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January 20, 2011

Hon. Douglas Shulman
Commissioner
Internal Revenue Service
1111 Constitution Avenue, N.W.
Washington, DC 20224

Re: Comments on Requirements for Tax-Exempt Hospitals

Dear Commissioner Shulman:

Enclosed are comments on requirements for tax-exempt hospitals. These comments represent the views of the American Bar Association Section of Taxation and the Health Law Section. They have not been approved by the Board of Governors or the House of Delegates of the American Bar Association and should not be construed as representing the policy of the American Bar Association..

Sincerely,

Linda A. Baumann
Chair, Health Law Section

Charles H. Egerton
Chair, Section of Taxation

Enclosure

cc: Michael F. Mundaca, Assistant Secretary (Tax Policy), Department of the Treasury
William J. Wilkins, Chief Counsel, Internal Revenue Service
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ABA SECTION OF TAXATION AND HEALTH LAW SECTION

COMMENTS ON REQUIREMENTS FOR TAX-EXEMPT HOSPITALS

These comments (“Comments”) are submitted on behalf of the American Bar Association Section of Taxation and Health Law Section and have not been approved by the House of Delegates or Board of Governors of the American Bar Association. Accordingly, they should not be construed as representing the position of the American Bar Association.

Principal responsibility for preparing these Comments was exercised by Ralph DeJong of and Robert Friz of the Exempt Organizations Committee of the Section of Taxation and the Tax and Accounting Interest Group of the Health Law Section. Substantive contributions were made by Richard Frazier, Laura Gabrysch, Elizabeth Mills, Richard Sevcik, and Gwen Spencer. The Comments were reviewed by Frederick J. Gerhart, Chair of the Exempt Organizations Committee, Douglas M. Mancino of the Committee on Government Submissions of the Section of Taxation, Michael A. Clark, Council Director for the Exempt Organizations Committee, and William W. Horton of the Health Law Section, in his role as Member of Council and Chair of the Policy Review and Coordination Committee.

Although the members of the Section of Taxation and Health Law Section who participated in preparing these Comments have clients who might be affected by the federal tax principles addressed by these Comments, no such member or the firm or organization to which such member belongs has been engaged by a client to make a government submission with respect to, or otherwise to influence the development or outcome of, the specific subject matter of these Comments.

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Date: January 20, 2011

EXECUTIVE SUMMARY

The Internal Revenue Service (the “Service”) issued Notice 2010-39.¹ The Notice solicits comments regarding the application of new requirements imposed on tax-exempt hospitals by section 501(r),² which was added to the Code by section 9007(a) of the Patient Protection and Affordable Care Act (the “PPACA”).³ Section 501(r) includes four new requirements that hospital organizations must meet to qualify as tax-exempt organizations described in section 501(c)(3). The PPACA also added new disclosure requirements relating to section 501(r).⁴

These Comments include the following recommendations regarding guidance issued under section 501(r):

1. With respect to the requirement that hospital organizations conduct a community health needs assessment (“CHNA”), we recommend that hospital organizations be allowed to build upon the many existing CHNA programs at the state and local level and that the Service consider identifying specific state CHNA provisions as safe harbors for complying with the CHNA requirement.
2. With respect to the requirement that hospital organizations make reasonable efforts to determine whether an individual is eligible for financial assistance before engaging in extraordinary collection actions, we recommend that:
 - (a) a hospital organization be deemed to have made reasonable efforts if it has either (i) obtained a written acknowledgment that the individual does not want to be considered for financial assistance or (ii) sent to the individual at least three notices stating that it has a financial assistance policy and providing information on how to apply for assistance; and
 - (b) the term “extraordinary collection actions” be defined (i) to exclude making a report to a credit rating agency or engaging a collection agent and (ii) to require that the action involve a judicial or administrative procedure under state law that would affect the individual or the property of the individual.
3. With respect to the effect of section 501(r) on the section 501(c)(3) status of a hospital organization, we recommend that:
 - (a) a good faith interpretation and compliance period be provided to organizations subject to the section 501(r) requirements, until final guidance is issued by the Service under section 501(r);

¹ 2010-24 I.R.B. 756.

² References to a “section” are to the Internal Revenue Code of 1986, as amended (the “Code”), unless otherwise indicated.

³ Pub. L. No. 111-148, § 9007(a), 124 Stat. 119, 855 (2010).

⁴ I.R.C. § 6033(b)(10)(D), (b)(15)(A).

- (b) a facts and circumstances test, similar to the one used under section 4958 to determine whether an excess benefit transaction should be treated as private inurement warranting revocation of section 501(c)(3) status, be used to determine whether a failure to comply with section 501(r) warrants revocation of section 501(c)(3) status, taking into account substantial compliance with section 501(r) and the organization's other exempt activities;
 - (c) if a hospital organization fails the facts and circumstances test and is not in substantial compliance with section 501(r), the hospital organization be reclassified as an organization exempt under section 501(c)(4); and
 - (d) existing law allowing a donor to rely on the Service's published listing of tax-exempt organizations to determine the deductibility of contributions apply as well to any hospital organization that loses its section 501(c)(3) status under section 501(r).
4. With respect to the application of section 501(r) to hospital organizations that operate multiple hospital facilities, we recommend that:
- (a) the tests recommended above also be applied in determining the tax-exempt status of separate hospital facilities;
 - (b) if and to the extent failure to comply with section 501(r) results in section 501(c)(4) status for one or more facilities but not the hospital organization as a whole, an approach similar to that in section 150(b)(3) be applied to address the treatment of tax-exempt bonds; and
 - (c) existing Regulations on changes of use⁵ be applied and the "safe harbor" protection of section 141 be expanded to include the failure to satisfy 501(r) and specific authorization be provided for rulings under Revenue Procedures 2010-1 and 1993-17 to address changes of use.⁶
5. With respect to the requirement that hospital organizations limit amounts charged to individuals eligible for financial assistance "to not more than the amounts generally billed" to individuals with insurance coverage, we recommend that:
- (a) hospitals be given flexibility in determining the "amounts generally billed," although using the Medicare rate is the simplest alternative when a Medicare rate is available;
 - (b) the Medicare rate be the actual Medicare rate used by the hospital, as adjusted for regional differences;
 - (c) for services that are not covered by Medicare, hospitals have the option of using either the Medicare rate for the nearest equivalent service or a discount that is

⁵ Reg. § 1.141-2.

⁶ Rev. Proc. 2010-1, 2010-1 I.R.B. 1 and Rev. Proc. 1993-17, 1993-1 C.B. 507.

determined by comparing the aggregate amount paid by Medicare for services covered by Medicare to the hospital's chargemaster rates for these same services;

- (d) a hospital basing the amounts billed to financial assistance recipients on its "best" rates, have several options for determining this amount, including (i) the actual lowest rate, regardless of insurer, if the hospital is able to make this determination or (ii) a blended rate of the actual rates offered by the insurer who on average pays the lowest rates;
 - (e) a hospital basing the amounts billed to financial assistance recipients on an average of its three "best" rates, be permitted to select the three best rates using one of the options for selecting the lowest rate and have the option to use a simple or a weighted average or to base the amounts on the rates billed to the insurers who cover a majority of the hospital's patient base;
 - (f) the amounts generally billed provision apply to any person who is eligible for financial assistance as well as any further discounts provided under the hospital's financial assistance policy; and
 - (g) a hospital organization has the option of excluding outpatient services when determining amounts generally billed.
6. With respect to the requirement that a hospital organization make its CHNA widely available to the public and the requirement that a hospital organization widely publicize its financial assistance policy, we recommend that the Service provide:
- (a) a safe harbor stating that a hospital organization makes its CHNA widely available to the public if it makes the CHNA available for public inspection without charge at its principal, regional, and district offices during regular business hours and either (i) provides a physical copy upon request or (ii) makes the CHNA widely available through an Internet posting;
 - (b) a safe harbor stating that a hospital organizations has widely publicized its written financial assistance policy within the community it serves if it uses the procedures mentioned in the foregoing paragraph and makes the policy available in a manner consistent with examples included in the instructions to Form 990, Return of Organization Exempt from Income Tax, Schedule H, Hospitals; and
 - (c) if a hospital organization does not satisfy these safe harbors, its compliance with the widely available to the public requirement would be evaluated based on all of the facts and circumstances.
7. With respect to the requirement that a hospital organization have a written policy requiring it to provide emergency medical care without discrimination and without regard to eligibility for financial assistance, we recommend that the organization be considered to satisfy this requirement if its written policy states that it will follow the procedures set

forth in section 1867 of the Social Security Act,⁷ without discrimination and regardless of an individual's ability to pay for such care.

