



IRS Mandatory ACA Reviews: Hospital Readiness

Forvis Mazars US Healthcare Practice



Presenters



Brian Todd
Partner

Brian is a tax specialist in the Healthcare Practice. He joined Forvis Mazars in 1999 and has experience providing tax services to both for-profit and nonprofit healthcare organizations. He regularly assists hospitals, senior living organizations, home health agencies, CHCs, colleges and universities, and other nonprofit agencies with navigating complex tax issues. He consults with nonprofit organizations on unrelated business income issues, Section 501(r) compliance, fringe benefit reporting, exemption applications, and alternative investment reporting. He has represented both for-profit and nonprofit organizations in IRS examinations and assisted both with joint venture tax considerations.



Garrett Gluth
Managing Director

Garrett Gluth is an Attorney, CPA, and former IRS Senior Executive with 20 years of legal, tax, financial, and regulatory experience. He drafted and reviewed statutory text that became ACA § 9007, which added §501(r) to the Internal Revenue Code and created mandatory recurring IRS reviews of tax-exempt hospitals. While at the IRS, he worked on publicly released tax-exempt hospital guidance, Form 990/Schedule H revisions and instructions, and tax-exempt hospital training and implementation efforts. His comments today are based on public law, regulations, IRS guidance, publicly available IRS procedures, published oversight reports, and professional experience.

Agenda

1. Tax-exempt hospital framework
2. ACA §9007, §501(r), and mandatory IRS reviews
3. CHNA and implementation-strategy readiness
4. FAP, AGB, billing, and collection readiness
5. Schedule H and public reporting
6. Federal and state scrutiny / emerging opportunities
7. Practical takeaways



Tax-Exempt Hospital Framework

Key point: tax-exempt hospital compliance is both an exemption issue and an ongoing operational/documentation issue.



IRC § 501(c)(3) baseline: organized and operated for charitable purposes, with no private inurement or impermissible private benefit.



Promotion of health: nonprofit hospitals may qualify as charitable organizations when they operate to promote health for the benefit of the community.



Community benefit standard: hospital exemption is evaluated under a facts-and-circumstances framework focused on whether the hospital benefits the community.



IRC § 501(r) overlay: ACA § 9007 added hospital facility-level requirements for CHNAs, financial assistance, limitation on charges, and billing/collection practices.

Promotion of Health - Community Benefit Standard (1969 -)

Readiness point: There is no federal minimum percentage required for a nonprofit hospital's community benefit spending. However, hospitals are well-served to adopt a reporting strategy.

Rev. Rul. 69-545 moved hospital exemption from a charity-care-focused standard to a broader community-benefit framework. Relevant factors may include:

- Operating an ER open to all, regardless of ability to pay;
- Community board;
- Open medical staff;
- Providing hospital care for all patients able to pay, including Medicaid and Medicare; and
- Using surplus funds to improve care, facilities, training, education, and research.

No single factor controls—the IRS evaluates all relevant facts and circumstances.

Why it matters: ACA § 9007 added on top of this framework.



Patient Protection and Affordable Care Act Enacted in 2010

- **Section 9007** of the Patient Protection and Affordable Care Act (ACA), Public Law 111-148 (124 Stat. 119 (2010)), significantly transformed the landscape for tax-exempt hospitals.
 - **Section 9007(a)** added IRC § 501(r) to the Internal Revenue Code.
 - **Section 9007(b)** added IRC § 4959 to the Internal Revenue Code.
 - **Section 9007(c)** requires the IRS to complete periodic mandatory reviews of tax exemption for Hospitals.
 - **Section 9007(d)** imposes additional reporting requirements.
 - **Section 9007(e)** requires reports on the levels of charity care and trends.



Mandatory ACA Reviews: What Can Happen Next

Readiness point: A hospital should be able to support its community benefit, FAP, CHNA, billing/collection, and Schedule H positions before questions arise.

Community Benefit Activity Review (CBAR)

- No-contact review of available information;
- Facts-and-circumstances evaluation; and
- Determination whether further review is needed.

Compliance check

- Generally used where identified issues relate to FAP requirements.

Examination

- Generally used where issues go beyond FAP or cannot be resolved through compliance-check procedures.



