American Hospital Association

Legal Advisory

March 14, 2011

REVISED SCHEDULE H AND INSTRUCTIONS AND MANDATORY EXTENSION FOR FILING IRS FORM 990

AT A GLANCE

The Issue:

On February 23, the Internal Revenue Service (IRS) released a revised Schedule H with Instructions, and announced a mandatory three-month extension for filing IRS Form 990 for certain filers. All filers with "hospital organizations" that have filing due dates before August 15, 2011 are directed **not** to file before July 1. In addition, the IRS amended Part V of Schedule H to incorporate into Form 990 the requirements of the recently enacted Internal Revenue Code Section 501(r), which sets forth new standards for exemption from federal income taxes for hospitals.

The new "H" vastly expands the paperwork required of hospitals beyond what is called for by the statute. Section V.B. requires responses to 21 questions, most of which have multiple sub-questions on behalf of **each** of the hospital's licensed facilities. Any facility that does not meet the new standards will not be considered to be exempt. The IRS has not provided any guidance to hospitals in respect of the new standards or the consequences of a facility losing exempt status.

Part V.B. lines 1-7 notes that the seven questions regarding community needs assessment are "optional" for the 2010 filing. The Instructions explain that 501(r)(3) does not impose community health needs assessment requirements until tax years beginning after March 23, 2012. The rest of Part V.B. is not marked "optional", but the questions are **NOT** applicable to hospitals whose 2010 fiscal year began **BEFORE** March 23, 2010. **Therefore, the newly revised 2010 Schedule H Part V.B. is entirely optional for calendar year filers and for filers whose fiscal year began January 1 through March 23, 2010.**

Our Take:

We believe that the mandatory extension is misleading, as it encourages filing for periods before the law was enacted. In addition, the new reporting requirements are onerous and redundant, and out of step with President Obama's call for "cutting down on the paperwork that saddles businesses with huge administrative costs." The revisions also contradict recommendations submitted to the IRS by AHA and other associations in September 2010, and the agency has left key issues unaddressed. The AHA will advocate for a resolution of these issues to reduce the burdens imposed on hospitals by the new Schedule H that are not necessary for compliance with Section 501(r).

What You Can Do:

Although the IRS extended the submission deadline for certain filers, hospitals that are not required to comply with 501(r) in 2010 should **NOT** complete Part V.B. Until further guidance is issued, hospitals should carefully review the revised Schedule H, specifically Section V.B., to determine what information will be required, and to consider what systems will be needed to provide such information. For those whose fiscal year begins after March 23, 2010, the window for compiling this information is short, and hospitals are urged to act promptly.

Further Questions:

Contact Melinda Hatton, AHA senior vice president and general counsel, at (202) 626-2336 or mhatton@aha.org or Maureen Mudron, AHA deputy general counsel, at (202) 626-2301 or mmudron@aha.org.

AHA's Legal Advisories are produced whenever there are significant developments that affect the job you do in your community. A five-page, in-depth examination of this issue follows.

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BACKGROUND

On February 23, the Internal Revenue Service (IRS) released a revised Schedule H with Instructions, and announced a mandatory three-month extension for filing IRS Form 990 for certain filers. All filers with "hospital organizations" that have filing due dates before August 15, 2011 are directed **not** to file before July 1. In addition, the IRS amended Part V of Schedule H to incorporate into Form 990 the requirements of the recently enacted Internal Revenue Code (IRC) Section 501(r), which sets forth new standards for exemption from federal income taxes for hospitals.

The new "H" vastly expands the paperwork required of hospitals beyond what is called for by the statute. Section V.B. requires responses to 21 questions, most of which have multiple sub-questions on behalf of **each** of the hospital's licensed facilities. Any facility that does not meet the new standards will not be considered to be exempt. The IRS has not provided any guidance to hospitals in respect of the new standards or the consequences of a facility losing exempt status.

Part V.B. Lines 1-7 notes that the seven questions regarding community needs assessment are "optional" for the 2010 filing. The Instructions explain that 501(r)(3) does not impose community health needs assessment requirements until tax years beginning after March 23, 2012. The rest of Part V.B. is not marked "optional", but the questions are **NOT** applicable to hospitals whose 2010 fiscal year began **BEFORE** March 23, 2010. **Therefore, the newly revised 2010 Schedule H Part V.B. is entirely optional for calendar year filers and for filers whose fiscal year began January 1 through March 23, 2010.**

Section 501(r)

Section 501(r) was added to the IRC by the *Patient Protection and Affordable Care Act of 2010* (PPACA). It imposes four additional requirements on hospital organizations that either operate a facility "required by a State to be licensed, registered, or similarly recognized as a hospital" or that the "Secretary determines has the provision of hospital care as its principal function." The requirements must be separately satisfied by each hospital facility operated by a hospital organization in order to maintain the hospital facility's tax-exempt status under IRC Section 501(c)(3).

