Obtaining tax-exempt status, and maintaining it, is not a luxury for many hospitals—it is an essential part of their financial structure, and certainly an intrinsic part of their mission and vision statements. However, the process of maintaining 501(c) (3) status became more complicated when Congress passed the Affordable Care Act.

New Rules in the ACA for Non-Profit Hospitals

In section 9007 of the ACA, additional rules summarized in the ACA and in the IRS Code [at 501(r)], were established for non-profit hospitals to follow:

Patient Discounts

Non-profit hospitals are now required to provide a formal discount structure for patient self-pays like what is furnished for HMOs and other payers. Hospitals cannot charge financially needy patients for 100 percent of the Chargemaster rates. The hospital needs to work on the discount plan—either by looking back to its historical accounts or by looking at what Medicare or Medicaid would pay for the same services. Additionally, the hospital needs to make reasonable efforts to contact patients regarding the possibility of discounts and also to explain the written charity care application process. Post clearance of these stages, if patients do not comply with the application process or show that they do not qualify for discounts financially, the hospital can now continue to collect the balances at gross charges.

After the hospital has satisfied the processes associated with its discount policies, and formally established the discount (or established that the patient does not qualify for a discount) the hospital may continue with ordinary collection efforts. At the same time, the patient’s failure to cooperate does not mitigate the hospital’s responsibility to make determinations about whether the patient would qualify for a financial discount.

Financial Assistance Policies

Top-performing hospitals have a written Financial Assistance Policy (FAP). The ACA now makes it mandatory to have a widely distributed written policy that includes eligibility criteria, comments about how much discounted care a patient might receive, and information on how charges are calculated. The FAP should also include instructions on how to apply for assistance, and should also include the forms that a patient should complete in order to obtain a discount. The FAP requirement should be in place now; Section 9007 stipulated that all sections except the CHNA (below) were effective with the hospital’s tax year beginning after March 23, 2010.
Community Health Needs Assessment (CHNA)

Every non-profit hospital is required to write a Community Health Needs Assessment (CHNA) plan at least once every three years. Providers who are updating their CHNAs must redefine the community they serve and assess the health needs of that community. In assessing the community’s health needs, the hospital must solicit and take into account input received from persons who represent the broad interests of its community, even as it builds on previous CHNAs. The written plan, which the hospital should distribute in the community each time it is updated, should show how the hospital is going to meet various local healthcare needs. There’s a hefty annual penalty per hospital ($50,000) for failure to maintain an updated plan. The deadline for the first written CHNA was the hospital’s tax year ending after March 23, 2012, so every nonprofit hospital should have written one by now. CHNAs that were first written in 2012 are now due for their second iteration, so hospitals need to check the date of their last CHNA to ensure that they are updating the plan in a timely manner.

Recent Developments and Effects

Hospitals and others who are analyzing CHNAs and IRS 990-H documents should read IRS Notice 2014-2 for clarifications about definitions, exemptions, and other finer points of the regulations. IRS Notice 2014-3 is also of interest with regard to a hospital’s rights and responsibilities on the correction of delinquencies regarding IRS 501(r) regulations. Bulletin 2015-5 is also important since it provides good directions in this matter.

Partnering on Self-Pay Services

Due to these types of post-reform pressures, from tax-exemption oversight to ICD-10 coding, provider BPO is projected to grow at 30% year over year, according to the World Health Organization. Undoubtedly, provider resources are stretched thin by these regulations and fiscal challenges. BPO vendors can augment clients’ revenue management efforts in an ongoing supplemental role or during specific events that typically lead to pressures on cash flow, including patient accounting system conversions, process transformation and redesign efforts, staff turnover, and talent recruitment challenges. These vendors can provide self-pay services to help identify areas of concern regarding charity care and community need, as well as ease the collection efforts with our customers’ communities.

About HGS

HGS is a leader in optimizing the customer experience and helping our clients to become more competitive. HGS provides a full suite of business process management services from marketing and digital enablement services, consumer interaction services to platform enabling back office business services. By applying analytics and interaction transformation design to deliver innovation and thought leadership, HGS increases revenue, improves operating efficiency and helps to retain valuable customers. HGS expertise spans the telecommunications and media, healthcare, insurance, banking, consumer electronics and technology, retail, consumer packaged goods industries, as well as the public sector. HGS operates on a global landscape with around 40,000 employees in 65 worldwide locations delivering localized solutions. HGS, part of the multi-billion dollar Hinduja Group, has over four decades of experience working with some of the world’s most recognized brands.