

Overview of Charity Care Requirements Imposed Upon Nonprofit Hospitals

By David M. Flynn (dflynn@duanemorris.com)

Class action lawsuits filed against nonprofit hospitals throughout the country, and recent actions by attorneys general in various states, have heightened the focus on appropriate “charity care” policies for nonprofit hospitals. In addition, comments made during the past year by the Chair of the Senate Finance Committee and the Chair of the House Ways & Means Committee questioning the rationale for exempting nonprofit hospitals from federal income tax have made charity care requirements a front-burner issue.

“Charity Care” Requirements under the Federal Tax Law

No Clear Requirement

Under current IRS-published precedential authority, the only clear requirement that applies for charitable tax-exempt status is that an acute-care hospital must operate a full-time emergency room providing treatment to all patients presenting themselves for service without regard to their ability to pay. Current law (and the IRS position) does not specify a minimum level of free or charity care that must be provided to indigent patients by an acute-care hospital in order to qualify for federal income tax exemption under section 501(c)(3) of the Internal Revenue Code. There is also no clear definition of what qualifies as charity care, nor any specific guidance concerning how to identify, statistically or otherwise, who can be classified as members of a class that should receive charity care.

The “Financial Ability” Standard

Although nonprofit hospitals qualify for federal income tax-exempt status under section 501(c)(3) provided they are organized and operated exclusively for charitable, scientific or educational purposes, “charitable” is not defined in the Code.

Rev. Rul. 56-185 (1956-1 C.B. 202), published approximately three years before the final section 501(c)(3) regulations were adopted,

listed four requirements, two of which were in addition to the requirements already prescribed in the statute. The first of these was that a hospital must be operated to the extent of its “financial ability” for those not able to pay for the services rendered. The second was that a hospital must not restrict the use of its facilities to any particular group of physicians and surgeons. The “financial ability” standard was somewhat flexible and could be met by hospitals in several ways.

The “Community Benefit” Standard

In 1969, Rev. Rul. 69-545 (1969-2 C.B. 117) expressly modified Rev. Rul. 56-185 to eliminate the financial ability requirement and replace it with the “community benefit” standard. The basic rationale of Rev. Rul. 69-545 was that a hospital that provides care on a nonprofit basis for members of its community is organized and operated in furtherance of a purpose considered charitable in the generally accepted legal sense of that term. It noted that the promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole, even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community.

In addition to an emergency room open to all persons without regard to ability to pay, other important factors supporting the community benefit standard for charitable status were: (1) a board of directors drawn from the community; (2) an open medical staff policy; (3) treatment of patients paying with the aid of public programs such as Medicare and Medicaid; and (4) the application of surplus to improving facilities, equipment, patient care, and medical training, education, and research.

The community benefit standard adopted in Rev. Rul. 69-545 was amplified in Rev. Rul. 83-157 (1983-2 C.B. 94), which involved a

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nonprofit hospital that did not operate an emergency room. In that ruling, the IRS held that the community benefit standard had been satisfied by some of the other factors identified above, and that the operation of an emergency room was not critical in all cases. The validity of Rev. Rul. 69-545 and its community benefit standard as a replacement for the financial ability standard of Rev. Rul. 56-185 was upheld by the United States Court of Appeals for the District of Columbia in 1974.¹

Subsequent Developments

Recently, in litigation concerning the tax-exempt status of the St. David's Health Care System,² the government appeared to take a charity care position quite different from the community benefit standard, asserting that a minimum amount of charity care was required for tax-exempt status. This position raises the possibility that, in addition to satisfying the community benefit requirements, a hospital must also provide an unspecified minimum level of charity care to qualify for the exemption.

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It seems unlikely at this time that the IRS will make any change to the current standard. Whether there will be a more formal change to the 501(c)(3) requirements, therefore, depends upon the mood and priorities in Congress.

State Law "Charity Care" Standards

Variations in Standards

Under state law, charity care requirements can be important for income tax-exempt status, real property tax-exempt status and sales tax-exempt status. The standards vary, often significantly, from state to state, and even the standards within a single state for different kinds of tax-exempt status can differ.

