January 22, 2015

FINAL “SECTION 501(r)” REGULATIONS FOR CHARITABLE HOSPITALS

At a Glance

The Issue
On Dec. 29 the Internal Revenue Service (IRS) and the Department of the Treasury issued final regulations (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf) implementing the requirements for charitable hospitals added by the Affordable Care Act. The final regulations largely adopt the provisions of the proposed regulations issued in 2012 (addressing financial assistance policy, limitation on charges, and billing and collection) and 2013 (addressing community health needs assessment and sanctions for noncompliance). The final rules apply to tax years beginning after December 29, 2015.

Our Take
The AHA and its members support the goals of Section 501(r), and hospitals are committed to meeting the requirements of the statute. Further, America’s hospitals are committed to being more transparent, not only about the price but the quality of care, so that patients can be more involved in and make informed decisions about their health care. The AHA has outlined guidelines (http://www.aha.org/content/12/120505-bill-collec-prac-statement.pdf) intended to strengthen the relationship between hospitals and their communities and to reassure patients, regardless of their ability to pay, of hospitals’ commitment to caring. To view the guidelines and other resources, visit www.aha.org.

We appreciate that the final regulations respond to a number of hospital concerns and suggestions to streamline the extremely detailed and prescriptive requirements in the proposed rules. In particular, we welcome the inclusion of a transition period of at least one year for hospitals to come into compliance with the final requirements, many of which continue to be very detailed and complex. We will monitor closely IRS’s implementation of the anticipated correction and disclosure procedures, which should provide hospitals a reasonable opportunity to remedy infractions of the regulations that may occur.

What You Can Do
Share this advisory with your leadership team and carefully review the final requirements to determine whether changes or modifications to existing policies or practices are needed. Disseminate information broadly across the organization to reach all who interact with patients and may have a role in implementing the new requirements.

Further Questions
Contact Maureen Mudron, deputy general counsel, at (202) 626-2301 or mmudron@aha.org, or Mindy Hatton, senior vice president and general counsel, at (202) 626-2336 or mhatton@aha.org.

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We appreciate that the final regulations responded to a number of hospital concerns and suggestions to streamline the extremely detailed and prescriptive requirements in the proposed rules. In particular, we welcome the inclusion of a transition period of at least one year for hospitals to come into compliance with the specifics of the final regulations. We will monitor closely the IRS’s oversight of hospital implementation of the requirements, including its authority to impose sanctions.

BACKGROUND

Section 501(r)
The ACA requires that each charitable tax-exempt hospital conduct a CHNA once every three years and develop an implementation strategy to address the identified needs;
adopt a written FAP and a policy relating to emergency medical care; limit the amounts an individual eligible for financial assistance is expected to pay for emergency and medically necessary services; and refrain from initiating certain collection actions before making reasonable efforts to determine if the individual is eligible for financial assistance.

A hospital organization that operated more than one hospital facility must meet each of these requirements with respect to each hospital facility in order to maintain exempt status.

This advisory highlights and summarizes key provisions of the final regulations.

**COMMUNITY HEALTH NEEDS ASSESSMENT**

Section 501(r)(3) requires that a hospital conduct a CHNA every three years that takes into account input from those representing the broad interests of the community served by the hospital, including those with special knowledge or expertise in public health. An implementation strategy must be adopted to meet the identified needs and the assessment must be made widely available to the public.

**Defining the Community Served**

A hospital has flexibility for how it defines the community it serves. The rule adopts a facts and circumstances approach and recognizes that hospitals will vary in the method used to define their communities (e.g., geographic area, target populations, principal function). It expressly acknowledges that, for some hospitals, the community may be defined by a particular area of specialty or a targeted disease. However, the medically underserved, low-income or minority populations who would otherwise be part of the community based on the method chosen may not be excluded.

**Assessing the Community’s Health Needs**

A hospital must identify the significant health needs of the community. It also must prioritize those needs and identify resources potentially available to address them. Hospitals have flexibility for determining what is significant and setting priorities. The health needs include what is important to improve or maintain health status in both the community at large and in particular parts (e.g., those experiencing disparities).

