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News, Articles, and Updates

A New Era of Responsibility for Hospital Boards Under PPACA

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The Patient Protection and Affordable Care Act (PPACA)¹ and related regulatory rules have imposed new reporting and implementation requirements on tax-exempt hospital organizations² that will play a role in shaping healthcare policy for years to come.³ The roles, responsibility, and effective board governance of such organizations will become paramount, not only for retention of tax-exempt status, but also for survival in the increasingly regulated healthcare sector. This article suggests key areas that warrant increased board involvement in 2012, provides further clarity on the role of governing boards reporting and implementing the Community Health Needs Assessment (CHNA) imposed by PPACA and IRS Code 501(r), and highlights key concerns of the IRS and the potential implications—both immediate and long-term—for non-compliance.

¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 ("PPACA").

² A hospital organization is an organization that operates a facility that state law requires to be licensed, registered, or similarly recognized as a hospital or any other organization the Secretary of the Treasury determines has the provision of hospital care as the basis for its exemption under 501(c)(3), 501(r)(2).

³ Tax-exempt hospitals will report information on Form 990 annually and tri-annually, including Schedule H information and related CHNA reports, which will be aggregated by the IRS and reported to Congress. Increased reporting requirements and access to compliance and implementation statistics will shape policy-making efforts.

Brief Overview of PPACA Requirements and Changes to Form 990 Schedule H

As a result of the implementation of PPACA, in addition to meeting the general requirements applicable under 501(c)(3), exempt hospital organizations must also demonstrate their charitable purposes and community benefit by meeting four new exempt qualification requirements, which have been codified in 501(r) of the IRS Code:⁴

1. The CHNA
2. Financial assistance policy
3. Limitations on charges for medical care
4. Billing and collection requirements

Compliance with, and reporting related to, these new requirements will be conducted through the annual filing of revised Schedule H of Form 990.⁵ Although many portions of revised Schedule H have not been adapted, revised Part V now requires tax-exempt hospital organizations to report detailed information regarding each facility owned by a hospital organization. This new requirement parallels PPACA's requirement that a hospital organization will not be exempt with

⁴ Internal Revenue Code of 1986, as amended.

⁵ Tax-exempt 501(c)(3) organizations must annually file Form 990 with the IRS, which includes the main form, and one of 16 schedules, dependent on the activity of the exempt entity. As of the 2012 tax year, all hospital organizations have been required to Part V of Schedule H and report separately on each separate hospital facility, which was not required in prior years.

respect to any facility that fails to meet the new requirements imposed by PPACA.⁶ Finally, revised Schedule H also requires hospital organizations to report on *Other Facilities that are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility*. Due to the increased reporting requirements and anticipated governmental scrutiny toward exempt hospital organizations, governing boards should increase their involvement in the following key areas:

1. The improvement of transparency in transactions
2. Management of relationships with physicians, providers, and vendors
3. Executive compensation
4. Sensitivity to unrelated business income
5. Oversight of joint venture transactions

Increased Board Involvement

1. Improving Transparency in Transactions:

Although a thorough due diligence review should be part of any transaction, implementation of 501(r) will increase focus on the adequacy of a target hospital's internal compliance processes and procedures. Governing boards should make informed decisions in evaluating transactions, particularly in relation to implementation of the CHNA, financial assistance policies, limitations on charges for medical care, and billing and collection requirements required under 501(r). Governing boards should utilize consultants, auditors, legal compliance experts, and other evaluative tools to determine whether potential partners are complying with 501(r) requirements for each separate hospital facility and what potential costs for non-compliance could be in relation to each facility.

2. Management of Relationships with Physicians, Providers, and Vendors:

Because the financial impact of non-compliance related to referral sources can result in loss of tax exemption and substantial financial and political setback for each hospital facility in violation of PPACA, anti-kickback and Stark law, governing boards of hospital organizations should pay close attention to relationships with physicians and other potential referral sources. Governing boards should direct an independent review of management and administrative service agreements, products and supply agreements, leases, employment agreements, and other contracts. Certain "disqualified persons" may have authority over a

⁶ 501(r)(2)(B)(ii).

transaction or arrangement that could potentially threaten an exempt hospital organization's charitable status, purposes, and community benefit efforts. Therefore, governing boards of hospital organizations should scrutinize relationships with physicians, medical directors, officers of each hospital organization and facility, officers of any affiliated tax-exempt physician practices, and the board of directors of both the hospital and each affiliated program or practice to ensure that relationships with disqualified persons do not induce private inurement, excess benefits, or transactions that could subject the hospital organization to unrelated business income (discussed below) or expose the organization to potential loss of exemption.

