The ACA’s Effect on Nonprofit Hospitals Re: Affordable Care Act

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By considering the promotion of health a charitable endeavor, the IRS has long granted nonprofit hospitals tax-exempt status under 501(c)(3), the charitable organization exemption. To maintain their status, nonprofit hospitals have always been required to meet specific requirements, such as having an independent board of trustees or offering preventive health outreach programs in their communities.

The Affordable Care Act (“ACA”) imposes four new requirements that hospital organizations must satisfy in order to be considered tax-exempt, as well as new reporting and excise taxes. The new requirements appear in Section 501(r), added to the IRS Code by the ACA.

The New Requirements

(1) Conducting a Community Health Needs Assessment Triennially

Hospitals must produce a written community health needs assessment every three years that demonstrates that it is serving the needs of its community. The documentation must include very specific items, such as the sources used to conduct the assessment and methods employed. The assessment must be made widely available. A written implementation strategy to meet the identified needs is also required.

Noncompliance exacts a heavy cost. A $50,000 annual excise tax will apply for failure to meet the CHNA requirement and for each succeeding year of noncompliance. The tax is applied on a facility-by-facility basis – meaning health systems that own more than one hospital will be taxed the penalty for each noncompliant facility.

(2) Establishing and Disclosing Financial Assistance Policies

Hospitals are now specifically required to have a written financial assistance policy in place. The financial assistance policies must be widely publicized and include eligibility criteria that discloses whether available assistance includes free or discounted care, how the amounts charged individuals are calculated, how to apply and what documentation will be used to determine qualification. While the regulations do not mandate particular eligibility requirements, the regulations are quite onerous. Each hospital, however, retains that ability to establish its the parameters of its respective eligibility criteria.

(3) Limiting Charges to Needy Individuals

Historically, hospitals have set prices and charged the uninsured and private pay patients at its set rates, but negotiated reduced prices for insured patients through insurance providers. This practice is now disallowed for the financially needy; charges for emergency or medically necessary care must be generally the same for both groups. To determine the amounts generally billed, hospitals may use one of two methods.

The “look back” method is based on actual amount of past claims paid to the hospitals facility by either Medicare fee-for-service or Medicare FFS plus private health insurers’ payments. The second method is prospective, requiring a hospital to estimate the amount it would be paid by Medicare and Medicare beneficiary for emergency/medically necessary care if the eligible individual were a Medicare FFS beneficiary.
Despite this new requirement, hospitals can still bill for gross charges for all care (not just emergency/medically necessary) where the individual does not qualify for financial assistance or has not submitted an application for assistance.

(4) Following reasonable billing and collection practices

Hospitals must make reasonable efforts to determine whether an individual qualifies under its financial assistance plan before engaging in extraordinary collection efforts (i.e., legal or judicial action). Hospitals must notify individuals about its financial assistance plan, provide assistance to an individual who submits an incomplete application; and determine and document whether an individual is qualified for the plan. Only after these requirements have been met may a hospital use extraordinary collections actions to obtain payment of a bill. Notably, a written waiver of the right to financial assistance does not alleviate the hospital’s duty to make reasonable efforts to determine whether the individual is eligible for assistance.

Failure to meet one or more of the above requirements may result in the revocation of a hospital’s exempt status on the first day of the taxable year in which the failure occurs. Proposed IRS regulations make clear that a hospital will not lose its tax-exempt status for failure to meet the detailed requirements of section 501(r) if the failure is neither willful nor egregious and the organization promptly makes corrections and related disclosures. However, creation, implementation and ongoing review of the policies and practices mandated by 501(r) is necessary to show a good-faith effort of compliance. Like many aspects of the ACA, the regulations put more regulatory burdens on hospitals at a time when emphasis on patient care is being emphasized more than ever. Nonprofits must be able to adapt or risk losing one of its most valuable assets – the tax-exempt status.

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