**Input Representing the Broad Interests of the Community**

There are two categories of persons whose input must be taken into account in conducting the assessment: one (nonfederal) governmental public health department (or equivalent), and members of medically underserved, low-income and minority populations, or organizations serving or representing their interests. The hospital has the option to choose which public health department with information relevant to its community to consult. Input regarding the needs of the underserved, low-income or minority populations would include, but is not limited to, financial or other barriers to
access care. When conducting a subsequent CHNA, written input received on a hospital’s existing CHNA or implementation strategy must be taken into account.

**Documenting the CHNA**

The CHNA report must include:

- a definition of the community served and a description of how it was determined;
- a description of the process and methods used to conduct the CHNA;
- a description of how the hospital took into account input from those representing the broad interests of the community;
- a prioritized description of the significant health needs, along with a description of the process and criteria used in determining which needs were significant and which were the priorities;
- a description of potential resources identified to address the significant needs; and
- an evaluation of the impact of any actions that were taken to address significant needs identified in the immediately preceding CHNA.

In describing the process and methods used to conduct the CHNA, the report should include:

- a description of the data and other information used (it is sufficient to cite public data relied on);
- the methods of collecting and analyzing the information; and
- any parties with whom the hospital collaborated, or with whom it contracted for assistance, in conducting the CHNA.

In describing how input from the community was taken into account, it is sufficient to summarize, in general terms, the input provided, as well as how it was received and over what period of time. For input from organizations representing specific populations, the name of the organization, the nature and extent of the input received, and population represented should be documented. In describing who participated in community meetings or other opportunities to provide input, identifying individuals or including names is not required.

**Adopting the CHNA**

The CHNA must be adopted by the governing body of the hospital, or a committee or other party authorized by the governing body to act on its behalf (to the extent permitted by state law).

**Collaboration**

Hospitals may collaborate with others in conducting a CHNA, and collaborating hospitals may develop a joint CHNA report if certain conditions are met: the collaborating hospitals must define their community to be the same, the report clearly
identifies that it applies to the hospital, and the governing body of each hospital facility adopts the joint report.

**Making the CHNA Widely Available**

Use of the internet continues to be a vehicle to meet this requirement as long as a paper copy is also available for public inspection without charge at the hospital facility. A CHNA report must be available on the internet and a hard copy at the facility at least until the date when the hospital’s two subsequent CHNA’s are made widely available. In addition, to be widely available through the internet, a complete version of the CHNA must be “conspicuously” posted, and an individual must not be required to create an account or provide personally identifiable information in order to access the report.

A CHNA is considered “conducted” when it is made widely available.

**IMPLEMENTATION STRATEGY**

**Content of Strategy**

For every significant health need identified in the CHNA, the hospital must describe how it plans to address the need or note that the need will not be addressed and explain why. For needs that will be addressed, in addition to describing the actions the hospital plans to take, it also must include the anticipated impact, the programs and resources the hospital plans to commit, as well as any planned collaboration with others in addressing the needs. The rule recognizes that not every significant need will be addressed and identifies lack of resources or expertise, relatively low priority, and the need being addressed by others as some of the reasons the hospital’s strategy may not address a need.

**Joint Strategy**

Hospitals that collaborated in developing a joint CHNA report also may develop a joint implementation strategy, if certain requirements are met. The strategy must clearly identify that it applies to each hospital; the hospital’s particular role and responsibilities must be clearly identified, including the programs and resources it plans to commit; and a summary or other tool must be included to help the reader easily locate those portions of the strategy that relate to the hospital facility.

**Adoption**

Similar to the CHNA report, the implementation strategy must be adopted by the governing body, or an authorized representative (to the extent permitted by state law). As requested by hospitals, the final rule extends the time period within which the implementation strategy must be adopted. Instead of requiring that the implementation strategy be adopted in the same taxable year in which the CHNA is completed, the final rule allows an additional four-and-a-half months (to match the due date, without extensions, of the hospital’s Form 990).
**Reporting on Form 990**
The hospital’s most recently adopted implementation strategy must either be attached to the hospital’s Form 990 or the Form must include the address (URL) for a website where the strategy has been located and made widely available. The hospital’s Form 990 in subsequent tax years must include an update on implementation of the strategy.

