Community Benefit & Other Tax-Exempt Hospital Requirements

Community Benefit Definition:

Community benefit is a well-defined set of activities articulated by the Internal Revenue Service in its instructions to its Form 990 Schedule H https://www.irs.gov/pub/irs-pdf/i990sh.pdf. Community benefits are programs and services designed to improve health in communities and increase access to health care. IRS Form 990, Schedule H instructions defines community benefit as activities or programs that respond to community health needs and that seek to achieve one or more of the following objectives: improving access to health services, enhancing public health, advancing generalizable knowledge and relieving the government burden to improve health.

Community benefit activities are integral to the mission of Catholic and other not-for-profit health care organizations and are the basis of tax exemption. For over 30 years, CHA has been the leading source of information and tools for planning and reporting hospital community benefit. In 2008, CHA's accounting system for reporting community benefit was used in the development of the IRS Form 990 Schedule H.

Community Benefit Requirements:

IRC Section 501(c)(3)* and *Revenue Ruling 69-545	***IRS Form 990, Schedule H* reporting requirements and *instructions***	***IRC 501(r)(3)* requirements**
Published in 1969, RR 69-545 describes a non-profit hospital having the following characteristics which, collectively, warrant tax exemption under Section 501(c)(3). • Operating an emergency room open to all, regardless of ability to pay • Maintaining a board of directors drawn from the community • Maintaining an open medical staff policy • Providing hospital care for all patients able to pay, including those who pay their bills through public programs such as Medicaid and Medicare • Using surplus funds to improve facilities, equipment, and patient care • Using surplus funds to advance medical training, education, and research	*Introduced in 2008, Form 990 Schedule H requires tax-exempt hospital organizations to:* • Annually Report community benefit spending and activities by Employer Identification Number (EIN) • Report compliance with organization-wide community benefit standards • Report financial assistance and other community benefits in Sch. H, Part I, community-building activities in Part II, Medicare and bad debt in Part III, and Supplemental information in Part IV *After passage of ACA, IRS added reporting requirements on 501(r) in Part V of Sch. H.* • Annually reported for each hospital facility included in EIN • Includes reporting of compliance with community health needs assessment, financial assistance policy, and billing and collections requirements	*Enacted as part of the 2010 Affordable Care Act, imposed additional requirements for tax-exempt, non-governmental hospitals to promote transparency, clarity, and communications in the following areas:* • Community Health Needs Assessment (CHNA)* Section 501(r)(3) • Financial Assistance Policy and Emergency Medical Care Policy** Section 501(r)(4) • Limitations on Charges^^ Section 501(r)(5) • Billing and Collections^ Section 501(r)(6)

Community Benefit Compliance:

The Affordable Care Act (ACA) requires the IRS to review, once every three years, community benefit activities of each tax-exempt hospital. In response, the IRS reviews approximately 1,000 tax-exempt hospitals each year. These reviews include hospitals' Forms 990 Schedule H, hospitals' websites and other public and nonpublic information on hospitals' community benefit.

IRS has reported conducting over 500 501(r)-related exams through its 2018 fiscal year and has assessed over 100 $50,000 excise taxes for CHNA violations. In the Tax Exempt and Government Entities (TE/GE) 2022 Accomplishments Letter, IRS provided data on 501(r) community benefit reviews of tax-exempt hospitals, reporting 1,260 reviews conducted, 67 hospitals referred for exam and 58 closed examinations in FY22. It is 2021 Accomplishment letter it reported 1,019 reviews conducted and 71 hospitals referred for exam.

*Community Health Needs Assessment (CHNA)

Section 501(r)(3)

Requires tax-exempt, non-governmental hospitals to conduct a CHNA and develop and adopt a CHNA report and an Implementation Strategy (IS), which identify and describe plans to address identified significant community health needs, at least once every 3 years.

CHNA: This written report must be adopted by the governing board of each hospital facility, made widely available to the public, and include

- Definition of community served,
- Description of the process and methods used to assess the health needs of the community,
- How the hospital solicited and took into account input from the community, including a public health agency, on identifying and prioritizing significant community health needs,
- Description of significant community health needs and prioritization,
- Description of resources potentially available to address the identified needs, and
- Evaluation of impact of any actions taken since prior CHNA

Implementation Strategy (IS): This written report must be adopted by the governing body of the hospital facility and either attached to Form 990, Schedule H or posted online. The written IS describes what actions the hospital plans to take to meet significant health needs identified in its CHNA, the anticipated impact of these actions, programs and resources the hospital plans to commit to address those health needs, and any planned collaboration between the hospital facility and other facilities or organizations. For each significant health need identified in its CHNA report that the hospital does not intend to meet, the IS needs to explain why the hospital does not intend to meet that heath need.

