Section 501(r): final regulations for tax-exempt hospitals

CHA Community Benefit Program
June 7, 2015

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Today’s agenda

- 501(r) background
  - ACA Section 9007
  - IRS report to Congress
  - Timing of 501(r) regulations
- 501(r) requirements
  - Community health needs assessment (CHNA)
  - Financial assistance policy (FAP) and Emergency Medical Care Policy
  - Billing and collections requirements
  - Limitations on charges
- Failure to meet Section 501(r) requirements
Sec. 501(r) background

Background

► Congress passed the Affordable Care Act (ACA) in 2010.
► ACA Sec. 9007 creates new rules for charitable hospitals.
  ► Added Internal Revenue Code Sec. 501(r)
  ► Requires the IRS to review at least once every three years the community benefit activities of each charitable hospital organization
  ► Requires the IRS, with the US Department of Health and Human Services (HHS), to submit reports to Congress comparing attributes of taxable, tax-exempt and government hospitals

IRS report to Congress on community benefit provided by hospitals

► January 2015: The IRS provides first report based on 2011 data.
► Charity care provided, based on Centers for Medicare and Medicaid Services (CMS) data:
  ► Taxable hospitals: 1.31% of total expenses
  ► Tax-exempt hospitals: 2.13% of total expenses
  ► Government hospitals: 6.56% of total expenses
► Unreimbursed costs for services provided by means-tested programs, based on CMS data:
  ► Taxable hospitals: 1.77% of total expenses
  ► Tax-exempt hospitals: 1.94% of total expenses
  ► Government hospitals: 4.01% of total expenses
► Total community benefit expenses provided by tax-exempt hospitals: 9.67% of total expenses.
Section 501(r): proposed and final regulations

- Final regulations released December 29, 2014.
  - Effective/applicability date for most provisions of final regulations: tax years beginning after December 29, 2015.
- Despite the generous effective/applicability date, hospital organizations should begin preparing to comply with the final 501(r) regulations as soon as possible, given the scope and complexity of the regulations and changes to proposed regulations.
- Documentation of 501(r) compliance is crucial.
  - Document compliance for IRS, auditors and tax-exempt bond counsel.

Who does Section 501(r) apply to?

- A hospital organization that operates more than one hospital facility must meet each Section 501(r) requirement separately for each hospital facility.
- Hospital facility – “a facility that is required by a state to be licensed, registered or similarly recognized as a hospital.”
- A hospital organization “operates” a hospital facility if it owns a capital or profits interest in a partnership/LLC that operates the facility, directly or indirectly.

Instances in which a hospital organization does not have to meet Section 501(r)

- Unrelated trade or business: A hospital organization does not have to meet the requirements of Section 501(r) with respect to activities that constitute an unrelated trade or business with respect to the hospital organization.
- Corporations (physicians practices): The Preamble clarifies that a hospital facility does not have to meet the requirements of Section 501(r) with respect to corporations (e.g., physicians practices) that provide care in the facility, even if the corporation is owned by the hospital organization.
Sec. 501(r): CHNA

CHNA regulations – Section 1.501(r)(3)

General rules

- For any taxable year in which a hospital organization operates a hospital facility:
  - The hospital facility must conduct a CHNA in the taxable year or in either of the two preceding taxable years.
  - The clock resets when a hospital organization acquires a hospital facility formerly operated by another legal entity.
  - An authorized body of the hospital facility must adopt:
    - A CHNA report
    - An implementation strategy to meet the community health needs identified in the CHNA

CHNA: defining community served and assessing community health needs

- To conduct a CHNA, a hospital facility must:
  - Define the community served, taking into account all the relevant facts and circumstances, including:
    - Geographic area served
    - Target populations served
    - Principal functions, e.g., specialty area or targeted disease
    - May not exclude low-income or medically underserved individuals
  - Identify and prioritize significant health needs of the community
    - Must solicit and take into account input from persons representing the broad interests of its community, including all of the following:
      - At least one public health department or State Office of Rural Health with knowledge or expertise relevant to the community's health needs
      - Medically underserved, low-income and minority populations
      - Written comments on its most recent CHNA and implementation strategy
    - May also solicit and take into account input from others with special knowledge of or expertise in public health
CHNA: producing a CHNA Report