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**FINANCIAL ASSISTANCE AND EMERGENCY MEDICAL CARE POLICIES**

**Financial Assistance Policy (FAP)**
Under Section 501(r)(4)(A), a hospital is required to establish a written FAP with respect to emergency and medically necessary care that specifies:

- eligibility criteria for financial assistance, and whether such assistance includes free or discounted care;
- the basis for calculating amounts charged to patients;
- the method for applying for financial assistance;
- in the case of an organization that does not have a separate billing and collections policy, the actions the organization may take in the event of non-payment; and
- measures to widely publicize the policy within the community to be served by the organization.

The regulations prescribe detailed information that must be included in the FAP for the FAP to satisfy each of the five requirements. Additionally, to comply with the regulations, a hospital will be required to have a number of policies and forms, including an FAP, a plain language summary of the FAP, an FAP application form and instructions. Each of these documents must be provided in other languages if the community served by the hospital includes a limited English proficient population that is the lesser of 5 percent of those served, or 1,000 individuals (the final regulation lowers the proposed threshold of 10 percent).

The final regulations also add two new items that must be included in the FAP, if applicable: sources of information used, other than the individual, to make determinations of presumptive eligibility, and the extent to which prior FAP-eligibility determinations are used; a list of providers, other than the hospital, delivering care in the hospital specifying which are, and are not, covered by the FAP.

**Eligibility Criteria and Basis for Calculating Amounts Charged to Patients**
In order to meet the first two requirements of Section 501(r)(4)(A), the FAP must set forth all financial assistance, including all discounts available to the patient, along with all eligibility criteria that must be satisfied by an individual to receive each discount, free care or any level of assistance offered by the hospital. The FAP must state that a FAP-eligible individual will not be charged more for emergency or other medically necessary
care than the amounts generally billed (AGB) to individuals who have insurance covering such care. Additionally, the FAP must indicate which of the two types of methods prescribed by regulations for calculating the AGB the hospital facility uses, and must either describe how the hospital facility arrived at the AGB if the “look-back” method is used, or explain how the public may obtain such information free of charge.

**Method for Applying for Financial Assistance**

A hospital’s FAP must describe how to apply for financial assistance. The FAP or FAP application form also must specify all the information the hospital requires to make a determination of FAP eligibility. An applicant may not be denied financial assistance for failure to provide information that is not specifically required by the FAP or the FAP application form. In addition, the FAP or the FAP application form must provide the contact information of hospital facility staff who can answer individuals’ questions regarding the FAP and the FAP application process, along with contact information for any nonprofit organization or governmental agency capable of providing assistance with FAP applications.

**Actions that May be Taken in the Event of Non-payment**

A hospital’s FAP, or a separate billing and collection policy, must describe any actions, including collection actions, that the hospital, or an authorized party, may take to obtain payment, as well as the time frames within which such actions may be taken, including the reasonable efforts that the hospital will make to determine if an individual is FAP-eligible. Additionally, an FAP or billing and collection policy must indicate the department, committee or other body that is responsible for evaluating whether the hospital made reasonable efforts to determine FAP eligibility. If the hospital maintains a separate billing and collection policy that meets these requirements, the FAP must reference it and explain how a copy can be readily obtained free of charge.

