



JONES DAY  
**COMMENTARY**

# HEALTH CARE REFORM RAISES THE STAKES FOR TAX-EXEMPT HOSPITALS

## THE NEW REPORTING REGIME FOR NONPROFIT HOSPITALS

A handful of provisions included in the Patient Protection and Affordable Care Act (“PPACA”), enacted in March 2010, have added a heightened level of transparency and accountability to the requirements for tax-exempt status for nonprofit hospitals. Significant additional requirements for Section 501(c)(3) status under Section 9007 of PPACA include the following requirements:

- Conduct a community health needs assessment once every three years for the community served by each facility with community input, make the results “widely available,” and adopt an implementation strategy.<sup>1</sup> Tax-exempt hospitals already were required to report on Form 990, Schedule H, Part VI, Line 2, how they assess the health care needs of the communities they serve. The legislative history notes that: “The assessment may be based

on current information collected by a public health agency or non-profit organizations and may be conducted together with one or more other organizations, including related organizations. The assessment process must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise of public health issues.”<sup>2</sup>

- Adopt, implement, and widely publicize a written financial assistance policy specifying the eligibility criteria and whether available assistance includes free or discounted care, basis for calculating charges to patients, how to apply for assistance, and possible actions for nonpayment (e.g., collections actions and credit agency reporting) if not reflected in a separate billing and collections policy.<sup>3</sup>

<sup>1</sup> Code § 501(r)(1)(A) & (3).

<sup>2</sup> Technical Explanation of the Revenue Provisions of the “Reconciliation Act of 2010,” as Amended, in Combination with the “Patient Protection and Affordable Care Act,” JCX-18-10, at p. 81 (March 21, 2010) (hereafter, “JCX-18-10”).

<sup>3</sup> Code § 501(r)(1)(B) & (4)(A).

- Adopt a written policy prohibiting discrimination in emergency care regardless of whether they qualify for financial assistance (a requirement that is arguably duplicative of the EMTALA anti-dumping law).<sup>4</sup>
- Limit charges for “emergency or other medically necessary care” provided to uninsureds who qualify for some charity care so that they pay no more than “the amounts generally billed” for insured patients covered for that service; not Chargemaster rates or “gross charges.” The legislative history indicates that hospitals may bill patients at the lowest negotiated commercial rate, an average of the three lowest negotiated commercial rates, or the applicable Medicare rate.<sup>5</sup>
- No extraordinary collection methods (e.g., suits, liens on residences, arrests, body attachments, or similar collection processes) without prior reasonable efforts to determine qualification for financial assistance. Treasury was directed to issue guidance defining “reasonable efforts”; however, the legislative history indicates that Congress intended the term to include “notification by the hospital of its financial assistance policy upon admission and in written and oral communications with the patient regarding the patient’s bill, including invoices and telephone calls, before collection action or reporting to credit agencies is initiated.”<sup>6</sup>
- Review by Treasury or the IRS every three years of “the community benefit activities of each hospital organization” that is subject to the new Section 501(r) requirements, although the level of detail of the review and follow-up are not specified.<sup>7</sup> Note that Section 501(r) applies to any “hospital organization” that is otherwise treated as an organization described in Section 501(c)(3) with no special provision for exception of dual status entities (i.e., those exempt as an organization described in Section 501(c)(3) whose income is also exempt from taxation under Section

115 such as a governmental hospital).<sup>8</sup> A “hospital organization” is defined in a manner similar (although not identical) to the Form 990 definition as a facility that is required by state law to be licensed, registered, or similarly recognized as a hospital, with some flexibility for Treasury to expand that definition to include other organizations with the provision of hospital care as their principal function or purpose.<sup>9</sup> For hospitals that file Schedule H (i.e., non-dual status hospitals), the review may be accomplished as a desk audit by reviewing Schedule H;<sup>10</sup> however, governmental entities are not currently required to file Form 990 (including Schedule H) even if they are also recognized as 501(c)(3) organizations.

