Disparities*, 55 How. L.J. 687, 701–02 (2012) (forecasting failure to address population health disparities despite the new CHNA obligations in light of the IRS's lack of expertise in the field of public health policy). Crossley offers a disheartening anecdote of a hospital employee who indicated the determination of how to comply with the CHNA requirements had been turned over to the marketing department. *Id.* at 702 n.69. *See* Rubin et al., *supra* note 30, at 615 (calling for an outcome-based population health approach, crediting the CHNA obligations with compelling an evaluation of changes in population health as only a "first step toward a modified approach to nonprofit hospital tax exemption").

[88] *See infra* Part III.B.

[89] *See supra* Part II.D.

[90] Treas. Reg. § 1.501(r)-1(b)(17).

[91] I.R.C. § 501(r)(2)(B).

[92] Prop. Treas. Reg. § 1.501(r), 77 Fed. Reg. at 38,161 ("Except as otherwise provided in published guidance, a hospital organization may treat multiple buildings operated under a single state license as a single hospital facility.").

[93] Treas. Reg. § 1.501(r)-1(b)(17) ("Multiple buildings operated under a single state license *are* considered to be a single hospital facility.") (emphasis added); s*ee also* discussions in T.D. 9708, 2015-5 I.R.B. 341 (explaining that a definition based on

compliance easier because hospital systems aggregate multiple facilities operating under the same state license for purposes of performing the CHNA and creating an implementation strategy. On the other hand, this definition could present inconsistency based on the licensing standards used by each state—whether one or multiple licenses are required. For example, two commenters during the notice period for the proposed regulations explained that many California hospitals share a state facility license, yet are located in communities with distinctly different needs and different community stakeholders.[94] Aggregation in this scenario will work against efforts to address needs endemic to the local community.

A rigid definition that looks solely to state licensure to determine which entities must comply individually may impose a greater burden on a single facility that operates under multiple state licenses, although it operates in the same physical location. Such a facility may serve the same theoretical community, and yet be required to perform multiple CHNAs to correspond to each state license. However, the hospital's ability to collaborate with its licensed components—or with unrelated facilities or organizations—while conducting the CHNA tempers this burden. These collaborative efforts would reflect the pooling of resources in preparing data-sharing mechanisms.

In fact, all hospital facilities may collaborate with one another, or with unrelated facilities or organizations while conducting the CHNA.[95] As a result, the regulations acknowledge that portions of each facility's respective CHNA report may be "substantively identical."[96] Such allowance was an explicit response to comments received from large hospital organizations[97] in light of the decade's recent trend toward healthcare

licensure alone would be "simpler and more administrable") and Prop. Treas. Reg. § 1.501(r), 78 Fed. Reg. at 20,525 (explaining that flexibility would make it "harder for the IRS and the public to understand").

[94] *See, e.g.*, Letter from Anthony Barrueta, Senior Vice President, Gov't Relations, Kaiser Permanente, to the I.R.S. 1–2 (July 3, 2013), https://www.regulations.gov/contentStreamer?documentId=IRS-2013-0016-0049&attachmentNumber=1&disposition=attachment&contentType=pdf; Letter from Alyssa Keefe, Vice President, Federal Regulatory Affairs, Cal. Hosp. Ass'n, to the I.R.S. 3 (July 3, 2013), https://www.regulations.gov/contentStreamer?documentId=IRS-2013-0016-0038&attachmentNumber=1&disposition=attachment&contentType=pdf.

[95] Treas. Reg. § 1.501(r)-3(b)(6)(iv). Hospitals that collaborate on the CHNA are permitted to issue a joint CHNA report in accordance with Treas. Reg. § 1.501(r)-3(b)(6)(v) if they define their community to be the same.

[96] Treas. Reg. § 1.501(r)-3(b)(6)(iv); *see also* T.D. 9708, 2015-5 I.R.B. 351–53; Prop. Treas. Reg. § 1.501(r), 78 Fed. Reg. at 20,532.

[97] *See, e.g.*, Letter from Melinda Reid Hatton, Senior Vice President and Gen. Counsel, Am. Hospital Ass'n, to the I.R.S. 2 (June 27, 2013), https://www.regulations.gov/contentStreamer?documentId=IRS-2013-0016-0012&attachmentNumber=1&disposition=attachment&contentType=pdf (welcoming "improvements" to the guidance to allow greater collaboration in the development of a joint CHNA and joint implementation strategy).

consolidation within a given state or region.[98] The ability to collaborate satisfies critics' concerns that meeting the new CHNA obligations will divert time and resources away from the hospital's primary mission and add unnecessary burden[99] because facilities can pool their resources to perform the assessment. Hospitals that collaborate on the CHNA are further permitted to issue a joint CHNA report in accordance with the final regulations if they adopt the same community definition.[100] This allows hospitals the ability to minimize resources allocated toward the completion of the CHNA.

However, undesirable side effects may arise when hospitals collaborate with one another. When facilities across larger geographic areas collaborate, the resulting product may be less applicable to the local community of each facility. A need shared by a majority of the collaborating hospitals may ultimately be determined a significant need of a minority hospital, regardless of whether its community actually exhibits the need. Potentially worse, a minority need applicable to a single collaborating facility may become lost when considered alongside needs that span across all collaborating facilities.

Whether a hospital employs aggregation during a CHNA as a by-product of state licensure or because of voluntary collaboration with other partners, this aggregation may obfuscate the true needs of an individual hospital. This permits a hospital to craft a financially favorable outcome. Within large, consolidated systems, hospital executives may desig-designate a centralized team to coordinate the CHNA process on behalf of multiple hospitals to conserve resources. A centralized team may feel greater pressure to produce reports aligned with the system's strategic investments than each individual hospital would when working alone. As a result, the reports for each hospital may be essentially duplicates. A sys-

[98] SUZANNE M. KIRCHHOFF, CONG. RESEARCH SERV., R42880, PHYSICIAN PRACTICES: BACKGROUND, ORGANIZATION, AND MARKET CONSOLIDATION 2 (2013) (discussing physician consolidation as "part of a broader trend toward consolidation in health care, with the overall number of mergers and acquisitions in the sector at the highest level in a decade"); Rich Daly, *Hospital Consolidation Trend to Continue*, HEALTHCARE FIN. MGMT., July 2014, at 11, 11.

[99] *See* Letter from Melinda Reid Hatton, *supra* note 97, at 2–3. The American Hospital Association suggested compliance with the proposed regulations "may involve thousands of hours." *Id.* at 2. One healthcare system, Texas Health Resources, provides a dramatic anecdote suggesting satisfying the proposed regulations "*has* involved thousands of hours and the expenditure of more than hundreds of thousands of dollars." Letter from Douglas Hawthorne, Chief Exec. Officer, Tex. Health Res., to the I.R.S. 2 (July 5, 2013), https://www.regulations.gov/contentStreamer?documentId=IRS-2013-0016-0032&attachmentNumber=1&disposition=attachment&contentType=pdf (emphasis added).

[100] Treas. Reg. § 1.501(r)-3(b)(6)(v). Hospitals that do issue a joint CHNA report have the additional option to issue a joint-implementation strategy in accordance with Treas. Reg. § 1.501(r)-3(c)(4).

tem's hospitals should not collaborate on the CHNA as a method to advance a financially based agenda of the hospital system. At best, the resulting CHNA will have diminished value if it is an inaccurate assessment of the community's needs. At worst, the CHNA becomes a meaningless exercise, providing false support for activities a hospital intended to pursue anyway.

B. What Is the "Community" Really?

Surprisingly, given the significance that identifying a facility's community has in the ultimate determination of a community's needs, the final regulations provide only minimal guidance on how a hospital identifies its community. A hospital may take into account "all of the relevant facts and circumstances" when defining its community.[101] The IRS provides a suggested list including the geographic area served by the hospital facility, target populations served, and principal hospital functions (for example, focus on a particular specialty area or targeted disease).[102] However, a facility is not required to use any of the given factors.[103] The manner in which a hospital defines its community is unjustifiably flexible. Hospitals are permitted a wide degree of latitude, allowing the potential for self-serving identification of community boundaries.

