Hospital Community Benefit Program

The Hilltop Institute

analysis to advance the health of vulnerable populations

Community Benefit Briefing

June 2011

Through news updates, state research and policy analysis, and policy questions, this newsletter is meant to assist state and local policymakers to understand and monitor hospital community benefit activities. The Community Benefit Briefing will report, discuss, and analyze various aspects of hospital community benefits, including the effects of the Affordable Care Act (ACA).

News

From the Front Lines of ACA Implementation: Don Stuart, Esquire

Donald B. Stuart is a partner in the Tennessee law firm of Waller, Lansden, Dortch & Davis, LLP, and serves as Vice Chair of the Tax and Finance Practice Group of the American Health Lawyers Association (AHLA). AHLA is a nonprofit educational organization that focuses on legal issues in the health care field. Since the Affordable Care Act (ACA) was enacted last year, Mr. Stuart has monitored federal regulatory guidance pertaining to I.R.C. 501(r) (§9007 of the ACA, "New Requirements for Nonprofit Hospitals"). Last year he facilitated the online posting of responses to IRS Notice 2010-39 (http://www.wallerlaw.com/quotes/2010/08/10/comments-available-for-review-on-new-tax-exemption-requirements-for-nonprofit-hospitals.132997), by which the IRS sought comments on the need for agency guidance on the I.R.C. §501(r) requirements and on requirements for nonprofit hospitals under the new law. Our conversation with Mr. Stuart occurred on June 8, 2011.

Hilltop: As you know, the IRS received over a hundred responses to its notice requesting comments on I.R.C. §501(r). Have you perceived any recurring themes in these comments?

Stuart: There is a clear consensus that guidance is, in fact, needed in all four areas covered by the statute: community needs assessment, financial assistance policies, limitations on charges, and billing and collection activities. Many responders cited a need for more specific standards that hospitals can follow to ensure that they retain their federal tax-exempt status.

Hilltop: As a tax attorney representing nonprofit hospital clients, are you seeing a lot of confusion within the industry about the I.R.C. §501(r) requirements? For example, do you think most hospitals know what they must do (and when they must do it) to satisfy the statute's community health needs assessment (CHNA) requirements?

Stuart: There's certainly a lot of confusion about the effective dates of certain requirements and about the potential penalties for noncompliance. It's my understanding that guidance from the IRS is forthcoming

shortly. In the meantime, what nonprofit hospitals need to know is that except for CHNA reporting, all §501(r) requirements are in effect *now*. It should be recognized that many nonprofit hospitals already were doing voluntarily the same kinds of things that §501(r) now requires. These hospitals need to review their existing policies to ensure that they satisfy the new requirements. As for CHNAs, hospitals shouldn't think they can wait until 2013 to conduct one. For any tax year beginning after March 23, 2012, a nonprofit hospital must be able to report that it has conducted a CHNA *either during that year or in one of the two prior years*, has developed an implementation strategy, and must describe how it is addressing needs identified by the CHNA, as well as explain what identified needs are not being addressed and why not. It is unlikely that a hospital can accomplish all this if it does not conduct its CHNA before 2013.

Hilltop: What about the potential penalties for noncompliance?

Stuart: The law provides for assessment of a $50,000 tax liability against a nonprofit hospital that fails to comply with the CHNA requirement. But that sanction does not apply when noncompliance relates to either financial assistance policies, limitations on charges, or billing and collection practices. The absence of an intermediate sanction for these requirements is likely to be problematic. The ultimate penalty—loss of an organization's tax exemption—seems excessive unless the noncompliance is willful or extreme. To make matters worse, a tax-exempt organization that operates multiple hospitals can lose its tax exemption if only one of its hospitals is out of compliance.

In its comments responding to the IRS notice, the American Bar Association made several suggestions for a moderate approach to the application and enforcement of §501(r) (http://www.americanbar.org/content/dam/aba/migrated/tax/pubpolicy/2011/012011comments_2.authcheckdam.pdf). For example, the IRS might recognize compliance with similar preexisting state CHNA requirements similar to §501(r) laws as a 'safe harbor.' Other suggestions included limiting sanctions to a hospital that has a 'substantial failure' to comply, allowing a 'cure period' during which a noncompliant hospital has an opportunity to correct its noncompliance. It's my sense that IRS, in the short term, is unlikely to impose sanctions against a hospital that makes a good faith effort to satisfy the requirements of §501(r).

Hilltop: Has the IRS started monitoring compliance with §501(r)?

Stuart: The ACA requires review of each hospital organization's community benefit activities at least every three years, and the IRS review process has begun.

Hilltop: When do you think IRS will propose regulations or issue another form of guidance on §501(r)?

Stuart: I expect it won't happen all at once; it's probably going to be piecemeal. It's my sense that something will come out in a matter of weeks, maybe relating just to the CHNA requirements. I expect that by the end of the year, there will be final guidance that is more definitive and concrete.

A Look at State Policy: States with Minimum Expenditure Requirements

A primary goal of the Hospital Community Benefit Program is to analyze and present various methodologies states initiate to ensure that nonprofit hospitals fulfill their community benefit responsibilities.