In many states, exemption from corporate income tax

will apply based solely upon qualification for federal income tax-exempt status, with no separate state law requirements. In other states (for example, California), separate applications for income tax-exempt status must be submitted and approved by the taxing authority.

In the case of many nonprofit hospitals, exemption from state and local real property taxes may be of greater significance financially than exemption from federal and state income taxes.

Classification of "Charity Care" in Financial Statements

The Auditing and Accounting Guide to Healthcare Organizations of the AICPA defines charity care as follows:

Charity care represents healthcare services that are provided but are never expected to result in cash flows. As a result, charity care does not qualify for recognition as receivables or revenue in the financial statements. Distinguishing charity care from bad-debt expenses requires the exercise of judgment. Charity care is provided to a patient with demonstrated inability to pay. Each organization establishes its own criteria for charity care consistent with its mission statement and financial ability. Only the portion of the patient's account that meets the organization's charity care criteria is recognized as charity. Although it is not necessary for the entity to make this determination upon admission or registration of an individual, at some point the entity must determine that the individual meets the established criteria for charity care.

The AICPA generally requires nonprofit hospitals to disclose their charity care service policies and the amount of charity care services they have provided, but the accurate classification and documentation of healthcare services to patients who are unable to pay, as contrasted with patients who may be unwilling to pay, is not always a simple process. An example of some of the problems faced, and the correlation (or lack thereof) of financial accounting standards with legal requirements for tax exemption, is illustrated by the opinion of the District Court in the *St. David's* case.

In that opinion, the District Court unequivocally concluded that every hospital owned by the St. David's Health Care System provided emergency care without

regard to the patient's ability to pay. In addition, with respect to the government's arguments that most or all of St. David's uncompensated care should be classified as bad debt and not as charity care, the Court stated:

The government attempts to quibble about how St. David's differentiates between free care that is charity and free care that is bad debt. The Court thinks that is a silly and meaningless distinction for purposes of this case. When all who need emergency care are treated regardless of willingness or ability to pay, the function is charitable regardless of what the accountants discover later. ... [K]nowing that the hospital will not be compensated for much of the care rendered can be sufficient even if it cannot be predetermined which patients can pay and which cannot pay.

Thus, even financial accounting standards may not always correlate to applicable legal standards.

Conclusion

Nonprofit hospitals may want to consider identifying and documenting the charitable activities, free care, education, research and investment that may generally constitute a community benefit provided by the facility. The time may not be too far in the future when the hospital will be called upon to use this documentation to justify continuation of its tax exempt status. |||

1. *Eastern Kentucky Welfare Rights Organization v. Simon*, 506 F.2d 1278 (D.C. Cir. 1974), *reh'g and banc denied*, 506 F.2d 1292 (D.C. Cir. 1974), *vac'd on another ground*, 426 U.S. 26 (1976).
2. *St. David's Health Care System, Inc.*, 2002-1 U.S.T.C. ¶50,452 (W.D. Tex. 2002), *vac'd and remanded*, 349 F.3d 232 (5th Cir. 2003).

New Federal Patient Safety Law Creates Unanswered Questions

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On July 29, 2005, Congress enacted the Patient Safety and Quality Improvement Act of 2005 ("PSQIA"), a federal patient safety law that establishes a confidential, voluntary medical error reporting system. The law permits healthcare providers to report patient safety issues to a new type of entity called a "patient safety organization" ("PSO"). PSOs, in turn, would analyze the aggregate data and propose patient safety improvement strategies to eliminate medical errors. The statute also empowers the Department of Health and Human Services ("HHS") to create and maintain a network of patient safety databases to which healthcare providers and PSOs may report patient safety information. These databases will be used by HHS to analyze national and regional statistics, including trends and patterns of healthcare errors, and will be available to the public.

