Nonprofit Healthcare: What Does the Future Hold?

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It didn't come as any surprise to healthcare providers that when the Patient Protection and Affordable Care Act (PPACA) was passed last year, legislators managed to work in a few provisions about requirements for nonprofit healthcare providers. However, the requirements for conducting and reporting on the healthcare assessment, as well as some changes to how charges to patients qualifying for financial assistance and debt collection should be calculated did come as a surprise.

Key provisions of the healthcare reform legislation adopted in the PPACA and the Health Care and Education Reconciliation Act of 2010 (HCERA) introduce new requirements for all section 501(c)(3) organizations operating a state-licensed hospital or providing healthcare as their principal purpose. These organizations are required under new section 501(r) of the Internal Revenue Code to:

- Conduct a community health assessment for each hospital it operates at least every three years, implement a strategy to meet the needs identified in the assessment, and make the assessment available to the public.
- Publicize written financial assistance policies including eligibility criteria, basis for calculating patient charges, method for applying for assistance, and policies regarding the provision of emergency care on a non-discriminatory basis without regard to eligibility under the financial assistance policy.
- Limit charges to patients qualifying for financial assistance to amounts generally billed to insured patients for emergency or other medically necessary care.
- Comply with new billing and debt collection practices.

I. NEW REPORTING OBLIGATIONS

What Role Does The IRS Play Under These New Rules?

In addition to the operational changes, the IRS will review the tax-exempt status of each hospital every three years. Tax-exempt section 501(c)(3) hospitals will also be subject to the following additional reporting requirements on their annual Form 990 filed with the IRS:

- A description of the level of charity care.
- A designation of how the hospitals meet the needs identified in the health assessment or an explanation if those needs are not being met.
- A description of unreimbursed costs of means tested and non-means tested programs.
- Audited financial statements, prepared either on a separate or consolidated basis, which will be subject to the public disclosure rules applicable to Form 990 and therefore will be made available to the public.

In the anticipation of health reform, the IRS incorporated the following information requests into Schedule H of the 2009 Form 990 regarding charity care and community benefit:

- Cost, revenue offset, and net cost of charity care.
- Net cost of unreimbursed Medicaid services.

- Amount of community/health improvement services, research, cash, and in-kind contributions.
- Information on how the hospital's charity care policy is communicated to patients.

These new tax rules are a result of Sen. Charles Grassley's (R. IA) concern that tax-exempt hospitals were not "sufficiently operating in a charitable manner." The healthcare reform legislation requires the Department of Treasury (Treasury) and the Department of Health and Human Services (HHS) to submit an annual report to Congress on the level of charity care, bad debt expenses, and the unreimbursed costs of means tested and non-means tested government programs. Beginning in 2010, a tax-exempt hospital will have both the Treasury and HHS looking over its operations for at least five years when a final report to Congress is to be issued by these departments on the trends of the assessments reported on an annual basis.

In addition to the other compliance issues facing nonprofit hospitals today, the new legislation has added another layer of concern for hospital administrators. It is important that section 501(c)(3) hospitals conduct compliance audits on their operations not only on these new rules, but also on existing rules regarding good governance practices, excess benefit transactions, compensation, and potential Medicare and Medicaid fraud and abuse.

What Action Has the IRS Taken?

The IRS has redesigned its core reporting Form 990 to provide opportunities to describe how their policies and activities comply with the new act. In addition, a new Schedule H, with instructions, has been designed for hospitals.

The 2010 Form 990 Schedule H includes questions relating to the new requirements, currently in effect, addressing the financial assistance, emergency medical care, and billing and collection policies. These questions were optional for hospital organizations with tax years beginning on or before March 23, 2010, while required for those with tax years beginning after this date. For 2010 returns, all hospitals have the option to address these questions, with it becoming a requirement for tax years beginning after March 23, 2012. Note that the IRS recently solicited public comments on the Form 990 in IRS Announcement 2011-36.

New Reporting on a Facility-by-Facility Basis

Hospital organizations will file a single Schedule H with the organization's Form 990 for 2010; however, based on the new 501(r) requirements, one section requires separate reporting for each hospital facility.

On the 2010 Schedule H, Part V, "Facility Information" was expanded to include several new sections:

- Section A: The filer will list the hospital facilities it operated during the tax year.
- Section B: The filer will report separately on the activities, policies and practices of each of its hospital facilities listed in Section A. Since non-hospital healthcare facilities are not required to meet the requirements of section 501(r), hospital organizations do not need to report on the policies of non-hospital healthcare facilities listed in Part V, Section C in this section.
- Section C: The filer will list its non-hospital healthcare facilities.