One method observed in three states is minimum expenditure requirements. **Pennsylvania** (*10 Pa. Cons. Stat. Ann. §§371-85*) has established seven statutory standards—four of which are minimum expenditure

requirements. **Texas** (*Tex. Health & Safety Code Ann. §§ 311.031-.048*) has four statutory standards—all of which are specific to charity care. Minimum expenditure requirements in these two states are expressed as a percentage of net patient revenue. **Utah's State Tax Commission** has imposed the highest minimum expenditure standard among the three states, requiring hospitals seeking tax exemption to "provide gifts to the community in excess of [their] annual tax liability" (Coalition for Nonprofit Health Care, 2003). Nonprofit hospitals in Utah may exercise discretion as to what comprises gifts to the community.

Incorporating a minimum expenditure requirement as a model of accountability can be facilitated by the revised Schedule H (Form 990) and ACA requirements. There is more financial disclosure for states to articulate their desired benefit thresholds as defined by their community health needs assessment. To date, the effectiveness of minimum expenditure requirements in a post-ACA environment has not been examined. Assessing a nonprofit hospital's performance or effect on overall community health, rather than expenditure analysis alone, has been mentioned as an imperative concern.

The Hospital Community Benefit Program continues to investigate (1) the advantages and disadvantages of adopting minimum expenditure requirements based on hospital financial data reported through the revised Schedule H (Form 990), (2) the application and practicality of instituting such requirements, and (3) how the ACA may affect this model's functionality.

Key Research:

- Gray, B., & Schlesinger, M. (2009, July). Charitable expectations of nonprofit hospitals: Lessons from Maryland. *Health Affairs*. Retrieved from http://content.healthaffairs.org/content/28/5/w809.full.pdf+html
- Kennedy, F. A., Burney, L. L., Troyer, J. L., & Stroup, C. (2010, June). Do non-profit hospitals provide more charity care when faced with a mandatory minimum standard? Evidence from Texas. *Journal of Accounting and Public Policy* 29(3), 242-258.
- Coalition for Nonprofit Health Care. (2003). *Redefining the community benefit standard: State law approaches to ensuring the social accountability of nonprofit health care organizations.* Retrieved from http://www.communityhlth.org/communityhlth/files/files_resource/Community%20Benefit/CNHC_CommBeneReport.pdf

The Hilltop Institute Symposium

Many researchers, thought leaders, and practitioners involved with hospital community benefits attended a symposium sponsored by The Hilltop Institute on June 28, 2011. The symposium, *Responding to Community Health Needs within the Framework of the Affordable Care Act*, discussed hospital community benefit issues within the broader frame of community health. Among the speakers at the event were Michelle Larkin, Assistant Vice President of the Health Group at the Robert Wood Johnson Foundation; Abbey Cofsky, Program Officer with the Public Health Team at the Robert Wood Johnson Foundation; and Eileen Barsi, Director of Community Benefit at Catholic Healthcare West in San Francisco. Others present included Julie Trocchio, Connie Evashwick, and Chris Kinnebrew. To learn more about the speakers, view the presentations, and see the agenda, go to http://www.hilltopinstitute.org/Symposium/2011Symposium.cfm.

IRS Announcement 2011-37

On June 9, the IRS announced that Part V B of Schedule H (Form 990) is optional for the 2010 tax year. Part V B collects information about hospital organizations' activities relating to the community benefit requirements of I.R.C. §501(r). Lines 1-7 already were optional for tax years beginning on or before March 23, 2012. Announcement 2011-37 also makes optional questions in Schedule H relating to financial assistance policies (lines 8-13), billing and collections (lines 14-18), and charges for medical care (lines 19-21). The announcement reflects the IRS's decision to give hospital organizations more time to familiarize themselves with the new requirements of I.R.C. §501(r). All other sections of Schedule H remain mandatory. Regardless of whether or not a hospital organization elects to complete Part V B of Schedule H for 2010, hospitals with a 2010 tax year beginning after March 23, 2010, must submit audited financial statements.

Announcement 2011-20 directing hospital organizations not to file the 2010 Form 990 before July 1, 2011, and instituting an automatic three-month filing extension for hospital organization returns due before August 15, 2011, remains in effect. Announcement 2011-37 is posted at http://www.irs.gov/pub/irs-drop/a-11-37.pdf.

Upcoming Webinars

1. "Adapting Safety Net Access Programs to Serve the Changing Uninsured Populations," July 21, 2011, 11:00 to 12:00 PST, $40- $80. Sponsored by the Association for Community Health Improvement. http://www.communityhlth.org/communityhlth/education/audio.html#july21
2. "Assessing and Addressing Community Health Needs," October 25, 2011, 12:00 p.m. – 1:30 p.m. ET. Registration $0-$60. Sponsored by the Catholic Hospital Association and VHA, Inc. http://www.chausa.org/Pages/Events/Programs/CB_Webinar_-_Oct__2011/Overview

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a nationally recognized policy and research center dedicated to improving the health and wellbeing of vulnerable populations. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations, and nonprofit organizations at the national, state, and local levels.

***Hilltop's Hospital Community Benefit Program** is the central resource created specifically for state and local policymakers who seek to assure that tax-exempt hospital community benefit activities are more responsive to pressing community health needs. The program provides tools to state and local health departments, hospital regulators, legislators, revenue collection and budgeting agencies, and hospitals, as these stakeholders develop approaches that will best suit their communities and work toward a more accessible, coordinated, and effective community health system. The program is funded for three years through the generous sponsorship of the Robert Wood Johnson Foundation (www.rwjf.org) and the Kresge Foundation (www.kresge.org).*

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