To its credit, the IRS acknowledged concerns regarding the risk of self-serving conduct, highlighted by commentators, in the 2013 proposed regulations.[104] The final regulations include a prohibition against defin-

[101] Treas. Reg. § 1.501(r)-3(b)(3). The final regulations "continue to give hospital facilities broad flexibility to define the communities they serve or intend to serve." T.D. 9708, 2015-5 I.R.B. 346. *See also* Prop. Treas. Reg. § 1.501(r), 78 Fed. Reg. at 20,529 (Each hospital has the "flexibility to take into account all of the relevant facts and circumstances in defining the community it serves"). The 2013 proposed regulations illustrate this extreme flexibility through the inclusion of a provision that a hospital facility could even define its community to include populations "in addition to its patient populations and geographic areas outside of those in which its patient populations reside." *Id.* This allowance appeared to be directly related to the ability of facilities and organizations to collaborate when conducting a CHNA. *See id.* (discussion about MSA). However, in response to concerns that such inclusion could create confusion among both hospitals and the public, the IRS removed language providing this explicit allowance from the final regulations. *See* T.D. 9708, 2015-5 I.R.B. 346.

[102] Treas. Reg. § 1.501(r)-3(b)(3).

[103] *See id.*

[104] "[T]he Treasury Department and the IRS continue to share the interest expressed by some commenters in ensuring that hospital facilities assess and address the needs of medically underserved, low-income, and minority populations in the areas they serve." Prop. Treas. Reg. § 1.501(r), 78 Fed. Reg. at 20,529 (when describing restrictions on community definitions specifically designed to exclude various patient groups); *see, e.g.*, Letter from Georges C. Benjamin, Exec. Dir., Am. Pub. Health Ass'n, to the I.R.S. 2–3 (July 3, 2013), https://www.regulations.gov/contentStreamer?documentId=IRS-2013-0016-0037&attachmentNumber=1&disposition=

ing "community" in a self-serving way to exclude patient populations—such as medically underserved, low-income, and minority populations—that either (1) live in the geographic areas from which the hospital facility draws its patients, or (2) otherwise "should be included based on the method the hospital facility uses to define its community."[105] Despite the prohibition, there is considerable room for a hospital to define its community favorably to ultimately demonstrate needs conforming to services the hospital has historically provided to its existing patient population—a population that already tends to exclude certain patient populations such as low-income individuals.

A 2014 review of hospital CHNAs conducted by the Public Health Institute (PHI) in collaboration with the CDC found that, in a representative random selection, all hospitals defined community in their most recent CHNA in terms of patient service area.[106] Yet, 52% of hospitals "did not provide information on the methodology used to define their service area."[107] This led researchers to speculate that lack of knowledge and understanding of population health among hospital staff correlates with a tendency to derive patient-service area based on an internally derived measure.[108] Use of an existing internally derived measure can cause artificial overrepresentation of insured patients. For example, if a hospital selects a patient service area that corresponds to its existing target audience

attachment&contentType=pdf ("given this flexibility . . . we recommend that the final rule explicitly tie the CHNA requirement for hospitals to consult public health and community stakeholders to this step of defining the community, to ensure that no essential populations are excluded . . . . We strongly support the requirement that a hospital[] . . . must not exclude key populations . . . ."); *see also* AM. PUB. HEALTH ASS'N ET AL., MAXIMIZING THE COMMUNITY HEALTH IMPACT OF COMMUNITY HEALTH NEEDS ASSESSMENTS CONDUCTED BY TAX-EXEMPT HOSPITALS 13 (2012), http://www.astho.org/Programs/Access/Community-Health-Needs-Assessment/Consensus-Statement ("Recommendation 6: The community served by a hospital facility should not be defined to exclude medically underserved or low-income populations[.]").

[105] Treas. Reg. § 1.501(r)-3(b)(3). If a hospital chooses to include patient population as a method of defining its community, such hospital must additionally consider all persons who receive care as "patients" without regard to whether they or their insurers pay for care or qualify for financial assistance. *Id. See also* Prop. Treas. Reg. § 1.501(r), 78 Fed. Reg. at 20,529. Unfortunately, the IRS concurrently provided two exceptions to this prohibition. First, hospitals may exclude a patient population if it is not part of the facility's target population or it is not affected by the facility's principal functions. Treas. Reg. § 1.501(r)-3(b)(3). Second, chronic disease is not one of the dimensions for which exclusion is prohibited. Prop. Treas. Reg. § 1.501(r), 78 Fed. Reg. at 20,529.

[106] KEVIN BARNETT, PUBLIC HEALTH INSTITUTE, SUPPORTING ALIGNMENT AND ACCOUNTABILITY IN COMMUNITY HEALTH IMPROVEMENT: THE DEVELOPMENT AND PILOTING OF A REGIONAL DATA-SHARING SYSTEM, 47 (2014), http://nnphi.org/CMSuploads/SupportingAlignmentAndAccountabilityInCommunityHealthImprovement.pdf.

[107] *Id.*

[108] *Id.* at 76.

for marketing purposes, the resulting service area may underrepresent uninsured patients because the uninsured are not normally high-priority marketing targets. Using an internally derived measure may also result in categorical identification of needs that the hospital is already aware of by virtue of having previously served patients with those same needs. For example, if the hospital augments a geographically defined community by including patients who reside outside of the geographic area (but who previously received treatment from the hospital) the health needs corresponding to these patients may be overrepresented in the definition of community that results. The flexibility for a hospital to define community in such self-serving fashion can fail to generate the complete picture of unmet health needs and health disparities within the community.[109]

C. Legitimate Input or Lip Service?

Aiming to produce a comprehensive assessment, a CHNA must take into account "input from persons who represent the broad interests of the community served by the hospital facility."[110] This input is considered so crucial that it is one of only two requirements,[111] other than timing,[112] specifically mandated by Congress addressing the manner in which the CHNA is performed.[113] Nonetheless, the final requirements fall short of what some commentators hoped to see, once again permitting extensive discretion by a facility. The final regulations require the solicitation of input from three types of sources, at a minimum.[114] Public-health profes-

[109] *Id.* at 19–20. Furthermore, defining community based on patient service area can result in a disproportionate allocation of community benefit among hospitals in the same geographic area, and "reinforces a proprietary approach to community benefit. The net result is missed opportunities to leverage limited resources among hospitals and other stakeholders." *Id.* The report offers three examples of how hospitals' use of zip code and county geographic boundaries resulted in excluding areas of high poverty from the "community" used for purposes of conducting a CHNA. *Id.* at 50–52. Areas of high poverty have a proven correlation with greater health disparities and disease burden. Gloria L. Beckles & Benedict I. Truman, *Education and Income—United States, 2009 and 2011,* 62 CTRS. FOR DISEASE CONTROL AND PREVENTION MORBIDITY AND MORTALITY WKLY. REP. (SUPPLEMENT 3) 9, 9 (2013). Thus, excluding these areas may result in a CHNA reflecting an inaccurate assessment of the community's health needs.

[110] I.R.C. § 501(r)(3)(B)(i) (2012).

[111] *Id.* The other requirement is that the CHNA must be "made widely available to the public." I.R.C. § 501(r)(3)(B)(ii).

[112] I.R.C. § 501(r)(3)(A)(i).

[113] Congress gave regulatory authority to the Secretary to issue regulations and guidance for all other provisions of subsection § 501(r). *See* I.R.C. § 501(r)(7). Secretary is defined in I.R.C. § 7701(a)(11)(B) (2012) as "the Secretary of the Treasury or his delegate."

[114] Treas. Reg. § 1.501(r)-3(b)(5)(i) (2015). Beyond the minimum three required, the IRS provides a suggested list of sources from which input may be taken

sionals and patient-advocacy groups welcomed such broad representation as an opportunity for greater collaboration among groups in the sector.[115]

The first source is a public health department or equivalent (from a state, local, tribal, or regional government) that has knowledge, information, or expertise relevant to the health needs of the community.[116] This satisfies an explicit requirement by Congress to include persons "with special knowledge of or expertise in public health,"[117] and hopefully ensures identification of all significant health needs during the assessment even if not ultimately targeted for intervention.[118]

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into account in Treas. Reg. § 1.501(r)-3(b)(5)(ii), including healthcare consumer advocates, academic experts and health insurance organizations, to name a few.