8. With respect to the new statutory reporting and disclosure requirements imposed on hospital organizations,⁸ we recommend that:
 - (a) the term "hospital" be defined for section 501(r) reporting purposes in the same manner that "hospital" is currently defined in the instructions for Form 990, Schedule H; and
 - (b) any new reporting and disclosure requirements relating to section 501(r) be contained in a separate part of Schedule H and not be effective until tax years beginning after March 23, 2012.

⁷ Pub. L. No. 74-271, 49 Stat. 620 § 1867 (1935), 42 U.S.C. § 1395dd.

⁸ I.R.C. §§ 6033(b)(10), (b)(15)(A).

COMMENTS

Section 501(r)(1) provides that a hospital organization shall not be tax-exempt as an organization described in subsection (c)(3) unless it:

- (A) meets the community health needs assessment requirements described in paragraph (3),
- (B) meets the financial assistances policy requirements described in paragraph (4),
- (C) meets the requirements on charges described in paragraph (5), and
- (D) meets the billing and collection requirements described in paragraph (6).

These Comments review selected provisions of these new exemption requirements for hospital organizations and recommend guidance to implement these requirements and related new reporting requirements.

1. **Community Health Needs Assessment (“CHNA”)**

Section 501(r)(1)(A) provides that a hospital organization shall not be treated as a tax-exempt organization described in section 501(c)(3) unless it meets the CHNA requirement of section 501(r)(3). In implementing the CHNA requirement, we believe the guiding principles should be “don’t reinvent the wheel” and “one size does not fit all.”

Don’t Reinvent the Wheel. Many organizations and agencies at the local, state, and national levels have been involved for many years in assessing the health needs of the community and developing plans to address those needs. States containing at least a third of the country’s population already require hospitals to prepare plans to identify and meet community needs. We believe that the implementation of section 501(r)(3) should build upon and extend these efforts rather than duplicating them or creating a parallel but different requirement.

One Size Does Not Fit All. Through analysis of its hospital survey results, the Service has recognized that not every hospital provides the same size of community benefit (as described in the IRS Exempt Organizations (TE/GE) Hospital Compliance Project Final Report, referred to as the “Hospital Report”).⁹ Likewise, the process of undertaking a CHNA, and the product of that process, will differ among rural hospitals, urban inner-city hospitals, suburban hospitals, and academic medical centers with research and teaching functions. The purpose of requiring a CHNA, rather than mandating the provision of specific community benefits, is to enable a hospital to address the needs of its own community and to define its community consistent with its particular charitable mission. Similarly, each hospital needs the flexibility to conduct and implement a CHNA that is consistent with work it and others have already done, with its local planning structure and environment, and with its resources.

⁹ IRS Exempt Organizations (TE/GE) Hospital Compliance Project Final Report (Feb. 12, 2009) (available at <http://www.irs.gov/pub/irs-tege/frepthospproj.pdf>) at 6-9, 57-65.

(a) Existing Community Health Assessment Programs

State health agencies and local city or county health departments have for many years examined data indicating the public's health status, identified priority health deficits, and planned steps to improve the public's health. This is a data-intensive effort and the resulting documents may be hundreds of pages long. Rather than have hospitals duplicate this effort, we believe hospitals should build on the work already done. For example, if a state or local plan already has identified the top health deficits, we believe the hospital should be able to refer to this analysis in the hospital's CHNA and focus on identifying interventions that the hospital will undertake. This would not only conserve resources, but also would enhance community coordination as to priorities. In addition, to be meaningful and accessible to hospital employees and the community, we believe a CHNA should be relatively short and easy to read. A short document would highlight implementation priorities and would be easier to make available to interested parties. We believe permitting references to data and analyses in other documents would further this aim.

This approach draws support from section 501(r)(3)(B)(i), which requires that the CHNA take into account input from persons who represent the broad interests of the community served by the hospital, including those with special knowledge of or expertise in public health. Community health assessment programs conducted by state or local agencies frequently provide for extensive public input. If the hospital, in developing its CHNA, builds on a community health assessment that takes into account public input, we believe this public input should carry over to the CHNA.

(b) Existing State Requirements for Hospital CHNAs

Beginning in the 1990s, a number of states enacted laws or regulations requiring tax-exempt hospitals to prepare plans to address periodic health needs. As an illustration and not as a complete list, California, New York, Illinois, Texas, Massachusetts, Maryland, and New Hampshire have laws or regulations on the books requiring such hospital plans.¹⁰ These states include more than a third of the United States population. Thus, a substantial portion of the country already is subject to a requirement similar to section 501(r)(3). The fact that many states already have programs requiring CHNAs has several implications for implementing section 501(r).

Just as it has identified state corporate laws that require a satisfactory dissolution provision for section 501(c)(3) organizations,¹¹ we recommend that the Service identify specific state CHNA provisions that already satisfy section 501(r)(3). Hospitals in those states that satisfy their state's requirements would then be deemed to comply with section 501(r)(3). Such hospitals would still be required to report their implementation progress on their Form 990, but

¹⁰ Calif. Health & Safety Code §§ 127340 – 127360; NY Public Health Law § 2803-l; 210 ILCS 76/1 et seq; Texas Health and Safety Code § 311.044; New Hampshire RSA 7:32-c; Massachusetts Attorney General's Community Benefits Guidelines for Nonprofit Acute Care Hospitals (available at http://www.mass.gov/Cago/docs/healthcare/hospital_guidelines.pdf) and Massachusetts Attorney General's Community Benefits Guidelines for Health Maintenance Organizations (available at http://www.mass.gov/Cago/docs/healthcare/hmo_guidelines.pdf).

¹¹ Rev. Proc. 1982-2, 1982-1 C.B. 367.

the requirement to develop a CHNA taking into account public input would be met by compliance with the approved state requirements.

More broadly, we recommend that the Service identify specific state CHNA provisions as section 501(r)(3) “safe harbor” models for hospitals in states that do not have adequate requirements. As a hypothetical example, if the requirements of the states listed above (California, New York, Illinois, Texas, Massachusetts, Maryland, and New Hampshire) were all deemed to satisfy section 501(r)(3), and Oklahoma did not have a statute, an Oklahoma hospital would be permitted to comply with the requirements set forth for any one of the seven safe harbor states to be in compliance with section 501(r)(3). Even if specific state requirements are not given safe harbor status, we suggest that the Service identify specific state requirements as models for other states.