**Widely Publicizing the FAP**

The regulations require the hospital to implement each of the following measures, a description of which must be provided in the FAP or referenced in the FAP and provided elsewhere free of charge:

- make the FAP, FAP applicable form and a plain language summary of the FAP available on a website of the hospital facility or the hospital organization, or a third-party website, so long as the website of the hospital organization or facility contains a conspicuous link to the third-party site;
- make paper copies of the FAP, FAP application form and plain language summary of the FAP available upon request and without charge, both in public locations in the hospital facility and by mail;
- inform and notify visitors to the hospital about the FAP through conspicuous displays or other measures that will attract attention; and
- inform and notify residents of the community served by the hospital facility about the FAP in a manner that will reach the community members in need of financial assistance.
The final regulation includes two additional steps a hospital must take to widely publicize the FAP:

- Offering a paper copy of the summary of the FAP to patients as part of the intake or discharge process; and
- Conspicuously locating on billing statements a notice of the availability of financial assistance, a phone number at the hospital to contact for more information, and the direct website address where copies of the FAP, application form and summary may be obtained.

These provisions were added as a substitute for the detailed billing requirements in the proposed regulations (and are similar to what hospitals proposed).

**Policy Relating to Emergency Medical Care**

Under Section 501(r)(4)(B), a hospital facility must establish a written policy that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of whether they are FAP eligible. The regulations enable a hospital to comply with this requirement if a hospital’s policy requires the hospital to provide care required by the Emergency Medical Treatment and Labor Act (EMTALA). However, the emergency medical care policy additionally must prohibit the hospital from engaging in actions that would discourage individuals from seeking emergency medical care, such as demanding that emergency department patients pay before receiving treatment for an emergency medical condition or permitting debt collection activities would interfere with the rendering of emergency care. The final rule clarifies that the prohibition on debt collection activities is intended to apply only to those activities that could interfere with the provision of emergency care, not all payment activities (e.g., the collection of co-pays after stabilization or upon discharge).

**Establishing Hospital Policies**

Under the regulations, a hospital organization is considered to have established an FAP, a billing and collection policy and an emergency medical care policy for each hospital facility only after each policy has been adopted by an authorized body of the organization and the hospital facility has implemented the policy. An authorized body may be the governing body, or an authorized representative (to the extent permitted by state law.

A hospital organization operating more than one hospital facility may establish an FAP and an emergency medical care policy that applies across facilities, provided that policy clearly identifies each facility to which it applies. However, if individual hospital facilities have differing AGB percentages, the policy must include the AGB for each facility.
LIMITATION ON CHARGES

Section 501(r)(5) places a ceiling on the amount a hospital can charge an FAP-eligible individual for emergency or other medically necessary care – the AGB to the insured.

Method for Determining AGB
The regulations permit a hospital to select from two methods of determining AGB – a “look back” method and a “prospective” method.

Under the “look-back method,” the AGB is based on all claims allowed by Medicare and/or Medicaid, or a combination of Medicare and/or Medicaid and all private insurers. (The final rule added Medicaid.) Amounts paid to the hospital in the form of co-insurance, copayments or deductibles are also taken into account. A hospital may only charge an FAP-eligible individual an amount determined by multiplying the gross charges for the care provided to such individual by the AGB percentage of gross charges (AGB percentage).

A hospital must calculate AGB percentage(s) at least annually by reviewing all claims allowed during a preceding 12-month period. Once determined, a hospital must implement AGB percentage(s) no later than 120 days (instead of 45 days in the proposed rule) after the end of a given 12-month period. Hospitals may calculate either one average AGB percentage for all emergency or medically necessary care or several AGB percentages based on categories of care or separate items or services.

Under the “prospective method,” a hospital may determine AGB by using the same billing and coding process the hospital facility would use if the individual were a Medicare or Medicaid (added by the final rule) beneficiary. The hospital may then set the AGB for the care at the amount that would be paid by Medicare or Medicaid, together with what the beneficiary would be personally responsible for paying.

Under the final rule hospitals are no longer locked into the method initially chosen for calculating the AGB. The hospital may change the method it uses at any time; however, it may not be implemented until incorporated into the FAP.

The final rule clarifies that, for purposes of an insured individual eligible for financial assistance, the AGB limitation is applicable only to the amount the individual is personally responsible for paying after all reimbursement from the insurer has been applied (even if the total amount paid by the individual and the insurer exceeds AGB).