[115] *See, e.g.*, COREY DAVIS, THE NETWORK FOR PUB. HEALTH LAW, NEW REQUIREMENTS FOR NONPROFIT HOSPITALS PROVIDE OPPORTUNITIES FOR HEALTH DEPARTMENT COLLABORATION, 4 (2011), https://www.networkforphl.org/_asset/fqmqxr/CHNAFINAL.pdf (stating that "[m]any agencies and organizations endorse such collaboration" including the American Hospital Association and the Association of State and Territorial Health Officers); Letter from Robert M. Pestronk, Exec. Dir., Nat'l Ass'n of County and City Health Officials, to the I.R.S. 5 (June 28, 2013), https://www.regulations.gov/contentStreamer?documentId=IRS-2013-0016-0016&attachmentNumber=1&disposition=attachment&contentType=pdf ("[T]he CHNA requirements have great potential to promote new, mutually beneficial collaborations between non-profit hospitals and local health departments to improve the health of the communities each serves."); *see also* CLINICAL & TRANSLATIONAL SCI. AWARDS CMTY. ENGAGEMENT KEY FUNCTION COMM. TASK FORCE, NIH PUBLICATION NO. 11-7782, PRINCIPLES OF COMMUNITY ENGAGEMENT, 50 (Mina Silberberg et al. eds., 2d ed. 2011), http://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf (citing the fifth principle as "[p]artnering with the community is necessary to create change and improve health"); Trevor Hancock & Meredith Minkler, *Community Health Assessment or Healthy Community Assessment*, *in* COMMUNITY ORGANIZING AND COMMUNITY BUILDING FOR HEALTH AND WELFARE 153, 153 (Meredith Minkler ed., 3d ed. 2012) ("[T]o be truly empowering and health promoting, assessment should be of the community, *by the community,* and for the community.") (emphasis added).

[116] Treas. Reg. § 1.501(r)-3(b)(5)(i)(A).

[117] I.R.C. § 501(r)(3)(B)(i). Earlier Notice 2011-52 separated persons with specific public health knowledge and local health departments or agencies into two groups. I.R.S. Notice 2011-52, 2011-30 I.R.B. 60, 63. The IRS consolidated the two in the 2013 proposed regulations, subsequently adopted in the final regulations, by requiring input to come from a health department specifically, stating "[b]ecause a governmental public health department presumably has special knowledge of or expertise in public health, requiring input from a public health department eliminates the need for a separate requirement to consult with a person with special knowledge of or expertise in public health . . . ." Prop. Treas. Reg. § 1.501(r), 78 Fed. Reg. at 20,530.

[118] A significant need must be reported in the implementation strategy even if not targeted by a hospital for intervention. Treas. Reg. § 1.501(r)-3(c)(1). If, hypothetically, a hospital was not required to seek input from a public health department or those with special expertise during the assessment, it is possible for that hospital to fail to discover (or intentionally ignore) a health need that exists in the community. Thus, the need would be absent from the CHNA and

The second source is medically underserved, low-income, and minority populations in the facility's community[119]—emphasizing involvement of a broad class. These populations may be represented directly by members or indirectly through individuals or organizations serving or representing the interests of such populations.[120] No specific method is prescribed, although the IRS offers "meetings, focus groups, interviews, surveys, or written comments" as examples.[121]

Finally, as the third source, a facility must incorporate written comments received in relation to the hospital's most recently conducted CHNA and most recently adopted implementation strategy.[122] Many commentators suggested a requirement to circulate the CHNA for comments from the public before final adoption.[123] However, because of the anticipated complexity caused by the additional timeframes and procedures required,[124] the final regulations did not contain a public feedback requirement.

Although the three types of sources seem to be comprehensive at first glance, there is still ample room for discretion by a hospital. Two concerns arise: (1) input is not required to be *collected*, but merely to be "solicited," and (2) no standard exists by which input must be incorporated into the CHNA or implementation strategy.

The first concern, that the final regulations require only that input be "solicited," was the result of a response to specific comments foreseeing a situation where a hospital is unable to collect input from one or more of the required three sources.[125] If a hospital is unable to collect input from a required source the hospital need only explain its effort to do so in the hospital's CHNA report.[126] Further, there is no requirement that hospitals use best efforts to obtain input. With no measurable standard of effort established, a hospital might do nothing more than post a voluntary survey on its website.[127] Permitting hospitals to choose the manner of

implementation strategy, and the hospital could evade accountability to serve the need.

[119] Treas. Reg. § 1.501(r)-3(b)(5)(i)(B).

[120] *Id*; *see also* Prop. Treas. Reg. § 1.501(r), 78 Fed. Reg. at 20,530 (explaining the distinction).

[121] Treas. Reg. § 1.501(r)-3(b)(6)(iii).

[122] Treas. Reg. § 1.501(r)-3(b)(5)(i)(C). Of course, input from this category is only applicable beginning with a hospital's second CHNA, likely conducted in 2015 or 2016.

[123] *See, e.g.*, Letter from Georges C. Benjamin, *supra* note 104, at 5 ("APHA disagrees with the decision [in the proposed rule] not to require hospitals to make a draft copy of a CHNA report available for public comment. . . .").

[124] T.D. 9708, 2015-5 I.R.B. 349.

[125] Treas. Reg. § 1.501(r)-3(b)(5)(i) ("must *solicit* and take into account input *received*") (emphasis added); *see also* T.D. 9708, 2015-5 I.R.B. 348.

[126] Treas. Reg. § 1.501(r)-3(b)(6)(iii); *see also* T.D. 9708, 2015-5 I.R.B. 348.

[127] Only a small portion of patients and community members are likely to find

solicitation allows them to satisfy the requirement even if solicitation fails to provide anything of substance.

The second concern is that the regulations establish no standard for incorporating input into the CHNA. The regulations consider obligations met if the CHNA report "summarizes, in general terms, any input provided . . . and how and over what time period such input was provided."[128] Some commentators suggested a requirement for hospitals to use highly collaborative models, such as advisory groups or community advisory boards.[129] Unfortunately, the IRS did not adopt these suggestions.

The PHI report questioned whether the opportunities for input during the CHNA process were "meaningful."[130] The report suggested community members had limited opportunities to provide input, expressing fear that when opportunities did exist they could be "a function of fulfilling legal requirements, rather than to inform the process."[131] Public health groups have echoed this concern.[132] Although the Treasury Department and the IRS stated a belief that incorporating community input can "increase the likelihood of well-targeted initiatives,"[133] it remains to be seen whether hospitals will leverage this input in the creation of effective strategies that ultimately improve community health outcomes while meeting their community benefit requirement. A cynical view, by contrast, predicts hospitals will place their own interests ahead of the community's interests.

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and complete a survey posted in this fashion. Such strategy may prove particularly useless to reach underserved, low-income and minority populations. Household income is one of the strongest negative predictors for internet usage. Kathryn Zickuhr & Aaron Smith, PEW RESEARCH CTR'S INTERNET & AM. LIFE PROJECT, DIGITAL DIFFERENCES 5–6 (2012), http://www.pewinternet.org/files/old-media//Files/Reports/2012/PIP_Digital_differences_041312.pdf. Although the gap in internet usage between whites and minorities is closing, race and ethnicity remain factors associated with lower internet usage. *Id.*

[128] Treas. Reg. § 1.501(r)-3(b)(6)(iii).

[129] *See, e.g.*, Letter from Paul Jarris, Exec. Dir., Ass'n of State & Territorial Health Officials, to the I.R.S. 2 (July 5, 2013), https://www.regulations.gov/contentStreamer?documentId=IRS-2013-0016-0073&attachmentNumber=1&disposition=attachment&contentType=pdf (community advisory board); Letter from Robert M. Pestronk, *supra* note 115, at 2; *see also infra* Part IV.B. (referencing the proposals from Professors Nina Crimm and Jessica Berg).