In drawing from existing state statutes, we have identified two issues that we believe the Service would need to be address. Some states, such as Illinois, California, and Texas, exempt some or all small and rural hospitals from CHNA requirements.¹² If the Service does not exempt such hospitals from the section 501(r)(3) requirement, the Service might impose less detailed CHNA requirements on such hospitals. Small and rural hospitals have fewer resources to prepare a CHNA and, as noted in the Hospital Report, the mere existence of a particular hospital may meet the health needs of the community.

Some states permit hospital systems to complete their state reporting requirement on a system-wide basis.¹³ If the system reports to the state on a system-wide basis and wishes to continue this practice, we believe the system should not be required to prepare an entirely new report for each hospital to satisfy section 501(r)(3). Rather, we recommend that the sections of the CHNA relevant to the reporting hospital be used as that hospital’s CHNA.

(c) One Size Does Not Fit All

We believe the Service should require reporting hospitals to explain what they are doing to implement the CHNA requirement. If the reporting hospital is located in a state that has a specific planning requirement, we believe the reporting hospital should explain how the plan is developed. If several hospitals work together to develop a community-wide plan, we believe each reporting hospital should explain the joint planning effort. If the reporting hospital’s service area for planning purposes is different from the region surrounding the hospital, we believe the reporting hospital should explain how it determines its service area. For example, a hospital may provide specialty care and draw from a national or international patient base or provide extensive research and teaching activities. Rather than having a series of specific check boxes on Form 990 or Schedule H to indicate compliance with specific CHNA aspects, we believe the emphasis should be on a yes/no answer to the question “Did you conduct a CHNA?” accompanied by a description of the plan and process in a narrative schedule. We provide specific recommendations for the Form 990 later in these Comments.

¹² 210 ILCS 76/5; Calif. Health & Safety Code § 127345(f); Texas Health and Safety Code § 311.042(9)(B).

¹³ See, e.g., 210 ILCS 76/5.

2. Provisions Regarding Billing and Collection

Section 501(r)(1)(D) provides that a hospital organization shall not be treated as a tax-exempt organization described in section 501(c)(3) unless it meets the billing and collection requirements of section 501(r)(6). Section 501(r)(6) requires that a hospital organization not engage in extraordinary collection actions against an individual before it has made reasonable efforts to determine whether the individual is eligible for assistance under the hospital organization's financial assistance policy. To implement this provision, we believe guidance should define what constitutes "reasonable efforts" to determine eligibility for financial assistance and what constitutes "extraordinary collection actions."

The staff of the Joint Committee on Taxation, in its Technical Explanation of PPACA,¹⁴ states that "extraordinary collection actions include lawsuits, liens on residences, arrests, body attachments, or other similar collection processes."¹⁵ As to "reasonable efforts," the Technical Explanation states: "[i]t is intended that for this purpose, 'reasonable efforts' includes notification by the hospital of its financial assistance policy upon admission and in written and oral communications with the patient regarding the patient's bill, including invoices and telephone calls, before collection action or reporting to credit agencies is initiated."¹⁶

We recommend that guidance provide definitive examples of activities that would satisfy the "reasonable efforts" requirement. For example, we suggest that a hospital organization should have satisfied the "reasonable efforts" requirement of section 501(r)(6) if it has done either of the following:

1. The hospital has obtained the written acknowledgment from the individual (or other person responsible for the individual) that the individual does not want to be considered for financial assistance under the hospital organization's financial assistance policy; or
2. The hospital has sent the individual at least three notices stating that the hospital has a financial assistance policy and providing contact information to apply for financial assistance or request additional information about financial assistance. The hospital sent the second and third notices at least 30 days after the most recent prior notice, and the hospital did not initiate extraordinary collection actions until at least 65 days after sending the third notice. We further recommend that the hospital be permitted to include any such notice with bills or reminders to the individual regarding outstanding bills.

With respect to the definition of "extraordinary collection actions," we believe the last sentence of the Technical Explanation under "Collection processes"¹⁷ is unclear regarding the concepts of collections and "extraordinary collection actions." The sentence also refers to

¹⁴ Staff of the Joint Committee on Taxation, *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as amended, in combination with the "Patient Protection and Affordable Care Act"* (JCX-18-10) (March 21, 2010) ("Technical Explanation").

¹⁵ *Id.* at 82.

¹⁶ *Id.*

¹⁷ The referenced sentence is quoted above in the text associated with footnote 16.

reporting to credit rating agencies, even though that is not listed in a previous sentence¹⁸ as an example of “extraordinary collection actions.” We recommend that guidance define the term “extraordinary collection actions” to exclude making a report to a credit rating agency or engaging a collection agent to distinguish between the routine collection process and “extraordinary” collection actions.

We also recommend that the term “extraordinary collection action” be defined to require that the action involve a judicial or administrative procedure under state law that would affect the individual or the property of the individual, which is consistent with the references of the Technical Explanation to lawsuits, liens on residences, arrests, and body attachments (which generally involve such a judicial or administrative procedure).

3. **Effect of Failure to Comply with Section 501(r) on Section 501(c)(3) Status**

Section 501(r)(1) provides that a hospital organization shall not be treated as a section 501(c)(3) organization unless it meets the four requirements of section 501(r). Moreover, section 501(r)(2)(B) provides:

If a hospital organization operates more than 1 hospital facility—

- (i) the organization shall meet the requirements of this subsection separately with respect to each such facility, and
- (ii) the organization shall not be treated as described in subsection (c)(3) with respect to any such facility for which such requirements are not separately met.

Notice 2010-39¹⁹ requests comments:

regarding section 501(r)(2)(B)(ii), which provides that an organization that operates more than one hospital facility “shall not be treated as described in [section 501(c)(3)] with respect to any such facility for which such requirements are not separately met,” including the tax consequences of a failure with respect to some, but not all, facilities and the proper tax treatment in future periods in such a case.

Section 501(r)(2)(B) complicates the application of section 501(r) and particularly the consequences of failing to comply with section 501(r). Without regard to section 501(r)(2)(B), we believe guidance is needed with respect to the circumstances in which the section 501(c)(3) status of a hospital organization whose only activity is operating one hospital facility that does not comply fully and at all times with section 501(r) would be jeopardized. When a hospital organization has more than one hospital facility or has one hospital facility and significant other activities described in section 501(c)(3) (*e.g.*, a university that operates an academic medical center), section 501(r)(2)(B) raises the novel possibility that the organization might have a bifurcated tax status, qualifying in part under section 501(c)(3) and in part under section 501(c)(4), because a substantial portion of the organization may continue to satisfy all the

¹⁸ The referenced sentence is quote above in the text associated with footnote 15.

¹⁹ 2010-24 I.R.B. 756.

requirements for ongoing section 501(c)(3) status while also maintaining a hospital facility that has failed to satisfy section 501(r). As described in more detail below, we recommend that, even if an organization or facility does not satisfy section 501(r), the Service continue to recognize the organization or facility as tax-exempt under section 501(c)(4) until the organization is able to restore its, or its facility's, section 501(c)(3) status.²⁰

(a) Good Faith Interpretation Period

The requirements of section 501(r) are new and give rise to numerous interpretation and application complexities. The failure to comply fully and at all times appears to result in a “strict liability” consequence of revocation of section 501(c)(3) status. We recommend that, until final guidance is published by the Service as to the interpretation of the section 501(r) requirements, hospital organizations subject to the section 501(r) requirements be permitted to exercise good faith in interpreting and applying the section 501(r) requirements and that the Service not seek revocation of section 501(c)(3) status of a hospital organization or any of its hospital facilities for any violation of section 501(r) during that period if the organization has interpreted and applied the section 501(r) requirements in good faith.