To encourage reporting of medical errors and other safety information, PSQIA contains privilege and confidentiality provisions protecting the provider who reports errors as well as the reported information, termed "patient safety work product." Patient safety work product is privileged and not subject to disclosure (1) in response to federal, state, local civil, criminal or

administrative subpoenas or orders; (2) as part of discovery; (3) under the Freedom of Information Act or similar law; (4) as evidence in any federal, state or local governmental civil or criminal proceeding,

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administrative rulemaking or administrative adjudicatory proceeding; or (5) as evidence in any professional disciplinary proceeding. Further, an accreditation agency may not require a provider to reveal its communications with a PSO. PSQIA also protects employees who report to PSOs by prohibiting providers from taking any adverse employment action against an employee who submits information to a PSO.

PSOs will be self-certified entities that may be free-standing or part of another organization, but must have patient safety and quality of care as primary activities. A PSO cannot be part of a health insurer.

While the confidentiality provisions of PSQIA are relatively clear, several substantive issues remain unresolved. For example:

- Because PSQIA is a voluntary system, it is unclear how state mandatory medical error reporting systems, such as those enacted in Pennsylvania and Connecticut, will intersect with PSQIA, particularly where state and federal laws conflict. Although reporting under PSQIA is voluntary, can an accreditation organization or reimbursement system, such as Medicare, make it mandatory by requiring providers to report under PSQIA as a condition of participation?

- PSQIA provisions do not prescribe the specific information to be reported or any particular format for reporting that would facilitate the aggregation of data.
- There is no limit to the number of PSOs by state, region or otherwise, nor any provision to coordinate the activities of PSOs.

PSQIA reflects a legislative compromise between those principally concerned with creating a more comprehensive system of medical reporting to improve patient safety and those concerned with limiting misuse of that information to the detriment of healthcare professionals. The result is a vague outline of a program that will require future administrative rule-making by the HHS to create sufficient detail for the program to function. The Agency for Healthcare Research and Quality is the HHS entity charged with this significant task. |||

HHS Proposes New Safe Harbor for Federally Qualified Health Centers

by Patricia Williams (pkwilliams@duanemorris.com)

On July 1, 2005, the U.S. Department of Health and Human Services (HHS) issued proposed rules describing a new “safe harbor” to the federal Antikickback Statute. This new proposed safe harbor protects certain payments or gifts to federally qualified health centers.

Federally qualified health centers (“FQHCs”) are governmental or private nonprofit organizations that serve medically underserved populations, most of which receive Public Health Service grants under Section 330 of the Public Health Service Act. Because of their mission to serve predominantly low-income individuals, FQHCs often maintain collaborative relationships with hospitals and other healthcare providers that agree to provide the FQHC with goods, services or financial assistance free of charge or at a reduced rate, or make in kind donations of equipment.

These relationships raised concerns that the free or reduced goods or services might be considered illegal remuneration under the Antikickback Act or other fraud and abuse provisions by healthcare providers in

exchange for referrals from FQHCs. The new proposed safe harbor, which Congress mandated in the Medicare Prescription Drug, Improvement and Modernization Act of 2003, addresses these arrangements.

The safe harbor is limited to FQHCs that receive funding directly from the Public Health Service or indirectly through a grant from another FQHC. Two other categories of federally qualified health centers – centers not receiving PHS funding and those treated as comprehensive federally funded health centers as of January 1, 1990, for Medicare Part B purposes – are not entitled to safe harbor treatment. As in all instances under the Antikickback Act, arrangements that do not come within the safe harbor are not necessarily illegal, but must be evaluated on a case-by-case basis.

In order to fall within the proposed safe harbor, the goods, services, donations or loans must be medical or clinical in nature, or relate directly to patient services furnished by the health center (e.g., billing services, technology support or transportation services). The safe harbor only covers remuneration from an outside

party to an FQHC and does not include any payments made by the FQHC to another party. Moreover, the safe harbor only protects benefits provided to the FQHC itself, not to its board members, physicians or other professionals or administrators. HHS intended to protect only remuneration that contributes to the FQHC's ability to maintain or increase services and to the economic benefit of the health center.