[130] BARNETT, *supra* note 106, at 77.

[131] *Id.*

[132] ASS'N OF STATE & TERRITORIAL HEALTH OFFICIALS, SUCCESSES AND CHALLENGES IN COMMUNITY HEALTH IMPROVEMENT: STORIES FROM EARLY COLLABORATIONS (2014), http://www.astho.org/Successes-and-Challenges-in-Community-Health-Improvement-Issue-Brief/ ("There is also a concern that hospital[s] may steer CHNAs . . . to prioritize preferred programs and interventions.").

[133] Prop. Treas. Reg. § 1.501(r), 78 Fed. Reg. at 20,531.

D. A Community Benefit Without Ongoing Community Input?

Quality assurance and overall enforcement of the CHNA and implementation strategy lacks the strength necessary to create the change Congress sought to effect. "The Treasury Department and the IRS recognize that conducting a CHNA and developing an implementation strategy are part of one fluid process, with no definite point at which the CHNA ends and the implementation strategy begins."[134] Consistent with this statement in the 2013 proposed regulations, the final regulations establish an integrated cycle between the CHNA and the implementation strategy. Currently, the IRS is empowered to issue sanctions prior to revoking exempt status;[135] however, the regulations lack standards for enforcing content validity and conformity to a structured scope.

Two primary areas highlight this conundrum. First, hospitals retain unilateral discretion to determine "prioritization" given to the implementation strategy,[136] thus resulting in a minimal level of engagement or general outreach to the public within the hospitals' respective communities. Second, the hospitals' unilateral discretion compounds issues stemming from negligible levels of transparency in the CHNA development process.

1. Implementation and Prioritization: Where Is the Community Involvement?

First and foremost, the general intent of the CHNA is to strengthen the community benefit standard to which nonprofit hospitals must adhere.[137] Therefore, prioritization and implementation of the CHNA must unquestionably adhere to the needs of the community. The implementation strategy contains the specific actions the hospital will (or will not) take in response to the findings in the CHNA and must be filed with the hospital's annual tax returns.[138] A CHNA will produce a prioritized list of health needs identified in the community. The hospital further divides

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[134] Prop. Treas. Reg. § 1.501(r), 78 Fed. Reg. at 20,532.

[135] *See* Treas. Reg. § 53.4959-1 (2015) (allowing the imposition of a $50,000 excise tax on hospitals that fail to meet CHNA requirements).

[136] *See* Treas. Reg. § 1.501(r)-3(b)(4) (2015).

[137] *Cf.* Terry L. Corbett, *Healthcare Corporate Structure and the ACA: A Need for Mission Primacy Through a New Organizational Paradigm?*, 12 IND. HEALTH L. REV. 103, 155–56, 156 n.278 (2015) (crediting criticisms of nonprofit hospitals as one factor leading to the adoption of 501(r) and excise tax provisions); Mark T. Morrell & Alex T. Krouse, *Accountability Partners: Legislated Collaboration for Health Reform*, 11 IND. HEALTH L. REV. 225, 267 (2014) ("In response to years of questioning whether hospitals deserve their tax-exempt status, the [ACA] requires tax-exempt hospitals to demonstrate on an ongoing basis that they are in fact providing community benefits."); Somerville et al., *supra* note 77, at 57 ("The [CHNA] requirements are intended to ensure tax-exempt hospitals' responsiveness to their communities' priority health needs.").

[138] I.R.C. § 6033(b)(15)(A) (2012); Treas. Reg. § 1.6033-2(a)(2)(ii)(l)(2) (2015).

this list into two categories to address in the implementation strategy: (1) the needs which it intends to address and why, and (2) the needs that will not be addressed and why not.[139]

The final regulations presently permit a hospital to "use any criteria to prioritize the significant health needs it identifies . . . ."[140] This likely places full authority for prioritization of health needs and the carrying out of objectives through an implementation strategy with the hospital's board of directors—the "authorized body" for the facility.[141] By internalizing these procedures, hospitals are diminishing the "public" focus and reach of the CHNA, critical for elevating the community benefit standard.[142]

With respect to the needs to be addressed, a hospital must go beyond basic itemization of its planned actions. The strategy must include an explanation of the anticipated impact of each action,[143] an identification of the resources that will be committed,[144] and a description of any planned collaboration between a hospital facility and other facilities towards addressing the needs.[145] The documentation is much less robust with respect to the needs that a hospital does not plan to address. A hospital need only provide "a brief explanation" of the reason the need will not be addressed.[146] The IRS seems unconcerned with the reasons provided, going so far as to include "resource constraints" and "lack of expertise or competency" as suggestions.[147] Not only does a hospital have nearly free reign to identify health needs, it also retains full authority to prioritize those needs once identified. In addition, a hospital may use any criteria it desires to perform the prioritization.[148] Despite many commentators ad-

[139] Treas. Reg. § 1.501(r)-3(c)(1).

[140] Treas. Reg. § 1.501(r)-3(b)(4).

[141] Treas. Reg. § 1.501(r)-3(c)(5).

[142] *See* SARA ROSENBAUM, GEO. WASH. SCH. OF PUB. HEALTH AND HEALTH SERVS., PRINCIPLES TO CONSIDER FOR THE IMPLEMENTATION OF A COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS, 6 (June 2013), http://nnphi.org/CMSuploads/PrinciplesToConsiderForTheImplementationOfACHNAProcess_GWU_20130604.pdf (stating the importance of transparency in the decision making process: "Transparency helps foster better input and decision making, more accountability, and shared responsibility for outcomes. Greater transparency in identifying and investing in community health needs fosters community trust and understanding. . . . Broad awareness encourages all involved to make the choices that will be most likely to be successful.").

[143] Treas. Reg. § 1.501(r)-3(c)(2)(i).

[144] Treas. Reg. § 1.501(r)-3(c)(2)(ii).

[145] Treas. Reg. § 1.501(r)-3(c)(2)(iii).

[146] Treas. Reg. § 1.501(r)-3(c)(3).

[147] *Id.*

[148] Treas. Reg. § 1.501(r)-3(b)(4). The IRS also provides a non-exclusive list of common-sense dimensions such as severity or urgency of the health need, among others. *Id.* In the preamble to the final regulations, the IRS responded to comments

vocating that a hospital address all needs identified in the CHNA,[149] a hospital is only required to prioritize, and only faces further obligations for, those deemed "significant."[150] Once again, hospitals retain full authority during this decision-making process and "may determine whether a health need is significant based on all of the facts and circumstances present in the community it serves."[151]

2. Where Is the Engagement and Awareness?

A valuable part of the CHNA and accompanying implementation strategy lies with the integration of public input and an increase in transparency that mandatory publication creates. The general public and interested parties are invited to review and comment at various stages of the cycle.[152] The necessity to involve parties external to hospital employees is vital; it comprises the only encoded requirements, other than timing, that address the manner in which the CHNA is performed.[153] Apart from input specifically solicited during the CHNA,[154] hospitals must still accept input after the report is complete by virtue of two requirements: (1) hospitals must make the report widely available to the public,[155] and (2) subsequent CHNA reports must incorporate written comments submitted about the report.[156]

To address the first requirement, in the 2013 proposed regulations the IRS adopted "most of the comments seeking to enhance transparency

calling for a requirement that specific criteria be used by stating, "[T]o ensure transparency with respect to a hospital facility's prioritization, the final regulations, like the 2013 proposed regulations, require a hospital facility's CHNA report to describe the process and criteria used in prioritizing the significant health needs identified." T.D. 9708, 2015-5 I.R.B. 347.

[149] AM. PUB. HEALTH ASS'N ET AL., *supra* note 104, at 14. ("Recommendation 7: Implementation strategies should address all the needs identified through the CHNA[.]").

[150] Treas. Reg. § 1.501(r)-3(b)(4). See also discussion in T.D. 9708, 2015-5 I.R.B. 347 ("The Treasury Department and the IRS note that the list of possible health needs in the final regulations is only a list of examples, and a hospital facility is not required to identify all such types of health needs in its CHNA report if all such types are not determined by the hospital facility to be significant health needs in its community.").

