



## NEW INTERNAL REVENUE SERVICE (IRS) REGULATIONS FOR NONPROFIT HOSPITALS

By: James Orlando, Senior Legislative Attorney

### ISSUE

This report summarizes requirements under the Affordable Care Act for nonprofit (charitable) hospitals to maintain their tax-exempt status.

### SUMMARY

The Patient Protection and Affordable Care Act ("ACA") added requirements that a nonprofit hospital must meet in order to maintain its § 501(c)(3) tax-exempt status under the Internal Revenue Code. Under these provisions, a nonprofit hospital must:

1. conduct a community health needs assessment at least once every three taxable years and adopt an implementation strategy to meet the needs identified in the assessment;
2. establish a financial assistance policy (FAP) and emergency care policy;
3. bill patients eligible for the FAP at no more than the amount generally billed to patients with insurance, and not use gross charges; and
4. make reasonable efforts to determine whether the patient is eligible for the FAP before undertaking extraordinary collection actions, such as making a negative report to a credit bureau.

Nonprofit hospitals that fail to meet these requirements may lose their tax-exempt status, among other penalties.

These provisions took effect for taxable years beginning after March 23, 2010, except that the community health needs assessment requirement took effect in tax years beginning after March 23, 2012. In 2012 and 2013, the IRS issued proposed regulations providing guidance regarding these requirements.

On December 29, 2014, the IRS issued final regulations regarding these provisions. Most of the final regulations apply to a hospital's taxable years beginning after December 29, 2015; some provisions take effect before then.

Below, we provide a summary of the statutory requirements and an overview of significant features of the final regulations. For a more detailed description of the regulations, see the [Federal Register notice](#) (79 Fed. Reg. 78954-01). The report also does not address other existing requirements for nonprofit hospitals to maintain tax-exempt status.

## **ACA REQUIREMENTS FOR NONPROFIT HOSPITALS TO MAINTAIN TAX-EXEMPT STATUS**

### ***Community Health Needs Assessment***

**ACA.** The ACA requires each nonprofit hospital facility to conduct a community health needs assessment at least once every three taxable years and adopt an implementation strategy to meet the community health needs identified through the assessment. This process must take into account input from people representing the broad interests of the community served by the facility, including those with special knowledge or expertise in public health issues. The assessment must be made widely available to the public (26 U.S.C.A. § 501(r)(3)).

A facility that fails to conduct the assessment and adopt the strategy is subject to a \$50,000 tax penalty (26 U.S.C.A. § 4959).

In addition, a nonprofit hospital must include in its IRS Form 990 filing (the tax return for organizations exempt from the income tax):

1. a description of how the facility is addressing the needs identified in the assessment,
2. a description of any needs not being addressed and the reasons why, and
3. a copy of its audited financial statements (26 U.S.C.A. § 6033(b)(15)).

**Regulations.** The regulations specify the steps that a hospital must take to complete a community health needs assessment. A hospital must:

1. define the community it serves;
2. assess the community's health needs;
3. in assessing those needs, solicit and take into account input received from persons who represent the broad interests of that community, including those with special knowledge of or expertise in public health;

4. document the assessment in a written report adopted by an authorized body of the hospital; and
5. make that report widely available to the public.

The regulations describe these steps in greater detail. For example, in defining the community it serves, a hospital may take into account all of the relevant facts and circumstances, including the geographic area and target populations it serves and its principal functions (e.g., focus on a particular specialty area). But a hospital must not define the community in a way that excludes medically underserved, low-income, or minority populations that otherwise should be included.

In assessing community health needs, a hospital facility must identify significant health needs, prioritize those needs, and identify resources (such as community-based or hospital programs) potentially available to address them. Health needs include requisites for improving or maintaining health status in the community at large and in particular parts of the community. Examples include the need to address financial and other barriers to accessing care; preventing illness; ensuring adequate nutrition; or addressing social, behavioral, and environmental factors that influence health in the community.

The regulations specify the required components of the written report documenting the assessment (e.g., the process and method used to conduct the assessment and a prioritized description of the significant health needs of the community identified).

The regulations provide details on the implementation strategy the hospital must develop to meet the needs identified in the assessment. These include a description of the actions the hospital intends to take to address an identified health need and the anticipated impact of these actions, or the reasons why the hospital does not plan to address it.

Among other things, the regulations:

1. specify the groups from which the hospital must solicit input, including (a) government public health departments and (b) members of medically underserved, low-income, and minority populations or persons serving or representing their interests; and
2. specify the circumstances in which two or more collaborating hospitals or other organizations may adopt a joint assessment report or implementation strategy (26 CFR § 1.501(r)-3).

## ***Financial Assistance Policy***

**ACA.** The ACA requires each nonprofit hospital to establish a written FAP that includes:

1. the eligibility criteria for financial assistance, and whether the assistance includes free or discounted care;
2. the basis for calculating patient charges;
3. the process for applying for assistance;
4. the actions the hospital may take in the event of nonpayment if it does not have a separate billing and collections policy; and
5. measures to widely publicize the policy within the community the hospital serves (26 U.S.C.A. § 501(r)(4)).