- Must include both the implementation strategy for community health needs assessment results and the complete audited financial statements in Form 990. If the filing organization is included in consolidated financial statements, then the consolidated statements must be filed with the Form 990.<sup>11</sup> Currently, financial statements are not among the permitted attachments, although presumably that will change in future versions of the Instructions. Similarly, current software programs may not accommodate such attachments in their current versions.
- Annual reports (and a five-year trend study) from the Department of Health & Human Services (“HHS”) and Treasury to Congress on charity care, bad debt, and cost shortfalls from public programs for 501(c)(3), government, and proprietary hospitals.<sup>12</sup> (Note that any significant reduction in the ranks of the uninsured following enactment of health care reform may lead to pressure for Congress to change the current law by enacting bright-line expenditure minimums for 501(c)(3) status or pressure on the IRS to modify the community benefit standard for hospital exemption.)
- Penalties for failure to comply with these new standards would include a \$50,000 excise tax for failure to do a community health needs assessment (which tax payment would

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4 Code § 501(r)(1)(B) & (4)(B). The legislative history indicates that the emergency medical treatment “policy must prevent discrimination in the provision of emergency medical treatment, including denial of service, against those eligible for financial assistance under the facility’s financial assistance policy or those eligible for government assistance.” JCX-18-10, *supra*, at p. 82.

5 Code § 501(r)(1)(C) & (5); JCX-18-10, *supra*, at p. 82.

6 Code § 501(r)(1)(D), (6) & (7); JCX-18-10, *supra*, at p. 82.

7 Pub. L. 111-148, § 9007(c).

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8 Code § 501(r)(1).

9 Code § 501(r)(2)(A).

10 JCX-18-10, *supra*, at p. 82.

11 Pub. L. 111-148, § 9007(d); Code § 6033(b)(15).

12 Pub. L. 111-148, § 9007(e).

be reportable on Form 990), and loss of 501(c)(3) status with respect to any noncompliant facility (which provision makes exemption facility-specific even if an organization owns more than one hospital). Taxpayers also may be liable for existing penalties for filing an incomplete return.<sup>13</sup>

The above changes are effective, with limited exceptions, for tax years beginning after the date of enactment. The community health needs assessment requirement is effective for tax years beginning after March 23, 2012; however, the new excise tax in Section 4959 is effective immediately. Read together, these varying effective dates appear to mean that the excise tax could first be assessed for tax years ending in 2013.<sup>14</sup>

On May 27, 2010, the IRS released Notice 2010-39, in which it requested comments on these new provisions, including whether any guidance is needed at all. The specific areas on which the IRS solicited comments are: (a) the appropriate requirements for a community health needs assessment; (b) what constitutes “reasonable efforts” to determine whether a patient is eligible for financial assistance; and (c) application of the new provision for loss of exemption as to individual facilities that do not meet the requirements of Section 501(r), including what the tax consequences should be of a failure to meet the requirements of Section 501(r) with respect to some, but not all, of an organization’s hospitals and the proper tax treatment in future periods. Comments were requested by July 22, 2010. Although litigation was filed challenging the constitutionality of the health care reform legislation in various courts, the challenges tend to focus on the individual mandates and fines and physician ownership provisions, not on the additional transparency requirements for nonprofit hospitals.

## EFFECT OF HEALTH CARE REFORM ON COMMUNITY NEED AND COMMUNITY BENEFIT

Changes initiated in PPACA regarding payment levels and mandatory coverage also could have a ripple effect on how tax-exempt hospitals fulfill their community benefit missions. For example, changes to the Medicaid payment rate for

primary care physicians, if implemented in a particular state as contemplated in PPACA, may detract somewhat from the argument that requiring recruited physicians to provide Medicaid services or recruiting physicians to a shortage area provides a significant community benefit. Under the reconciliation portion of the legislation, primary care physicians (defined as family practice, internal medicine, and pediatrics, with no mention of obstetrics/gynecology) would be paid at a rate equal to at least 100 percent of the Medicare Part B rate for services rendered in 2013 and 2014.<sup>15</sup> In addition, PPACA created a five-year, 10 percent Medicare bonus payment for select evaluation and management codes furnished by physicians and other primary care providers beginning on January 1, 2011.<sup>16</sup> There is a separate 10 percent bonus for major surgical procedures provided in a health professional shortage area, also beginning on January 1, 2011.<sup>17</sup> These adjustments on their surface, if actually implemented, would appear designed to relieve some of the difficulties in recruiting physicians to serve Medicaid beneficiaries or to practice in health professional shortage areas.

