On The Front Lines

# New Section 501(r) — Codification of Requirements for Charitable, Tax-Exempt Hospitals

**by Albert Lin, LLM, CPA**

*Shortly before President Obama signed the Patient Protection and Affordable Care Act ("Affordable Care Act") (P.L. 111-148), the Illinois Supreme Court, in a ruling overshadowed by the wide-reaching healthcare reform, ruled against the Provena Covenant Medical Center in finding the hospital responsible for millions of dollars in past property taxes. In a reminder of the constant scrutiny of this industry, the high court noted, "While Illinois law has never required that there be a direct, dollar-for-dollar correlation between the value of the tax exemption and the value of the goods or services provided by the charity, it is a sine qua non of charitable status that those seeking a charitable exemption be able to demonstrate that their activities will help alleviate some financial burden incurred by the affected taxing bodies in performing their governmental functions."*[1]

The Illinois Supreme Court filed their decision on March 18; the Affordable Care Act became law on March 23. Within the Affordable Care Act (itself modified by the Health Care and Education Reconciliation Act of 2010 ("HCERA") (P.L. 111-152), signed on March 30), key provisions bear particular notice from the tax-exempt healthcare compliance officer. This article summarizes new Section 501(r) of the Internal Revenue Code of 1986, as amended ("Code"), including public comments from industry groups which were provided in July of 2010.

## A. New Section 501(r)

Previously, the actual text of Section 501 (the operative Code section providing for the definition and general rule for a tax-exempt charitable organization) never outlined any specific rules for hospitals and charity care. Now, new Section 501(r) requires that hospitals meeting statutory definitions must meet four specific requirements to qualify for, and continue to maintain, federal tax exemption under Section 501(c)(3). The requirements relate to a periodic "community health needs assessment," written financial assistance and emergency care policies, a limitation on emergency or medically necessary care charges within such policies, and requirements relating to billings and collection actions. To an extent, many of these requirements existed in one form or another, but the Affordable Care Act formally put these requirements into the actual tax Code and provided for specific penalties for noncompliance.

## B. Effective Date

The effective date rules bear special note. The last three policy requirements, relating to financial/emergency care policies, charge limitations, and billing/collections requirements, are effective immediately for tax years beginning after March 23, 2010 (the date of the Affordable Care Act enactment). In other words, if a hospital has a tax year ending March 30, 2010, the requirements start April 1, 2010; if a hospital has a tax year ending August 30, 2010, the requirements start September 1, 2010. The first requirement, relating to "community needs assessments," will be required for tax years beginning after March 23, 2012. As such, the tax-exempt healthcare compliance officer needs to review its policies immediately in light of Section 501(r). This way, the revised policies can be in place and be reported as effective in the organization's next Form 990 filing for the applicable tax year.

## C. Application and Requirements

### *1. Applicability to Hospitals*

New Section 501(r)(2)(A) provides that the four new requirements apply to:

> "(i) an organization which operates a facility which is required by a State to be licensed, registered, or similarly recognized as a hospital, and
> (ii) any other organization which [the Internal Revenue Service ("IRS")] determines has the provision of hospital care

as its principal function or purpose constituting the basis for its exemption under [Section 501(c)(3) of the Code] (determined without regard to this [Section 501(r)])."

Section 501(r)(2)(B) further clarifies that if a single tax-exempt organization operates more than one hospital facility, each facility must meet the requirements separately.

In responses to an IRS request for comments,[2] various interested organizations emphasized that the definition in the new statute in subsection (i) above is largely consistent with the definition of "hospital" as described in the new Schedule H (Hospitals) to Form 990[3] (that is, the definition is largely reliant upon state definitions as opposed to definitions among Medicare and Medicaid).[4] The public comments largely request that the IRS avoid deviating from the Schedule H definitions when it eventually adds any organizations under the authority granted in subsection (ii) above.

### *2. Community Health Needs Assessment*

Section 501(r)(3), relating to the new community health needs assessments, is the most burdensome and applicable for tax years beginning after March 23, 2012. Under Section 501(r)(3), applicable hospitals must:

"(i) [have] conducted a community health needs assessment which meets the requirements of subparagraph (B) in such taxable year or in either of the 2 taxable years immediately preceding such taxable year, and

(ii) [have] adopted an implementation strategy to meet the community health needs identified through such assessment."

