McDermott Will & Emery

Creeping Normality:
IRS Releases Final Regulations Under Section 501(r)

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SPECIAL REPORT

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On December 31, 2014, the U.S. Department of the Treasury and the Internal Revenue Service (collectively, IRS) released 64 pages of regulations [1] (Final Regulations) finalizing a number of requirements with which charitable hospitals must comply in order to avoid significant fines or the loss of their tax-exempt status. Despite their length, the Final Regulations do not contain any dramatic surprises (positive or negative) or onerous *new* requirements compared to the various proposed rules under Section 501(r) issued over the past few years.

Instead, the Final Regulations contain dozens of small changes to the previously issued proposed rules that will become mandatory for compliance with Section 501(r) of the Internal Revenue Code for tax years beginning after December 29, 2015. The multitude of various requirements will make for important (but tedious) reviews of existing financial assistance and billing and collection policies to ensure full compliance with the Section 501(r) and the new regulations. For those hospitals that previously drafted financial assistance and collection and billing policies to satisfy the requirements set forth in the proposed rules, numerous small revisions will still be required to such policies. For those hospitals that did not revise their policies to rely on the proposed rules, the ability to rely solely on the statute for reasonable interpretations of Section 501(r) for tax years beginning after December 29, 2015, will be gone, and significant revisions to their existing policies will be required.

Failure to comply with Section 501(r) (other than minor omissions and errors) can result in the imposition of a $50,000 fine per hospital and/or loss of tax-exempt status. In addition, failure to have "bullet-proof" policies under Section 501(r) could be a meaningful impediment to hospitals seeking new or refunding bonds when such hospitals must demonstrate, on an unqualified basis, that they are described in Section 501(c)(3) of the Code as a condition of financing.

Below are just some of the changes set forth in the Final Regulations as they apply to each subsection under Section 501(r).

[1] Department of the Treasury, Internal Revenue Service, "Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return," 79 Fed. Reg. 78954, available at https://federalregister.gov/a/2014-30525.

Community Health Needs Assessments (Code Section 501(r)(3))

Under Section 501(r)(3), a charitable hospital is required to conduct a community health needs assessment (CHNA) every three years and to adopt an implementation strategy to meet the community needs identified in such CHNA. The proposed regulations focused on how to define the "community" served by the hospital, how to assess the needs of such community, how to solicit the requisite input from persons representing the broad interests of the hospital's community, how to document in writing the results, how such CHNA must be approved by an authorized body, and how a hospital must make both the CHNA and implementation strategy widely available to the public. The proposed regulations also provided guidance on how multiple hospitals may work together to prepare a joint CHNA.

For the most part, the Final Regulations follow the guidance provided by the proposed regulations, but they also include important clarifications and additional guidance regarding the requirements for satisfaction of Section 501(r)(3).

EXPANDING THE SCOPE OF A COMMUNITY'S NEEDS

In the Final Regulations, the IRS expanded the scope of "health needs" a hospital could assess for purposes of the CHNA beyond just financial and barriers to care. The rules now include the need to prevent illness; to ensure adequate nutrition; and to address social, behavioral and environmental factors that influence health in the community. The Preamble to the Final Regulations notes that the list of possible health needs in the Final Regulations is only a list of examples and that a hospital is not required to identify all such types of health needs in its CHNA report if such types of needs are not determined to be *significant* health needs in the community.[2] Treas. Reg. § 1.501(r)-3(b)(4).

DEFINING A HOSPITAL'S "COMMUNITY"

The Final Regulations continue to provide great flexibility to hospitals with respect to determining what constitutes a hospital's "community" for purposes of the CHNA requirement, provided that the community is not defined in

[2] *Id.* at 78963.

a manner to exclude medically underserved, low-income or minority populations. Treas. Reg. § 1.501(r)-3(b)(3).

PRACTICE NOTE

Hospitals are required to define their communities in a variety of contexts for tax purposes, including Section 501(r) and unrelated business income tax compliance. Especially with accountable care organizations (ACOs) and health information exchanges (HIEs) redefining the community of a hospital for Section 501(c)(3) purposes, it is imperative for a hospital to have consistent definitions of its community throughout its tax positions, or have reasonable arguments as to why it uses the term differently in different contexts.

JOINT CHNAS WITH OTHER HOSPITALS

The Final Regulations permit unrelated hospitals that identically define their communities to prepare a joint CHNA and a joint implementation strategy. For hospitals participating in a common ACO, this strategy may achieve cost efficiencies. Further, the Final Regulations permit hospitals that have overlapping but not identical communities to jointly prepare parts of their CHNAs, and provide procedures that should be followed by such hospitals in such instance. Treas. Reg. §§ 1.501(r)-3(b)(6)(v) and 1.501(r)-3(c)(4).

