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In this article, Ghatan reviews the pre- and post-section 501(r) landscape for maintaining tax-exempt status as a charitable hospital. He examines the requirements imposed on tax-exempt hospitals by that section and its complex final regulations, and he discusses some of the ongoing compliance challenges facing tax-exempt hospitals.

I. Introduction

On May 4, after much negotiation and an earlier false start, the House took a first step toward repealing the Affordable Care Act with the passage of H.R. 1628, the American Health Care Act (AHCA). Whether the AHCA will become the new law of the land remains to be seen and will depend on its reception in the Senate. But while the AHCA makes many significant changes regarding access to and the affordability of health insurance in the United States, it does not represent an outright repeal of the ACA, despite much political rhetoric to the contrary. In part this is a strategic decision by the Republicans to dismantle as much of the ACA as they can without any Democratic support by relying on the Senate reconciliation process, which would allow the Republicans to pass the AHCA by a simple majority vote rather than the typical 60-vote majority required to overcome a filibuster. But in part it reveals that some provisions of the ACA will likely remain in place, even with Republicans now in control of both chambers of Congress and the White House.

One of the ACA provisions that remains untouched by the AHCA is section 501(r), which imposes specific requirements on charitable hospitals to be recognized as tax exempt under section 501(c)(3). Section 501(r) holds the distinction of being one of the few ACA provisions drafted in a bipartisan manner. Sen. Chuck Grassley, R-Iowa, who has demonstrated a long-standing interest in the tax-exempt sector, wrote earlier versions of the provisions that would become section 501(r), and that were ultimately incorporated by the Democrats into the ACA. Moreover, despite Grassley having voted against passage of the ACA, he champions his authorship of section 501(r), suggesting that it is here to stay.[1]

II. Background on Section 501(r)

A. The Pre-Section 501(r) Landscape

Although section 501(c)(3) enumerates specific purposes that entitle an organization to tax-exempt status under that section of the code, the provision of healthcare services is not among them. The promotion of health has long been understood to come under the umbrella of "charitable,"[2] but not every activity that promotes

[1] *See* Grassley release (Mar. 24, 2010).

[2] *See* Rev. Rul. 69-545, 1969-2 C.B. 117, citing the Restatement (Second), Trusts for this principle.

health is considered charitable under section 501(c)(3).[3]

Before section 501(r), hospitals seeking tax-exempt status were evaluated under the community benefit standard articulated in Rev. Rul. 69-545 by way of two contrasting examples. The revenue ruling established that a hospital can be described in section 501(c)(3) on the basis of promoting the health of the community — even when the charitable class benefited by the hospital is not primarily the poor and indigent — if the facts and circumstances demonstrate that the hospital is providing a benefit to the community.[4] Specific facts considered in the ruling include: (1) the presence of a community board composed of prominent civic leaders; (2) a medical staff open to all qualified physicians in the area, consistent with the size and nature of the facilities; (3) operation of a full-time emergency room; (4) the treatment of patients covered by public programs such as Medicare; and (5) whether the hospital engages in medical research and education.

The IRS later clarified that not all of these factors must necessarily be present to find that a hospital qualifies for exemption under section 501(c)(3).[5] Although the provision of charity care continued to be one of the factors the IRS would consider in assessing the community benefits provided by a hospital seeking to be recognized as a section 501(c)(3) organization, some critics of the community benefit standard contended that exemption should be granted only to hospitals that engage in charity care.[6]

B. The Section 501(r) Landscape

Section 501(r), which does not displace the community benefit standard but adds to it, introduced four new obligations for tax-exempt hospitals:

1. *Community health needs assessment.* At least once every three years, the hospital must conduct a community health needs assessment (CHNA) that takes into account input from persons who represent the broad interests of the community served by the hospital, and it must adopt an implementation strategy to meet those health needs.

2. *Written policies.* The hospital must adopt two specific policies:

   a. A written financial assistance policy (FAP) that includes: (i) eligibility criteria for financial assistance and whether that assistance includes free or discounted care; (ii) the basis for calculating amounts charged to patients; (iii) the method for applying for financial assistance; (iv) for a hospital that lacks a separate billing and collections policy, the actions the hospital may take in the event of nonpayment, including collections action and reporting to credit agencies; and (v) measures to widely publicize the FAP within the community served by the hospital.

   b. A written emergency care policy requiring the hospital to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the FAP.

3. *Limitations on charges.* The hospital must (a) limit the amounts charged for emergency or medically necessary care provided to individuals eligible under the FAP to not more than the amounts generally billed to individuals who have

[3] An oft-cited example in IRS guidance is a pharmacy, which promotes health by selling prescription medicines but cannot qualify for exemption under section 501(c)(3) on that basis alone. *See* Rev. Rul. 98-15, 1998-1 C.B. 718 (citing *Federation Pharmacy Services Inc. v. Commissioner*, 72 T.C. 687 (1979), *aff'd*, 625 F.2d 804 (8th Cir. 1980)).