Subparagraph (B) expressly requires the community health needs assessment to take into account input from the broad community served by the hospital, including those with specialized knowledge in public health. Moreover, the community health needs assessment must be made widely available to the public.

Public commentators like the American Hospital Association ("AHA") remarked that no actual definition of "community health needs assessment" was written in the new statute - in other words, the IRS hasn't said what it is, but knows what it should have in it. The AHA recommended the definition be a written document developed by the hospital, which includes descriptions of:

(i) the process used to conduct the assessment;
(ii) how the organization took into account input from community members and public health experts;
(iii) the community serviced;
(iv) the health needs identified through the assessment process;
(v) the needs the organization will address and the reasons such needs were selected; and
(vi) the implementation strategy the organization will take to address such needs.[5]

Another recommendation was to piggyback any required state reports such that where state requirements are substantially similar to the IRS requirements, the state report is deemed to satisfy the hospital's requirements under Section 501(r)(3).[6] The new Schedule H, in Part VI, line 2, already had a general requirement that tax-exempt hospitals must identify "how the organization assesses the needs of the communities it serves." The AHA suggested that the instructions to this line 2 incorporate Section 501(r)(3) requirements, such that the response to line 2 be a summary of the community health needs assessment.

Since a separate new Section 6033(b)(15)(A) requires actual analysis of the community health needs assessment report, a separate review should also, in response to Section 6033(b)(15)(A), discuss why particular needs identified are not being addressed.

With respect to the "widely available" requirement, commentators recommend that because Form 990s have a "widely available requirement" as described in the instructions to Form 990,[7] the community health needs assessment should have similar standards. Form 990s are deemed "widely available" if the hospital complies with Internet posting requirements and notice requirements relating to provision of the web address.

### *3. Financial Assistance Policy/Emergency Medical Care Policy*

Applicable tax-exempt hospitals should immediately begin reviewing their existing charity care policies to take into account new Section 501(r)(4) requirements for a written "financial assistance policy" and (an element already required by other federal law) a written policy on emergency medical care. The financial assistance policy has five related requirements under Section 501(r)(4)(A):

(i) It must contain eligibility criteria for financial assistance, and whether such assistance includes free or discounted care.
(ii) It must contain the basis for calculating amounts charged to patients.
(iii) It must describe the method of applying for financial assistance.
(iv) If the hospital does not have a separate billing and collections policy, the financial assistance policy must describe the actions the hospital may take in the event of non-payment, including collections actions and reporting to credit agencies.
(v) The policy must be widely publicized within the community to be served.

Section 501(r)(4)(B) requires a written policy requiring the hospital to provide, without discrimination, care for emergency medical conditions to individuals regardless of eligibility under the financial assistance policy. The AHA noted in its comments that new Section 501(r)(4)(B) reflects already existing federal law and is not intended to create new requirements.

The new statutory requirements here can be viewed as additions to charity care policies required under Schedule H, Part I, lines 1-5. As such, "widely publicizing" the financial assistance policy requirements can be piggybacked on the publicizing of the charity care policy. Posting of the policy in admission areas,

emergency rooms, and other areas of a hospital, providing the policy at the intake process, discharge materials, in patient bills, and discussion with the patients would satisfy the publicity requirement.

### *4. Limitation on Charges*

New Section 501(r)(5) requires tax-exempt hospitals to limit the *amounts charged* for "emergency or other medically necessary care," to individuals eligible for financial assistance under the Financial Assistance Policy, to an amount not more than the "*amounts generally billed*" to individuals who have insurance covering such care. In addition, the use of "*gross charges*" is prohibited.

This requirement may cause the most confusion. It has been explained that "it is intended that the amounts billed to those who qualify for financial assistance under the organization's financial assistance policy may be based on either the best, or an average of the three best, negotiated commercial rates, or Medicare rates."[8]

Within the industry, it is standard practice to send a bill to a patient with "gross charges," which represent the hospital's full-established rates for all services.[9] This is necessary for Medicare calculation purposes, such that Medicare only pays a proper amount of allocated overhead costs. The amount the patient actually pays results after reductions are made for discounts or contractual allowances for commercial insurers or Medicare/Medicaid.