Public TIGTA Data Shows Real Follow-Up

TIGTA reported (Report Number 2025-100-019) that CBAR referrals resulted in compliance checks and examinations, including:

- **FY 2023:** 64 compliance checks from CBAR referrals; a majority resulted in agreed corrective action.
- **FY 2024:** 75 compliance checks from CBAR referrals; 85% closed with agreed corrective action.
- **FY 2023:** 22 examinations completed after CBAR referrals.
- **FY 2024:** 9 examinations completed based on CBAR referrals.

Readiness point: Even where no formal action results, avoiding documentation and reporting issues is a best practice that can reduce follow-up questions, corrective-action requests, and avoidable demands on tax, legal, compliance, revenue-cycle, and community-benefit teams.



Tax-Exempt Hospitals IRS Examination Strategy

Public TIGTA materials report both a revised CBAR process and a separate tax-exempt hospital examination strategy focused on potential IRC § 501(r) noncompliance.

- As noted in TIGTA Report Number: 2025-100-019, the Compliance Planning and Classification (CP&C) functional subdivision developed a tax-exempt hospitals examination compliance strategy that includes identifying potential noncompliance with IRC § 501(r) requirements.
- The strategy uses a data-driven approach to identify potential compliance issues for “at risk” organizations subject to § 501(r) requirements.
- The CP&C function identified 45 organizations for examination under this compliance strategy.
- TIGTA indicated, “We believe that these examinations will accomplish both a presence of enforcement and improve voluntary compliance with I.R.C. § 501(r) and the community benefit standard.”

Readiness points:

- As a best practice, hospitals should treat § 501(r), Schedule H, CHNA, FAP, billing/collection, and public-facing documentation as connected review areas — not separate compliance silos.
- As reviews proceed under revised CBAR procedures, hospitals should consider proactively reviewing public-facing documents for issues.
- Clear, current, and consistent CHNA reports, implementation strategies, FAPs, billing/collection policies, and Schedule H reporting can potentially reduce follow-up questions and avoidable internal burden.

Section 501(r) - Additional Requirements for Charitable Hospitals



- **IRC § 501(r) added requirements that apply on a facility-by-facility basis:**
 - Community Health Needs Assessment (CHNA) – IRC § 501(r)(3),
 - Financial Assistance Policy and Emergency Medical Care Policy – IRC § 501(r)(4),
 - Limitation on Charges – IRC § 501(r)(5), and
 - Billing and Collections – IRC § 501(r)(6).
- A hospital organization reports related policies, practices, and community benefit information on **Form 990, Schedule H**.

Why it matters: A failure at one hospital facility can have facility-level tax consequences and, in significant cases, may put the organization’s federal tax exemption at risk.

Section 501(r)(3) – Community Health Needs Assessment (CHNA)

- A hospital facility must, at least once every three years:
 - Conduct a CHNA;
 - Take into account input from persons representing the broad interests of the community, including public health expertise;
 - Make the CHNA report widely available to the public; and
 - Adopt an implementation strategy to address identified health needs.
- Failure to satisfy section 501(r)(3) may result in a \$50,000 excise tax under IRC §4959, in addition to other potential §501(r) consequences.

Readiness point: The CHNA, implementation strategy, and Schedule H should tell a consistent story. Approach § 501(r)(3) compliance strategically, not as a check-the-box exercise.

Assessing Community Health Needs

26 CFR § 1.501(r)-3(b)(4).



Readiness point: The CHNA should show not only what needs were identified, but **why certain needs were prioritized** and **what resources were considered**.

Documentation of a CHNA

Regulatory Requirements (26 CFR § 1.501(r)-3(b)(6))

The CHNA report should clearly document:

COMMUNITY SERVED:

definition of the community and how it was determined

PROCESS AND METHODS:

data sources, analysis, collaborators, and externally sourced information

COMMUNITY INPUT:

who was solicited, how input was received, what was heard, and how **required** sources were addressed

SIGNIFICANT NEEDS AND PRIORITIES:

identified health needs, prioritization criteria, and reasons for prioritizing certain needs.

