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Nonprofit Organizations

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IRS Issues Long-Awaited Final Regulations for Charitable Hospitals

In this Issue:

The IRS has published final amended regulations that are consistent with previous guidance but provide additional clarity and rules specific to charitable hospitals under Section 501(r) of the Internal Revenue Code of 1986. The regulations, which may be accessed here, were published on Dec. 31, 2014, and become effective for tax years beginning after Dec. 29, 2015.

To see previous Polsinelli Updates on Section 501(r) click here and here.

What You Should Do

Charitable hospitals should carefully review the final regulations and ensure that they will be in compliance by the tax year beginning after Dec. 29, 2015. For tax years beginning before Dec. 29, 2015, charitable hospitals may continue to rely on a reasonable, good faith interpretation of Section 501(r), which includes compliance with the previously issued proposed regulations or with the final regulations.

Background

The Patient Protection and Affordable Care Act added Section 501(r) to the Code, introducing new requirements for charitable hospitals to be described in Section 501(c)(3), and adding new reporting requirements and excise taxes. Specifically, Section 501(r) requires charitable hospitals that operate one or more hospital facilities to perform the following on a facility-by-facility basis:

- Conduct a community health needs assessment ("CHNA") and adopt an implementation strategy to meet the community needs identified by the CHNA at least once every three years;

- Establish a written financial assistance policy ("FAP") and emergency medical care policy;
- Limit amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the FAP; and
- Make reasonable efforts to determine whether an individual is eligible for assistance under the FAP before engaging in an extraordinary collection action ("ECA").

Final Regulations

While the final regulations are generally consistent with previous IRS guidance, the final regulations make several changes and clarifications to the proposed regulations, including the following highlights:

Hospital Facilities and Organizations

Section 501(r)(2) applies to all organizations that operate a facility required to be licensed, registered, or similarly recognized as a hospital under Section 501(c)(3). Each organization must separately meet the requirements of Section 501(r) for each hospital facility.

- **Hospital Facility Consisting of Multiple Buildings.** Multiple buildings operated by a hospital organization under a single state license continue to be considered a single hospital facility for purposes of Section 501(r). The final regulations clarify that if the hospital facility serves different geographic areas or populations through the different buildings, the community served by the hospital facility is the aggregate of such areas or populations for purposes of its CHNA. However, the hospital organization can document the assessments in separate chapters or sections of the hospital facility's CHNA report and implementation strategy.
- **Operating a Hospital Facility.** A hospital organization is considered to operate a hospital facility if it owns a capital or profits interest in an entity treated as a partnership for federal tax purposes. The final regulations clarify that a hospital organization is considered to own a capital or profits interest in an entity treated as a partnership for federal tax purposes if it owns such interest directly or indirectly through one or more lower-tier entities that are treated as a partnership for federal tax purposes. The final regulations also clarify that a hospital organization does not need to meet the requirements of Section 501(r) for any hospital facility that it is not "operating" as defined in the regulations.
- **Unrelated Trades or Business.** The final regulations specifically provide that a hospital organization is not required to meet the requirements of Section 501(r) with respect to any of its activities that constitute an unrelated trade or business described in Section 513.

Failures to Satisfy the Requirements of Section 501(r)

- **Minor Omissions and Errors.** Generally if minor and inadvertent omissions and errors are due to reasonable cause and are promptly corrected, disclosure is not required and no sanctions will result. The final regulations provide that the option for correction without disclosure is available if the omission or error is minor and *either* inadvertent or due to reasonable cause. To be minor, omissions or errors must be minor in the aggregate.
- **Reasonable Cause.** The final regulations clarify the meaning of "reasonable cause" for these purposes.

Community Health Needs Assessments

Section 501(r)(3) requires a charitable hospital to conduct a CHNA and adopt an implementation strategy to meet the community needs identified by the CHNA at least once every three years. The CHNA must 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.

- **Examples of Health Needs.** The final regulations expand the examples of health needs that a hospital facility may consider in its CHNA to include not only the need to address financial and other barriers to accessing care but also the need to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community.

- **Community Input.** The final regulations only require a hospital facility to "solicit" input from those representing the broad interests of the community and take into account the input "received" when completing its CHNA. Therefore, if the hospital facility does not receive input from a particular group after making reasonable efforts to solicit such input, the hospital facility will not be penalized if it documents these efforts. When prioritizing the significant health needs of the community identified in its CHNA, a hospital facility may use any criteria, but the final regulations clarify that community input must be taken into account not only for identifying significant needs but for prioritizing them.

- **Plan to Address a Significant Health Need.** The final regulations replace the proposed requirement that the implementation strategy describe a plan to evaluate its impact with a requirement that the CHNA report include an evaluation of the impact of any actions that were taken since the hospital facility finished conducting its immediately preceding CHNA to address the significant health needs identified in the hospital facility's prior CHNA(s).