[151] Treas. Reg. § 1.501(r)-3(b)(4).

[152] *See* T.D. 9708, 2015-5 I.R.B. 349–50.

[153] I.R.C. § 501(r)(3)(B) (2012) (CHNA must take into account input from persons who represent broad interests of the community and must make the report widely available to the public). Congress gave regulatory authority to the Secretary to issue regulations and guidance for all other provisions of subsection § 501(r). *See* I.R.C. § 501(r)(7). Secretary is defined in I.R.C. § 7701(a)(11)(B) as the Secretary of the Treasury or his delegate.

[154] *See supra* Part III.C.

[155] I.R.C. § 501(r)(B)(ii).

[156] Treas. Reg. § 1.501(r)-3(b)(5)(i)(C).

of a hospital facility's CHNA by expanding the requirements to make the CHNA report widely available to the public."[157] The final regulations sustained the focus on transparency through the addition of an extensive description of procedures for making the report widely available. The report must be made available for download on a website and for physical inspection without charge.[158] Copies of the report must be available until the hospital issues two subsequent reports.[159]

However, structure for the second requirement is lacking. The IRS did not adopt comments calling for a requirement to collect public input on draft versions of the CHNA before finalization "due to the complexity of the additional timeframes and procedures such a process would require."[160] As a result, nearly three years could pass before a hospital is required to incorporate comments collected, when a subsequent CHNA is issued. Additionally, no specific method for collection of these written comments is required, giving hospital facilities the "flexibility to set up a collection and tracking system that works with their internal systems and makes the most sense for their particular community."[161]

Moreover, although hospitals are required to provide substantive information in support of their CHNA reports, a lack of procedural conformity has strained the scope of public knowledge and awareness. There is no broad instruction governing the procedural protocol. Rather, § 501(r)(3)(A) merely instructs that the report be made available to the public, including conspicuous display on the hospital website. However, if the members of the community were not engaged in the process of creating the content for the CHNA, it is highly unlikely that they would be aware of the presence of the CHNA on the website for their viewing. Thus, not surprisingly, a 2014 analysis of CHNAs found "[i]n general, engagement of community stakeholders dropped off dramatically among hospitals in the . . . subsequent priority-setting processes, program planning, and program implementation processes."[162] The requirement for

[157] Prop. Treas. Reg. § 1.501(r), 78 Fed. Reg. at 20,533.

[158] Treas. Reg. §§ 1.501(r)-3(b)(7)(i), -1(b)(29).

[159] Treas. Reg. § 1.501(r)-3(b)(7)(i).

[160] T.D. 9708, 2015-5 I.R.B. 349.

[161] T.D. 9708, 2015-5 I.R.B. 350.

[162] BARNETT, *supra* note 106, at 56. One hospital surveyed expressed the solely internal method of the administration in devising a plan:

> The implementation planning process began with the Chief Executive officer. The Chief Executive officer first reviewed identified issues and opportunities discovered in the CHSD report. The CEO then determined which issues or opportunities could be addressed considering [X] hospital's parameters of resources and limitations. . . . The administrator declared four issues or opportunities could be addressed through the implementation planning process considering said parameters. Then, the hospital's leadership team worked together to prioritize these four issues and opportunities using the additional parameters of: organizational vision, mission, values, relevant mandates, and community partners.

the hospital to make the report available does not effectively enhance public awareness and involvement. Rather, the most important community stakeholder—the public, with needs to be addressed—is sidelined in the process of developing the CHNA. Members of the public become mere spectators who can vocally express valuable input, but are not necessarily permitted to be in the game with the "authorized body" of the hospital. And that is if they even know that the game is being played. Of equal concern is the public's overall lack of awareness of the opportunity to play an active role in defining the community's needs.

E. Too Many Questions, Too Much Discretion

Although the CHNA obligations attempt to add structure to the historically nebulous requirements for tax-exempt status, they permit hospitals too much discretion to be a sufficient solution. This Part has discussed the possibility of inconsistent operation of § 501(r)(3) on hospital entities caused by aggregation and collaboration during the CHNA process. It explored loopholes created in the identification of the hospital's community and the manner in which input is gathered from stakeholders. Finally, it highlighted the absence of ongoing community input. These problems may ultimately cause the efforts of § 501(r)(3) to fail to make meaningful progress towards strengthening the community benefit standard. Yet, as the adage goes: A pessimist sees the difficulty in every opportunity; an optimist sees the opportunity in every difficulty.[163] The remainder of this Paper unearths the secondary benefits from the regulations, which harbor the potential to inspire meaningful change.

IV. CULTIVATING THE BENEFIT OF § 501(r)(3)

In light of the problems with the statutory and regulatory structure, the most beneficial effects of § 501(r)(3) are secondary in nature. This Part explores the secondary effects that flow from the CHNA requirements. We recognize enhanced opportunities for data collaboration among advocates and experts with the potential to improve the health of a community. We also see the potential for strengthened public influence on hospitals, made possible by greater transparency of health information and each hospital's intended activities to provide for its community. The transparency allows for sustained scrutiny made possible by effective media advocacy. In the aggregate, these effects have the potential to inspire meaningful change in the community benefit standard and ensure nonprofit hospitals are meeting their duty to provide for their communities.

Id. at 56 (alteration in original).

[163] Falsely attributed to Winston Churchill. CHURCHILL BY HIMSELF: THE DEFINITIVE COLLECTION OF QUOTATIONS 578 (Richard M. Langworth ed., 2008).

A. Opportunities for Data Collaboration

Involving a collaborative partner that has the familiarity and resources necessary to provide data to describe a thorough and targeted community class will elevate the value of the CHNAs in an effort to improve the community benefit standard. "Few, if any of the stakeholder institutions engaged in community health improvement processes possess the resources and breadth of expertise to serve as the convener, facilitator, manager, and monitoring entity for a collaborative community health improvement process."[164] Therefore, the collaboration on, and not just outsourcing of, data collection promotes efficiency of resources and accuracy for attaining community objectives.

Hospitals are not restricted from coordinating with third parties during the CHNA and are in fact required to solicit input from persons representing a broad interest, a crucial requirement given the subjective nature of a hospital's ability to define its community.[165] This promotes reliance on data that is based on input supported by qualitative research, as opposed to the hospital's individual perception of the facts and circumstances. However, despite the requirement for hospitals to "solicit" information from what is essentially a third party,[166] there is no requirement that the data actually be collected and synthesized in a manner addressing the community's true needs. Thus, the hospital's incorporation of public partners—whose focus is on collection of data and not merely its solicitation—provides an invaluable amount of knowledge likely to represent the true needs of the community.

With evolving collaborative efforts, an opportunity exists for advocacy groups to provide proficient tools and resources useful in influencing the process hospitals use to define their communities' needs. We identify three ways these groups benefit the CHNA process. First, they act as an independent body representing a broad scope of the community and its needs. Second, these advocacy groups are commonly grounded in public health disciplines, and therefore provide meaningful understanding of the concerns at hand. Third, they provide an accountability mechanism on data interpretation. The concern is that although a hospital is prohibited from defining its community in a self-serving manner it may still define its community in ways that will be deemed most beneficial to itself—possibly due to a lack of time and internal resources.

By way of example, three available resources are the Community Commons,[167] the Association for Community Health Improvement ("ACHI") Assessment Toolkit,[168] and the National Center for Rural

[164] BARNETT, *supra* note 106, at 87e.

[165] *See supra* Part III.B.

[166] *See supra* Part III.C.

[167] COMMUNITY COMMONS, http://www.communitycommons.org.

[168] ACHI CMTY. HEALTH ASSESSMENT TOOLKIT, http://www.assesstoolkit.org.

Health Works.[169] These third-party advocacy groups represent a broad cross-section of the various communities in which a hospital may reside, and their intended purpose is to leverage the gathering of qualitative data into meaningful findings for hospitals to report on their CHNAs. An overview of each showcases the collaborative benefits provided as a means for improving data transparency and the overall enhancement of the CHNA—with the intended purpose of elevating the community benefit standard.