RESOURCES AND IMPACT:

resources available to address identified needs and evaluation of the impact of actions taken since the prior CHNA.

Readiness point: The report should tell a clear story from data and input → identified needs → priorities → implementation strategy.

Implementation Strategy

26 CFR § 1.501(r)-3(c).

For each significant health need identified in the CHNA, the implementation strategy should:

DESCRIBE

How the hospital plans to address the health need, including planned actions, anticipated impact, resources, and collaborations; or

EXPLAIN

Why the hospital does not intend to address the need, such as resource constraints, lower priority, existing community resources, or lack of effective interventions.

TIMING

An authorized body of the hospital facility must adopt the implementation strategy by the 15th day of the 5th month after the end of the tax year in which the CHNA was conducted.

Readiness point: The implementation strategy should connect directly back to the CHNA's prioritized needs.

Schedule H, Part V, Section B

Community Health Needs Assessment (CHNA)

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	<input type="checkbox"/>	<input type="checkbox"/>
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	<input type="checkbox"/>	<input type="checkbox"/>
3 During the tax year or either of the 2 immediately preceding tax years, did the hospital facility conduct a CHNA? If "No," skip to line 12	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes," indicate what the CHNA report describes (check all that apply):		
a <input type="checkbox"/> A definition of the community served by the hospital facility		
b <input type="checkbox"/> Demographics of the community		
c <input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input type="checkbox"/> How data was obtained		
e <input type="checkbox"/> The significant health needs of the community		
f <input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <input type="text"/>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	<input type="checkbox"/>	<input type="checkbox"/>

6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	<input type="checkbox"/>	<input type="checkbox"/>
6b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	<input type="checkbox"/>	<input type="checkbox"/>
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):	<input type="checkbox"/>	<input type="checkbox"/>
a <input type="checkbox"/> Hospital facility's website (list url): <input type="text"/>		
b <input type="checkbox"/> Other website (list url): <input type="text"/>		
c <input type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	<input type="checkbox"/>	<input type="checkbox"/>
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <input type="text"/>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	<input type="checkbox"/>	<input type="checkbox"/>
a If "Yes," list url: <input type="text"/>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	<input type="checkbox"/>	<input type="checkbox"/>
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	<input type="checkbox"/>	<input type="checkbox"/>
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	<input type="checkbox"/>	<input type="checkbox"/>
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ <input type="text"/>		

Section 501(r)(3) – Readiness Questions

- Is the current CHNA timely, adopted by an authorized body, posted online and easy to find?
- Is a free paper copy available upon request at the hospital facility?
- Is the community definition clear, supported, and inclusive of required populations?
- Is required community input documented, including how considered?
- Are significant health needs prioritized using stated criteria?
- Does the implementation strategy address each prioritized need or explain why not?
- Was the implementation strategy adopted on time by an authorized body?
- Can a reviewer follow the story from **data and input** → **identified needs** → **priorities** → **implementation strategy**?