INABILITY TO GET INPUT FOR CHNA FROM ALL REQUISITE STAKEHOLDERS

The Final Regulations recognize that there may be times where a hospital, despite reasonable efforts, may not be able to secure input on its CHNA from all the required categories of persons listed in the regulations. Accordingly, the Final Regulations clarify that failure to secure input from all required categories of persons will not cause a hospital's CHNA to fail compliance with Section 501(r)(3) provided that the hospital has made and has documented that it has made reasonable efforts to secure the input from such persons. The CHNA report must describe such reasonable efforts made by the hospital. Treas. Reg. § 1.501(r)-3(b)(6)(iii).

REQUIRED COMPONENTS OF IMPLEMENTATION STRATEGY

In the proposed regulations, hospitals were required to include in their implementation strategy a plan to evaluate the impact made by such strategy. In the Final Regulations, this requirement has been replaced with a new requirement that a hospital's CHNA include an impact evaluation of the actions taken by the hospital on significant health care needs it identified in its previous CHNA. Treas. Reg. § 1.501(r)-3(b)(6)(i)(F).

EXTENSION OF TIME TO ADOPT IMPLEMENTATION STRATEGY

One source of controversy in the proposed regulations was the requirement that the authorized body of the hospital adopt an implementation strategy by the end of the same taxable year in which the hospital finished conducting the CHNA. The Final Regulations provide additional flexibility by extending the due date for implementation strategy adoption to a date on or before the 15th day of the fifth month after the end of the taxable year in which the CHNA was conducted. Accordingly, the authorized body must adopt the implementation strategy by the initial (non-extended) due date of the hospital's Form 990. Treas. Reg. § 1.501(r)-3(c)(5).

CHNA DUE DATE FOR ACQUIRED OR TRANSFERRED HOSPITAL FACILITIES

The Final Regulations contain an assortment of rules regarding the transfer or acquisition of hospital facilities and the effect that the timing of such events has on the CHNA requirements. With respect to hospitals that are transferred during any given year, the Final Regulations expressly state that such transferred hospital facility is not required to meet the requirements of Section 501(r) in the year of transfer. The IRS declined, however, to exempt newly acquired hospitals (along with new or newly subject to Section 501(r) hospitals, for that matter) altogether, explaining that the proposed regulations were intended to give such entities the standard three tax periods (albeit less than three full calendar years) to comply with Section 501(r)(3). Because of how short-periods function during the year of acquisition or placement into service, the CHNA clock resets as a short taxable year of less than 12 months and is considered a full taxable year for Section 501(r) purposes. Treas. Reg. §1.501(r)-3(d)(4).

Financial Assistance Policies (Code Section 501(r)(4))

Under Section 501(r)(4), a charitable hospital is required to have a written financial assistance policy (FAP) that includes 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; the collection actions a hospital may take against a patient in the event of non-payment (unless the hospital has a separate written policy addressing billing and collection); and measures to widely publicize the policy to the community. Section 501(r)(4) also requires hospitals to provide non-discriminatory care for emergency medical conditions to individuals regardless of their eligibility under the FAP. In the proposed regulations, hospitals were required to prepare a plain-language summary of the FAP and include a copy of such summary with all (but at least three) billing statements during the 120-day period after the date on which care was received. In addition, hospitals were required to translate the FAP, FAP Application Form and a plain-language summary of the FAP (FAP Documents) into the primary language of any populations with limited English proficiency that constituted more than 10 percent of the residents of the community served by the hospital.

REDUCTION IN NUMBER OF PLAIN-LANGUAGE SUMMARIES THAT MUST BE PROVIDED

Under the Final Regulations, hospitals are now required to include a plain-language summary in only one post-discharge mailing, provided that the hospital also includes a "conspicuous written notice" in every bill issued during the 120-day post-discharge period that informs the patient as to the availability of financial assistance, includes a phone number of the office or department that can advise patients as to the availability of financial assistance, and includes a direct website address (URL) where copies of the FAP Documents may be downloaded. Treas. Reg. § 1.501(r)-4(b)(5)(i)(D).

NEW PROVISION REQUIRED IN FAP REGARDING INDEPENDENT CONTRACTOR PROVIDERS TO HOSPITALS

A hospital is now required to list *in the FAP* all providers other than the hospital delivering emergency or other medically necessary care, and specify which of those providers are covered by the hospital's FAP and which are not. Treas. Reg. § 1.501(r)-4(b)(1)(iii)(F).

> **PRACTICE NOTE**
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> Presumably, the provider list would be contained in an appendix to the FAP so that it could be revised easily without having to redraft the entire FAP every time a provider is added or deleted.

FAILURE TO REQUIRE INDEPENDENT CONTRACTOR EMERGENCY ROOM PHYSICIANS TO ADOPT FAP IS PROBLEMATIC

The Preamble clarifies that if a Section 501(c)(3) hospital has "outsourced" its emergency room operations to a third party, it must require such third party to operate consistently with the FAP for care provided in the hospital's emergency room, or the hospital's operation of the emergency room will not be considered to satisfy the emergency room factor in the community benefit standard test set forth in Rev. Rul. 69-545.[3]

> **PRACTICE NOTE**
>
> While failure to satisfy one of the community benefit factors should not be problematic from an exemption standpoint, the IRS has identified the operation of an emergency department as one of the *key* factors in the community benefit standard analysis. Further, with respect to any bond financings, the inability to include the emergency department as a favorable factor in the community benefit standard could make it much more difficult to issue new or refinance existing tax-exempt bonds, since it could be more difficult to deliver an unqualified opinion that a hospital is described in Section 501(c)(3) of the Code.