Commentators have requested clarification that the prohibition of gross charges under new Section 501(r)(5) should not be construed to mean that gross charges cannot be used as a starting point. This is because in order to calculate "amounts generally billed," hospitals must take into account differing discounts or contractual allowances. In addition, the prohibition on gross charges must apply only to patients known to qualify for financial assistance (some patients may not be known to qualify prior to billing). Ultimately, the results should be that persons qualifying are charged the amount the statute intends.

Finally, the commentators recommend that the IRS issue guidance clarifying whether compliance with Section 501(r)(5) is based on overall performance or on an individual patient basis.

### *5. Billing and Collection Requirement*

Tax-exempt hospitals must not "engage in extraordinary collection actions before [they] have made reasonable efforts to determine whether [they are] eligible" for financial assistance pursuant to the Financial Assistance Policy.[10] "Extraordinary collections actions" is defined, in the Technical Explanation, to include lawsuits, liens, arrests, and similar measures. Measures not deemed extraordinary include typical actions such as notification of the Financial Assistance Policy upon admission, written and oral communication about the bill, including invoices and telephone calls. These should be done before collection action or adverse credit reporting is begun.[11]

Commentators recommended more clarification from the IRS, which may incorporate the Technical Explanation suggestions. In particular, the AHA Letter remarks that sometimes it is not possible to make a definitive determination of eligibility before beginning collection action, "depend[ing] on the individual patient's willingness to respond."[12]

Satisfaction of this new Section 501(r)(6) requirement may be reported in Schedule H, Part III, line 9, where hospitals report information on written debt collection policies.

### *6. Penalties*

Finally, new Section 4959 imposes a $50,000 excise tax on hospitals that fail requirements under Section 501(r). To document compliance and the adoption requirement, the hospital's governing body should make special efforts to ensure board minutes or resolutions incorporate a review and approval of the community health needs assessment, as well as the financial assistance policy/emergency care policy.

## D. Conclusion

Section 501(r) codifies into the federal tax code several industry "best practices" requirements, which were seen coming through the recent revisions to Form 990 and Schedule H. The most pressing concern will be evaluation of charity care/financial assistance, emergency room, and collections policies. These are the elements that are required to be complied earliest. The community needs assessment report requirement will not be formally required later, but may likely already be required in substantially similar form by state law. Hence, most tax-exempt healthcare systems will already have Section 501(r) requirements substantially in place. At any rate, the tax-exempt compliance officer should be well-versed in the new Section 501(r) and watch for additional clarifications that will be forthcoming from the IRS after it has disseminated the public comments. ■

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1 Provena Covenant Medical Center v. Illinois Dept. of Revenue, Docket No. 107328 (March 18, 2010), *available at* http://www.state.il.us/court/Opinions/SupremeCourt/2010/March/107328.pdf.

2 Notice 2010-39, I.R.B. 2010-24 (June 14, 2010).

3 *Available at* http://www.irs.gov/pub/irs-tege/form990scheduleh.pdf.

4 Letter from Association of American Medical Colleges to IRS (July 21, 2010), *available at* http://www.aamc.org/advocacy/library/teachhosp/corres/2010/07212010.pdf.

5 Letter from American Hospital Association, Healthcare Financial Management Association, Premier, Inc., and VHA, Inc. to IRS (July 22, 2010) ("AHA Letter"), *available at* http://www.aha.org/aha/letter/2010/100722-CL-IRS-501-r.pdf.

6 *Id.*

7 *Available at* http://www.irs.gov/pub/irs-pdf/i990.pdf.

8 Notice 2010-39 (citing Joint Committee on Taxation, Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as amended, in combination with the Affordable Care Act (JCX-18-10) at 81 (March 21, 2010) ("Technical Explanation")).

9 *See* AHA Letter at 6.

10 I.R.C. §501(r)(6).

11 Technical Explanation at 82.

12 AHA Letter at 8.