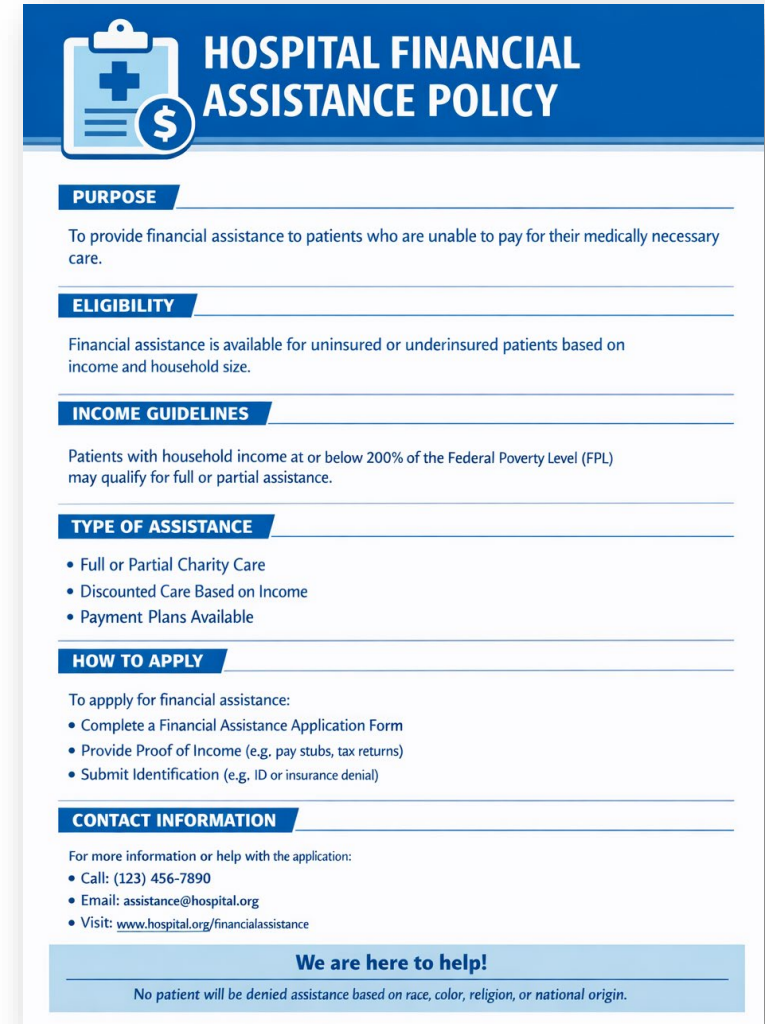


Section 501(r)(4) – Financial Assistance Policy

A hospital facility must establish a:

- **Financial Assistance Policy (FAP)**
 - Addresses eligibility, free or discounted care, how amounts are calculated, how patients apply, collection actions, and publicity.
- **Emergency Medical Care Policy**
 - Requires emergency medical care without discrimination, regardless of FAP eligibility.

Readiness point: The written policy, plain-language summary, application, website, signage, billing statements, and revenue-cycle practices should tell the same story.



The graphic shows a document titled "HOSPITAL FINANCIAL ASSISTANCE POLICY" with a blue header and a white body. It includes an icon of a clipboard with a cross and a dollar sign. The document is organized into sections: PURPOSE, ELIGIBILITY, INCOME GUIDELINES, TYPE OF ASSISTANCE, HOW TO APPLY, and CONTACT INFORMATION. A blue footer bar contains the text "We are here to help!" and "No patient will be denied assistance based on race, color, religion, or national origin."

HOSPITAL FINANCIAL ASSISTANCE POLICY

PURPOSE

To provide financial assistance to patients who are unable to pay for their medically necessary care.

ELIGIBILITY

Financial assistance is available for uninsured or underinsured patients based on income and household size.

INCOME GUIDELINES

Patients with household income at or below 200% of the Federal Poverty Level (FPL) may qualify for full or partial assistance.

TYPE OF ASSISTANCE

- Full or Partial Charity Care
- Discounted Care Based on Income
- Payment Plans Available

HOW TO APPLY

To apply for financial assistance:

- Complete a Financial Assistance Application Form
- Provide Proof of Income (e.g. pay stubs, tax returns)
- Submit Identification (e.g. ID or insurance denial)

CONTACT INFORMATION

For more information or help with the application:

- Call: (123) 456-7890
- Email: assistance@hospital.org
- Visit: www.hospital.org/financialassistance

We are here to help!

No patient will be denied assistance based on race, color, religion, or national origin.

Schedule H, Part V, Section B

Part V Facility Information (continued)			
Financial Assistance Policy (FAP)			
Name of hospital facility or letter of facility reporting group: _____			
Did the hospital facility have in place during the tax year a written FAP that:			
		Yes	No
13	Explained eligibility criteria for financial assistance and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:		
a	<input type="checkbox"/> FPG, with FPG family income limit for eligibility for free care of <input type="text"/> <input type="text"/> <input type="text"/> % and FPG family income limit for eligibility for discounted care of <input type="text"/> <input type="text"/> <input type="text"/> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input type="checkbox"/> Medical indigency		
e	<input type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance status		
g	<input type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	14	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	15	
a	<input type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of their application		
b	<input type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of their application		
c	<input type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		

16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	16	
a	<input type="checkbox"/> The FAP was widely available on a website (list url): _____		
b	<input type="checkbox"/> The FAP application form was widely available on a website (list url): _____		
c	<input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): _____		
d	<input type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by limited-English proficiency (LEP) populations		
j	<input type="checkbox"/> Other (describe in Section C)		



Financial Assistance Policy Readiness Questions

- Are eligibility criteria clear and current?
- Does the FAP explain free and discounted care?
- Is the application process easy to understand?
- Are translation, website, and physical-location posting requirements satisfied?
- Do billing statements and patient communications direct patients to financial assistance?
- Do actual revenue-cycle practices match the written policy?