MORE TRANSLATIONS OF THE FAP DOCUMENTS

Regarding requisite translations of the FAP Documents, the Final Regulations now require translations of all such documents into the primary language of any populations with

[3] *Id.* at 78972.

limited English proficiency that constitute more than 5 percent of the community served by the hospital. In certain communities, this could meaningfully increase the number of required translations of such documents. Treas. Reg. § 1.501(r)-4(b)(5)(ii).

SPECIFYING TYPES OF ASSISTANCE PROVIDED UNDER FAP

The proposed regulations required a FAP to specify *all* financial assistance available under the FAP, including all discounts and free care. The Final Regulations, however, permit a hospital to provide discounts outside of the hospital's FAP and indicate that such assistance will not be subject to the requirements contained in Sections 501(r)(4)-(6) of the Code. Accordingly, under the Final Regulations, the FAP is now only required to describe discounts available under the FAP, rather than all discounts offered by the hospital. While hospitals are permitted to offer assistance outside of the FAP, such discounts will not be considered to be "financial assistance" for Form 990, Schedule H purposes or "community benefit activities" for the Affordable Care Act's community benefit reporting purposes. Nor will such discounts be taken into account when determining if the hospital generally qualifies for tax-exempt status under Section 501(c)(3). Treas. Reg. § 1.501(r)-4(b)(2)(i)(A).

PRACTICE NOTE

Hospitals should attempt to shoehorn as many discounts as possible under the FAP, unless such expansion is impractical or unworkable.

TIMING OF FAP-ELIGIBILITY DETERMINATION REMAINS FLEXIBLE

Despite requests for specificity, the IRS declined to adopt a particular "point in time" for making FAP-eligibility determinations, preferring to give hospitals flexibility to choose their own determination time period.[4] Treas. Reg. § 1.501(r)-4(b)(3).

PRACTICE NOTE

Hospitals may use the service date, the application date or some other date to assess eligibility. Whatever period the hospital chooses should inform how the hospital designs its FAP application. For example, will the hospital accept as evidence of household income last month's paystub? If so, this suggests a narrower period for assessing eligibility. Will the hospital accept last year's tax return? This suggests a broader period for assessing FAP-eligibility.

GRANTING FINANCIAL ASSISTANCE IF PATIENT FAILS TO COMPLETE APPLICATION OR PROVIDE SUPPORTING DOCUMENTS

The Final Regulations clarify that a hospital is permitted to grant financial assistance to a patient under its FAP even if the patient fails to provide information or documentation required by the FAP Application Form. This clarification dovetails with adjustments to the reasonable efforts requirements under Section 501(r)(6). Treas. Reg. § 1.501(r)-4(b)(3).

MAKING THE FAP DOCUMENTS WIDELY AVAILABLE

While the Final Regulations maintain the proposed regulations' language regarding the requirements for hospitals to make their FAPs "widely available," the Preamble notes that the IRS views making the FAP available on the hospital's website and providing written copies of the FAP to persons upon their request as the "minimal steps" necessary to ensure patients have the information they need to seek financial assistance if needed.[5] One positive change in the Final Regulations is that the FAP no longer must include a list of the measures taken by the hospital to widely publicize its FAP in the community.[6]

[4] *Id.* at 78973.

[5] *Id.* at 78974.

[6] *Id.*

FAP AND RELATED DOCUMENTS STILL REQUIRED TO BE ON HOSPITAL'S WEBSITE

The Final Regulations retain the requirement that hospitals make their FAP Documents available on their websites. Treas. Reg. § 1.501(r)-4(b)(5)(i)(A).

PRACTICE NOTE

Posting PDF versions of the FAP Documents on a hospital's website alone is unlikely to be sufficient, however. Each hospital should consider embedding a link on its home page leading viewers to a dedicated FAP webpage, the text of which includes a plain-language summary of the FAP.

ADDITIONAL REQUIREMENTS FOR PLAIN-LANGUAGE SUMMARY

Under the Final Regulations, the plain-language summary must now include a description of the FAP application process and the appropriate times to apply for financial assistance. Treas. Reg. § 1.501(r)-1(b)(24).

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

Under Section 501(r)(5), hospitals must discount the amounts they charge patients eligible for assistance under their FAPs. FAP-eligible individuals must pay no more than the amounts generally billed (AGB) to insured patients for emergency or other medically necessary care, and must pay less than gross charges for other medical care covered under the FAP. The proposed regulations offered hospitals two options for calculating AGB: the "Medicare prospective" method or the "look-back" method. Under the Medicare prospective method, a hospital had to assume that each FAP-eligible individual was a Medicare beneficiary and estimate the amount it would receive as payment from Medicare for the care provided. Under the look-back method, a hospital reviewed claims paid by all private health insurers and Medicare, or Medicare alone, over the prior 12 months. A hospital could select one AGB percentage for all services or adopt multiple AGB percentages for separate items and services. As proposed, the look-back method required hospitals to quickly calculate and implement AGB percentage(s) within 45 days after their 12-month calculation period's end. Moreover, under the proposed regulations, a hospital was locked into its elected method forever.