(b) Facts and Circumstances Test and Substantial Compliance

A failure to comply fully and at all times with the requirements of section 501(r) may result from a broad range of acts and omissions, some of which we believe may reasonably be viewed as inadvertent or benign. For example, a hospital organization may have adopted a financial assistance policy before the enactment of the PPACA. The hospital organization may in fact have widely publicized the policy within the community served, but may not have

²⁰ We believe any hospital organization or part of a hospital organization that loses its section 501(c)(3) status due to section 501(r) should still be tax-exempt under section 501(c)(4) if it otherwise complies with the requirements of section 501(c)(3). The Service itself has said that “[a]s a general rule, all organizations exempt under section 501(c)(3) could also qualify under section 501(c)(4)” *Chapter G, Social Welfare: What Does It Mean? How Much Private Benefit Is Permissible?*, 1981 Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook (1981), available at <http://www.irs.gov/pub/irs-tege/eotopicg81.pdf>. The common link between the two provisions is that “social welfare” is a charitable purpose under section 501(c)(3) as well as a basis for exemption under section 501(c)(4). Reg. § 1.501(c)(3)-1(d)(2). Section 501(c)(4) is much broader in scope because eligibility is based on a primary purpose test, whereas section 501(c)(3) status is not permitted if an organization engages more than insubstantially in nonexempt activities. *Compare* Reg. § 1.501(c)(3)-1(c)(1) with Reg. § 1.501(c)(4)-1(a)(2)(i); *see* I.R.M. 7.25.4.6. For example, an organization that would otherwise qualify under section 501(c)(3) except that it conducts substantial lobbying or social activity, or does not benefit a sufficiently large class of the public, can still qualify under section 501(c)(4). Reg. § 1.501(c)(4)-1(a)(2)(ii); Rev. Rul. 1975-286, 1975-2 C.B. 210; Rev. Rul. 1974-361, 1974-2 C.B. 159, *superseding* Rev. Rul. 1966-221, 1966-2 C.B. 220; Rev. Rul. 1966-179, 1966-1 C.B. 139; *compare* Rev. Rul. 1980-215, 1980-2 C.B. 174 with Rev. Rul. 1970-4, 1970-1 C.B. 126; *cf.*, TAM 199145001 (Mar. 14, 1991). In addition, an organization that otherwise qualifies under section 501(c)(3) but fails to file the notice required by section 508(a) within the time permitted will be recognized by the Service as tax-exempt under section 501(c)(4) for the period prior to filing the notice. Rev. Rul. 1980-108, 1980-1 C.B. 119; I.R.M. 7.25.4.6; Form 1023, Application for Recognition of Exemption Under Section 501(c)(3) of the Internal Revenue Code (Rev. June 2006), Part VII, Line 2, and Schedule E, Line 8; Instructions to Form 1023 at 21-22. Foreign charitable organizations created after 1969 can effectively choose between section 501(c)(3) and section 501(c)(4) status. *See, e.g.*, PLR 200846041 (Aug. 19, 2008). One reason the private foundation termination provisions of section 507 were added to the Code was to prevent a large scale shift of existing private foundation from section 501(c)(3) status to section 501(c)(4) status. *See* H.R. Rep. No. 91-414, pt. 1, at 38 (1969), *reprinted at* 1969-3 C.B. 200; *see also* Reg. § 1.509(b)-1(a).

described such measures in the policy itself, which would violate the literal wording of section 501(r)(4)(A) (*i.e.*, its fifth required element). While acknowledging the need to comply with, and correct violations of, the section 501(r) requirements, we believe that minor violations such as that illustrated above should not justify revoking a hospital organization's exempt status in the event such violation is timely corrected.

We recommend that the Department of the Treasury ("Treasury") and the Service adopt an approach similar to the approach used to reconcile "excess benefit transactions" under section 4958 with the private inurement prohibition of section 501(c)(3). Just as a single excess benefit transaction subject to excise tax under section 4958 does not automatically cause a section 501(c)(3) organization to lose its section 501(c)(3) status for violating the private inurement prohibition,²¹ we believe the failure of a hospital organization to satisfy all the requirements of section 501(r) should not lead automatically to the revocation of its section 501(c)(3) status. Instead, we believe the Service could consider all relevant facts and circumstances.

An organization that engages in an excess benefit transaction subject to excise tax under section 4958 also violates the private inurement prohibition of section 501(c)(3). The Service does not impose a strict liability standard and automatically revoke the organization's section 501(c)(3) status. In determining whether to continue recognizing the section 501(c)(3) status of an organization that has engaged in one or more excess benefit transactions, the Service considers all relevant facts and circumstances, including but not limited to, the following:

- (A) The size and scope of the organization's regular and ongoing activities that further exempt purposes before and after the excess benefit transaction or transactions occurred;
- (B) The size and scope of the excess benefit transaction or transactions (collectively, if more than one) in relation to the size and scope of the organization's regular and ongoing activities that further exempt purposes;
- (C) Whether the organization has been involved in multiple excess benefit transactions with one more persons;
- (D) Whether the organization has implemented safeguards that are reasonably calculated to prevent excess benefit transactions; and
- (E) Whether the excess benefit transaction has been corrected . . . , or the organization has made good faith efforts to seek correction from the disqualified person(s) who benefited from the excess benefit transaction.²²

All factors are to be considered, although the Service may assign greater or lesser weight to some factors than to others in a given situation.²³

²¹ Reg. § 1.501(c)(3)-1(f)(2).

²² Reg. § 1.501(c)(3)-1(f)(2)(ii).

²³ Reg. § 1.501(c)(3)-1(f)(2)(iii).

We recommend that a similar facts and circumstances test be used for determining when revocation of section 501(c)(3) status is an appropriate consequence for a failure to comply with section 501(r). We believe that such a facts and circumstances test should take into account whether the organization had substantially complied with section 501(r), such as failing to comply for only a limited period of time, in limited or benign respects, or as to a small portion of its overall exempt activities. We recommend that revocation be considered only when a hospital organization has committed substantial or repeated violations of section 501(r).

(c) Section 501(c)(4) Status Upon Revocation of Section 501(c)(3) Status

Section 501(r) does not specify what status a hospital organization will have if its section 501(c)(3) status is revoked. If after taking into account all of the facts and circumstances as recommended above, the Service decides to revoke section 501(c)(3) status, then we believe the hospital organization should continue to be recognized as tax-exempt under section 501(c)(4) until it is able to restore its section 501(c)(3) status if it otherwise complies with the requirements of section 501(c)(3).²⁴

We believe section 501(c)(4) status is the most likely and logical status for a hospital organization that has its section 501(c)(3) status revoked under section 501(r). The Service already has a practice of recognizing section 501(c)(4) status for certain types of health care organizations that do not qualify under section 501(c)(3), such as health maintenance organizations (“HMOs”).²⁵

Recognizing section 501(c)(4) status for a hospital organization that loses its section 501(c)(3) status under section 501(r) is supported by a comparison of section 501(r) with section 501(m). Unlike section 501(m), which denies both section 501(c)(3) status and section 501(c)(4) status for an organization that provides substantial “commercial-type insurance,” section 501(r) only denies section 501(c)(3) status. We believe this implies that section 501(c)(4) status is available for a hospital organization that fails to comply with section 501(r). If Congress had intended to deny both section 501(c)(3) status and section 501(c)(4) status to a hospital organization that fails to comply with section 501(r), then Congress could have done so by adopting the approach it used in section 501(m).