3. Executive Compensation: Another central concern warranting increased board oversight is executive compensation, particularly in relation to acquisitions, combinations, and the operation of hospital-owned or affiliated physician practices. Governing boards may be exposed to penalties in the form of excise taxes for activities that could be considered excess compensation, such as salaries, deferred compensation, and fringe benefits in excess of fair market value. Other excess benefits can take the form of non-fair market leases, compensation related to billing services, and excessive payments for administrative services.⁷

4. Sensitivity to Unrelated Business Income:

Tax-exempt organizations must be cognizant of any "unrelated business income," which is created when an exempt organization participates in any activity that is (i) a "trade or business"⁸ that is (ii) regularly carried on, and (iii) is not related to furthering the exempt purpose of the hospital organization. Taxation under sections 513 and 514 of the Code tax the net income from such activities, and governing boards should be aware of activities that might subject the organization to additional taxation. Some examples of potential "unrelated business income" include: commercially sponsored scientific research if the results are not made public or directed toward benefitting the public, pharmacy sales to the general public, direct operation of public parking lots, certain exclusive provider relationships, and certain joint ventures with for-profit organizations (discussed below).

⁷ 26 USC 4958, Reg. 1.61-2(a)(1).

⁸ A trade or business is "any activity carried on for the production of income from selling goods or performing services."

5. Oversight of Joint Ventures: The IRS has set forth two ways to determine whether each hospital facility remains qualified for tax-exemption while participating as a partner in a joint venture with for-profit-entities: (i) the charitable purpose test, whereby the exempt organization's participation in the joint venture must accomplish the charitable purpose that serves as the basis for its exemption under 501(c)(3), and (ii) the private benefit test, whereby exempt organizations must demonstrate that the agreement governing the joint venture permits the entity to act exclusively in furtherance of its exempt purposes and not to the benefit of the for-profit partners. Failure of either test by any facility of a hospital organization could jeopardize the organization's exempt status and expose charitable assets to financial risk and penalties. When considering whether to approve a joint venture, governing boards of hospital organizations should exercise oversight to ensure that a proposed transaction encompasses all of the following elements to overcome IRS scrutiny:

1. The partnership agreement or other governing documents expressly state the exempt purpose and its priority over other objectives of the venture.
2. The structure of the joint venture agreement limits the liability of the exempt organization and protects its assets from financial risk through contractual language, indemnities, insurance measures, and a limitation on guaranties made by the exempt organization.
3. The governing documents allow the exempt organization to control voting rights and organizational deliberations of the venture.
4. Services or other assets contributed to the joint venture have been independently valued at fair market value by an appraiser.
5. An independent committee structure, comprised of individuals who do not have an ownership interest in the joint venture, is drafted into the governance documents to ensure that excess benefits, such as more than reasonable compensation for services or assets, have not been provided to insiders.

Community Health Needs Assessment (CHNA)

One of the four requirements imposed by PPACA and revised section 501(r) for hospital organizations recognized as, or seeking to become, 501(c)(3) organizations is that hospital organizations must conduct a community health

needs assessment every three years for each facility within a hospital organization in the U.S., including government hospitals and hospitals operated by pass-through entities, such as partnerships and limited liability companies that have a tax-exempt partner or member.⁹ The CHNA is a top priority for governing boards of hospital organizations because hospital organizations, within this fiscal year, must not only conduct the assessment, but also must adopt an implementation strategy, and prepare, approve, and make publically available the CHNA report for each hospital facility by the last day of the taxable year which began on March 23, 2012.

1. Form of Report: The CHNA must take the form of a written report, including five separate requirements, and penalties for non-compliance are steep. The five areas are:

- i. *Information about the community served:* The CHNA must describe the community served by each facility of a hospital organization. Although the "community served" will normally be assessed through consideration of the geographic radius of a hospital or hospital facility, other factors, such as a particular target population (e.g., a children's hospital), will also be considered. The IRS and the Treasury will use a "facts and circumstance" approach rather than a one-size-fits-all approach to determine whether the health needs of the community being served are met for each assessment period.
- ii. *Processes and method used to conduct the CHNA:* The CHNA must describe the processes and methods used to conduct the assessment, including: (a) a listing of sources and dates of data accumulations; (b) explanation of any analytical methods used to identify community health needs; (c) identification of any gaps in data collection; and (d) information regarding the organizations with which the hospital organization collaborated in gathering data (including information about any third parties used to gather data).
- iii. *External input:* The CHNA must explain the process used to gain input from persons representing the broader interests of the community that is served by the hospital through the use of both qualitative and quantitative data from primary and secondary sources. The explanation should include: (a) a description of when and how the hospital