Gross Charges
The regulations specify that a hospital must charge a FAP-eligible individual less than the gross charges for any medical care covered under the facility’s FAP. The regulations recognize, however, that a hospital may use gross charges in a billing statement as the starting point to which it applies discounts and deductions, so long as the amount the FAP-eligible individual is expected to pay is less than the gross charges for such care.
Safe Harbor for Certain Charges
A hospital will not violate Section 501(r)(5) if it charges more than AGB to a FAP-eligible individual if, at the time of the charge, the individual has not submitted a completed FAP application or has not otherwise been determined to be FAP-eligible. However, if an application is subsequently submitted and the individual is determined to be FAP-eligible, the hospital must refund any amounts paid that exceed the amount the individual is personally responsible for paying. The safe harbor does not apply if the overcharge occurred when payment was required as a pre-condition for receiving medically necessary care.

BILLING AND COLLECTION ACTIVITIES

Section 501(r)(6) requires a hospital to make “reasonable efforts” to ascertain whether an individual is FAP-eligible before engaging in “extraordinary collection actions.” The regulations define what that term means and prescribe procedures that must be followed for a hospital’s efforts to be considered reasonable.

Collection Actions Subject to the Regulation
The regulations provide a list of actions that are subject to the reasonable efforts requirement. They include reporting to credit agencies, selling an individual’s debt to another party and pursuing a legal or judicial action against an individual, such as placing a lien or foreclosing on property, attaching bank accounts, causing an arrest, garnishing wages, causing the issuance of a writ of body attachment, and commencing a civil action (collection actions). As requested by hospitals, the final rule clarifies that liens placed on proceeds from a patient’s lawsuit against a third-party who caused the patient’s injuries are not subject to the rule.

In addition to the collection actions in the proposed rule, the final rule adds a new type of action that is subject to the reasonable efforts requirements: delaying, denying or requiring prepayment for medically necessary care due to an outstanding bill for previously provided services. If care is delayed, denied or prepayment is required and the individual has an outstanding bill, the regulations presume the action was taken because of the unpaid bill. In order to proceed, certain written and oral notices must be given and, if an FAP is submitted, it must be processed on an expedited basis. (Requests for emergency medical care continue to be covered by EMTALA and the emergency care policy provisions.)

Reasonable Efforts
This section of the final regulation makes the most significant changes to the proposed regulations. While a waiting period of 120 days is still required before collection actions may be initiated (now 120 days after the first post-discharge billing statement), the final rule eliminates the “notification period” and related billing requirements that were in the proposed rule (e.g., at least three billing statements, summary of FAP with each billing
statement). Instead, the emphasis is on specific communications that must occur with an individual before the hospital initiates collection actions subject to the regulation.

Hospitals are still required to provide certain communications to the individual at least 30 days in advance of initiating collection actions. The written communication requirement remains the same. It must include:

- notice of the availability of financial assistance;
- a list of the specific collection action(s) it intends to initiate;
- a deadline after which the action may be initiated (that is no earlier than 30 days after the date the notice is provided); and
- a summary of the FAP must be included with the notice.

The oral communication requirement has been modified: the hospital must make a reasonable effort to orally notify the individual about the FAP and how the individual may obtain assistance with the application process (instead of the proposed requirement that a discussion of the FAP occur in every oral communication with the individual).

The 240-day “application period” within which a hospital must accept and process an application for financial assistance (generally beginning with the date of the first post-discharge billing statement) is maintained in the final rule. While a collection action may be initiated after the first 120 days, if an application is subsequently received during the application period, certain steps must be taken to reverse or suspend the process.

If an individual submits an incomplete FAP application at any time during the application period the hospital must notify the individual about how to complete the application and give a reasonable opportunity to do so. The hospital must suspend any collection actions during that period and provide a written notice describing the additional information or documentation required, as well as contact information for further assistance.

If a complete application is submitted during the application period, a hospital must process the application, suspend any collection actions that are in process, and notify the individual of the eligibility determination. If the individual is determined to be eligible for assistance, the hospital must refund any amount paid that exceeds the amount he or she is personally responsible for, and take all reasonable steps to reverse any collection actions.