(d) Operation by an Organization of One or More Hospital Facilities

When an organization operates more than one hospital subject to section 501(r), and one such hospital facility fails to comply with section 501(r) while the remaining hospital facility or facilities satisfy section 501(r), we recommend that the Service consider the broader tax-exempt operations of the hospital organization in determining whether revocation should occur. In other words, taking into account all the exempt activities of the hospital organization as a whole, the Service might conclude, using the facts and circumstances test recommended above, that the organization as a whole has, over an appropriate period of time, been in substantial compliance with section 501(r) and should not lose its exempt status (at the entity level or at the facility level). If, however, the Service determines, after taking into account all of the facts and

²⁴ See discussion in footnote 20.

²⁵ See, e.g., GCM 39,828 (1987); GCM 39,829 (1990); GCM 39,830 (1990); see also discussion in footnote 20.

circumstances, that the noncompliant hospital facility no longer should qualify for section 501(c)(3) status, then we recommend that the loss of exemption apply at the facility level rather than at the entity level.

In applying this facts and circumstances test, we suggest that the Service accord special weight to those situations in which a hospital organization serves other section 501(c)(3) purposes in addition to providing health care, such as serving educational purposes by operating college or university teaching hospitals or lessening the burdens of government. As noted in the Hospital Report, the mix of community benefit expenditures among uncompensated care, medical research, medical education, and community programs varies considerably across different types of hospitals.²⁶ We recommend that the facts and circumstances approach take into account the diversity of those organizations that operate hospital facilities.

(e) Bifurcated Tax Status for Separate Hospital Facility

As noted above, Notice 2010-39²⁷ requests comments on the consequences when an organization that operates more than one hospital facility does not satisfy the section 501(r) requirements with respect to some, but not all, facilities. A hospital organization's section 501(c)(3) status might only be partly revoked. This situation might arise when a hospital facility that fails to comply with section 501(r) is only one of several facilities that a hospital organization operates or is only part of a larger organization such as a teaching hospital that is part of a university. This raises the novel possibility that an organization might have bifurcated tax status – section 501(c)(4) status for the facility that fails to comply with section 501(r) (as recommended above) and section 501(c)(3) status for the rest of the hospital organization's operations.

A similar question has arisen in the context of balancing an organization's section 501(c)(3) activities against its unrelated business activities. There is a great deal of variation in the cases and rulings on how much unrelated business activity a section 501(c)(3) organization may conduct, but when the unrelated business furthers the section 501(c)(3) organization's tax-exempt purposes, the Regulations and the Service's administrative practice apply a "primary purpose" test that permits the unrelated business to represent a substantial part of its activities, so long as the organization's primary purpose remains a section 501(c)(3) purpose.²⁸

Similarly, a separate hospital facility that does not comply with section 501(r) would still promote health and be integrally related (absent other violations of ongoing exemption requirements) to the promotion of the section 501(c)(3) purposes of the hospital organization that owns it. In determining what proportion of a hospital organization's activities may be represented by one or more hospital facilities that do not comply with section 501(r), and if section 501(c)(4) exempt status were permitted for the hospital facility that fails to satisfy section 501(r), we believe that the Service would be justified in allowing more section 501(c)(4) activity than the Regulations allow under the primary purpose test for unrelated business activities (and

²⁶ Hospital Report at 40.

²⁷ 2010-24 I.R.B. 756.

²⁸ Reg. § 1.501(c)(3)-1(e); I.R.M. 7.25.3.19, 7.27.4.1.1x (1999).

thereby to apply such standard in determining whether the entire organization continues to qualify for section 501(c)(3) exempt status).

If a hospital organization had a bifurcated tax status (partly section 501(c)(3) and partly section 501(c)(4)), the organization would need to differentiate between the two parts. If such bifurcated tax status were provided, we recommend that Treasury and the Service adopt an approach similar to the allocation provisions of the unrelated trade or business provisions of the Code with respect to the allocation of costs and expenses between the section 501(c)(3) activities and the section 501(c)(4) activities. For example, in computing unrelated business taxable income, the gross income derived from an unrelated business is reduced by those deductions that are directly connected with the carrying on of such business, subject to certain modifications.²⁹ To be “directly connected with” the conduct of an unrelated business, a deduction must have a “proximate and primary relationship” to the carrying on of that business.³⁰ When facilities or personnel are used in both exempt activities and an unrelated business, expenses, depreciation and similar items attributable to such facilities and personnel are allocated on a reasonable basis.³¹ We recommend that the Service provide similar approaches to separate a hospital organization’s section 501(c)(3) activities from its section 501(c)(4) activities.

(f) Effect on Donors

We recommend that guidance on the effect of noncompliance with section 501(r) confirm the application of existing law that allows a donor to rely on the published listing of exempt organizations to determine the deductibility of contributions (in other words, that the status of contributions and grants to the organization will not be affected by a subsequent revocation of the organization’s exempt classification until the date on which the notice of change in status is made to the public).³²

(g) Effect on Organizations with Tax-Exempt Financing

If the consequence of failing to satisfy section 501(r) at a hospital facility level (when the exempt hospital organization operates more than one hospital facility or engages in exempt activities broader than the operation of the hospital facility that failed to satisfy section 501(r)) includes treatment of income derived from that facility as being derived from section 501(c)(4) activities, we recommend that guidance adopt an approach similar to that in section 150(b)(3) to address those organizations that operate a hospital facility that does not satisfy section 501(r). Section 150(b)(3) addresses qualified 501(c)(3) bonds that were used to finance a portion of a facility that is used subsequently in an unrelated trade or business. We also recommend that Treasury and the Service consider the application of the Regulations under section 141 that apply to changes of use to those facilities that do not satisfy section 501(r).³³ We further recommend that Treasury and the Service expand the “safe harbor” protection of section 141 to include the failure to satisfy section 501(r) and to specifically provide the Service with the authority to issue rulings under Revenue Procedures 2010-1 and 1993-17 to address changes of use.³⁴

²⁹ Reg. § 1.512(a)-1(a).

³⁰ *Id.*

³¹ Reg. § 1.512(a)-1(c).

³² Reg. § 1.509(a)-7(a); Rev. Proc. 1982-39, 1982-2 C.B. 759.

³³ Reg. § 1.141-2.

³⁴ Rev. Proc. 2010-1, 2010-1 I.R.B. 1; Rev. Proc. 1993-17, 1993-1 C.B. 507.

4. **Limitation on Charges -- Defining Amounts Generally Billed**

Section 501(r)(5) limits the amount that a hospital organizations may charge individuals eligible for financial assistance. Section 501(r)(5) provides that a hospital organization meets the requirements of section 501(r)(5) if the hospital organization prohibits the use of gross charges and “limits amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy . . . to not more than the amounts generally billed to individuals who have insurance covering such care.”³⁵ The statute offers no guidance on what constitutes “amounts generally billed.”

(a) Difficulties in Interpreting “Amounts Generally Billed”

(i) *Technical Explanation*

The Technical Explanation states that “[i]t is intended that the amounts billed to those who qualify for financial assistance may be based on either the best, or an average of the three best, negotiated commercial rates, or Medicare rates.”³⁶ While the Technical Explanation offers some guidance, it is not binding and by its own terms is suggestive. Further, the use of the word “generally” in the section 501(r)(5)(A) phrase “amounts generally billed” implies amounts billed to a majority of individuals, which may or may not be the same as the amounts billed under one of the three methods suggested in the Technical Explanation.

(ii) *Amounts Charged v. Amounts Billed*

Section 501(r)(5) limits the “amounts charged” to a person eligible for financial assistance. The Technical Explanation interprets those words to mean “amounts billed.” The terms “charges” and “amounts billed” typically have different meanings in the health care industry. Generally, the term “charges” refers to the amounts found on a hospital’s price list, or “chargemaster.” Managed care payors generally negotiate a discount from the hospital charges, so that they are billed an amount that is often much lower than the listed price. To avoid confusion, these Comments will follow the approach used in the Technical Explanation and treat “amounts charged” to mean the amounts actually billed to a patient, which may (and usually will) differ from the listed chargemaster prices.