Only Part V Section B of the 2010 Schedule H requires separate reporting for each individual hospital facility. All other portions will be completed on an organization-wide basis.

II. COMMUNITY HEALTH NEEDS ASSESSMENTS

IRS Issues Guidance on Tax-Exempt Hospitals CHNA Requirements

IRS Notice 2011-52 provides additional guidance on requirements to satisfy the community health needs assessment (CHNA) requirements of PPACA. As expected, the Notice requires that the assessment standard will be required for each hospital facility in a system of hospitals. The Notice substantially tracks the legislation under section 501(r) but leaves open several important issues. It also allows hospitals to rely on this initial guidance until six months after further guidance is issued. The IRS has asked for comments on the new requirements.

Other Hospital Organizations Required to Conduct CHNA

A state-licensed hospital facility operated through a disregarded entity, such as an LLC or other joint venture treated as a partnership, will be subject to section 501(r) when one party is a section 501(c)(3) organization. This also means that government hospitals that are (or seek to be) recognized under section 501(c)(3), even if they have a dual status under section 115 and section 501(c)(3), will be subject to alternative methods of complying with section 501(r)(3). This is true even if they are not required to file information return Form 990, but are required to file a business income tax Form 990T. Moreover, hospital facilities located outside of the United States will not be considered a state-licensed facility.

Hospital Organizations Operating Multiple Hospital Facilities

The Notice requires that hospital organizations operating more than one hospital facility must meet the requirements of section 501(r) separately for each hospital facility. Any facility for which the requirements are not separately met, will not be treated as an organization described in section 501(c)(3). The IRS and Treasury intend and require that a hospital conduct and adopt an implementation policy for each hospital facility it operates.

Documentation of a CHNA

- Written report including:
  - A description of the community served. This is generally defined by a geographical location such as a city, county or metropolitan region. A community may also take into consideration certain hospital focus areas i.e., cancer, orthopedic or behavioral health. The Notice cautions that "community" should not be defined so narrowly as to avoid addressing the need of targeted groups, such as the elderly or low income individuals.
  - Process and methods used to conduct the assessment including collaboration with other hospital organizations.
  - Identification of organizations with which hospital organizations consulted.
  - Prioritized description of all of the community health needs identified by the CHNA.
  - Description of existing healthcare facilities within the community available to meet the community health needs identified in the CHNA.

- An implementation strategy:
  - That is separate from the written report specifically addressing each of the community health needs. The implementation strategy must be approved by an authority or governing body of the hospital facility.

Conducting the CHNA; Penalties for Failure to Comply

- The CHNA must describe the process and methods used to conduct the CHNA, including any data or information that identified the community health need. If the hospital collaborated with other organizations, such organizations must be identified along with any potential gaps in data collection.
- The CHNA must be conducted in the tax year that a written report is made and must be widely available to the public. This means that the written CHNA and the implementation plan must be made available in the same tax year. Under section 501(r) the CHNA must be conducted every three years. Otherwise, a hospital's tax-exempt status under section 501(c)(3) could be revoked and the hospital subjected to a $50,000 penalty excise tax.
- The Notice indicates that the CHNA can be published on the hospital website and will be considered "widely publicized" if:
  - The website indicates that the report is available and how it can be downloaded, in a format that can either be viewed or printed, without any special hardware or charge, and how individual copies can be obtained.
  - In this regard, it should be understood that substantial compliance is not good enough. The CHNA will be considered conducted only if it (1) identifies and assesses the health needs and (2) considers input from persons who represent the broad needs of the community. The Notice makes clear that the CHNA cannot rely on state law community benefit reporting to meet the CHNA requirements.

Implementation Strategy

Once the CHNA report is prepared, an implementation strategy for each hospital facility operated by an organization must be designed in writing addressing each of the health needs and how the hospital either addresses or plans to address the need. If the hospital does not plan to address the need, it must provide an explanation.

The strategy plan must contain a description and data to support its explanation looking at hospital resources and priorities and how hospital resources and plans will meet the health need. Similar to the CHNA report, the hospital can engage in collaborative efforts with government agencies and other nonprofit organizations to implement its strategy. It may also collaborate with related hospital organizations; however, the implementation strategy will still be required for each hospital on an individual basis.