FAP Readiness: Where Gaps Commonly Appear

Hospitals should periodically test whether the FAP is aligned across:

- **Policy documents:** FAP, plain-language summary, application, emergency medical care policy, and billing/collection policy.
- **Public access:** website postings, translations, physical-location notices, and patient-facing materials.
- **State-law overlays:** eligibility thresholds, presumptive eligibility, collection restrictions, refund rules, and required notices.
- **Revenue-cycle operations:** billing statements, call-center scripts, vendor notices, collection workflows, and account holds.
- **Governance and accountability:** approval history, periodic updates, monitoring, and documentation that practices match the written policy.

Readiness point: The risk is often not the FAP itself — it is whether the FAP, patient communications, vendors, systems, and actual workflows tell the same story.



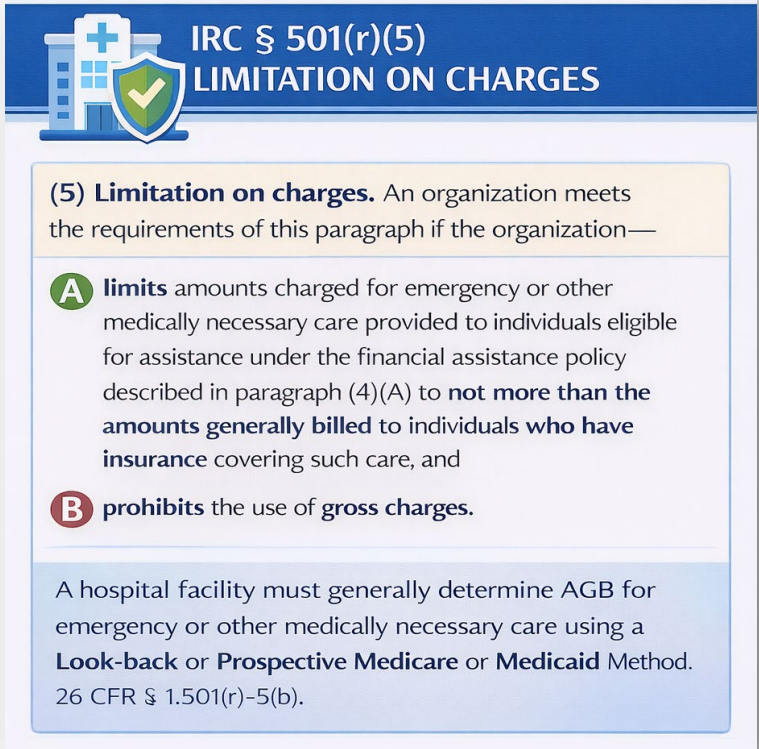
Section 501(r)(5) – Limitation on Charges

A hospital facility must:

- **Limit amounts charged** for emergency or other medically necessary care provided to FAP-eligible individuals to no more than **amounts generally billed (AGB)** to insured patients.
- **Prohibit the use of gross charges** for FAP-eligible individuals receiving emergency or other medically necessary care.

Hospitals generally determine AGB using one of two permitted methods:

- **Look-back method:** based on allowed claims during a prior 12-month period.
- **Prospective method:** based on the amount Medicare or Medicaid would allow for the care.



The infographic features a blue header with a white cross icon and a shield with a checkmark. The text is organized into a light blue box with a yellow highlight for the main requirement and a white box for sub-points A and B. A light blue footer box contains the determination method and a regulatory reference.

**IRC § 501(r)(5)
LIMITATION ON CHARGES**

(5) Limitation on charges. An organization meets the requirements of this paragraph if the organization—

- A** **limits** amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy described in paragraph (4)(A) to **not more than the amounts generally billed** to individuals who have insurance covering such care, and
- B** **prohibits** the use of **gross charges**.