(iii) *Complexity of Reimbursement Systems*

There are myriad methods for compensating hospitals under commercial insurance arrangements, including HMOs and other forms of managed care plans. Hospitals may have in place at any time many different plans with many different payment methodologies. Even contracts with the same insurer may provide different payments based on the type of coverage selected by the participant. For instance, a contract may have different payment methodologies for participants in HMOs and participants in preferred provider organizations. Additionally,

³⁵ Earlier versions of PPACA would have provided that hospital organizations should limit charges to not more than *the lowest amounts charged* to individuals who have insurance covering such care. The wording was changed after public comments that the provision would require disclosure of confidential trade information.

³⁶ Technical Explanation at 82.

some types of services, such as organ transplants and behavioral health, often are covered under separate arrangements. There are generally specified payments for both inpatient and outpatient services, including outpatient services performed at off-site facilities.

The traditional method for setting billing rates has been a global discount from the fee-for-service rates listed on the hospital's chargemaster. These rates would be relatively simple to identify for the purpose of determining the negotiated commercial rates if all health plans paid hospitals in this manner. This method has, however, become less common because it provides insurers with little certainty as to cost. As an alternative, hospitals are increasingly paid on a per diem or case basis.

Per diem payments are a fixed amount per day per patient. Case-based payments are based on the types of cases presented for a specified condition or disease. Both types of payments may be further categorized based on the level of care provided. The contract between the hospital organization and the insurer may specify that the payment includes or excludes certain items and services.

Many managed care contracts will provide for stop-loss coverage, which becomes effective after costs or charges exceed a certain amount for a single admission. After this point, the insurer typically will pay the hospital a certain percentage of hospital charges.

There may be continuous adjustments between the amounts actually billed and the amounts correctly billed and actually collected. The amount actually billed may not be the amount actually collected or even the correct amount that should have been billed. For instance, if an insurer does not pay a properly filed claim within a specific time frame, the insurer may be required to pay at chargemaster rates or may have to pay interest on the claim. Downward adjustments may be made for "never events,"³⁷ or for services deemed by the insurer to be in excess of those necessary in the particular case. Payments may be denied for unauthorized services.

Additionally, hospitals may bill multiple insurers for the same services. For example, an insurer may be a secondary insurer on a claim, and the hospital may bill that one insurer an amount that is considerably less than the amounts billed for the service as a whole.

One commentator described a typical hospital managed care contract as follows:

Let's assume this payer pays for inpatient services on a per-diem basis, with separate rates for medical and surgical cases. In addition, carve-outs are present for cardiology DRGs. Finally, obstetrics and nursery care services are paid on case rates. To provide some additional risk protection to the hospital, a stop loss provision is also inserted after total charges exceed a certain limit. Outpatient services are paid on a mix of fee schedules and discounted billed charges. Outpatient surgical cases are paid on a fee schedule based upon designated ambulatory surgical [procedure] groups. Emergency

³⁷ The term "never events" refers to a defined listing of serious reportable events involving patient care, first compiled in 2002 by the National Quality Forum, a nonprofit membership organization. Listings of such events, with reimbursement implications, have been adopted by the Centers for Medicare & Medicaid Services and by other payors.

visits are also on a fee schedule, based upon level of services. Other fee schedules exist for specific imaging procedures, and everything else is paid on a discounted, billed-charge basis. Multiply this one payer by 100 to recognize other payers and throw in Medicare and Medicaid payment rules, and you have a nightmare in administration.³⁸

(iv) *Problems with Determining the “Best” Commercial Rates*

The Technical Explanation states that a hospital may base its amounts billed to financial assistance recipients on the “best, or an average of the three best, negotiated commercial rates.” This is easier said than done. This best rate might conceivably be calculated in many different ways.

First, this amount might refer to the single lowest rate for a particular service, regardless of the insurer. For instance, the lowest rate for procedure X may be found in a contract with insurer 1 whereas the lowest rate for procedure Y may be found in a different contract with insurer 2. Second, this amount might refer to the rates offered by one insurer under a contract (or within a specific plan under a contract) that generally are less than the rates offered by another insurer under another contract.

These approaches may not result in comparisons of comparable amounts. For example, one contract may call for discounted charges whereas another may call for per diem rates. In addition, per diem or case rates paid by different insurers may include or exclude different items or services.

(v) *Problems with Single Best Rate*

We believe many hospitals will be reluctant to use a single best rate. First, disclosing such a rate may put hospitals at a disadvantage when negotiating with insurers, because no insurer would be willing to offer the hospital a rate higher than the “best rate” (and indeed, some insurers would likely try to negotiate a discount off that rate, creating a “death spiral” effect due to the pressure to decrease the single best rate). Second, many managed care contracts have confidentiality provisions that restrict a hospital from disclosing the terms of the agreement and provide for damages or termination of the contract in the event of a disclosure. Although managed care contracts usually include exceptions for disclosures required by a government agency, if using the “single best rate” is but one option, then such disclosures might not be mandatory.

(vi) *Problems with Using Multiple Rates*

If a hospital uses an average of the commercial rates, it is unclear whether the hospital should select the rates based on rates, revenues, or patient encounters. Section 501(r)(5) limits the amounts charged to the “amounts generally billed,” which implies that the hospital should take into account the rates that apply to the majority of its patients. On the other hand, the Technical Explanation states that the hospital should take into account the plans that offer the lowest rates. However, the three largest payers by volume may not offer the best rates.

³⁸ William O. Cleverley, Ph.D., Foreword, in Anne B. Casto & Elizabeth Layman, *Principles of Healthcare Reimbursement* (2006).

Conversely, the plans with the lowest rates may not apply to a majority of the patients seen by a hospital.

If the best-three approach is used, a hospital must determine whether the average will be a simple or weighted average. For instance, if the three best rates were 50%, 55%, and 60% of the charges, then a simple average would be 55%. However, if the plans by volume accounted for 40%, 8% and 52% of revenues or patient encounters, then the percentage could be weighted and could result in a significantly different average. The issues are further complicated because hospitals generally offer discounts for financial assistance on a sliding scale. For instance, it is common practice for persons whose income is below 100% of the federal poverty level (“FPL”) to receive free services and for those whose income is higher to receive discounted services on a sliding scale. Hence, a person whose income is at 200% of the FPL would receive a larger discount than a person whose income is at 300% of the FPL.

(vii) *Problems with Using Medicare Rates*

The Medicare program typically pays hospitals a flat fee per case. There are hundreds of different case rates, or DRGs (diagnosis-related groups, the basis for Medicare hospital payments). The rates are updated annually. Medicare rates vary based on geography. Presumably the Medicare rates mentioned in the Technical Explanation would refer to the adjusted Medicare rate that is received for services performed at a particular hospital facility location.

Although probably the simplest option of those mentioned in the Technical Explanation, the Medicare rate option will present problems in some instances for children’s hospitals or for pediatric care services provided by general hospitals, because Medicare does not establish rates for many types of pediatric services. Finally, hospitals may be reluctant to use the Medicare rate because they may fear that insurers will argue that they should pay the lower Medicare rate if it is given to persons who qualify for financial aid.