Adoption

The implementation strategy is adopted only when it is approved by either an authorized governing body of the hospital, i.e., board of directors controlling the hospital; a committee of the governing body that can legally act for the board; or a party that is authorized to act on its behalf.

Hospitals must take special care that the implementation strategy be approved in the same taxable year that CHNA is approved.

What Guidance Did the IRS Fail to Provide?

The IRS did not provide guidance on the effect on a hospital system when one hospital, as part of a system, fails to meet the 501(r) requirements. It had been suggested by various commentators that the system should still be able to qualify under 501(c)(4) until all the individual hospitals are in compliance. The IRS and Treasury have deferred to future guidance for the consequences of failing to meet the CHNA requirements.

What Issues Are Causing Hospitals Concern?

- Requirement that hospitals adopt an implementation strategy and have it approved by the board of directors or committee of a board before the end of the tax year. The perceived problem is that hospital boards only meet once a quarter and the assessment has to be conducted in the same tax year.
- Requirement for hospitals to address "all identified needs" in the implementation study even though section 501(r) only contemplated that a hospital could choose those priorities which need to be addressed.
- "Community served" under the proposed Notice is defined by its geographic locations and target populations. It does not mention teaching and research activities which are important activities for hospitals that draw international patients.

For a further discussion of section 501(r) and initial concerns raised by the nonprofit community, see "IRS Offers Three-Month Filing Extension of Form 990 for Exempt Hospital Entities," "Nonprofit Health Lawyers Present Unique Approach to Section 501(r)," "IRS Addresses Hospital Concerns Regarding Section 501(r)," and "Nonprofit Hospitals in Need of an Aspirin."

Additional Categories of Tax-Exempt Organizations Ushered in Under PPACA include:

- **Small** Business **Health Option Programs (SHOPs)** operating under section 501(c)(29) of the IRC created under PPACA to establish requirements for qualified nonprofit health insurance issuers in order to receive grants from HHS.
- **Nonprofit Health Insurance Insurer (NHIIs)** operating under section 501(c)(29) and organized as a nonprofit issuer of health plans in the individual and small group market that meets certain requirements.
- **Accountable Care Organizations (ACOs)** providing managed care for groups of Medicare beneficiaries. Under PPAC, ACOs that meet quality standards would share in any costs savings achieved by more efficient care delivery.
- **Health Insurance Exchanges (HIEs)** that assist uninsured individuals to purchase health insurance and employees of small businesses that do not provide health benefits. Under PPACA, states are required to include a risk adjustment program for health plans that would compensate insurers handling pools of the insured with higher risks.

The IRS has issued guidance on how two of these organizations could qualify for 501(c) tax-exempt status. A lot of attention has been directed to ACOs and NHIIs.

III. ACCOUNTABLE CARE ORGANIZATIONS

On March 31, 2011, together with proposed regulations and guidelines from several other federal regulatory agencies, the IRS issued Notice 2011-20 to

solicit public commentary on the application of current law to tax-exempt organizations participating in the Medicare Shared Savings Program (MSSP) through ACOs. Rather than proposing new regulations, the IRS solicited comments from the public to assess the impact of ACO participation on tax-exempt status, private benefit and unrelated business income. In addition, the IRS is soliciting comments on whether additional guidance is needed for other types of shared savings arrangements with commercial payors (aside from the MSSP).

Private Benefit

The IRS said that due to the Centers for Medicare and Medical Services (CMS), oversight in the compliance and eligibility for participation of ACOs in the MSSP program would not “generally” result in prohibited inurement or private benefit if the following guidelines were met:

- The terms of the tax-exempt organization's participation (including its share of MSSP payments) are set forth in advance in writing and negotiated at arm's length.
- CMS has accepted the ACO into the MSSP.
- The tax-exempt entity's share of economic benefits from the ACO is proportional to the benefits or contributions provided to the ACO by the tax-exempt entity. If the tax exempt entity receives an ownership interest in the ACO, the amount of its capital contributions must be proportional and equal in value to its ownership interest and distributions must be made in proportion to ownership interests.
- The tax-exempt entity's share of the ACO's losses doesn't exceed its share of the economic benefits.
- All transactions among the tax-exempt entity and the ACO (or its participants) must be fair market value.

Unrelated Business Income Tax

Absent any inurement or private benefit, participation in an ACO would be substantially related to the charitable purpose of "lessening the burdens of government," so long as the ACO is satisfying CMS' participation requirements. This is due in part to the fact that the MSSP was conceived as a way to help reduce governmental costs (and increase quality) associated with the Medicare program. As a result, ACO participation in the MSSP generally shouldn't generate unrelated business income tax (UBIT) for its tax-exempt stakeholders.