[4] Before the issuance of Rev. Rul. 69-545, to qualify for tax exemption under section 501(c)(3), hospitals were required to provide free or reduced-cost care to those unable to pay. Rev. Rul. 56-185, 1956-1 C.B. 202.

[5] Rev. Rul. 83-157, 1983-2 C.B. 94.

[6] For additional insightful reading on the background of tax exemption for charitable hospitals, see Douglas Mancino and Robert C. Louthian III, *Taxation of Hospitals and Health Care Organizations*, section 4.03 (2d ed. 2016); and Thomas K. Hyatt and Bruce Hopkins, *The Law of Tax-Exempt Healthcare Organizations*, chs. 1 and 3 (4th ed. 2013). *See also* Susannah Camic Tahk, "Tax-Exempt Hospitals and Their Communities," 6 *Colum. J. Tax L.* 33 (2014).

insurance; and (b) prohibit the use of gross charges.[7]

4. *No extraordinary collection actions.* The hospital may not engage in extraordinary collection actions before it has made reasonable efforts to determine whether an individual is eligible for assistance under the FAP.

These four requirements have spun off five notices,[8] a revenue procedure,[9] two sets of proposed regulations,[10] and final regulations[11] that occupy 64 pages in the *Federal Register* and establish a multitude of highly specific substantive and procedural steps hospitals must take to ensure compliance with the four statutory requirements of section 501(r).

As an acknowledgement by Treasury and the IRS of the many foot faults introduced by the final regulations, the regulations include opportunities for correcting compliance problems depending on their severity. Although the types of compliance issues are not expressly laid out as such, essentially they may be grouped into three categories:

1. *Category 1: minor omissions and errors.* These are omissions or errors that are (1) minor and (2) either inadvertent or due to reasonable cause. These compliance failures will not be treated as a failure to meet the requirements of section 501(r) if the hospital promptly corrects the omission or error, including establishing practices or procedures reasonably designed to promote and facilitate overall compliance with the requirements.[12]

2. *Category 2: failures that are neither willful nor egregious.* These are failures that presumably do not fit within the first category, either because they are more than minor, or were not inadvertent, or lacked reasonable cause.[13] These failures will be excused if they are corrected in accordance with the procedures in Rev. Proc. 2015-21 and disclosed on the hospital's Form 990.[14] Importantly, correction must have at least begun before the hospital is contacted by the IRS concerning an examination.

3. *Category 3: all other failures.* These failures are either willful or egregious, or are Category 1 or Category 2 failures that have not been corrected by the hospital.

Perhaps as another acknowledgement by Treasury and the IRS about the high likelihood for compliance problems, the final regulations also perform a sleight of hand, converting what appears to be an absolute requirement in the code to comply with the requirements of section 501(r) into a facts and circumstances analysis. Section 501(r) states that a hospital will not be recognized as described in section 501(c)(3) unless it complies with the requirements enumerated in section 501(r), whereas under the final regulations, a hospital failing to meet one or more of the requirements of section 501(r) "may" have its section 501(c)(3) status revoked at the discretion of the commissioner based on the relevant facts and circumstances. Although a facts and

[7]The statute does not explain what the prohibition on gross charges entails, although the final section 501(r) regulations, described further below, provide that a hospital must charge an individual eligible under the hospital's FAP less than the gross charges for any medical care covered under the FAP. However, the billing statement issued by the hospital may state the gross charges for care provided and apply contractual allowances, discounts, or deductions to the gross charges if the actual amount that the FAP-eligible individual is responsible for paying is less than the gross charges for the care.

[8]Notice 2010-39, 2010-23 IRB 756; Notice 2011-52, 2011-30 IRB 60; Notice 2014-2, 2014-3 IRB 407; Notice 2014-3, 2014-3 IRB 408; and Notice 2015-46, 2015-28 IRB 64.

[9]Rev. Proc. 2015-21, 2015-13 IRB 817.

[10]REG-130266-11; and REG-106499-12.

[11]T.D. 9708.

[12]The terms "minor," "inadvertent," and "reasonable cause" are not expressly defined in the regulations. In considering whether multiple errors or omissions are minor, the errors or omissions are considered in the aggregate. In considering whether an error or omission was inadvertent, the fact that the same error or omission occurred previously and was corrected is a factor suggesting that it was not inadvertent. And finally, in establishing reasonable cause, the fact that the hospital had established practices or procedures reasonably designed to promote and facilitate section 501(r) compliance before the occurrence of the error or omission is a factor tending to show that there was reasonable cause.