(b) Recommendations for Determining “Amounts Generally Billed”

(i) *Flexibility*

We recommend that hospitals be accorded flexibility in determining the “amounts generally billed.” Hospitals are required to implement this requirement without having the benefit of the time to determine what is administratively feasible. Moreover, health care delivery methods may change as health care reform is implemented over the next several years. We believe that a rigid structure would not serve the public interest when the methods of delivering health care to those who need financial assistance may change. The Service should have more information available when it makes the required five-year report,³⁹ and additional refinements may be added at that time.

³⁹ PPACA § 9007(e).

(ii) *Medicare Rate*

The simplest method would be for a hospital to base its billings to financial assistance recipients on the Medicare rate. If a hospital adopts this method, we believe the Medicare rate for purposes of the 501(r) requirement should be the actual Medicare rate used by the hospital, as adjusted for regional differences.

If a hospital performs services that are not covered by Medicare, we believe the hospital should have the option of using either the Medicare rate for the nearest equivalent service or a discount that is determined by comparing the aggregate amounts paid by Medicare for services covered by Medicare to the hospital's aggregate chargemaster rates for these same services.

(iii) *Lowest Rates*

If guidance follows the suggestion in the Technical Explanation and allows a hospital organization to base its "amounts generally billed" on the single best rate for a procedure, then we recommend that a hospital be allowed to use the following options for determining best rates:

(1) Using the actual lowest rate, regardless of insurer, if the hospital is able to make this determination. If a hospital receives per diem payments from different payers, and these rates are lower than discounted charge rates paid by other payers, then we believe the hospital should be permitted use the lowest per diem rate. We also believe any stop loss measures or adjustments that apply to the lowest per diem rate should be taken into account; or

(2) Using a blended rate or the actual rates offered by the insurer who on average pays the lowest rates. In determining the insurer who pays the lowest rates, we believe the hospital should calculate the historical aggregate amounts billed to (or paid by) the insurer (including amounts received from patients in the form of copayments, coinsurance or deductible amounts) and compare these to the hospital's chargemaster rates for these same services. The blended rate would be based on this aggregate discount.

(iv) *Average of Three Best Rates*

If a hospital were allowed to base its amounts billed to financial aid recipients on an average of the three best rates, we recommend that the hospital be allowed to select the three best rates using one of the options discussed immediately above for selecting the lowest rate, and have the option of using a simple or a weighted average.

(v) *Amounts Billed to Majority*

Instead of basing the amounts billed on the average of the three best rates, we believe the hospital should have the option of using the rates billed to the insurers who cover a majority of the hospital's patient base. We believe these amounts should be calculated in the same manner as above.

(vi) *Sliding Scale Discounts*

Hospitals have differing financial assistance policies, with varying sliding scale eligibility factors. We recommend that the rates based on amounts generally billed under section 501(r)(5) apply to any person who qualifies for financial assistance, regardless of the percentage of FPL that triggers eligibility for assistance under the hospital's policy. The patient would then be eligible for further discounts from those rates based on the hospital's financial assistance policy.

(vii) *Other*

We recommend that hospital organizations have the option of excluding outpatient services when determining amounts generally billed. We also recommend that hospital organizations have the option of separately calculating the rates for services that generally are covered under separate agreements, such as mental health care services, based on the rates provided in those separate agreements.

5. Meaning of Widely Available to the Public and Measures to Widely Publicize

(a) Meaning of Widely Available to the Public

Section 501(r)(3)(B)(ii) provides that the CHNA must be made widely available to the public. We recommend that, in defining the meaning of widely available to the public for this purpose, guidance establish a safe harbor modeled on the approach taken in the Regulations implementing similar requirements for exemption applications and annual information returns.

A tax-exempt organization's exemption application and annual information return on Form 990 are available for public inspection under section 6104. The Regulations require the organization to make its exemption application and its annual information return available for public inspection without charge at its principal, regional, and district offices during regular business hours.⁴⁰ In addition, the organization must either provide copies of those documents on request to anyone who asks for them, or make them "widely available."⁴¹ Making a document "widely available" means either posting the document on a World Wide Web page that the organization itself establishes and maintains or having the document posted as part of a database of similar documents of other organizations on a World Wide Web page established and maintained by another entity, provided the Internet posting meets the following three conditions:

(i) The World Wide Web page through which it is available clearly informs readers that the document is available and provides instructions for downloading it;

(ii) The document is posted in a format that, when accessed, downloaded, viewed and printed in hard copy, exactly reproduces the image of the document as it was originally filed with the Service, except for information permitted by statute to be withheld from public disclosure, and

⁴⁰ Reg. § 301.6104(d)-1(a).

⁴¹ Reg. §§ 301.6104(d)-1(a), 301.6104-2(a).

(iii) Any individual with access to the Internet can access, download, view and print the document without special computer hardware or software (other than software that is readily available to members of the public without payment of any fee) and without payment of a fee to the tax-exempt organization or to another entity maintaining the World Wide Web page.⁴²

In addition, for the document to be considered widely available through an Internet posting, the entity maintaining the World Wide Web page must have procedures for ensuring the reliability and accuracy of the document that it posts on the page and must take reasonable precautions to prevent alteration, destruction or accidental loss of the document when posted on its page.⁴³ In the event that a posted document is altered, destroyed or lost, the entity must correct or replace the document.⁴⁴

If a tax-exempt organization has made its exemption application and annual information return widely available, it must notify any individual requesting a physical copy where the documents are available (including the address on the World Wide Web, if applicable).⁴⁵ If the request is made in person, the organization must provide such notice immediately, but if the request is made in writing, the notice must be provided within seven days of receiving the request.⁴⁶

Consistent with this established practice, we recommend a similar approach for the CHNA, so that a hospital organization would satisfy the requirement for making its CHNA widely available to the public if it made the CHNA available for public inspection without charge at its principal, regional, and district offices during regular business hours, and either provided a physical copy of the CHNA upon request or made the CHNA widely available through an Internet posting similar to that described above.

We further recommend that the Regulations provide that failure to follow the foregoing procedure would not mean that the hospital organization has not met the requirements of section 501(r), but that compliance with section 501(r) would then be evaluated based on all of the facts and circumstances.

(b) Meaning of Measures to Widely Publicize

Section 501(r)(4)(A)(v) requires that a hospital organization's written financial assistance policy must include measures to widely publicize the policy within the community the organization serves.

We recommend that, in defining appropriate measures to widely publicize the policy within the community served by the organization, the Service and Treasury consider not only the discussion above regarding "widely available to the public," but also the instructions to Form 990, Schedule H, Hospitals, Part VI, Supplemental Information, Part V, Line 3, which

⁴² Reg. § 301.6104(d)-2(b)(2)(i).

⁴³ Reg. § 301.6104(d)-2(b)(2)(iii).

⁴⁴ *Id.*

⁴⁵ Reg. § 301.6104(d)-2(d).

⁴⁶ *Id.*

requests a description of how an organization informs and educates patients and persons who are billed for patient care about their eligibility for assistance under the organization's charity care policy. The instructions also request that an organization enter, for example, whether it:

- (i) posts its charity care policy, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of the organization's facilities where eligible patients are likely to be present;
- (ii) provides a copy of the policy, or a summary thereof, and financial assistance contact information to patients as part of the intake process;
- (iii) provides a copy of the policy, or a summary thereof, and financial assistance contact information to patients with discharge materials; [or]
- (iv) includes the policy, or a summary thereof, along with financial assistance contact information, in patient bills . . . ⁴⁷

We recommend that Treasury and the Service provide a safe harbor confirming that the written financial assistance policy satisfies the requirement to include measures to widely publicize the policy within the community served by the organization if the hospital organization (a) makes the financial assistance policy available for public inspection without charge at its principal, regional, and district offices during regular business hours; (b) either provides a physical copy upon request or makes the policy widely available by Internet posting as described above; and (c) makes it available consistent with the examples set forth in (i) - (iv) above consistent with the instructions to Form 990, Schedule H.