EXPANDED AGB CALCULATION METHODS BUT NO "COMMERCIAL-ONLY" METHOD

The Final Regulations expand the AGB calculation methods to allow hospitals to base AGB on Medicaid rates, either alone or in combination with data from Medicare and (under the look-back method) from all private health insurers. This expansion is particularly relevant for children's hospitals, because Medicaid is their largest governmental payor.

The IRS declined, however, to include a "commercial-insurance"-only AGB calculation method. The IRS stated that Medicare reimbursements are a large percentage of most hospitals' total insurance reimbursements, despite comments noting that most hospitals' uninsured populations more closely resemble the commercially insured population in demographics and health status. The IRS explained that establishing an AGB method that excluded Medicare and would rely on data only from private health insurers would be inconsistent with the statutory phrase "amounts generally billed to individuals who have insurance."[7] Treas. Reg. § 1.501(r)–5(b)(3)(ii).

GROSS CHARGES LIMITATION APPLIES TO ALL OTHER MEDICAL CARE "COVERED UNDER THE FAP"

The proposed regulations confusingly made it seem as if the limit on gross charges applied to all care provided to FAP-eligible individuals, even elective care. The Final Regulations clarify that this limitation only applies to "all other medical care *covered under the FAP*." Treas. Reg. § 1.501(r)–5(a)(2).

HOSPITALS MAY SWITCH AGB CALCULATION METHODS

Under the Final Regulations, the IRS allows hospitals to change their AGB calculation method at any time, although hospitals may use only one method at any given time. The Final Regulations also clarify that a hospital organization operating multiple facilities can select various AGB calculation methods across its facilities; it is not obligated to use the same

[7] *Id.* at 78979.

calculation method for each hospital facility. Treas. Reg. § 1.501(r)–5(b)(1).

CHARGES FOR UNINSURED OR UNDER-INSURED FAP-ELIGIBLE INDIVIDUALS

The Final Regulations do not distinguish between insured and uninsured FAP-eligible individuals, despites pleas from commenters to exclude insured individuals. The IRS has clarified, however, that for purposes of the Section 501(r)(5) limitation, a FAP-eligible individual is considered to be "charged" only the amount that person is personally responsible for paying, taking into account all deductions and discounts applied and any amounts reimbursed by insurers. Treas. Reg. § 1.501(r)–5(b)(1).

> **PRACTICE NOTE**
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> FAPs may—but often do not—cover elective or non-medically necessary care. Hospitals should review their FAPs to determine whether they should explicitly exclude care that is neither emergency nor medically necessary. Further, the FAP should define what constitutes "medically necessary care." The Final Regulations allow hospitals to import definitions based on state law, including a Medicaid definition, on generally accepted standards of medicine in the community or on an examining physician's determination.

ADDITIONAL AGB CALCULATION METHODS REMAIN POSSIBLE

Recognizing that reimbursement methodologies are shifting, the IRS reserved the ability to provide additional AGB determination methods in future guidance, including methods that capture "value-based," accountable care or shared savings payments.[8]

MORE TIME GIVEN TO CALCULATE AND IMPLEMENT AGB PERCENTAGES

The Final Regulations provide more time to calculate AGB percentages at the end of each 12-month period. Hospitals may take up to 120 days (up from 45 days) to calculate the AGB percentage(s) but must also begin applying them within that timeframe. This gives hospitals more time to coordinate AGB calculations and FAP updates, as they will have to update their FAPs (or other readily obtainable material) at least once a year—and possibly more frequently—to reflect the updated AGB discount percentages. Treas. Reg. § 1.501(r)–5(b)(3)(iv).

DISCLOSING AGB PERCENTAGES IN FAP

Instead of listing the AGB percentage(s) in its FAP, a hospital can explain how individuals may readily obtain such percentage(s) and provide a free, written description of the calculation(s). The IRS rejected a recommendation that health systems be permitted to calculate system-wide AGB percentages. One exception was provided for hospital facilities that are covered by the same Medicare provider agreement. Such hospital facilities may calculate one AGB percentage or multiple AGB percentages for various categories of care or services. Treas. Reg. § 1.501(r)–4(b)(2)(i)(C) and 1.501(r)–5(b)(3)(vi).

USE OF REPRESENTATIVE SAMPLES NOT PERMITTED

Instead of culling all claims data to calculate AGB percentages under the look-back method, a few commenters sought permission to use representative samples of claims. The IRS declined, citing transparency and consumer protection concerns, and explained that it was unclear how samples could be selected in a "representative and reliable way."[9]

Billing and Collection Policies (Code Section 501(r)(6))

Under Section 501(r)(6), a charitable hospital can engage in "extraordinary collection actions" (ECAs) to protect the use of its charitable assets, but only after it determines, using "reasonable efforts," an individual's FAP-eligibility. Under the proposed regulations, ECAs included any collection actions taken by a hospital facility against an individual for care covered under its FAP that required a legal or judicial process or involved selling an individuals' debt to another party. Examples of actions requiring a legal or judicial process included placing a lien on or

[8] *Id*. at 78981.