A hospital facility must generally determine AGB for emergency or other medically necessary care using a **Look-back** or **Prospective Medicare** or **Medicaid** Method.
26 CFR § 1.501(r)-5(b).

Readiness point: The selected AGB method should be documented, updated timely, reflected in the FAP, and consistently applied in billing operations.

Schedule H, Part V, Section B

Part V Facility Information (continued)

Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)

Name of hospital facility or letter of facility reporting group: _____

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care:		
a	<input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b	<input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
c	<input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
d	<input type="checkbox"/> The hospital facility used a prospective Medicare or Medicaid method		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care?	<input type="checkbox"/>	<input type="checkbox"/>
	If "Yes," explain in Section C.		
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?	<input type="checkbox"/>	<input type="checkbox"/>
	If "Yes," explain in Section C.		



Section 501(r)(5) — Readiness Questions

- Does the FAP clearly describe the AGB method used?
- Is the AGB percentage calculated and updated on schedule?
- Are FAP-eligible patients protected from charges above AGB?
- Do billing systems apply the correct discounts automatically?
- Are gross charges prohibited for FAP-eligible emergency or medically necessary care?
- Are patient statements, estimates, vendor scripts, and collection workflows consistent with the FAP and AGB methodology?
- Can the hospital reconcile its AGB calculation to supporting data?



Section 501(r)(6) – Billing and Collection

- A hospital facility may not engage in **extraordinary collection actions (ECAs)** before making reasonable efforts to determine whether an individual is eligible for financial assistance.
- ECAs may include: lawsuits; credit reporting; liens, garnishments, and deferring or denying medically necessary care because of prior unpaid bills.
- Reasonable efforts generally include: FAP notice, application access, time to apply, consistent application processing, and vendor coordination.


Readiness point: Billing and collection workflows should show that patients had a meaningful opportunity to apply for assistance before any ECA.

Schedule H, Part V, Section B

		Yes	No
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written FAP that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	<input type="checkbox"/>	<input type="checkbox"/>
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	<input type="checkbox"/> Actions that require a legal or judicial process		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		
f	<input type="checkbox"/> None of these actions or other similar actions were permitted		
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	<input type="checkbox"/> Actions that require a legal or judicial process		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) on line 19 (check all that apply):		
a	<input type="checkbox"/> Provided a written notice about upcoming extraordinary collection actions (ECAs) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)		
b	<input type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)		
c	<input type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C)		
d	<input type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C)		
e	<input type="checkbox"/> Other (describe in Section C)		
f	<input type="checkbox"/> None of these efforts were made		

Section 501(r)(6) — Readiness Questions

- Do billing statements, notices, and call-center scripts clearly direct patients to financial assistance?
- Is the FAP application period tracked before accounts are referred to collections?
- Are collection agencies and other vendors contractually required to follow the hospital's FAP and § 501(r)(6) procedures?
- Are ECAs identified, approved, suspended, and reversed consistently?
- Are lawsuits, credit reporting, liens, garnishments, and care-deferral practices reviewed for compliance before use?
- Do revenue-cycle practices align with the written FAP and billing/collections policy?
- Can the hospital document reasonable efforts before any ECA?




IRC § 501(r)(6) BILLING AND COLLECTION REQUIREMENTS

! IMPORTANT: An organization meets the requirement of this paragraph only if the organization does not engage in extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy described in paragraph (4)(A).

Extraordinary Collection Actions Include:

- ! Lawsuits or Legal Action
- ! Credit Reporting
- ! Garnishing Wages or Property Liens
- ! Deferring or Denying Medically Necessary Care



Reasonable efforts must be made to determine eligibility for financial assistance **before** engaging in any of the above extraordinary collection actions.

Ongoing Scrutiny of Charitable Hospitals

Tax-exempt hospitals face scrutiny from multiple directions:

- **IRS:** mandatory ACA reviews, tax-exempt hospital examinations, and data-driven compliance priorities.
- **Congress:** hearings and correspondence focused on community benefit, charity care, and financial assistance.
- **Public reports:** TIGTA, CRS, GAO, Lown, and academic studies questioning transparency and consistency in community-benefit reporting.
- **State lawmakers:** expanding financial-assistance, billing, collection, and nonprofit-accountability requirements.