** Financial Assistance Policy and Emergency Medical Care Policy Section 501(r)(4)

Each hospital facility must establish a written financial assistance policy (FAP) that applies to all emergency and other medically necessary care provided by the hospital facility. The FAP must describe the financial assistance (including discounts and free care), eligibility criteria for financial assistance (including income/asset limits, how prior FAP eligibility will be used for current determinations). FAP must list non-employed providers who deliver emergency or other medically necessary care in the facility, and which providers are and are not covered under the FAP.

The hospital facility must widely publicize the FAP, FAP application form, and plain language summary of the FAP in the community it serves. This includes conspicuous notice on all bills and public displays (including the emergency room and admissions areas). These documents must be available in English and in any other language in which limited English proficiency (LEP) populations constitute more than the lesser of 1,000 individuals or 5% of the community served by the hospital.

Each hospital facility must have an emergency care policy requiring the facility to provide care, without discrimination, for emergency medical conditions to individuals whether or not they are FAP-eligible, and prohibiting the facility from engaging in actions that discourage individuals from seeking emergency medical care. The emergency medical care policy may be included in the same document as the FAP, or in a document relating to emergency medical care (e.g., document setting forth Emergency Medical Treatment and Active Labor Act (EMTALA) compliance requirements).

^Billing and collections requirements Section 501(r)(6)

A hospital facility may not engage in extraordinary collection actions (ECAs) against an individual, or another individual responsible for payment of the individual's bill for hospital care, before making "reasonable efforts" to determine the individual's eligibility under the FAP.

Applies to any ECAs taken by:

- Any purchaser of the individual's debt,
- Any debt collection agency to which the facility referred debt, or
- Any substantially related entity

ECAs include:

- Selling an individual's debt, except with an agreement that restricts purchaser from engaging in ECAs and meets certain other conditions.
- Requiring payment on past unpaid bills for FAP-related care before providing medically necessary care or defer or deny such care because of nonpayment.
- Reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus.
- Actions requiring a legal or judicial process, including imposition of liens and garnishments.

Reasonable efforts include minimum notification actions and providing FAP application timelines.

^^Limitations on charges

A hospital facility must limit the amounts charged for to any FAP-eligible individual for care covered under the FAP. The amount "charged" includes the amount a FAP-eligible individual is personally responsible for paying, after all deductions and discounts (including those under the FAP), and less any amounts reimbursed by insurers, as follows:

- In the case of emergency or other medically necessary care: Amounts charged must not exceed more than the amounts generally billed (AGB) for individuals who have insurance covering such care
- In the case of all other medical care: Amounts charged must not exceed the gross charges for such care.

There are two acceptable methods for determining AGB - the look-back method, and the prospective Medicare or Medicaid method.
Safe harbor: Even if a hospital facility charges more than AGB, it will meet the Section 501(r)(5) limitation if:

- The charge in excess of AGB was not made as a pre-condition of providing medically necessary care to the FAP-eligible individual,
- FAP-eligible individual has not submitted a complete FAP application at the time of the charge, and
- If the individual subsequently submits a complete FAP application and is determined eligible, the hospital refunds any amounts that the individual paid that exceed the amount he/she is determined to be responsible for paying.
- Regulations include a $5 *de minimis* exception.

CHA Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

About The Catholic Health Association of the United States (CHA)

For over 30 years, CHA has been the leading source of information and tools for planning and reporting hospital community benefit. In 2008, CHA's accounting system for reporting community benefit was used in the development of the IRS Form 990 Schedule H.

A Passionate Voice for Compassionate Care. CHA represents more than 650 hospitals and 1,600 long-term care and other health facilities in all fifty states. Our hospitals were established to address health needs in their communities and that tradition continues today. Catholic hospitals are a critical source of care and services in their communities. This includes community-based services that address significant health and health-related needs reported as community benefit.