Three of the four requirements became effective for tax years that begin after March 23, 2010. The community health needs assessment requirement will be effective March 23, 2012. The four requirements are summarized briefly below.

Community health needs assessment. The assessment must be conducted every three years, and the hospital must adopt an implementation strategy to meet the community health needs identified by the assessment.

Financial assistance policy. A hospital must adopt a written financial assistance policy that details eligibility criteria for such assistance, the basis for calculating amounts charged, methods of application for assistance, and actions that may be taken in cases of nonpayment by organizations without separate billing and collections policies. Additionally, a hospital must provide care for emergency medical conditions, regardless of an individual's eligibility for financial assistance.

Limitation on charges. A hospital must limit charges for emergency or other medically necessary care provided to individuals eligible for financial assistance to amounts generally billed to individuals who have insurance covering such care. A hospital is prohibited from using gross charges to bill patients.

Billing and collection. A hospital must refrain from extraordinary collection actions before making reasonable efforts to determine an individual's eligibility for financial assistance.

AT ISSUE

Part V, titled "Facility Information," requires the hospital organization to complete a separate Section V.B. for each facility either licensed, registered or similarly recognized as a hospital. Section V.B. is **optional** for hospital organizations reporting tax years beginning on or before March 23, 2010. Schedule H does not, however, indicate that Section V.B. is optional, which will result in confusion and reporting by hospitals before they have fully complied with 501(r).

Instructions to Schedule H require a hospital organization to first list and classify each facility operated during the tax year in Section V.A. Then, for each facility identified in Section V.A., the organization must answer a series of questions in Section V.B., aimed at monitoring compliance with the four requirements of Code Section 501(r). A new Section V.C. requires the hospital to list all non-hospital health care facilities operated during the year, but exempts the organization from completing Section V.B. for such facilities.

The Instructions also direct a hospital organization to submit a copy of its audited financial statements to the IRS. If a hospital files a consolidated financial statement with other organizations, the consolidated financial statement must be attached to Form 990.

In addition to the onerous reporting obligations imposed on hospital organizations by Section V.B., Section V.C. requires disclosure not contemplated by Section 501(r). The provisions of Section 501(r) apply only to licensed or similarly recognized hospitals or facilities providing "hospital care." Section V.C., on the other hand, mandates disclosure of all non-hospital health care facilities that an organization operates, including

"rehabilitation and outpatient clinics, diagnostic centers, long-term acute care facilities, and skilled nursing facilities." Such disclosures contravene the explicit provisions of Section 501(r); they reach beyond the scope of Section 501(r); and they should be eliminated.

Schedule H, Section V.B. and 501(r) Requirements

Community Health Needs Assessment. Lines 1 through 7 of Section V.B. evaluate a hospital's compliance with the community health needs assessment requirement. Section 501(r)(3)(B) requires that a community health needs assessment be conducted every three years and it should be conducted so that it:

> (i) takes into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and
> (ii) is made widely available to the public.

The 28 detailed questions inquire at the facility level whether and when a "needs assessment" was conducted, what the needs assessment described, how the assessment was publicized, and how the needs identified in the assessment were addressed. There is no question that allows a hospital to respond that the community health needs assessment is conducted jointly on behalf of all facilities. In fact, this section does the opposite. After completing each of the 28 questions for **each** facility, Question 4 requires that each facility list each of the **other** facilities that participated in the community health needs assessment. Neither the question nor the instructions allow a hospital to respond that **all** facilities participated, or to list once **which** facilities participated. Rather the question and instructions require redundancy in the required responses, and supplemental information called for in Part VI.

Financial Assistance Policy. The financial assistance policy requirements in Code Section 501(r)(4) are reflected in Lines 8 through 13 of section V.B. Section 501(r)(4)(A) mandates a hospital to adopt a financial assistance policy that includes:

> (i) eligibility criteria for financial assistance and whether such assistance includes free or discounted care,
> (ii) the basis for calculating amounts charged to patients,
> (iii) the method for applying for financial assistance,
> (iv) in the case of an organization which does not have a separate billing and collections policy, the actions the organization may take in the event of non-payment including collections action and reporting to credit agencies, and
> (v) measures to widely publicize the policy within the community to be served by the organization.

As part of the financial assistance requirement, a hospital must have a written policy requiring the organization to provide, without discrimination, care for emergency medical conditions to individuals, regardless of their eligibility under the financial assistance policy.