**Regulations.** The regulations provide details on how a hospital's FAP can meet the requirements noted above. The policy must apply to all emergency and other medically necessary care provided by the hospital.

The regulations prohibit a hospital's policy from denying financial assistance based on an applicant's failure to provide information or documentation unless that information or documentation is described in the policy or policy application form.

As another example, the regulations specify how a hospital must widely publicize its FAP. Among other things, it must:

1. make the FAP, the application form, and a plain language summary of the policy available in various formats and locations (including the hospital emergency room and admissions area);
2. offer a paper copy of the plain language summary to patients as part of the intake or discharge process; and
3. include a conspicuous written notice on billing statements about the availability of financial assistance under the policy.

As part of this requirement, a hospital must translate the FAP documents into the primary language of any limited English proficiency populations that constitute the lesser of 1,000 individuals or 5% of the community served by the hospital or the population likely to be affected or encountered by the hospital.

Among other provisions, the regulations also require the FAP to include a list of outside providers delivering necessary medical care in the facility, specifying which of these are covered by the policy and which are not (26 CFR § 1.501(r)-4).

### ***Emergency Medical Care Policy***

**ACA.** The ACA requires each nonprofit hospital to adopt a policy to provide, without discrimination, emergency medical treatment to individuals, regardless of whether they are FAP-eligible (26 U.S.C.A. § 501(r)(4)).

**Regulations.** Under the regulations, a hospital's emergency medical care policy must prohibit the hospital from engaging in actions that discourage individuals from seeking emergency medical care, such as by (1) demanding that emergency department patients pay before receiving treatment for emergency conditions or (2) permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care.

A policy is in compliance if it requires the hospital to provide the care required by the Centers for Medicare and Medicaid Services regulations on standards and certification. This includes requirements under the Emergency Medical Treatment and Active Labor Act (EMTALA) (26 CFR § 1.501(r)-4).

### ***Limitations on Charges***

**ACA.** Under the ACA, a nonprofit hospital must limit the amounts charged for emergency or other medically necessary care it provides to those qualifying for assistance under the hospital's FAP to no more than the amounts generally billed (AGB) to individuals with insurance coverage. The hospital may not use gross charges (26 U.S.C.A. § 501(r)(5)).

**Regulations.** Among other things, the regulations:

1. specify that for purposes of these provisions, a person is considered to be charged only the amount he or she is personally responsible for paying, after all deductions, discounts (including those available under the FAP), and insurance reimbursements have been applied;
2. require hospitals to determine AGB using one of two methods (the look-back or prospective method) or any other method specified in regulations or IRS guidance;
3. specify how to calculate AGB using the look-back or prospective methods; and

4. provide a safe harbor for certain charges in excess of AGB, and require refunds of such charges over \$5, if the person is later determined to be FAP-eligible (26 CFR § 1.501(r)-5).

### ***Billing and Collection Requirements***

**ACA.** Under the act, a hospital may not take extraordinary collection actions before it makes reasonable efforts to determine whether the individual is eligible for assistance under the hospital's FAP. The treasury secretary must issue guidance on what constitutes "reasonable efforts" (26 U.S.C.A. § 501(r)(6), (7)).

**Regulations.** Under the regulations, extraordinary collection actions generally include the following actions by a hospital to obtain payment for care covered under the hospital's FAP:

1. selling an individual's debt to another party (except in certain circumstances);
2. reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus;
3. deferring or denying, or requiring a payment before providing, medically necessary care because an individual did not pay for previous care covered under the hospital's FAP; and
4. initiating actions that require a legal or judicial process (e.g., placing certain liens on property, bringing a civil action, or garnishing wages).

The filing of a claim in a bankruptcy case is not an extraordinary collection action.

Among other things, the regulations also describe what constitutes reasonable efforts to determine whether an individual is FAP-eligible. The particular requirements vary depending on the basis of the determination (e.g., third-party information or notification and processing of an application for assistance). For example, if an individual's eligibility has not been determined, the final regulations (1) require the hospital to notify the individual about the FAP and (2) prohibit a hospital from undertaking extraordinary collection actions for 120 days after the hospital provides the first post-discharge billing statement (26 CFR § 1.501(r)-6).

### ***Revocation of 501(c)(3) Tax Exempt Status and Related Issues***

The regulations provide that the IRS will consider all relevant facts and circumstances when determining whether to revoke a hospital's 501(c)(3) status for failure to meet one or more requirements noted above. Examples include (1) the

size, scope, nature, and significance of the failure, and the reason for it; (2) whether the hospital promptly corrected the failure after discovering it; and (3) whether the hospital has previously failed to meet the requirements.

The regulations provide that omissions or errors regarding certain requirements are excused if (1) they were minor and either inadvertent or due to reasonable cause and (2) the hospital corrects them as promptly after discovery as is reasonable given the nature of the omission or error.

The regulations also provide that a hospital's failure to meet any requirement is excused if the (1) failure was not willful or egregious and (2) hospital corrects and makes disclosure in accordance with IRS guidance.

If a hospital organization operates more than one facility and one such facility fails to meet requirements, the regulations provide for imposing a tax on the noncompliant facility (while the organization as a whole retains its tax-exempt status) (26 CFR § 1.501(r)-2).

JO:tjo/jk