Moreover, if the rate of uninsured drops significantly due to the mandate for most Americans to purchase insurance and the expansion of eligibility for Medicaid, critics of the nonprofit health care industry may argue that the need for free care has become far less significant.<sup>18</sup> Providing coverage, however, is not the same as necessarily covering all of the costs of the care that coverage allows patients to receive. Accordingly, even if the need for 100 percent free care declines, the need for other forms of community benefit (including below cost care for the formerly uninsured) may increase. For example, the temporary increase in Medicaid payment rates only affects physician payments and does nothing to address the cost shortfall experienced by hospitals in treating Medicaid beneficiaries.

It remains to be seen, however, whether these changes will be implemented uniformly on the state level and whether they will continue if there is not enough federal funding to

13 Code §§ 501(r)(2)(B), 4959, 6033(b)(10)(D) & 6652.

14 JCX-18-10, *supra*, at p. 83, n. 192.

15 Pub. L. 111-152, § 1202(a)(1).

16 Pub. L. 111-148, § 5501(a).

17 Pub. L. 111-148, § 5501(b).

18 Pub. L. 111-148, §§ 1411, 1501, 2001 *et seq.* & 10201-10203.

cover the increased costs to the states. That specter of a quick or unexpected end to additional payments may continue to hinder recruitment efforts (as would the lack of such incentives for other specialties), which could support arguments of continuing community need for physicians in a particular specialty—*i.e.*, uncertainty over funding may lead physicians to continue to seek hospital income guaranties and cause the supply of physicians in an area to remain static at best without the guaranties. Moreover, high-volume Medicaid facilities often may be located in undesirable areas for professionals, thus increasing the need for financial incentives to attract physicians in the needed specialties. In addition, the looming 21.2 percent cut in the Medicare payment rates to meet the Sustainable Growth Rate (“SGR”) requirement (pending legislation, H.R. 4213, would defer SGR compliance for three years), if not “fixed,” may actually strengthen the case for community need for physicians serving both Medicare and Medicaid patients. Likewise, the groundwork laid in the 2010 health care reform legislation to transition Medicare from fee-for-service to quality-based compensation may provide support for additional incentives in the private sector that are similarly based on quality.<sup>19</sup>

## WHAT THE LATEST CHANGES MEAN FOR NONPROFIT HOSPITAL TAX COMPLIANCE

At a minimum, these changes highlight the importance of thoroughly documenting community need for physician recruitment strategies (as opposed to individual hospital need). That increased premium on documentation also may apply to the range and value of other community benefits provided by tax-exempt hospitals as contemplated by Form 990, Schedule H, which the IRS is now likely to review every three years for each tax-exempt hospital.<sup>20</sup> In fact, Congress has directed the Treasury Department and HHS to submit annual reports to Congress on, and to report within five years on trends with respect to, the levels of charity

care, bad debt expense, and unreimbursed costs of care (from means-tested and non-means-tested government programs) among taxable, private tax-exempt, and governmental hospitals, as well as the costs incurred for community benefit activities at private tax-exempt hospitals.<sup>21</sup> Those studies may result in even more intense scrutiny of nonprofit hospitals and increased pressure for them to distinguish themselves and their activities from their for-profit counterparts or face additional legislated mandates in order to maintain their tax-exempt status.

Both the reporting requirements for community benefit and the stakes involved have never been higher for nonprofit hospitals. There will be more information required, more routinized and patient-friendly billing and collection practices, and a virtually certain IRS review of all Schedule H filings every three years. Getting a community benefit tracking and reporting system in place now with dry runs to work out the bugs will play a key role in ensuring timely compliance with these new requirements.

## LAWYER CONTACTS

For further information, please contact your principal Firm representative or one of the lawyers listed below. General email messages may be sent using our “Contact Us” form, which can be found at [www.jonesday.com](http://www.jonesday.com).

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<sup>19</sup> See Pub. L. 111-148, § 3007.

<sup>20</sup> See Pub. L. 111-148, § 9007(a) & (c); Code § 501(r)(2)(B).

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<sup>21</sup> Pub. L. 111-148, § 9007(e).