Readiness point: IRC § 501(r) compliance, Schedule H reporting, and state-law obligations should be reviewed together — not in silos.

Proposed Federal Legislation: Continued Focus on §501(r)

The Holding Nonprofit Hospitals Accountable Act (H.R. 3019, 2025), would amend IRC § 501(r) to establish more specific community-benefit standards for tax-exempt hospital organizations.

The proposal would generally require hospitals to spend an amount tied to the value of their tax exemptions on qualifying activities, including:

- training, education, or research designed to improve patient care;
- certain facility and equipment improvements; and
- free or discounted care under a financial assistance policy.

Status: Proposed legislation; not current law.

Key point: Regardless of whether the bill advances, it reflects continued federal attention on whether tax-exempt hospitals can demonstrate measurable community benefit, charity care, financial assistance, and transparency.

State Law Overlay: States Are Building on IRC § 501(r)

Readiness point: As a best practice, § 501(r) compliance should not be treated as a standalone federal tax exercise; it is increasingly part of broader federal/state hospital accountability.

IRC § 501(r) is increasingly serving as a baseline for state hospital financial-assistance, billing, collection, and accountability requirements.

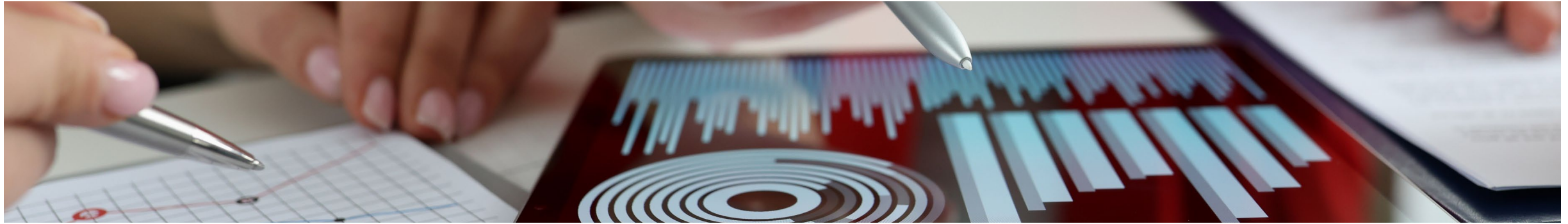
- **Some states expressly incorporate IRC § 501(r) concepts** into state financial-assistance or billing/collection laws.
- **States are adding more specific operational requirements**, such as presumptive eligibility screening, uniform applications, expanded eligibility thresholds, refund rules, debt-sale restrictions, credit-reporting limits, lawsuit restrictions, and interest caps.
- **Requirements can vary significantly by state** (and may apply more broadly).
- **Operational impact:** multistate systems may need to align IRC § 501(r), state-law requirements, FAPs, billing/collection workflows, vendor contracts, patient communications, and Schedule H reporting.



Schedule H, Part I, Line 7

7 Financial Assistance and Certain Other Community Benefits at Cost						
Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial assistance at cost (from Worksheet 1)						
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total. Financial assistance and means-tested government programs .						
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)						
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j Total. Other benefits						
k Total. Add lines 7d and 7j						

Readiness Opportunity: Benchmarking and Reporting



- Form 990, Schedule H, CHNAs, FAPs, implementation strategies, and financial statements are publicly available and easily compared.
- Tax-exempt hospital leaders should ask:
 - How does our **Schedule H reporting** compare to peer hospitals and similarly situated systems?
 - Are all reportable community-benefit activities being captured, documented, and reported consistently?
 - Do our costs, narratives, CHNA priorities, implementation strategy, and financial statements tell the same story?
 - Could underreporting make our community benefit appear lower than our actual investment?
 - Are there opportunities to strengthen programs, documentation, reporting, and public-facing narratives?
 - **Key point:** Hospitals should be able to explain not only **what** they provide, but **how they measured, documented, and reported it.**

Questions?



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