**Presumptive Eligibility**

As requested by hospitals, the final rule permits the use of presumptive eligibility determinations to include eligibility for assistance at less than the most generous available under the FAP, provided certain conditions are met. The hospital must notify the individual of the basis of the determination, provide a reasonable period of time for the individual to apply for more generous assistance before initiating a collection action,
and, if an application is submitted within the application period, take the steps otherwise required related to any pending collection actions.

**Agreements with Third Parties**

If a hospital sells or refers debt to another party during the application period, it must enter into a binding agreement with the third party that generally places restrictions on the third party’s ability to engage in collection actions to be considered as having made reasonable efforts required by the regulations. The agreement also must include a provision that obligates the third party to execute a similar agreement in the event the third party sells or refers the debt to another party during the application period.

**SANCTIONS FOR NONCOMPLIANCE**

The regulations adopt a calibrated approach for addressing noncompliance that excuses certain infractions and also sets the threshold for revocation of exemption. In addition, in the event one hospital in a multi-hospital organization willfully or egregiously fails to meet the requirements, the rules establish a mechanism to address the noncompliance without penalizing the entire organization.

**Excused Noncompliance**

The regulations identify two circumstances in which IRS will excuse a hospital facility’s failure to comply with Section 501(r) requirements.

First, no penalties will apply if an infraction is minor, inadvertent and due to reasonable cause, and the facility takes remedial steps as promptly as is reasonable given the circumstances. The inclusion of this exception recognizes that inadvertent errors may occur even when a facility has practices in place and makes good faith efforts to comply with Section 501(r).

Noncompliance that rises above the level of minor and inadvertent, but that is neither willful nor egregious, also will be excused if a hospital facility corrects and discloses the failure in accordance with guidance issued separately by IRS.

A hospital that fails to comply with the CHNA requirements will be subject to the $50,000 excise tax, unless the infraction falls within the “minor or inadvertent” category and the hospital takes the required action described above.

**Willful and Egregious Noncompliance**

If noncompliance is not excused under either of the two exceptions, all of the facts and circumstances would be evaluated to determine whether to revoke a hospital’s tax-exempt status. IRS expects that only willful or egregious noncompliance with the 501(r) rules would result in a loss of exemption. In assessing the nature and degree of noncompliance, the examination would include: prior infractions; the magnitude and reasons for noncompliance; the size and functions of the noncompliant facilities; the policies and procedures implemented to comply with Section 501(r) and whether they
Facility-level Tax
To address circumstances where a hospital organization operates multiple hospital facilities and one or more of them egregiously or willfully fails to comply with Section 501(r), but the failure does not warrant loss of exemption for the entire organization, the regulation would impose a “facility-level tax” on the organization for each noncompliant facility.

The noncompliant facility is treated as if it were a taxable corporation and the amount of the income tax it would have owed would be the amount of the facility-level tax the hospital organization must pay. The regulations provide detailed instructions on how to apply the corporate tax rules in this context. The hospital organization must report the facility-level tax on the Form 990-T, which is used for reporting unrelated business taxable income.

No impact on tax-exempt bonds: The final rule confirms that imposing a facility-level tax, will not, by itself, have an adverse effect on the status of tax-exempt bonds financing the facility. Although the facility will be treated as an unrelated business for 501(r) purposes, it does not change the status of the facility for tax-exempt bond purposes.

Effective Date of the Final Regulations
As requested by hospitals, there is a transition period for hospitals to come into compliance with the final regulations. The final rules apply only to taxable years beginning after Dec. 29, 2015. For taxable years beginning before Dec. 29, 2015, hospitals may rely on a reasonable, good faith interpretation of the statute.

FURTHER QUESTIONS

Contact Maureen Mudron, deputy general counsel, at (202) 626-2301 or mmudron@aha.org, or Mindy Hatton, senior vice president and general counsel, at (202) 626-2336 or mhatton@aha.org.