- Must document CHNA in a CHNA Report that includes:
  - A definition of the community served by the hospital facility and a description of how the community was determined
  - A description of process and methods used to conduct CHNA
  - A description of how the facility solicited and took into account input from persons representing broad interests of its community
  - A prioritized description of the significant health needs of the community identified through the CHNA
    - Including a description of process and criteria used in identifying certain health needs as significant, and prioritizing those needs
  - A description of resources potentially available to address the significant health needs identified through the CHNA
  - An evaluation of the impact of any actions the facility has taken to address the significant health needs identified in its prior CHNAs

CHNA: making the CHNA Report widely available to the public

- A hospital facility must make its CHNA Report widely available to the public.
- This is satisfied by making:
  - The CHNA Report widely available on a website
  - A paper copy of the CHNA Report available at the hospital facility

Collaboration

- A hospital organization may conduct a CHNA in collaboration with other organizations.
- Each hospital facility generally must document its CHNA in a separate CHNA Report.
- However, collaborating hospital facilities may produce a joint CHNA Report if they define their community to be the same and conduct a joint CHNA process.
  - They may also adopt a joint implementation strategy if each hospital facility’s role and responsibility in taking actions to meet significant health needs are clearly identified.
CHNA
Implementation strategy

► By the 15th day of the fifth month after the end of the taxable year during which the hospital facility conducts the CHNA, an authorized body must adopt an implementation strategy.
► The implementation strategy is required to:
  1. Describe actions the hospital facility intends to take to address each significant health need identified in the CHNA, and the anticipated impact of those actions, or identify the health need as one it does not intend to address and explain why
  2. Identify the resources the hospital facility plans to commit to address the health need
  3. Describe any planned collaboration with other facilities or organizations in addressing the health need

CHNA implications

► 501(r) regulations focus on process and transparency, but do not require a hospital to address a minimum number of needs or achieve a particular level of success
► The CHNA report and implementation strategy are very public documents and likely to be closely scrutinized
► IRS reviews the community benefit activities of every hospital once every three years
  ► These reviews involve publicly available information, which may include a hospital’s CHNA and Implementation Strategy
► CHNA reports and implementation strategies should clearly comply with each CHNA requirement
  ► For example, include language clearly explaining how community input was solicited and taken into account when prioritizing health needs in addition to when identifying health needs

Sec. 501(r): Financial Assistance Policy and Emergency Medical Care Policy
FAP regulations – Section 1.501(r)(4)

General rule

► Each hospital facility must establish a written FAP that applies to all emergency and other medically necessary care provided by the hospital facility.
► A FAP must include the following:
  ▶ Eligibility criteria
  ▶ Calculating amounts charged
  ▶ Method for applying for financial assistance
  ▶ Actions taken for nonpayment

FAP requirements

► The FAP must specify the eligibility criteria an individual must satisfy to receive financial assistance.
  ▶ Regulations do not require the type of financial assistance that must be provided or the type of individuals who must be covered.
► The FAP must state that FAP-eligible individuals will not be charged more for emergency or other medically necessary care than amounts generally billed (AGB) to persons with insurance covering such care.
  ▶ The FAP must describe the method used to determine AGB (look-back method or prospective Medicare or Medicaid method).
  ▶ If look-back method, the FAP must state AGB percentage(s) and how it was calculated, or how to obtain that information for free in writing.
► The FAP/FAP application form must describe how an individual applies for financial assistance, and the information and documentation required to be submitted.
► The FAP (or a separate billing and collections policy) must describe any actions that the facility or other authorized party may take to obtain payment, including any extraordinary collection actions (ECAs).

Widely publicizing the FAP

► A hospital facility must:
  ▶ Make its FAP, FAP application and plain-language summary widely available and conspicuously placed on a website
  ▶ Make its FAP, FAP application and plain-language summary available upon request (by mail and in public locations in facility)
  ▶ Inform and notify residents of the community served likely to require financial assistance about the FAP
    ▶ Not just through facility’s website
  ▶ Offer (though not necessarily provide) a plain-language summary of the FAP to patients as part of the intake or discharge process
  ▶ Require a conspicuous notice on all bills notifying recipients of availability of financial assistance
  ▶ Inform and notify visitors through “conspicuous” public displays, including in emergency rooms and admissions areas
LEP accessibility and translation

- The FAP, FAP application form and plain-language summary must be available in English and in any other language in which limited English proficiency (LEP) populations constitute the lesser of 1,000 individuals or 5% of the community served by the hospital facility.
- Any reasonable method may be used to determine the percentage or numbers of LEP individuals in the hospital facility’s community.
- Proposed regulations’ threshold for triggering LEP translation requirements was 10% of community served by the hospital facility.