The Community Commons is an interactive website providing tools and data for mapping and understanding identified communities.[170] It offers a "maps and data" section for hospitals and the greater communities, allowing hospitals to carry out a systematic approach to defining their communities and grounding their implementation strategies on true community needs via various report options.[171] The site also provides specialized channels for intensive review of a community's economy, education, environment, equity, food, and health.[172] Specifically, the Community Commons provides a direct means to run a CHNA report on health disparities, including metrics that identify a community's vulnerable populations based on poverty rate and educational attainment indicators.[173] Overall, the tool is intended to "assist hospitals and organizations seeking to better understand the needs and assets of their communities as well as collaborate to make measurable improvements in community health . . . ."[174] Purely from a data-sharing perspective, the customized dataset and visualization charts significantly reduce any justification for a claim of insufficient resources during the CHNA drafting and reporting processes.

The ACHI Assessment Toolkit provides hospitals with a "suggested assessment framework" based on six "core process steps" aimed at "prioritizing a community's health needs, accomplished through the collection and analysis of data, including input from community stakeholders."[175] The six steps include identification of team and resources, purpose and scope, collection and analyzing of data, prioritizing, effectively documenting and communicating results, and monitoring the progression of

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[169] NAT'L CTR. FOR RURAL HEALTH WORKS, http://ruralhealthworks.org.

[170] *About*, COMMUNITY COMMONS, http://www.communitycommons.org/about/.

[171] *Maps & Data*, COMMUNITY COMMONS, http://www.communitycommons.org/maps-data/.

[172] *Id.*

[173] *Community Health Needs Assessment*, COMMUNITY COMMONS, http://www.communitycommons.org/chna/ ("Our Vulnerable Population Footprint tool allows you to locate areas of concern for vulnerable populations and health disparities in your community based on spatial visualization of two key indicators, poverty rate and educational attainment.").

[174] *Id.*

[175] ACHI CMTY. HEALTH ASSESSMENT TOOLKIT, *supra* note 168.

efforts.[176] Emphasis on engaging with community stakeholders and the outlined core processes assists a hospital with ensuring that their approach to gathering data in support of their CHNA will have a direct correlation to the true needs of the community.

For a location-centralized approach, the National Center for Rural Health Works has revamped their original assessment tool, the Community Health Engagement Process, and tailored it to conform to the CHNA requirements.[177] "The CHNA toolkit will enable hospitals to conduct the process themselves or allow other organizations to facilitate the process for the hospitals."[178] The focus of the process is on three community meetings and, predominantly, "[t]he purpose of this toolkit is to provide a relatively quick, non-intensive process to complete the requirement for rural hospitals."[179]

The advantage of these various supporting organizations is to ensure that the CHNA is performed not only properly, but also in an effective and efficient manner that correctly identifies the needs of the community. "If aligned with other community-level data projects, CHNAs could coordinate investments from other key sources of community improvement, such as funds from Community Reinvestment Act-motivated banks, community foundations, socially motivated investors, and local governments."[180] For example, the Milken Institute School of Public Health at George Washington University received funding from the Robert Wood Johnson Foundation to provide a database collecting Form 990s electronically to promote the "linking [of] community benefit dollars to community health improvement."[181] Collaborative efforts such as this can effectively streamline the CHNA process, with the promising outcome of elevating the community benefits standard.

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[176] *Id.*

[177] *Community Health Needs Assessment – Tools & Templates*, NAT'L CTR. FOR RURAL HEALTH WORKS, http://ruralhealthworks.org/chn/.

[178] *Id.*

[179] *Community Health Needs Assessment Toolkit, Executive Overview*, NAT'L CTR. FOR RURAL HEALTH WORKS, http://ruralhealthworks.org/wp-content/files/1-CHNA-Toolkit-EXECUTIVE-OVERVIEW-May-2012.pdf ("The toolkit is designed for state level professionals such as state offices of rural health, state hospital associations, state cooperative extension agencies, health departments, or consultants to facilitate the process in rural hospitals at no or low cost to the hospitals.").

[180] Erik Bakken & David Kindig, *Can Data From Nonprofit Hospital Tax Returns Improve Community Health?*, *in* WHAT COUNTS: HARNESSING DATA FOR AMERICA'S COMMUNITIES, 168, 168 (Fed. Reserve Bank of S.F. & Urban Inst. eds., 2014), http://www.whatcountsforamerica.org/wp-content/uploads/2014/11/Bakken.Kindig.pdf.

[181] *Id.* at 173; *see also Grants: Developing the Prototype for a Web-based Tool to Make Public How Nonprofit Hospitals' Community-benefit Investments Impact Communities' Health Needs*, ROBERT WOOD JOHNSON FOUND., http://www.rwjf.org/en/library/grants/2013/10/developing-the-prototype-for-a-web-based-tool-to-make-public-how.html.

B. Strengthen Influence on Hospitals

Data-centric collaboration becomes an iterative process. The community is empowered through continually building data available to apply increasing influence on hospitals to meet the community's needs. The obligation of hospitals to involve the community in the process every three years, and take its input into account, has the effect of progressively strengthening influence during each subsequent round of CHNA reports.

The evolution of data-centric resources reflects a greater need for community involvement that has been desired for some time. Prior to the passage of the ACA, two commentators proposed introduction of a community-based oversight entity as one remedy for the IRS's lax community benefit standard.[182] In her 1995 article, Professor Nina Crimm suggested creating a community-based certification panel that would determine whether hospital tax exemption was appropriate based on an evaluation of hospital activities.[183] Crimm's proposal would abolish the current federal tax regime, which allows hospitals to qualify for tax-exempt status based on a form filing.[184] Instead, hospitals only earn tax deductions or credits after the panel concludes that the hospital's activities are "worth[y]" of being deemed a "charitable activity expense."[185] The panel determines worthiness by evaluating the activity in comparison to a community/regional medical plan previously developed by the panel that identifies the medical needs of a locale.[186] The use of panels to create this plan ensures that a hospital receives tax credits for the provision of services that address the actual needs identified in the community as opposed to activities the hospital selects in its sole discretion.

Similarly, in 2010 Professor Jessica Berg proposed the creation of a community benefit board (CBB) to evaluate and recommend appropriate efforts under the community benefit requirement.[187] Berg's proposal

[182] *See generally* Berg, *supra* note 34; Nina J. Crimm, *Evolutionary Forces: Changes in For-Profit and Not-for-Profit Health Care Delivery Structures; A Regeneration of Tax Exemption Standards*, 37 B.C. L. REV. 1 (1995). *But cf.* Kane, *supra* note 30, at 472 (proposing an internal "'tax-exempt compliance' committee" operated under the hospital board's control to increase compliance with the community benefit standard).

[183] Crimm, *supra* note 182, at 106–09.

[184] *Id.* at 103–04, 103 n.470.

[185] *Id.* at 104, 107.

[186] *Id.* at 104–107. Each item in the community/regional medical plan is first assigned a "weight range" by the panel to guide allocation when assessing the hospital's activities. *Id.* at 107–09. Each activity receives a point allocation within these ranges. Allocations are subsequently converted to a percentage used to calculate the resulting tax deduction or credit for the hospital. *Id.* Crimm's certification panels would also issue publically available report cards based on hospital's ratings, adding incentive to provide services which match community needs. *Id.* at 109.

[187] Berg, *supra* note 34, at 407–12.

stops short of authorizing the CBB to determine a hospital's tax exemption, however, preserving the existing authority of the IRS and local tax authorities. Instead, she emphasizes the CBB's role of offering expert guidance on the hierarchy of needs that exist in a community and whether the hospital is complying with the community benefit requirement in light of these needs.[188] By using a community-based entity, Berg suggests the services offered—the community benefits—will place greater emphasis on population health over individual charity care,[189] thus improving the effectiveness of the community benefit standard.