[9] *Id.* at 78982.

foreclosing against an individual's property, commencing a civil action against an individual, causing an individual's arrest or garnishing an individual's wages. ECAs also included reporting an individual to consumer credit reporting agencies or credit bureaus (Credit Agencies).

Before engaging in these actions, hospitals had to make reasonable efforts to notify patients about their FAPs. Notification included telling patients about the FAP upon admission, making reference to the FAP on billing statements and describing the FAP during follow-up telephone calls. In addition, hospital facilities had to inform patients about information missing from their FAP applications and inform them that such information was required by the FAP.

The proposed regulations required hospitals to take certain actions during a notification period and an application period to satisfy the reasonable efforts standard presumptively. The notification period was the period during which a hospital facility must notify patients about its FAP. It began on the date of care and ended 120 days after the first billing statement was mailed. For example, if a hospital issued a bill 45 days after providing care, the notification period would have been approximately 165 days. If a hospital did not receive a FAP application during the notification period, it could commence with ECAs. However, patients were still eligible to submit FAP applications up to 240 days after the first billing statement—the application period. If a hospital received a FAP application after it had commenced ECAs, but during this 240-day period, it was required to pause such actions, assess FAP-eligibility and timely inform the patient. Incomplete FAP applications received special treatment, including a written notice that if sufficient information was not provided, the hospital could resume ECAs within 30 days. If a hospital determined that an individual qualified for assistance, it had to reverse any ECAs taken, refund any excess payments made, and provide the FAP-eligible individual with a billing statement that indicated the amount owed with his or her FAP discount.

With the Final Regulations, the IRS attempts to reduce hospitals' compliance burden with respect to satisfying the "reasonable efforts" requirement under Section 501(r)(6). If a hospital never intends to initiate ECAs, then it need not concern itself with satisfying Section 501(r)(6)'s reasonable efforts requirement.

ADJUSTMENTS TO ECA'S DEFINITION

Many commenters requested that the definition of ECA be amended to exclude reporting accounts to Credit Agencies. The IRS declined to make this change, reasoning that reporting individuals to Credit Agencies can "have extraordinarily detrimental consequences for the affected individuals."[10] The Final Regulations clarify, however, that the following actions are not ECAs (*i.e.*, a hospital facility may engage in the following without first making reasonable efforts to determine FAP eligibility):

- Writing off an account to bad debt, sending a patient a bill or calling a patient by telephone, because none of these actions require a judicial process or involve reporting adverse information to a credit agency[11]
- Placing a lien against third parties that caused a patient's injuries
- Charging interest on medical debt[12]
- Filing a claim in any bankruptcy proceeding

Treas. Reg. §§ 1.501(r)–6(b)(3) and 1.501(r)—6(b)(4).

CERTAIN DEBT SALES ARE NOT ECAS

In general, debt sales are ECAs. The Final Regulations permit, however, certain debt sales to avoid treatment as ECAs if a hospital facility requires purchasers to avoid engaging in ECAs, apply IRS-established interest rates to amounts outstanding, return or recall debt to the hospital upon a positive FAP-eligibility determination, and adhere to FAP requirements themselves (if the debt is not returnable or recallable to the hospital) that the individual not be charged more than he or she would be responsible for paying as a FAP-eligible individual. In short, hospitals are now accountable for the actions of their debt buyers and must

[10] *Id.* at 78984.

[11] *Id.* at 78973.

[12] *Id.* at 78985.

ensure that they do not engage in ECAs before "reasonable efforts" are made. Treas. Reg. § 1.501(r)–6(b)(2).

EXPANDED ABILITY TO PRESUME FAP-ELIGIBILITY

Under the proposed rules, presumptive eligibility was available to satisfy the "reasonable efforts" standard *only if* a patient could receive the most generous assistance (*i.e.*, free care) available under the FAP. Many hospitals requested greater flexibility to make presumptive FAP-eligibility determinations using available information about patients (*i.e.*, homeless, deceased with no known estate, unemployed) and other reliable demographic and analytic tools.

The IRS expanded presumptive eligibility guidelines in the Final Regulations. While hospitals may still provide the most generous assistance to presumptive FAP-eligible individuals, the Final Regulations let hospitals determine if an individual qualifies for "less than the most generous assistance" under its FAP based on information other than that provided by the individual or based on a prior FAP eligibility determination. But hospitals must give these individuals an opportunity to demonstrate that they qualify for more generous assistance. Specifically, certain conditions must be met:

- The hospital must notify these presumed FAP-eligible individuals about how they can apply for more generous assistance under the FAP.
- The hospital must give them a reasonable amount of time to apply before initiating ECAs to obtain any outstanding amounts.
- The hospital must otherwise comply with the "reasonable efforts" requirements if a presumed FAP-eligible individual requests more generous assistance by completing a FAP application.