Other providers and FAP-eligibility sources

- The FAP must list providers other than the hospital facility that deliver emergency or other medically necessary care in the facility, and which providers are and are not covered under the FAP.
- The preamble states that if a hospital facility outsources its emergency room operation to a third party that is not subject to the facility’s FAP, the facility may not be considered to operate the emergency room for purposes of the community benefit standard under Rev. Rul. 69-545.
- The FAP must list any information obtained from sources other than an individual seeking financial assistance that the hospital facility uses to presumptively determine FAP-eligibility.

Emergency medical care policy

- Facility must provide care, without discrimination, for emergency medical conditions to individuals whether or not they are FAP-eligible.
- Emergency medical care policy must prohibit facility from engaging in actions that discourage individuals from seeking emergency medical care (e.g., demanding payment before providing treatment).
Establishing policies

- A FAP and an emergency medical care policy must be adopted by an "authorized body" of the hospital facility.
- A billing and collections policy must also be adopted by an authorized body, if that policy rather than the FAP describes actions that may be taken in the event of nonpayment.
- "Authorized body" of hospital facility:
  - Governing body of the hospital organization
  - Committee of the governing body
  - Other party authorized by governing body to act on its behalf
- Multiple hospital facilities may share identical policies:
  - If accurate for each hospital facility and if any joint policy states that it is applicable to each hospital facility.

FAP implications

- Like the CHNA, the FAP documents are public and likely to be closely scrutinized, so hospitals should ensure that these documents comply with each FAP requirement.
- The list of outside providers and LEP translation requirements may cause significant burden, though there are ways to reduce the burden.
  - Each hospital should develop a practical solution that works for its operations.
  - Translations of FAP documents must also be made widely available and regularly updated.
  - Hospitals may consider providing fewer or different types of financial assistance under FAP to avoid triggering FAP, AGB, and billing and collections requirements.

Sec. 501(r): Billing and collection requirements
Billing and collection requirements
Regulations Under Section 1.501(r)(6) – general rules

- A hospital facility may not engage in extraordinary collection actions (ECAs) against an individual, or another individual responsible for payment of the individual’s bill for hospital care, before making “reasonable efforts” to determine the individual’s eligibility under the FAP.
- Applies to any ECAs taken by:
  - Any purchaser of the individual’s debt
  - Any debt collection agency to which the facility referred debt

Billing and collection requirements
Extraordinary collection actions

Actions taken by hospital facility against an individual to obtain payment of a bill for care covered under its FAP that:
1. Involve selling an individual’s debt
   - Exception: when the sale is pursuant to a legally binding written agreement that restricts purchaser from engaging in ECAs and meets certain other conditions
2. “Defer or denial ECA”: require payment on past unpaid bills for FAP-related care before providing medically necessary care
3. Involve reporting adverse information about individual to consumer credit reporting agencies or credit bureaus
4. Require a legal or judicial process

Referral to a debt collection agency is not an ECA.

Billing and collection requirements
Reasonable efforts

- “Reasonable efforts” to determine whether an individual is FAP-eligible generally include notifying individual about FAP and refraining from initiating ECAs during a “notification period.”
- Notification period:
  - Begins on the date the facility provided the first post-discharge billing statement, ends 120 days later
### Billing and Collection Requirements

#### Notification

- To meet notification requirements before initiating ECAs, the hospital facility generally must have:
  - Provided at least one written notice to the individual disclosing:
    - That financial assistance is available for eligible individuals
    - The ECA(s) the facility intends to initiate (not all actions that may be initiated, as in proposed regulations) against the individual
    - The deadline after which such ECAs may be initiated (no earlier than 30 days after the date of the notice or 120 days after the first post-discharge billing statement, whichever is later)
  - Provided a plain-language summary of the FAP with the above notice
  - Made a reasonable effort to orally notify individual about the FAP and about how he/she may obtain assistance with the application process