We further recommend that Treasury and the Service provide guidance that failure to satisfy the safe harbor will not mean that these requirements have not been met, but that compliance will then be evaluated based on all of the facts and circumstances. Other relevant facts and circumstances might include whether the policies are given upon request to the patient, communicated at outpatient clinics as well as at the hospital, provided by financial assistance counselors, mentioned on the hospital's voice mail system, included at the hospital's help or information desk, provided on financial assistance applications, provided by affiliated collection agencies, communicated and coordinated with employed medical group physicians, and published in the press or online.

6. **Section 501(r)(4)(B) - Emergency Medical Care**

Section 501(r)(4)(B) states that a hospital organization must have a "written policy requiring the organization to provide, without discrimination, care for emergency medical conditions (within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd)) to individuals regardless of their eligibility under the financial assistance policy described in subparagraph (A)."

⁴⁷ Form 990, Schedule H, Hospitals, Part VI, Supplemental Information, Part V, Line 3 (2009) (paragraph numbers added).

The Technical Explanation states that “[t]he policy must prevent discrimination in the provision of emergency medical treatment, including denial of service, against those eligible for financial assistance under the facility’s financial assistance policy or those eligible for government assistance.”⁴⁸

Section 1867 of the Social Security Act provides that if an individual presents at a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either of the following:

- (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
- (B) for transfer of the individual to another medical facility in accordance with **[the rules described in section 1867 of the Social Security Act,]** subsection (c).⁴⁹

We believe that so long as an organization’s written policies state that it will follow the procedures set forth in section 1867 of the Social Security Act, without discrimination and regardless of an individual’s ability to pay for such service, the organization should be treated as having satisfied the requirement of section 501(r)(4)(B).

7. Satisfaction of Reporting and Disclosure Requirements

Section 6033(b)(15)(A) requires a hospital organization subject to section 501(r) to include on its Form 990 a description of how the organization is addressing the needs identified in each CHNA conducted under section 501(r)(3), a description of any needs not being addressed, and the reasons why the needs are not being addressed.

Section 6033(b)(10)(D) requires a hospital organization to report on its Form 990 the amount of any excise tax imposed on the organization under section 4959 by reason of failing to meet the CHNA requirements of section 501(r)(3).

A hospital organization is defined in section 501(r)(2)(A) as “(i) an organization which operates a facility which is required by a State to be licensed, registered, or similarly recognized as a hospital, and (ii) any other organization which the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption under [section 501(c)(3)] (determined without regard to this subsection).”

The instructions for Schedule H (Form 990), Who Must File, define a “hospital” as a facility that is, or is required to be, licensed, registered or similarly recognized by a state as a hospital. If the filing organization operates multiple hospitals, or if it files a group return under a group exemption for a group that operates one or more hospitals, then one Schedule H must be completed for all the hospitals operated by the filing organization or the group. The Schedule H in its current form applies for taxable years beginning after December 31, 2008.

⁴⁸ Technical Explanation at page 82.

⁴⁹ Social Security Act § 1867(b)(1), 42 U.S.C. § 1395dd.

(a) Recommended Definition of Hospital for Form 990 and Section 501(r) Purposes

We recommend that, for purposes of complying with the reporting and disclosure requirements of sections 6033(b)(10) and 6033(b)(15)(A), “hospital organization” be defined for section 501(r) reporting purposes in the same manner that “hospital” is currently defined for purposes of Form 990, Schedule H. As a result, each “hospital” properly reporting on Schedule H, to the extent it properly discloses information required by sections 6033(b)(10) and 6033(b)(15)(A), would satisfy such requirements. We see no policy reason to have hospital organizations file Schedule H for all purposes other than reporting on new section 501(r) requirements, but then to have a different type or level of entity then report on new section 501(r) requirements (including but not limited to the new CHNA requirement). We believe a common definition would more efficiently use available resources and would lead to more efficient and effective compliance with Form 990 reporting and disclosure requirements.

(b) Timing of Form 990 Reporting of Requirements Other Than CHNA

The CHNA requirements of section 501(r)(3) and the associated reporting and disclosure requirements of sections 6033(b)(10) and 6033(b)(15)(A) apply to taxable years beginning after March 23, 2012.⁵⁰ Neither section 501(r) nor section 6033 mandate disclosure on Form 990 of information relating to the other new requirements of section 501(r). To the extent that the Service decides to expand the Form 990 reporting and disclosure requirements to include information relating to the other new requirements under section 501(r), we recommend that any such new or expanded reporting and disclosure not be required on Form 990 until fiscal years beginning after March 23, 2012. In other words, we recommend that all new Form 990 reporting requirements relating to section 501(r) become applicable at the same time and on the same Form 990.

(c) Form of Reporting Compliance with Section 501(r) Requirements

We recommend that, when Form 990 requires reporting of compliance with section 501(r), all such reporting be contained on Schedule H, because section 501(r) pertains only to filing organizations that are or include hospitals. We recommend that the new questions pertaining to section 501(r) be contained in a separate section of Schedule H, and that current instruction for Part VI, Supplemental Information, Part V, Line 2, which states “[d]escribe whether, and, if so, how, the organization assesses the health care needs of the community or communities it serves” be deleted at that time due to redundancy. We recommend that the new questions pertaining to section 501(r) be worded as follows:

- 1a Did the organization conduct a community health needs assessment (“CHNA”) (see instructions) during the year?
- 1b If “Yes,” describe in Part VI (i) how the organization took into account input from persons representing broad community interests and (ii) how the assessment was made widely available to the public.

⁵⁰ PPACA § 9007(f)(2).

- 2 Enter the date after March 22, 2012, on which the most recent CHNA, if any, was conducted (enter “N/A” if no such CHNA has yet been conducted).
- 3 If a CHNA has been conducted, describe in Part VI (i) how the organization is addressing identified needs and (ii) any needs not being addressed and why such needs are not being addressed.
- 4 During the year, did the organization incur an excise tax under section 4959 for failure to meet the CHNA requirements of section 501(r)(3)? If “Yes,” describe in Schedule O the amount of the failure and the amount of the excise tax.
- 5 Does the organization have a written financial assistance policy that satisfies the criteria of section 501(r)(4)(A)?
- 6 Does the organization have a written policy on nondiscriminatory care for emergency medical conditions (satisfying section 501(r)(4)(B)) regardless of eligibility for financial assistance? If “No,” describe in Part VI why not.
- 7 Does the organization limit amounts charged for emergency and other medically necessary care provided to individuals eligible for assistance under the organization’s financial assistance policy to not more than the amounts generally billed to individuals who have insurance for such care?

We believe that if these questions (or similar questions) added, the current Part I, Lines 1a and 1b of Schedule H regarding the organizations charity care policy should be deleted as redundant.

(d) Retain Current Schedule H Disclosure of Collection Practices

The requirements of section 501(r)(6) concerning extraordinary collection practices are discussed elsewhere in these Comments. We recommend that these requirements continue to be addressed with the questions contained in Schedule H, Part III, Lines 9a and 9b, which we believe should provide sufficient information on billing and collection practices. The requirements of new section 501(r)(6) must be carried out in practice and we believe the appropriate level of disclosure is with respect to the existence of a written policy on collection practices. If it is necessary to include more detailed disclosure in Schedule H, Part III, Lines 9a and 9b, then we recommend that the question in Line 9b be expanded to read in part, “practices to be followed for patients who are known to qualify for charity care or financial assistance (including forgoing extraordinary collection actions as required by section 501(r)(6))?”