Hospitals do not satisfy the "reasonable efforts" requirement if they presume FAP-ineligibility, even if the FAP requires state residency or being uninsured, which can be readily determined other than through a FAP application. Treas. Reg. § 1.501(r)–6(c)(2).

ADJUSTMENTS TO THE APPLICATION AND NOTIFICATION PERIODS

Many commenters grumbled that the 120-day and 240-day periods needed to be shortened. The IRS maintained the length of both periods—and in some cases lengthened them further—and eliminated references to the "notification period." The concept remains, however. Instead of using the term "notification period," the Final Regulations simply refer to notification efforts made during the 120 days after a hospital facility provides its first "post-discharge" billing statement. During these 120+ days, a hospital may not initiate any ECAs. The IRS's introduction of a "post-discharge" element (designed to help prolonged-stay patients who might receive their first bills before their discharge date) likely lengthens the period formerly known as the notification period. The definition of application period also adopts this "post-discharge" language. Treas. Reg. §§ 1.501(r)–6(c)(3)(ii) and 1.501(r)–1(b)(3).

PRACTICE NOTE

In the time between now and tax years beginning after December 29, 2015 (the date on which these rules become effective), hospitals should consider how to make these procedures part of their standard internal operations. Implementing Section 501(r)(6)'s rules will be time-consuming, because they raise significant operational issues for scheduling, financial counseling and billing personnel, who must work together to successfully implement the FAP. For example, financial counselors must be able to capture necessary FAP-eligibility information that may be missed during intake.

MORE DETAILS PROVIDED ABOUT ECA INITIATION NOTICES

Hospitals must create ECA Initiation Notices and provide them to patients against whom they intend to engage in ECAs, whether or not a completed FAP application has been received. This written ECA Initiation Notice must describe the specific ECAs the hospital facility intends to initiate (or resume), provide the deadline after which such ECA(s) will be initiated (or resumed), and include a plain-language summary

of the FAP. The deadline may be no earlier than 30 days after the ECA Initiation Notice sent by mail or electronic mail.

Further, according to the IRS, by focusing on ECAs the hospital intends to take imminently, the Section 501(r)(6) regulations comply with the federal Fair Debt Collection Practices Act (15 U.S.C. 1601 *et. seq*.) If the individual fails to complete a FAP application (or provide the missing information) by the deadline, then the hospital may resume or initiate ECAs. If the individual submits a complete (or partially complete) FAP application by the deadline, then the hospital must treat him or her under the general guidelines for patients submitting complete or incomplete FAP applications. Treas. Reg. § 1.501(r)–6(c)(4)(i).

PRACTICE NOTE

Although not required, it would be beneficial for a hospital's ECA Initiation Notice to include contact information for a hospital office or department (or a nonprofit organization or government agency) that can help individuals with the FAP application process. Such information is required for the written statement to individuals who submit incomplete FAP applications.

RELAXED ORAL NOTIFICATION REQUIREMENT

Under the proposed regulations, hospital staff had to notify all patients about the FAP's availability if they called with questions about their invoices. Commenters suggested this was unnecessary, burdensome and difficult to document. While the Final Regulations continue to require oral notification about the FAP as part of the "reasonable efforts" requirement, such notification only needs to be given to those patients against whom the hospital intends to engage in ECAs—not all patients calling with billing questions. In addition, hospitals must only make a reasonable effort to orally notify individuals about the FAP during the "reasonable period" (*e.g.*, 30 days) between mailing the ECA Initiation Notice and resuming or initiating ECAs. The hospital does not have to actually speak with the individual; it just must make reasonable efforts. Treas. Reg. § 1.501(r)–6(c)(4)(i)(C).

ADJUSTMENTS TO APPROACH FOR ECAS TAKEN AGAINST INDIVIDUALS WHO SUBMIT INCOMPLETE FAP APPLICATIONS

Under the proposed regulations, ECAs taken against an individual who then submitted an incomplete FAP application had to be delayed for a period of at least 240 days from the first billing statement or until the FAP application was completed, whichever was the first to occur. Under the Final Regulations, ECAs taken against individuals who then submit incomplete FAP applications only have to be suspended for a "reasonable period of time" (*e.g.*, 30 days). If the individual fails to provide the requested information, a hospital may recommence collection activities. If, after recommencement but within the application period, the individual submits a complete FAP application, then the ECAs must again be suspended pending the hospital's ECA-eligibility determination. Hospitals are not required to reverse ECAs if the individual is determined to be ineligible under the FAP. Treas. Reg. §1.501(r)–6(c)(5).

PRACTICE NOTE

Hospitals might consider using predictive analytics to assess which patients are *unlikely* to be FAP-eligible, as ECAs taken against such individuals carry less risk of having to be unwound during the application period. Further, a completed FAP application does not suspend all ECAs. It suspends only those ECAs related to the care at issue. ECAs related to prior care may continue.