Yet both of these proposals contain inherent complications. Although the IRS and local governments retain the ability to make the final tax-exempt status determination, Berg's proposal nonetheless requires some manner of quantifying the benefits delivered by a hospital to be used as the basis for the CBB's recommendation. How to quantify community benefit has been hotly debated among both the academic community and the hospital industry with little consensus reached.[190] Crimm's proposal fares no better. In addition to quantification, her proposal requires creation of an entirely different federal tax regime, one that subjects hospitals to a process unlike that faced by other nonprofits. Even with the overhaul, the new system would be "extremely complex" and its flexibility "severely limited by the multiple layers of bureaucracy necessary to administer it."[191]

The CHNA requirements do not create a review panel of the type envisioned by Professors Crimm and Berg. Yet, they do create a *figurative* community review panel by virtue of the inclusion of community representatives during the assessment phase and by the requirement that the hospital incorporate feedback from the public in subsequent CHNAs. The new model avoids creation of a complex and unwieldy system of ac-

[188] *Id.*

[189] *Id.* at 412.

[190] CONG. BUDGET OFFICE, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS 7 (2006) ("there is little consensus on what constitutes a community benefit or how to measure community benefits"); U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-08-880, NONPROFIT HOSPITALS: VARIATION IN STANDARDS AND GUIDANCE LIMITS COMPARISON OF HOW HOSPITALS MEET COMMUNITY BENEFIT REQUIREMENTS 7 (2008) ("consensus does not exist to define bad debt and the unreimbursed cost of Medicare as community benefit"); Courtney, *supra* note 87, at 382–89 (discussing difference in perspectives from the Centers for Medicare & Medicaid Services, The American Hospital Association, the Catholic Health Association, VHA Inc., and the Healthcare Financial Management Association); *see, e.g.*, Berg, *supra* note 34, at 387–395 (expressing concerns that individual charity care is measured to a greater extent than population healthcare); Rubin et al., *supra* note 30, at 612 (calling for less focus on monetary inputs).

[191] John D. Colombo, *The Failure of Community Benefit*, 15 HEALTH MATRIX 29, 61 (2005). Crimm herself concedes her proposed system is complex and could present "numerous administrative challenges." Crimm, *supra* note 182, at 110.

tual community panels, while retaining the potential to achieve the same goals of greater oversight and accountability within the existing tax regime. The CHNA requirements do this by increasing transparency. The requirement to make CHNAs widely available allows the public to learn about needs identified specifically in their community from a credible source.[192] The requirement to submit an implementation plan with annual tax filings allows the public to learn what the hospital intends to do to address these needs. In the past, this information was known only to the hospital. Making this information available will strengthen the public's ability to influence the hospital's plans. It thereby becomes more difficult for a hospital to deviate from these needs to serve its own interests. "[N]onprofit hospitals are sensitive to public criticism and keenly aware of the value of maintaining a positive public image . . . ."[193] Community representatives can help identify a mismatch between what the data shows is needed and what the hospital has done. They may provide greater influence towards improving a hospital's conduct than any formal authority vested in an organized community board.

C. Using Media Advocacy

This new transparency from CHNAs allows the public greater opportunity to act efficiently by launching well-informed media campaigns. Advocacy groups can harness the power of the media to apply pressure for policy change.[194] "Media advocacy can be a significant force for influencing public debate and putting pressure on policymakers by increasing the volume of the public health voice and, in turn, by increasing the visibility of values, people, and issues behind the voice."[195] Effective media advocacy is strategic. A campaign's effectiveness links integrally to the advocate's ability to articulate the right message, spread by the right source, and received by the right recipient.[196] This requires identifying the party or parties the group is attempting to influence—the "target" or "target system"—and using a point of leverage to enact influence—a "handle."[197] A

[192] Despite previously discussed shortcomings in the collection of input (*see supra* Part III.C) the requirement to solicit input from health departments and other community representatives will likely result in at least *some* involvement in this process, lending some level of credibility to the list created.

[193] Hanson, *supra* note 34, at 405.

[194] Lori Dorfman & Priscilla Gonzalez, *Media Advocacy: A Strategy for Helping Communities Change Policy*, *in* COMMUNITY ORGANIZING AND COMMUNITY BUILDING FOR HEALTH AND WELFARE 407, 407 (Meredith Minkler ed., 3d ed. 2012); LAWRENCE WALLACK, LORI DORFMAN, DAVID JERNIGAN & MAKANI THEMBA, MEDIA ADVOCACY AND PUBLIC HEALTH: POWER FOR PREVENTION 25 (1993).

[195] WALLACK ET AL., *supra* note 194, at 2.

[196] Dorfman & Gonzalez, *supra* note 194, at 407–08 (providing an overview of media advocacy and strategy).

[197] LEE STAPLES, ROOTS TO POWER: A MANUAL FOR GRASSROOTS ORGANIZING 116–

handle might be concrete: a current situation, a recent incident, or a regulatory process.[198] But a handle might also refer to a broad current precedent or contradiction that demands change.[199] Regardless of its nature, a handle provides a means for change efforts to overcome resistance or inertia and achieve real accomplishments.[200] Numerous examples of successful media advocacy exist in the larger context of public health.[201] Yet, advocates have also engaged in media advocacy specifically to reform the community benefit standard for hospitals.

A flurry of class-action lawsuits against nonprofit hospitals filed in the early 2000's highlighted the failure of specific hospitals to meet the community benefit standard by providing inadequate care for the uninsured.[202] Though most judicial decisions were unfavorable to the plaintiffs,[203] we argue that the actions resulted in favorable outcomes following the successful deployment of media advocacy. Articles published in major newspapers generated public outrage over hospital practices and even inspired a report on the television newsmagazine 60 Minutes.[204] By using

27 (2d ed. 2004).

[198] *Id.* at 123–27.

[199] *Id.* at 122–23.

[200] *Id.* at 120.

[201] For advocacy efforts which resulted in changes made by corporate parties see, e.g., Dorfman & Gonzalez, *supra* note 194, at 411–12 (a social media campaign to persuade the American Academy of Family Physicians to abandon a partnership with Coca-Cola); WALLACK ET AL., *supra* note 194, at 30–31 (a celebrity-endorsed boycott of Nestlé products convincing the corporation to adopt the World Health Organization's Code of Marketing Breast Milk Substitutes). Many examples of broader systemic healthcare change supported by media advocacy exist. *See, e.g.*, Jacquie Anderson, Michael Miller & Andrew McGuire, *Organizing for Health Care Reform: National and State-Level Efforts and Perspectives*, *in* COMMUNITY ORGANIZING AND COMMUNITY BUILDING FOR HEALTH AND WELFARE 386, 390–93 (Meredith Minkler ed., 3d ed. 2012) (describing a variety of media advocacy strategies used to support federal and state healthcare reform during the late 1990s and early 2000s).

[202] The bulk of this litigation was led by prominent class-action litigator Richard Scruggs, of tobacco class-action fame. Hanson, *supra* note 34, at 401; Kane, *supra* note 30, at 459; Studdert et al., *supra* note 16, at 629. Some of these efforts were heavily influenced by union interests (SEIU and AFSCME were particularly active) for whom improving the community benefit standard may have been a secondary goal. The primary goal: improving the union's bargaining position by generating negative publicity about an employer-nonprofit hospital failing to care adequately for the uninsured. *See id.*

[203] Most were dismissed as a matter of law. Hanson, *supra* note 34, at 401. For a summary of many of these cases, see Richard G. Stuhan, *Decisions to Date on Dispositive Motions in the Charity Care Litigation*, HEALTH LAW. NEWS, Sept. 2005, at 18.