Further, Lines 8 through 13 replicate many of the inquiries contained in other sections of Schedule H. For example, Line 8 asks whether a policy explains eligibility criteria for financial assistance and Line 13 requires hospitals to indicate how the financial criteria

were publicized. Such questions, however, are covered in other parts of Schedule H. Part I, Line 1(a) already asks whether an organization has a financial assistance policy and Part VI, Line 3 requires a facility to describe its efforts to publicize various financial assistance programs. These Parts could have been modified to reflect new Section 501(r)(4) so as to avoid duplication. Instead redundancy of responses was the approach adopted by the IRS.

Lines 9 and 10 are particularly superfluous. In combination, they inquire about a hospital's use of federal poverty guidelines (FPG) to determine eligibility for providing either free or discounted care to low-income individuals and instruct a hospital to indicate the FPG family limit for free or discounted care. By referring to FPGs, the IRS implies that the guidelines should be used as eligibility criteria for financial assistance. However, Section 501(r)(4)(A)(i) only requires a description of criteria for eligibility under a hospital's financial assistance policy. The section does not prescribe that the FPG are the only means to meet the criteria. Part I Lines 3(a) and 3(b) request identical information from a hospital on a hospital-wide basis, but due to the facility by facility exemption standard in 501(r) Part V.B. Lines 9 and 10 must be completed for each facility, and the hospital still must respond to Part I. Again a policy of redundancy has been implemented instead of elimination of questions that require duplication of information submitted.

Billing and Collection. Section 501(r)(6) prohibits a hospital from engaging in "extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for financial assistance under the assistance policy. . ." Part V.B., Lines 14 through 17 inquire about a facility's billing and collections policies. Line 15 asks whether collection actions such as lawsuits, reporting to credit agencies, liens on residencies or body attachments were permitted during the tax year. Presumably this list of collection actions constitutes "extraordinary collection" efforts, but the IRS has yet to provide a general definition of the term and the Instructions fail to indicate whether such activities constitute "extraordinary collection actions." Likewise, on Line 17 the IRS lists actions that presumably represent "reasonable efforts" used to determine a patient's eligibility for financial assistance, again without defining the term. However, it is unclear whether taking only one or some of the listed actions would suffice as a "reasonable effort."

Limitation on Charges. Section 501(r)(5)(A) limits the amounts charged for emergency or other medically necessary care by providing that:

> (5) LIMITATION ON CHARGES.—An organization meets the requirements of this paragraph if the organization—
>
> (A) limits amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy described in paragraph (4)(A) to not more than the amounts generally billed to individuals who have insurance covering such care, and
>
> (B) prohibits the use of gross charges.

Part V.B., Lines 19 through 21 address the limitation-on-charges requirement of Section 501(r)(5). Line 19 asks how amounts billed to individuals who do not have insurance are determined. Line 20 asks if those eligible for assistance were billed more than those who had insurance. Line 21 asks if the hospital billed any patient using gross charges.

Both Lines 19 and 21 go beyond the reach of 501(r) and more is needed to make an informed answer to Line 20.

The statute is clear that the limitation on amounts billed only applies to individuals eligible for financial assistance (See 501(r)(5)(A)). And while the literal language of the prohibition on the use of gross charges in 501(r)(5)(B) is general, it is widely believed, however, that Congressional intent was to place limitations only on charges to those patients who qualified or could qualify for financial assistance. If a hospital facility used gross charges to bill wealthy uninsured patients, and therefore answers "yes" to Question 21, the facility will violate Section 501(r)(5)(B) and will risk losing its tax-exempt status. The IRS must issue guidance to address this discrepancy, because Congress could not have intended that a hospital facility can lose its tax-exemption for charging gross charges to a wealthy uninsured patient. Similarly, the IRS should clarify that Question 19 only applies to individuals qualified or who could qualify for financial assistance. Lastly, because the Instructions fail to explain how a facility should calculate an "amount that is generally billed," there is no way for an informed answer to be provided to Question 20.

NEXT STEPS

Although the IRS extended the time for submitting Form 990 and Schedule H for certain filers, hospitals that are not required to comply with 501(r) in 2010 should **NOT** complete Part V.B. Until further guidance is issued, hospitals should carefully review the revised Schedule H, specifically Section V.B. to determine what information will be required and to consider what systems will be needed to provide such information. For those whose fiscal year begins after March 23, the window for compiling this information is short and hospitals are urged to act promptly.

The new Schedule H is out of step with the President Obama's call for "cutting down on the paperwork that saddles businesses with huge administrative costs." The AHA will advocate for a resolution of these issues to reduce the burdens imposed on hospitals by the new Schedule H that are not necessary for compliance with Section 501(r).

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