- **Implementation Strategy.** The proposed regulations provided that an authorized body of the hospital facility must adopt an implementation strategy to address the health needs identified by the CHNA by the end of the taxable year that the hospital facility conducted its CHNA. The final regulations provide hospital facilities with an additional four and half months to adopt the implementation strategy. The final regulations do not allow the adoption to be extended to coincide with any Form 990 extensions.

- **Transferred or Terminated Hospital Facilities.** If a hospital organization transfers all ownership of a hospital facility to another organization or otherwise ceases its operation of the hospital facility before the end of a taxable year, the hospital organization is not required to meet the requirements of Section 501(r) with respect to that hospital facility for that year.

Financial Assistance Policies and Emergency Medical Care Policies

Section 501(r)(4) requires charitable hospitals to have a written 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;

- If the hospital does not have a separate billing and collection policy, the actions the hospital may take in the event of non-payment, including collections action and reporting to credit agencies; and
- Measures to widely publicize the policy within the community served by the hospital.

- **FAP Application to Third Parties.** The final regulations require the hospital facility's FAP to "apply to all emergency and other medically necessary care provided by the hospital facility, including all such care provided in the hospital facility by a substantially-related entity…" The final regulations also require a hospital facility's FAP to list the providers delivering emergency or other medically necessary care in the hospital facility and to identify which providers are covered by the FAP and those who are not. Interestingly, in the preamble to the final regulations, the IRS states that, "[I]f a hospital facility outsources the operation of its emergency room to a third party and the care provided by that third party is not covered under the hospital facility's [FAP], the hospital facility may not be considered to operate an emergency room for purposes of the factors considered in Rev. Rul. 69-545…" It is unclear how the IRS will interpret this statement. It could have a substantial impact on hospitals that contract with private physician practices to provide the physician and medical director services necessary to operate their emergency rooms.

- **Hospitals May Provide Discounts Outside of FAPs.** Because charitable hospitals may provide discounts that are not based on the financial need of a patient, such as self-pay discounts, state law mandated discounts, or those provided to out-of-state residents, the final regulations clarify that hospitals may continue to provide these discounts outside of their FAPs, without triggering the requirements of Section 501(r). In the preamble to the final regulations, the IRS cautions that these discounts will not count as "financial assistance" for purposes of Schedule H to the Form 990 or as other community benefits.

- **Eligibility for Financial Assistance.** The final regulations do not require hospitals to determine eligibility for financial assistance based solely on written information from the individual. Instead, the hospital may rely and oral information from the individual and information obtained from other sources if the hospital describes the information it uses in its FAP or application form.

- **Widely Publicize the FAP.** The final regulations no longer require hospitals to list the measures taken to widely publicize the FAP. Hospitals are now only required to implement the measures to widely publicize the FAP in the community it serves.

- **Paper Copies of the FAP.** Hospitals must make paper copies of the FAP, application, and plain language summary available in public places in the hospital, which include, at a minimum, the emergency room and admissions area and must notify and inform visitors about the FAP in public locations of the hospital facility, including, at a minimum, the emergency room and admissions areas.

- **Plain Language Summary.** The final regulations no longer require hospitals to include a plain language summary with each billing statement. Instead, the final regulations allow hospitals to include a conspicuous written notice on billing statements regarding the availability of financial assistance, including the telephone number of the hospital office or department that can provide information about the FAP and the application process and the website address where a patient can obtain copies of the FAP, application, and plain language summary.

- **Translations of FAP Documents.** The final regulations lower the threshold for having translations of the FAP documents available for populations with limited English proficiency to match guidelines issued by the Department of Health and Human Services. Under the final regulations, translations are required if those populations constituted more than the lesser of 5 percent of the population or 1,000 people of the community served by the hospital.

- **Combined FAP and Emergency Medical Care Policy.** A hospital may combine its FAP with its emergency medical care policy.

- **Multiple Hospital Facility Policies.** The final regulations clarify that multiple hospital facilities may have identical FAPs, billing and collection practices, and/or emergency medical care policies (or as part of a joint policy document), if the information in the policy or policies is accurate for all facilities and any joint policy clearly states that it is applicable to each facility.

Limitation on Charges

Section 501(r)(5) requires charitable hospitals to limit amounts charged for emergency or other medically necessary care provided to individuals eligible for financial assistance under the hospital's FAP to "not more than the amounts generally billed to individuals who have insurance covering such care" and prohibits the use of gross charges. The final regulations continue the use of the look-back and prospective method for calculating amounts generally billed ("AGB"), but allow for the establishment of additional methods in future guidance.