[204] Hanson, *supra* note 34, at 400–02, 400 n.25, 401 nn.26, 29 & 30, 402 n.33 (citing articles published in six periodicals publicizing union lawsuits in 2003 and state lawsuits in 2004 or later); Kane, *supra* note 30, at 459–62 (citing the 60 Minutes report and articles published in nine periodicals publicizing lawsuits and related Congressional scrutiny, including a "series of articles" in The Wall Street Journal).

the lawsuits as a specific "handle," advocates engaged in this media campaign to generate public pressure on the hospitals—their "primary target"—and on Congress and state legislatures or tax boards as "indirect secondary targets."[205] The target hospitals responded in some cases by changing their conduct.[206] The secondary targets responded too, through administrative and legislative action at the state and local level.[207]

D. Sustaining Scrutiny

The CHNA requirements present new opportunities for advocate groups—offering new "handles" to use in a sustained media campaign. We observe three handles with the greatest potential. First, the release of a CHNA report or implementation strategy by a hospital provides a handle for advocates to publicize the contents. If advocates felt they were treated as valued participants in the process, positive publicity serves as an incentive for the target hospital to sustain a high level of community engagement in future rounds. A hospital is less likely to risk losing a positive reputation. However, if advocates are displeased with the content of the reports, a release provides fuel for a negative publicity campaign against the target hospital and key decision-makers. Evidence of the hospital's failure to address in its implementation strategy a need identified in the CHNA, paired with an anecdotal story of a needy patient lacking services, becomes an attractive headline. Because the CHNA and implementation strategy require ratification by the hospital's own board of directors, decision-makers can be held directly accountable in the media for the hospital's failure to meet community needs.

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[205] An "indirect secondary target" is one with the ability to influence the actions of the primary target that is also vulnerable to pressure by the advocacy group taking action. STAPLES, *supra* note 197, at 119. Congress has the power to compel action from the hospital as does the IRS. The IRS was likely an additional target of this media campaign, but as a regulator, the IRS does not fit the traditional sense of an "indirect secondary target."

[206] *See, e.g.*, Hanson, *supra* note 34, at 406 (community coalition allowed to participate in hospital planning process).

[207] *Id.* at 405–06 (explaining the effect of grassroots community organizing against Provena Covenant Medical Center in Illinois, leading to the revocation of property tax exemption by the tax board); Press Release, Senator Chuck Grassley, Grassley Asks Non-profit Hospitals to Account for Activities Related to Their Tax-exempt Status (May 27, 2005), http://www.grassley.senate.gov/news/news-releases/grassley-asks-non-profit-hospitals-account-activities-related-their-tax-exempt (Senator Grassley requested accounting of charitable activities from ten hospitals, including those involved in litigation or local tax exemption revocation). Senator Grassley held his first of several hearings to examine the ways some tax-exempt organizations game the tax system in June 2004. *Id.* These efforts were supported by other members of Congress and subsequently lead to the passage of the PPACA. *See supra* Part II.c. For state and local legislative reforms, see Colombo, *supra* note 5, at 439–46; Hanson, *supra* note 34, at 406–407; Kane, *supra* note 30, at 460–61, 467–68.

A second handle forms from a broader articulation of the current precedent, setting the stage for later change. To recall a past example, consider the GAO and IRS reports issued in the late 2000s.[208] They presented concrete data on suspected widespread deficiency in community benefit spending across the sector. Advocates (including members of Congress) framed the problem with this precedent that became a catalyst for further investigation and eventually inspired the § 501(r)(3) obligations. The CHNA processes may provide a similar handle. If reports from multiple hospitals are compared and analyzed, trends in the provision of community benefit activities across the nation, or even just within a state or region, become apparent. If hospitals are found to make significant strides towards increasing their community benefit activities, this validates the regulations and lends support to continued oversight using the current established structure. However, if analysis demonstrates a continued lack of sufficiency in the hospital's activities, advocates are further justified in calling for more extensive overhaul of the regulatory system and are more likely to prevail in urging Congress to pursue stronger reforms.

Finally, the § 501(r)(3) regulatory structure introduces a completely new handle that advocates can use to expose hospitals that fail to comply with the new obligations. Two advocacy nonprofits already garnered news attention using this handle in August 2014 when they referred Jackson Health System to the IRS for possible noncompliance with tax law.[209] They subsequently issued a press release about the complaint.[210] Although the IRS response is confidential, a referral increases the chance that a hospital will be subject to additional IRS scrutiny without reliance on the normal audit triggers. Investigation may be even more likely when the complaint coincides with mass media publicity. Despite obligations placed on the IRS to report to congressional committees about the levels of charity care and trends uncovered by the CHNA reports,[211] one can imagine the Exempt Organizations Division of the IRS may hesitate to take action against nonprofits in light of the 2013 "tea party" scandal.[212]

[208] *See supra* notes 43–45 and accompanying text.

[209] Daniel Chang, *Advocates for Poor Say Jackson Health System Bars Needy from Charity Care,* MIAMI HERALD (Aug. 27, 2014), http://www.miamiherald.com/news/local/community/miami-dade/article1983097.html.

[210] Press Release, Nat'l Health Law Program, Health Advocates File IRS Complaint Against Miami County Non-Profit Health System For IRS Violations (Aug. 27, 2014), http://www.healthlaw.org/news/press-releases/258-health-advocates-file-irs-complaint-against-miami-county-non-profit-health-system-for-irs-violations (press release and memorandum submitted to the IRS.) IRS Form 13909 is a voluntary complaint that any person can file when he or she suspects a tax-exempt organization is not complying in tax law. I.R.S., *IRS Complaint Process For Tax Exempt Organizations*, http://www.irs.gov/uac/IRS-Complaint-Process-For-Tax-Exempt-Organizations.

[211] PPACA § 9007(e).

[212] The scandal unfolded as allegations were confirmed that some IRS employees

Advocates' focus on hospital compliance incentivizes the IRS and Congress to sustain scrutiny of hospitals subject to § 501(r)(3) and hold those that fail to comply accountable.

Together, these three handles will increase the effectiveness of media advocacy to sustain public scrutiny of hospitals' decisions regarding community benefit activities. They serve to sustain public scrutiny because the handles are perpetual. As each CHNA process continues a cycle, it creates a constant stream of new content for advocates to draw from while working to uncover shortcomings in a hospital's services. For the first time, the community has a reliable stream of data to demand the benefit hospitals are obligated to deliver.

V. CONCLUSION

Through § 501(r)(3), the community benefit standard has additional structure and greater clarity than before. The IRS is now empowered with the authority to issue sanctions on hospitals prior to revoking exempt status. Hospitals must report with greater detail the expenditures and activities they consider to be part of community benefit. Yet the substantial discretion afforded to hospitals in satisfying the requirements and the potential loopholes created by regulations that lack content validity may be fatal to the achievement of meaningful progress toward strengthening the community benefit standard. Despite the new statute, Congress evaded a complete overhaul of the nonprofit hospital tax structure that commentators have been calling for. And whether the community will be better served than it was prior to § 501(r)(3) remains to be seen.

In a void of comprehensive statutory overhaul, the most beneficial effects of § 501(r)(3) are secondary in nature. Enhanced oversight and compliance will come from more than just the IRS. The true "benefit" of § 501(r)(3) will come in part through greater opportunity for data collaboration among advocates and experts to comprehensively define a community's needs and its capacity to address them. The true "benefit" will also come from the strengthened influence the public will have on hospitals. This influence is made possible by greater transparency on health information and the hospital's intended activities to provide for its community. And the true "benefit" will continue to unfold from sustained scrutiny made possible by effective media advocacy. Advocates can harness the power of the media to apply pressure on hospitals, on the

had been subjecting conservative-leaning nonprofit groups to heightened scrutiny when evaluating their applications for tax-exempt status. Several congressional hearings were held in the subsequent months. For an extensive chronological summary of the scandal and media coverage, see Paul Caron, The IRS Scandal, Day 685, TAXPROF BLOG (Mar. 25, 2015), http://taxprof.typepad.com/taxprof_blog/2015/03/the-irs-12.html.

IRS, and on Congress, calling for policy change by using new handles created by § 501(r)(3).

The secondary effects of § 501(r)(3) hold great potential to ensure nonprofit hospitals are meeting their duty to provide for their communities. Though Congress created a plan for improvement, noticeable change will depend upon whether hospitals meaningfully comply with current requirements. The purpose is to eliminate the disconnect between the money hospitals save from their tax exemption and the amount hospitals spend on community benefit. If properly cultivated, § 501(r)(3) will be a positive step in advancing focus on the community that nonprofit hospitals are respectfully intending to serve.