PRACTICE NOTE

While the Final Regulations no longer specify a documentation requirement under the reasonable efforts standard, hospitals must be able to demonstrate that they satisfy the standard for Form 990 reporting purposes. Hospitals should consider contacting their tax return preparer to understand what papers will be requested.

NO FIXED DEADLINE FOR MAKING FAP-ELIGIBILITY DETERMINATIONS

Under the proposed regulations, hospitals had to make and document "in a timely manner" FAP-eligibility determinations and provide written notice to individuals about the decision and the basis for the decision. Commenters requested that FAP-eligibility determinations be made within a specific period (*e.g.*, five business days, 30 days, 45 days). The IRS declined, preferring to keep the time period's reasonableness subject to all facts and circumstances. In fact, the Final Regulations allow FAP-eligibility determinations to be postponed in order to give hospitals time for Medicaid applications and determinations. While completed FAP applications are awaiting eligibility decisions, ECAs may not be initiated or resumed, placing the onus on hospitals to conduct these determinations efficiently. Treas. Reg. § 1.501(r)–6(c)(6)(i).

ADJUSTMENTS TO ACTIONS REQUIRED FOR FAP-ELIGIBLE INDIVIDUALS

Under the proposed regulations, if a hospital determined that an individual was FAP-eligible, it had to take three additional steps:

- Provide the individual with a billing statement indicating the amount he or she owed and showing (or describing how the individual could get information about) the AGB for the care provided
- Refund any excess payments received from the individual for the FAP-eligible care
- Take all reasonably available steps to reverse any ECAs taken against the individual for the FAP-eligible care

The Final Regulations relax these requirements in a number of ways. First, if the patient is eligible for free care, a hospital need not provide AGB calculation details in his or her FAP-approval notice. This notice only needs to identify that the individual qualified for free care. Second, hospitals do not need to provide refunds to FAP-approved individuals for amounts they are personally responsible for paying if the refund amount is less than $5, increased by inflation. Third, hospitals must reverse and re-start (if applicable) ECAs against FAP-approved individuals. Any ECA that was commenced against a FAP-approved individual cannot be continued even if its purpose is to collect the discounted amount due. Treas. Reg. § 1.501(r)–6(c)(6)(i)(C)(1)-(3).

INDIVIDUALS CANNOT WAIVE THEIR FAP-ELIGIBILITY

The Final Regulations maintain the proposed regulations' requirement that hospitals cannot satisfy the reasonable efforts requirement if they rely on signed waivers to determine an individual's FAP-ineligibility. The IRS refused to heed requests for targeted and limited waivers (*e.g.*, for an individual with adequate insurance who is able to meet co-pays and deductibles). An individual's income attestation could, however, be included in a FAP application and provide the hospital with sufficient information to assess the applicant's eligibility, assuming the hospital has no reason to believe the information is incorrect or was obtained under duress or through a coercive practice. Treas. Reg. §§ 1.501(r)–6(c)(9) and 1.501(r)–6(c)(6)(ii)-(iii).

PRACTICE NOTE

Hospitals should consider adding a box to their FAP's income attestation section that allows people with income over certain thresholds or who meet certain other criteria relevant to FAP-eligibility to skip to the end and submit their FAP applications on that basis. Because a "complete" FAP application has been submitted, the hospital will be able to demonstrate that it has met the reasonable efforts requirement.

DENYING CARE FOR PAST NONPAYMENT IS MOST LIKELY AN ECA

The Final Regulations provide that deferring or denying medically necessary care because of an individual's nonpayment for prior care eligible for FAP coverage is an ECA with some exceptions. Hospitals do not need to provide oral notification or a written ECA Initiation Notice before deferring or denying care based on past nonpayment. This ECA has its own written (and oral) notice requirement and may occur immediately thereafter. The specific notification requirement for denying or deferring care can be satisfied if the hospital provides a copy of its FAP application form to the individual,

notifies him or her that financial assistance is available, and provides the deadline after which it will not accept a FAP application for the previously provided care. The individual must have at least 30 days to submit a FAP application for the previously provided care after receiving this notice. If a FAP application is timely submitted, then the hospital must process it on an expedited basis. Treas. Reg. §§ 1.501(r)–6(b)(1)(iii) and 1.501(r)–6(c)(4)(iii).

HOSPITALS STILL RESPONSIBLE FOR ACTIONS OF THIRD PARTIES

Under the proposed regulations, hospitals were held accountable for the billing and collection actions of third-party debt buyers and collection contractors. Commenters asked that the Final Regulations provide relief from strict liability for a third party's actions as long as the hospital acted in good faith to supervise its agents and took steps to remedy any discovered violations. The IRS did not accept this alternative, and the Final Regulations echo the proposed regulation's requirements. Treas. Reg. § 1.501(r)–6(c)(10).

PRACTICE NOTE

A hospital's 501(r)(6) failure based on a third party's actions may be excused if the failure is minor (*e.g.*, not willful or egregious) and the hospital both corrects and discloses the failure.