- **Changes in Method Used to Determine AGB.** A hospital facility may now change the method used to calculate AGB at any time provided it describes the new method used in its FAP before implementing the change.

- **Medically Necessary Care.** The final regulations allow hospital facilities to define the term "medically necessary care" for purposes of their FAPs and the AGB limitation, recognizing that health care providers and insurers may have reasonable differences in opinion on whether certain health care services are medically necessary in particular circumstances. In defining "medically necessary care" for purposes of their FAPs and the AGB limitation, hospital facilities may, but are not required to, use the state Medicaid definition, other definitions provided by state law, or another generally accepted definition.

- **Claims Allowed Under the Look-Back Method.** The final regulations describing the look-back method now look to claims "allowed" rather than claims "paid in full." The IRS believes that this change will clarify that hospitals are to include the both the amount to be reimbursed by the insurer and the amount (if any) that the individual is personally responsible for paying, regardless of whether the individual actually pays it.

- **Payors Under Look-Back Method.** The final regulations no longer refer to claims paid by "primary payors." Instead, the look-back method references claims paid by health insurers, without distinguishing between those with primary or secondary liability.

- **AGB Limitations Under the Look-Back Method.** The final regulations simplify the calculation of the AGB limitation for hospitals under the look-back method by using claims allowed for all medical care that the hospital facility provides rather than only those claims for emergency and other medically necessary care.

- **Gross Charges.** It is now clear that the use of gross charges is prohibited only to those that qualify under the hospital's FAP and for medical necessary or emergency care.

- **Safe Harbor for Certain Charges in Excess of AGB.** Under the proposed regulations, a hospital was not prohibited from charging more than AGB for emergency or medically necessary care to an individual eligible for financial assistance if the individual had not submitted a completed FAP application at the time of the charge if the hospital made reasonable efforts to determine if the individual was eligible for financial assistance. The final regulations provide that the safe harbor does not apply to a hospital facility that requires an individual to make an upfront payment for medically necessary care that exceeds AGB if the individual turns out to be eligible for financial assistance.

Billing and Collection

Section 501(r)(6) prohibits a hospital from engaging in ECAs before the hospital has made reasonable efforts to determine whether the individual is eligible for assistance under the FAP.

- **ECAs by Third Parties.** The final regulations continue to hold hospitals responsible for ECAs of third parties collecting debt on its behalf or to which it sells its debt. However, the IRS indicates in the preamble to the final regulations that a hospital may be excused if the violation was not willful or egregious and the hospital both corrects and discloses the failure.

- **Liens.** The final regulations provide that any lien a hospital is entitled to assert under state law on certain settlements, judgment, or compromises owed to a third party who caused the patient's injuries for which the hospital provided care will not be an ECA.

- **Debt Sales.** The final regulations provide that debt sales, while generally considered ECAs, will not be considered ECAs if the hospital enters into a legal binding contract with the purchaser that meets four conditions outlined in the regulations.

- **Notification and Application Periods.** Previous guidance required that hospitals provided a 120-day notification period for a hospital to notify an individual about the FAP and a 240-day application period for the hospital to process any application. The final regulations retain these periods, but provide that the 120-day period (no longer called a notification period) starts when the first "post-discharge" is provided instead of the first billing date, which could occur when the patient is still receiving care and is still at the hospital. Further, the final regulations provide that the 240-day application is extended under certain circumstances outlined in the regulations.

- **Notification Requirements.** The final regulations provide that a hospital only make reasonable efforts to orally notify an individual about the hospital's FAP and how the individual may obtain assistance before beginning ECA efforts against the individual. Further, hospitals are no longer required to document such notifications.

- **Incomplete FAP Applications.** If an individual submits an incomplete FAP, the hospital must suspend ECAs against the individual until the individual completes the FAP application, the hospital determines that whether the individual is eligible for financial assistance, or if the individual fails to respond within a reasonable time.

- **Determination of Eligibility for Financial Assistance.** Hospitals are no longer required to issue a written notification to those individuals where the individuals are eligible for free care and nothing is owed.
- **Refunds.** A hospital is not required to issue refunds for amounts less than $5. Such amount may be adjusted for inflation in the future.
- **Presumption of Eligibility for Financial Assistance.** The final regulations provide for three conditions that must be met when a hospital presumptively determines that an individual is eligible for less than the most generous assistance available under the FAP for purposes of the reasonable efforts test.

For More Information

While this update is intended to highlight notable changes and clarifications provided in the final regulations, it is not intended to serve as a complete summary and analysis. If you have questions regarding the final Section 501(r) regulations or how they may affect your hospital, please contact:

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* Law360, March 2014
** The American Lawyer 2013 and 2014 reports

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