Similarly, the exception does not apply to remuneration offered by suppliers to FQHC patients. The existing prohibitions on offering inducements to federal healthcare program beneficiaries should be examined in connection with such an arrangement.

The proposed safe harbor requires that the goods, services, donations or loans must be specified and fixed in advance in a signed written agreement. A fixed amount, percentage or methodology must be specified that describes the remuneration to be protected. As with all safe harbors, the amount may not be conditioned on the volume or value of federal healthcare program business generated by the parties.

In order to satisfy the safe harbor, the FQHC must reasonably expect the arrangement to contribute "meaningfully" to its ability to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population. Since all health centers that qualify for Public Health Service funding serve at least one medically underserved population, this requirement should be easy to satisfy. Documentation of the expectation, such as board of directors minutes approving the arrangement, must be created and made available to the Secretary of HHS upon request. Factors considered in evaluating a "meaningful" benefit include whether the goods or services are of the type commonly purchased by the health center; whether a donation increases availability of an item, service, technology or treatment needed by the medically underserved population but not previously available in sufficient quantities due to financial limitations; or whether the health center needs the donated funds, goods or services to fulfill the obligations of its Public Health Service grant. Thus,

for example, transportation services that help patients access healthcare at the FQHC fulfill a Public Health Service mission, but unnecessary office space or expired medications do not.

The arrangement will not lose its protected status retroactively if the expected benefit is not in fact realized, so long as there was a reasonable and documented expectation of sufficient benefit at the onset of the agreement. The health center must re-evaluate the arrangement at least annually to ensure that it continues to satisfy the meaningful benefit standard.

Certain other restrictions apply to these relationships. Exclusive arrangements are not covered. The FQHC must be permitted, if it chooses, to enter into agreements with competing providers. Health centers also

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must inform patients of their freedom to choose any willing provider or supplier, and must disclose the existence and nature of the contractual arrangements to any patient upon request.

Finally, providers and suppliers must still comply with all other federal and state laws. HHS warned that "[w]e are concerned that some providers and suppliers may seek to recoup amounts donated to a health center through improper billing of federal healthcare programs or inappropriate transfers of governmental funds. We will give further consideration to this potential problem in the final regulations. Once the final regulations are promulgated, we intend to monitor participants in the safe harbor arrangements for compliance with billing rules." |||

Disability Discrimination Issue in Independent Housing and Assisted Living

By Susan V. Kayser (svkayser@duanemorris.com)

Seniors housing communities assessing their liability risks should consider the anti-discrimination provisions of the Fair Housing Act,¹ amended by the Fair Housing Amendments Act² (collectively, the “FHA”), and the Americans with Disabilities Act (the “ADA”).³ There are indications that advocacy groups and others concerned with discrimination issues are shining the spotlight on alleged failures to protect the disabled generally and those in seniors housing in particular.

Although the anti-discrimination laws are designed to protect the disabled, they can affect seniors housing operations in several ways, from the time of the first encounter with prospective residents through their residency term. Seniors housing facilities assessing their liability should consider the laws’ impact on admissions procedures and retention/discharge considerations.⁴

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screen out individuals with disabilities, it may only be used if necessary in certain limited circumstances, including for the provision of the services.⁵

Applicable state regulations are an important factor for licensed assisted living residences in defining their admission criteria and the scope of services they can provide. Conforming a community’s admission/retention criteria to the state’s regulatory requirements should minimize the risk of a finding of unlawful discrimination.

Staff responsible for applicant interviews should receive training on the anti-discrimination laws so they do not put the community at risk of a charge of discrimination by asking inappropriate questions or making determinations that are inconsistent with the laws. A community’s policies and procedures should state the community’s commitment to abide by applicable anti-discrimination laws and also should define how applicant interviews will be handled. The application process should be conducted in the same manner for all, whether or not the applicant is obviously disabled. Management should advise staff that discriminatory practices will not be tolerated, and staff should understand that they should not make assumptions about a person’s capabilities or the inability of the community to provide for a disabled individual.