#### Application Period

- The hospital facility generally must accept a FAP application from a patient during an “application period,” even if the facility has already initiated ECAs against that individual.
  - Begins on the date care is provided
  - Ends 240 days after the facility provided the first post-discharge billing statement or 30 days after providing written notice of ECAs the facility plans to initiate, whichever is later
  - Must accept a FAP application during the 240-day application period even if the applicant has already submitted an incomplete FAP application during that period

### Timeline of Sec. 501(r) Notification to Satisfy Reasonable Efforts Before Initiating ECAs

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<th>Notification period</th>
<th>Day 0</th>
<th>Day 30</th>
<th>Day 60</th>
<th>Day 90</th>
<th>Day 120</th>
<th>Day 180</th>
<th>Day 210</th>
<th>Day 240</th>
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<td>30-day notice of ECAs</td>
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<td>Ends: generally 120 days after first post-discharge billing statement, unless 30-day notice was not sent timely</td>
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<td>30-day notice of FAP items and intended ECAs required</td>
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FAP application notifications – reasonable efforts

- If an individual does not submit an application during notification period (or later specified deadline in the written notice):
  - Hospital facility will be deemed to have made “reasonable efforts” to determine FAP-eligibility and may engage in ECAs
- If an individual submits an incomplete FAP application during the application period, facility will make reasonable efforts if it:
  - Gives a written notice that describes additional info needed to complete FAP and ECAs that may be taken if the individual fails to respond by a specified due date (after a reasonable period of time)
  - Suspends any ECAs until the individual fails to respond to requests for additional info within the reasonable period of time
- If an individual submits a complete FAP application during the application period, facility will make reasonable efforts if it:
  - Suspends any ECAs if it is taking against the individual
  - Determines (and documents) FAP-eligibility
  - Notifies the individual in writing of the eligibility determination

Billing and collections implications

- If a hospital facility does not engage in ECAs, this section of the regulations is not applicable to it.
- It is essential to provide a notice meeting the requirements of the regulations before engaging in ECAs.
- Presumptively determining that an individual is not FAP-eligible does not constitute reasonable efforts.
- If a hospital refers or outsources its debt collection efforts, or sells an individual’s debt, it must ensure that its agents and/or debt purchasers are complying with these requirements.
- Patient services/financial assistance and revenue cycle/treasury departments should work closely together to coordinate compliance with these requirements.

Sec. 501(r): Limitations on charges
Limitations on charges regulations
Section 1.501(r)(5) – general rule

- A hospital facility must limit the amounts charged to any FAP-eligible individual for care covered under the FAP.
  - In the case of emergency or other medically necessary care:
    - To not more than the amounts generally billed (AGB) to individuals who have insurance covering such care
  - In the case of all other medical care:
    - To less than the gross charges for such care
- The amount “charged” includes the amount a FAP-eligible individual is personally responsible for paying, after all deductions and discounts (including those under the FAP), less any amounts reimbursed by insurers.
  - Regardless of whether or not full amount allowed is actually paid

Limitations on charges
Available AGB calculation methods

- Two acceptable methods for determining AGB:
  1. The look-back method
  2. The prospective Medicare or Medicaid method
- A hospital organization operating more than one hospital facility may select a different method for each of its hospital facilities.
- A hospital facility may change its method at any time, provided it first updates its FAP to describe the new method before implementing.

Limitations on charges
Look-back method

- The look-back method calculates the AGB as follows:
  - Multiply the hospital facility’s gross charges for the care provided by one or more AGB percentages
  - Numerator: the sum of all claims allowed for emergency and other medically necessary care or the sum of all claims allowed [not just for emergency and other medically necessary care] during the prior 12-month period by:
    - Medicare fee-for-service
    - Medicare fee-for-service and all private health insurers that pay claims to the hospital facility
    - Or
    - Medicaid, either alone or in combination with the insurer(s) described above
  - Numerator should include both amounts insurer will pay or reimburse and amount (if any) individual is personally responsible for paying (e.g., co-payments, co-insurance, deductibles)
  - Denominator: the sum of the associated gross charges for those claims
  - AGB must be calculated at least annually under this method
Limitations on charges