⁹ IRS Notice 2011-52.

consulted with specific community representatives; (b) an explanation of whether input was gained through meetings, focus groups, interviews, surveys, or other means; (c) any third-party organizations from which information was obtained, and contact details for the individual who provided such information; (d) the name, title, and affiliation of at least one individual consulted and an illustration of their special knowledge of public health needs; and (e) input from leaders or representatives from the underserved within the community, and the nature of such leaders' roles.

- iv. *A prioritized description of health needs:* The CHNA must include a summary description of the health needs which are identified through the assessment process, and must describe the process and criteria used to prioritize each need as compared to other needs.
- v. *Existing facilities and resources:* The CHNA report must contain a description of healthcare facilities and other resources within the community that are already available to meet the community health needs, which were identified during the assessment process.

2. Implementation Strategy: In addition to the preparation and dissemination aspect of the CHNA, a hospital organization must also adopt an implementation strategy to meet the community health needs identified in the CHNA report. There must be a strategy set forth for each hospital facility, and each strategy must address each of the community health needs identified in the CHNA. Separate reporting is required even when a health system conducts strategic planning on a regional basis. The implementation plan must be a written, detailed explanation of how the hospital plans to meet the specific needs or why it does not intend to do so, and must take into consideration the resources, programs, and priorities the hospital intends to pursue and the potential impact of each consideration. The implementation strategy may be made in collaboration with other organizations, and the strategy itself should explain any anticipated collaboration with other organizations in developing an implementation strategy.

3. Adoption Upon Approval: A plan is not adopted until it has been approved by an authorized governing board that owes fiduciary duties to the hospital facility (discussed below), and the CHNA aspect of the PPACA requirements are not satisfied until the implementation strategy is approved. Governing boards should be careful to ensure that board members hold more than

mere accreditation authority, and multi-corporate hospitals must review the governing documents of each sub-organization to determine which governing body is the authorized board holding fiduciary duties to each separate corporation. Governance documents should also be reviewed to determine whether boards may act by committee versus an entire board under both state law and the governance documents themselves. Finally, in certain circumstances where a governing board has delegated its authority under a management agreement, such agreement and other similar contracts should be reviewed to determine whether the third party has the necessary authority to approve an implementation strategy.

The implementation strategy must be adopted in the same taxable year that the CHNA report is completed. Because hospital organizations must take multiple steps in 2012 to: (a) make the assessment; (b) prepare a CHNA report; (c) disseminate the CHNA to the public; (d) create an implementation strategy; and (e) approve an implementation for such strategy for each hospital facility prior to the end of the 2012 tax year, the CHNA requirement imposed by PPACA should currently be a high priority for governing boards.

Implications of the New Requirements and Related IRS Concerns

The impact of the new 501(r) reporting requirements, including the CHNA requirement, will range from immediate to long term. Failure to satisfy any of the 501(r) requirements that have already been implemented could result in loss of tax-exemption for the year in which the failure occurs or has occurred. Failure to satisfy the CHNA requirement will be evaluated at the end of this current 2012 tax year, and could result in a loss of exemption for each hospital or hospital facility that fails to meet the CHNA requirements. In addition, a \$50,000 excise tax will be imposed in the third year of the three-year period in which the requirement must be satisfied, with another \$50,000 excise imposed for each year each particular facility fails to comply. Such a penalty could result in significant financial expense to exempt hospital organizations. Moreover, the IRS will notify state officials of all excise taxes imposed, which may result in additional surcharges from state taxing authorities. Finally, any excise taxes that are imposed must be reported publicly on the Form 990 annually. This exposure could result in lack of support from

private and public supporters to exempt hospital organizations.

PPACA also requires that, after five years of data collection, the IRS must prepare a report to Congress regarding nationwide compliance by exempt hospital organizations with the new 501(r) requirements. The ultimate message is clear: the imposition of increased reporting requirements

over exempt hospital organizations will also give examining agents, state and federal regulators, and lawmakers power over the fate of the tax-exempt status of non-profit hospitals and over the proliferation of U.S. healthcare policy. The role of governing boards of non-profit hospital organizations will also become increasingly important to the fate of these organizations.

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