Miscellaneous Provisions Relating to Section 501(r)

MINOR ERRORS AND OMISSIONS IN SECTION 501(R) COMPLIANCE

Perhaps the most important change in the Final Regulations is the addition of a specific provision recognizing that "minor omissions and errors" with respect to the Section 501(r) requirements will not be considered a failure to meet the requirements of Section 501(r) if such omission or error was minor and *either* inadvertent or due to reasonable cause, and the hospital facility corrects such omission or error promptly after its discovery. Treas. Reg. § 1.501(r)–2(b)(1).

APPLICATION OF SECTION 501(R) TO GOVERNMENT HOSPITALS

Under the Final Regulations, the IRS unequivocally states that governmental hospitals that are recognized as Section 501(c)(3) organizations are subject to the Section 501(r) requirements. The IRS noted, however, that such governmental hospitals could voluntarily relinquish their Section 501(c)(3) status by submitting a request to the IRS to terminate such status.[13]

APPLICATION OF SECTION 501(R) TO MEDICAL GROUPS OWNED OR CONTROLLED BY HOSPITAL

Under the Final Regulations, if a Section 501(c)(3) hospital owns a capital or profits interest in a medical group, the hospital must meet the 501(r) requirements with respect to the care provided by physicians of such entity in the hospital facilities. Treas. Reg. § 1.501(r)–1(b)(28) (defining a "Substantially Related Entity").

STATE "DEEMED COMPLIANCE" EXCEPTION REJECTED

Approximately a third of the United Sates already requires hospitals to assess community health needs, including California, New York, Iowa, Illinois, Texas, Massachusetts, Maryland, Oregon and others. Many states have been regulating emergency care and financial assistance requirements for years. Some states already have rules on where to post an organization's FAP notices and have requirements on engaging in ECAs. The IRS declined to provide a "deemed compliance" exception for hospitals that satisfy their state regulations, reasoning that it would (i) result in widely divergent rules for charitable hospitals in different states, (ii) require IRS revenue agents assessing Section 501(r) compliance to become experts in each state's laws or otherwise obtain input from state regulatory officials that a hospital is satisfying the relevant state law during the year(s) under audit, and (iii) be inconsistent with Section 501(r)'s statutory text (*e.g.*, conducting CHNAs every five years, as in Iowa and Illinois, as opposed to every three years). Accordingly, hospitals will have to navigate both state and federal requirements.[14]

[13] *Id.* at 78958.

[14] *Id.* at 78994.

PRACTICE NOTE

Hospitals should treat Section 501(r)'s requirements as a baseline. From there, more stringent state law requirements will continue apply above and beyond Section 501(r)'s requirements.

IMPOSITION OF FACILITY-LEVEL TAX AND IMPACT OF SUCH TAX ON TAX-EXEMPT BONDS

Expanding on the statement in the 2013 proposed regulations, the Final Regulations provide that if the facility-level tax is imposed on any hospital facility for failure to meet one or more of the requirements under Section 501(r), such tax in and of itself will not adversely affect the tax-exempt status of bonds issued to finance the non-compliant hospital *and* will not be treated as an unrelated trade or business under Section 513(a). Treas. Reg. § 1.501(r)–2(d)(4)(i).

PRACTICE NOTE

While imposition of a facility-level tax for failure to satisfy a Section 501(r) requirement may not adversely affect the tax status of the bonds, it may nonetheless be a disclosure event under the relevant bond documents.

Conclusion

All tax-exempt hospitals, and particularly those that did not revise their policies to conform to the guidance in the proposed regulations, should immediately review their existing FAP, FAP application, plain-language summary (if already drafted), billing and collection, and all related policies to ensure full compliance with Section 501(r) and these Final Regulations. Hospitals that last conducted their CHNAs during FY 2012 should consider whether they wish to rely on the proposed regulations, the Final Regulations or another reasonable interpretation of Section 501(r)(3) for their FY 2015 CHNA cycle.

Creeping normalcy refers to the phenomenon in which many small changes over a broad timeline are perceived as "normal" because each shift is gradual and imperceptible. But, if one steps back and appreciates the broader change over time, one can recognize its significance. The Final Regulations appear to make relatively minor changes to the requirements under Section 501(r) of the Code, but the charitable hospital industry should understand that these seemingly modest adjustments are connected to a monumental shift in the way charitable hospitals must act to maintain their tax-exempt status under Section 501(c)(3). Hospitals have been living with Section 501(r) for nearly five years. For some, it may be difficult to remember that each minor Section 501(r) adjustment has been slightly more complex than the prior understanding. This final step in the guidance process is a meaningful one, notwithstanding the significant time lag between the statute's adoption, the IRS's initial guidance materials, the regulations' proposals and their finalization.

THE McDERMOTT DIFFERENCE

Section 501(r) is the most significant change to tax exemption standards for hospitals in more than 40 years. These Final Regulations represent a new normal, one that McDermott will help charitable hospitals comply with and master for continued success over the next 40 years. For more information, contact your regular McDermott lawyer or one of the authors.

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