Look-back method

- Under the look-back method, the AGB percentage may be:
  - One average percentage of gross charges for all care, or for all emergency and other medically necessary care, provided by the hospital facility
  - Multiple AGB percentages for separate categories of care, or for separate items or services
- Hospital facilities covered under the same Medicare provider agreement may calculate their AGB percentage(s) based on all claims and gross charges for all such facilities, and apply such percentage(s) across all such facilities.
- Start date: facility must begin using AGB percentage by the 120th day after the end of the 12-month period for which it is calculated.

Limitations on charges

Prospective Medicare or Medicaid method

- AGB is determined by using the billing and coding process that would be used if the FAP-eligible individual were a Medicare fee-for-service and/or Medicaid beneficiary.
- A hospital facility may base AGB under this method on Medicare fee-for-service, Medicaid or both, provided that if it uses both, its FAP must describe the circumstances under which the facility will use Medicare fee-for-service or Medicaid to determine AGB.

Limitations on charges implications

- Hospitals should perform a cost-benefit analysis to determine whether it is necessary to maximize their AGB percentage(s).
- If an individual is charged more than AGB and is later determined to be FAP-eligible, excess amounts of $5 or more need to be refunded.
- Hospitals should carefully define for what time periods an individual is FAP-eligible, otherwise refunds for all prior care might be required.
- Prepayment/deposit amounts should always be below AGB for that service, in case the individual paying is later determined to be FAP-eligible.
Failure to meet Section 501(r) requirements

A hospital facility’s failure to meet any Section 501(r) requirement could cause the hospital facility to be taxable and could jeopardize the hospital organization’s overall Section 501(c)(3) exemption.

A hospital facility’s failure to meet any CHNA requirement could also cause liability for a $50,000 excise tax.

Minor omissions and errors

An omission or error will not be considered a “failure” to meet a Section 501(r) requirement if:

- The omission or error was minor and either inadvertent or due to reasonable cause
- The hospital facility promptly corrects the omission or error
  - As part of correction, the facility must establish (or review and, if necessary, revise) practices or procedures reasonably designed to promote and facilitate Section 501(r) compliance.
Failure to meet Section 501(r) requirements

Where the exception for minor errors does not apply, a failure that is neither willful nor egregious will be "excused" for purposes of Section 501(r)(1) if the organization:
- Corrects the failure
- Makes proper disclosure
- A failure that is willful includes a failure due to gross negligence, reckless disregard or willful neglect.
- Specific correction and disclosure procedures are contained in Rev. Proc. 2015-21.

Disclosure

A failure is disclosed if the hospital facility reports on Form 990 Schedule H for the tax year when the failure is discovered:
- A detailed description of the failure
- A description of the correction made, including:
  - The method of correction
  - The date of correction
  - How persons affected by the failure were restored to their prior position and if some were not, why not
  - A description of any practices and procedures that were revised, or an explanation of why revisions were not needed

Taxation of noncompliant hospital facilities

Hospital organizations operating more than one hospital facility – income from a 501(r) noncompliant hospital facility will be subject to corporate income tax.
- Report facility-level income tax on Form 990-T
- Hospital facility may also be liable for $50,000 excise tax for failing to complete a CHNA.
- Report on Form 4720
- Noncompliance will not, by itself, result in the operation of the facility to be considered an unrelated trade or business described in Section 513.
- And therefore should not affect the exempt status of tax-exempt bonds issued to finance the noncompliant hospital facility
Failure and correction implications

- Some 501(r) noncompliance is inevitable, but the consequences of noncompliance can be mitigated.
- To avoid or minimize penalties, hospitals should ensure that they have excellent documentation of practices and procedures that demonstrate:
  - A good-faith attempt to implement and comply with all requirements
  - Processes for monitoring ongoing compliance
  - Processes to identify and correct any failures that do occur
- A hospital facility should promptly correct all errors and omissions that may constitute noncompliance with 501(r).
- If an error or omission is not clearly both minor and either inadvertent or due to reasonable cause, a hospital facility should promptly correct it and disclose it.

Thanks for listening! Questions?

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