Screening for Admission

Because these laws prohibit discrimination in housing, a community’s procedures for screening applicants to determine whether they are appropriate for admission should be handled carefully. Many older people and most candidates for assisted living are likely to be considered disabled under the anti-discrimination laws because their physical or mental impairment(s) substantially limit one or more of the major life activities (walking, speaking, breathing, seeing, hearing). Every person with a record of having a disability or those regarded (rightfully or not) as having a disability are covered under the laws.

Seniors communities should take special care in applying their admissions criteria to avoid accusations of discrimination. Where no special programs or services are provided, especially in the independent living setting, questions to the applicant concerning health and physical status may be prohibited altogether. Under the ADA, if a criterion screens out or tends to

Reasonable Accommodations

Policies and procedures on anti-discrimination should include the possibility of an applicant request for reasonable accommodations. Under both the FHA and ADA, the concept of “reasonable accommodation” is prominent. While “reasonable” is not defined in either law, a seniors housing community must make reasonable modifications to accommodate the disabled person and provide auxiliary aids and services unless such modifications would fundamentally alter the nature of the program or impose an undue financial or administrative burden on the provider.⁶ How a community determines the need for reasonable accommodation is likely to be case-specific and based on the following questions:

- Is the person disabled within the meaning of the anti-discrimination laws?
- Would an accommodation “fundamentally alter” the nature of the program?

- Would the cost of accommodation be so prohibitive as to be considered an “undue financial burden”?
- Would the accommodation result in an “undue administrative burden”?
- Does retention of the individual in the community conflict with state regulatory requirements?

Even if a community determines that accommodation of a disabled resident’s needs would fundamentally alter its program or cause undue financial or administrative burdens, individuals who are protected under the laws may themselves obtain outside services or make reasonable modifications to their dwellings or common use areas at their own expense to facilitate their admission to the program.

Retention/Discharge

The FHA and ADA rules can have significant impact on retention and discharge issues in seniors housing, especially when residents in independent housing or assisted living develop greater care needs. With autonomy as the cornerstone concept of assisted living, the individual’s desire to remain in the community when he or she is no longer capable of being autonomous may be difficult for the provider to address. On the one hand, it may be desirable to allow the resident to remain because the provider wants to accommodate the resident’s wishes and retaining such residents is important from a business perspective. However, allowing the resident to stay at the facility’s level of care may not be feasible, or state regulations may mandate that the resident move to another setting where higher acuity needs are addressed more readily. Under such circumstances, the community should evaluate the considerations outlined above in the discussion of admissions to determine whether the resident can be retained.

Providers facing discharge and retention dilemmas also should be mindful that the anti-discrimination laws provide an important exception for individuals who pose a direct threat to the health and safety of others, and such individuals are not required to be accommodated. However, applicable regulations

make clear that while it is necessary to ensure a safe environment for other residents, this exception has limited application⁷ and there is a danger in relying extensively on this exception.

Few court decisions have been handed down to date in cases where seniors housing/assisted living providers have been sued for violating anti-discrimination laws. Typically, cases involving discrimination issues will be determined based on a detailed examination of the particular facts. The best defense against a claim of disability discrimination is for management and staff

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to have a clear understanding of applicable laws, a commitment to adhere to the laws, carefully drawn policies and procedures for handling circumstances that raise potential violation of the laws and consistent, fair application of the policies and procedures. |||

1. 42 U.S.C. § 3601 *et seq.*
2. 42 U.S.C. § 3604(f).
3. 42 U.S.C. § 12101 *et seq.*
4. While the ADA does not apply to seniors housing operations that provide only apartment units with no services, the FHA will apply. Accordingly, the discussion in this article applies to both independent housing and assisted living. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 702 *et seq.*, applies to activities of recipients of federal housing assistance, including local housing authorities and private owners of assisted housing. However, the emphasis in this article is on the FHA and the ADA.
5. 28 C.F.R. § 36.301(a).
6. 28 C.F.R. § 36.208(b) (ADA rules).
7. 28 C.F.R. § 36.208(b) (ADA rules).

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