Treatment of Activities Unrelated to MSSP

The more difficult question involves ACOs that conduct activities outside the context of the MSSP. The IRS appears to indicate that some of these activities will not be related to charitable activities (e.g., negotiating with private payors on behalf of unrelated parties). Other activities, such as participating in shared savings arrangements with Medicaid, could be determined to further or be substantially related to a charitable purpose. In this Notice, the IRS does not specifically identify which types of activities would or would not be deemed to further charitable purposes. As a result, it is still unclear as to which non-MSSP activities could result in threats to an organization's tax-exempt status or UBIT. The IRS is soliciting comments on this issue in particular. They have asked that comments address the following: (1) description of activities a tax-exempt entity might participate in through an ACO; (2) the rationale whereby participation in non-MSSP activities might further exempt purposes; (3) what criteria,

requirements and safeguards would ensure furtherance of exempt purposes (given the absence of the types of safeguards that are present in MSSP, such as quality standards and oversight and monitoring).

What Activities Are Deemed Charitable

While the IRS did not identify which activities would or would not be deemed to further charitable purposes, it did cite two important precedents that have guided IRS positions in the past. First, in Revenue Ruling 98-15, the IRS recognized that the activities of a LLC are considered to be the activities of a nonprofit organization that is an owner of the LLC when evaluating whether the nonprofit organization is operated exclusively for tax-exempt purposes within the meaning of section 501(c)(3). Apparently, the IRS will review ACOs in the same manner. Second, the IRS cited Revenue Ruling 2004-51 for the proposition that the activities of an LLC treated as a partnership for federal tax purposes will be attributed to a tax-exempt entity for the purpose of determining whether the tax-exempt organization was engaged in an unrelated trade or business. Since these two revenue rulings were cited in the published Notice, it is a signal that the IRS may not be backing off of its general approach to joint ventures in the ACO context.

More Guidance on Accountable Care Organizations Needed From IRS

While Notice 2011-20 appears to assure tax-exemption to participants that are properly structured ACOs and organizations that meet CMS criteria, other statements in the Notice indicate that the IRS will evaluate ACO arrangements on a case-by-case basis. The American Hospital Association (AHA) has requested that the IRS specifically address the potential for tax-exempt status for an eligible ACO itself and to issue the following guidance:

- A clear statement that tax-exempt hospitals, participating in an eligible ACO, will not result in impermissible inurement and private benefit and will not generate UBIT, so long as the ACO complies with regulations promulgated by CMS.
- A clear statement indicating whether the IRS will consider granting tax-exempt status to ACOs.
- Clear guidance that the IRS will extend its existing joint venture precedents to other clinically integrated organizations that do not choose to participate in the ACO program, but provide similar benefits, and do so in a flexible manner that recognizes that such organizations may take a variety of forms in their efforts to provide accountable care to diverse communities.

Joint Venture Guidance on the Following Factors Suggested by the AHA:

- The venture promotes health among a broad spectrum of the community.
- The amount of control the tax-exempt organization exerts over the venture, which may be evidenced either by the number of votes the exempt organization possesses on the board, the power that is granted to the exempt organization by the venture's governing documents, or the operational role of the exempt organization in the venture. See Rev. Rul. 98-15 and Rev. Rul. 2004-51.
- Management of the entity consistent with tax-exempt purposes evidenced by provisions in the organizational documents of the venture and also in the management of the venture by parties unrelated to the for-profit member.

- Limitations on investment made by the tax-exempt organization and the exempt organization's ownership interests in the venture relative to its investment.
- Distributions received and whether they are consistent with the parties' economic interests in the venture.
- Expertise that an exempt organization obtains from the venture , which may not be otherwise available to it.
- Recruitment incentives to physicians that reasonably promote and protect the health needs of the community under Rev. Rul. 97-21.

Other Concerns Expressed about Notice 2011-20

Proportionality

Recently released letters from major hospital associations focus on whether the IRS requirement on proportionality will be a big disincentive for doctors and other service providers to be involved in a joint venture ACO. The comments specifically question the IRS requirement regarding proportionality of gains and losses based on ownership interests and capital contributions rather than applying the CMS' approach which appears to contemplate the distributions of significant portions of the shared savings based on the medical care provider's contributions towards quality performance and attainment of savings goals – irrespective of ownership interests.