[13]Willful failures include failures attributable to gross negligence, reckless disregard, or willful neglect. Egregious failures include only very serious failures, taking into account the severity of the impact and the number of affected persons.

[14]Rev. Proc. 2015-21 addresses corrections of Category 2 compliance problems but provides that the correction procedures described therein may also be used to address Category 1 compliance problems.

circumstances analysis is certainly preferable to an absolute loss of tax exemption, given that the determination is entirely at the discretion of the IRS, hospitals seeking to retain their tax-exempt status should not rely on this apparent regulatory easing of the strict 501(r) compliance required by the code.

III. Managing Section 501(r) Compliance

Although the requirements of section 501(r) generally took effect upon enactment of the ACA in 2010 (the CHNA requirement took effect two years later), the final regulations became effective only with a hospital's first tax year beginning after December 29, 2015. It has therefore been only over the past year that hospitals have begun to fully turn their attention to, and to feel the full burden of, complying with the requirements of the final regulations. For example, hospitals with a September 30 year-end did not become subject to the final regulations until the year beginning October 1, 2016.

In our experience, it has been rare to come across a hospital that has simply disregarded its obligations under section 501(r). More commonly we have worked with hospitals that are genuinely seeking to comply with section 501(r) but are struggling to avoid all the foot faults of the final regulations. We have seen clients performing major surgery on their FAPs and their billing and collections policies to bring them into full compliance with the substantive provisions of the final regulations, and working diligently to check every box required by the regulations regarding conducting their CHNAs and widely publicizing their FAPs. We have found that creating and following a comprehensive checklist of each discrete action, step, and piece of substantive information that must be included in a particular policy is the most effective way to ensure full compliance.

Moreover, following the introduction of section 501(r), the IRS revised Schedule H of Form 990, the schedule completed by tax-exempt hospitals, to include questions targeted toward determining a hospital's compliance with the requirements of section 501(r). Most of the questions are drafted in a yes-or-no format or ask the hospital to check all the applicable boxes in a list. Hospitals should be cautious in answering these questions because they are traps for the unwary. The wrong answer may demonstrate a compliance problem with the final regulations under section 501(r).

For example, Schedule H includes a question asking the hospital to check the box for each of the methods it uses to widely publicize its FAP. In the years before the final regulations took effect, failure to check all the boxes in the list would not necessarily have meant a compliance failure. But now, failure to check any of those boxes — each of which is tied to a specific procedure the final regulations impose on a hospital to widely publicize its FAP — would demonstrate a compliance failure that could jeopardize the hospital's tax exemption if not corrected.

Also, beyond self-identified compliance issues and problems that surface while completing the Form 990, lurking in the background for every tax-exempt hospital is section 9007(c) of the ACA, which mandates that the Treasury secretary or the secretary's delegate review at least once every three years the community benefit activities of each hospital organization to which section 501(r) applies. As of September 30, 2016, the IRS had conducted 968 reviews of tax-exempt hospitals and had referred 363 of them (37.5 percent) for field examinations.[15] Thus, each hospital can expect to be reviewed at least once every three years, and for the time being, the chance of a field examination is not insignificant.

Although the scope of these reviews has thus far been limited to compliance with only the basic section 501(r) statutory requirements (conducting a CHNA, adopting a FAP, and satisfying the billing and collections obligations), the reviews can soon be expected to focus on regulatory compliance as well. If 37.5 percent of reviews focused solely on statutory compliance have resulted in referrals for field examinations, it's anybody's guess what the percentage of referrals will be once the IRS begins to consider compliance with the final section 501(r) regulations.

These reviews could also become broader than section 501(r), given that the statutory

[15] IRS Tax-Exempt and Government Entities FY 2017 Work Plan (Sept. 28, 2016) (as amended Mar. 8, 2017).

language does not limit the IRS to reviewing only section 501(r) compliance; it instructs the Treasury secretary to review the community benefit activities of tax-exempt hospitals. It will be interesting to see whether, once the dust settles on compliance with the final section 501(r) regulations, the IRS uses these marching orders to also review a hospital's compliance with the community benefit standard of Rev. Rul. 69-545.

IV. Conclusion

Although elected officials have often championed repealing the ACA, the reality is that even if the AHCA becomes law, section 501(r) — one of the most significant provisions of the ACA for tax-exempt hospitals — does not appear to be going anywhere soon. Nothing is certain in Washington, particularly when it comes to healthcare, but section 501(r) appears to be one of the few components of the ACA that has bipartisan support. All tax-exempt hospitals are now subject to the highly detailed final 501(r) regulations and should by now have sought to bring themselves into compliance with those rules.

Compliance problems are likely — and perhaps inevitable. Hospitals would be well advised to continue reviewing their compliance because meeting the requirements of section 501(r) is for now and the foreseeable future a condition for maintaining section 501(c)(3) exemption. ■