Disincentives

The comments also noted that there are disincentives for entering into an ACO because of the sizeable startup costs for hospitals and doctors who are concerned about being adequately rewarded for their efforts. CMS has estimated that startup costs for the first year of an ACO's existence will be in the range of $131-$263 million. More guidance is also needed on the issues of impermissible private benefit. This issue was also raised in the AHA's comment on May 31, for guidance from the IRS that financial incentives to staff physicians would not be treated as impermissible private benefit and clarification on what factors would trigger a review of an arm's length transaction.

IV. HEALTH INSURANCE ENTITIES

IRS Issues First Guidance on Exempt Health Insurance Entities

IRS-issued guidance on the tax-exemption requirements for qualified NHIIs described in Internal Revenue Code Section 501(c)(29) in IRS Notice 2011-23 on March 10, 2011. Like ACOs regulated by CMS, IRS is likely to rely heavily on the HHS determinations whether these consumer operated and oriented plans (co-ops) will be granted tax-exempt status.

Qualified Nonprofit Health Insurance Issuers

A qualified NHIIs is an organization: (1) that is organized as a nonprofit, member corporation under state law; (2) where substantially all of its activities consist of the issuance of qualified health plans in the individual and small group markets in each state in which it is licensed to issue such plans; and (3) that meets additional requirements set forth in subsections (c)(2). Under the program HHS will award loans and grants to entities applying to become NHII providers. The program must be approved by both the IRS and HHS.

Affordable Care Act Excludes Certain Issuers

Excluded are organizations or their related entities, or a predecessor of either, that was a NHII as of July 16, 2009; or an organization that is sponsored by a state or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision.

Requirements to be a Qualified NHII Issuer

- Governance requirements.
- Must use any profits that it makes to lower premiums, improve benefits, or for other programs intended to improve the quality of healthcare delivered to members.
- Must meet all state law requirements that other issuers of qualified health plans are required to meet in any state where the issuer offers a qualified health plan.
- Qualified issuer may not offer a health plan in a state until that state has in effect (or the Secretary of HHS has implemented for the state) the market reforms required by a part of a title XXVII of the Public Health Service Act, as amended by the PPACA.
- Qualified issuer that receives a grant or loan under the co-op program must enter into an agreement with HHS, which requires it to meet (and continue to meet) both the requirements under § 1322 to be treated as a qualified issuer, and all requirements of the loan or grant agreement. Such an agreement must include a requirement that no portion of the funds made available by any loan or grant under the co-op program may be used for carrying on propaganda, or otherwise attempting, to influence legislation, or for marketing.

Section 501(c)(29) Requirements for Tax-Exempt Status

An organization is tax-exempt under Section 501(c)(29) if:

- It received a loan or grant under the co-op program and is compliant with PPACA requirements and any loan or grant agreement with HHS.
- It gives notice to Treasury that it plans to apply for exempt status recognition as an organization under Section 501(c)(29).
- None of the organization's earnings “inure to the benefit of any private shareholder or individual.”
- It does not attempt to influence legislation.
- It does not participate in political campaigns for or against any candidates for public office.

Revenue Procedure

The IRS said it plans to issue a revenue procedure on how and when qualified NHII issuers can apply for recognition of tax-exempt status. The procedure also will address the effective date of a qualified issuer's tax-exempt status. The service said it will not accept applications before guidance is published.

Request for Comments

The Treasury and IRS requested comments on or before May 27, 2011, regarding the above provisions, including, in particular, the need, if any, for guidance regarding such provisions. Comments were specifically requested regarding:

1. Any special factors the IRS should consider when establishing procedures for applying for recognition of tax-exempt status under §501(c)(29).
2. The proposed effective date of qualified issuer's tax exemption, as described in Section 7 of the Notice.
3. Any special consideration regarding the application to qualified issuers of the prohibition on private inurement in 501(c)(29)(B)(iv), the taxation of excess benefit transactions under §4958, and the taxation of unrelated business taxable income under §511.

CONCLUSION:

As we see from the above discussion, the nonprofit healthcare area is complex, evolving and filled with uncertainty as the health sector seeks to work with the guidance and regulations that are being issued by the federal agencies charged with implementing the PPACA passed by Congress. At the same time, Congress continues to address the concerns about the growing cost of healthcare and seeks to create new and creative vehicles to deliver needed healthcare. It is important for healthcare leaders to keep informed, seek the advice of experts, and react as new interpretations of the law are developed at the congressional and regulatory level that affect their operations.

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