SUMMARY OF SECTION 501(r) FINAL RULE
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Executive Summary

The IRS issued a final rule on December 31, 2014 implementing additional requirements for hospitals to maintain exemption from federal income tax under Section 501(c)(3) as required under the Affordable Care Act (ACA) and outlined in Section 501(r) of the Internal Revenue Code. The rules encompass Community Health Needs Assessments (CHNAs); Financial Assistance Policies; Limitation on Charges; and Billing and Collections.

The rule is applicable to governmental hospitals that also have Section 501(c)(3) status even though they are not required to file IRS Form 990. Failure to meet the requirements for conducting CHNAs could result in a $50,000 excise tax and failure to meet the remaining sections could result in loss of exempt status. Hospitals have had to comply with the CHNA provisions of Section 501(r) since 2012, and the remaining provisions since 2010. The requirements now outlined in this rule are applicable for taxable years beginning after December 29, 2015. For periods before this date, hospitals may rely on a reasonable, good faith interpretation of section 501(r) and goes on to provide a safe harbor for deemed compliance if it has complied with the provisions of the proposed or final rule.

The requirements regarding financial assistance, charge limits, and billing and collections are voluminous, detailed and have significant changes from the 2012 proposed rule. For example, while some requirements for billing during the 120-day notification period have been eliminated, there is now a requirement that policies list providers performing emergency services at the hospital and whether or not they are covered under the hospital's financial assistance policy. CHNA requirements overall remain the same as issued in the 2013 proposed rule, with the final rule providing further clarification and some changes in response to comments.

The rule specifically rejects IHA and others' recommendations that states that have passed laws addressing many of these same issues be deemed in compliance with the federal law for those specific issues, e.g., Illinois' Hospital Uninsured Patient Discount Act discounts compared to the Amounts Generally Billed discount. The reasoning was that state laws vary, and this would result in divergent rules for hospitals in different states; IRS revenue agents would need to learn each state's laws; and the state laws do not match the federal law. The IRS notes that the federal regulations are minimum requirements, and hospitals are always able to be more generous and also will need to comply with any state laws that may have additional or stricter requirements.

IHA will develop guidance for hospitals to help navigate the interaction between this rule and Illinois laws (Hospital Uninsured Patient Discount Act and Fair Patient Billing Act). Below is a summary of provisions contained in the final 501(r) rule.

Organizations Subject to Rule
The ACA, enacted March 23, 2010, added a new Section 501(r) to the Internal Revenue Code for hospital organizations to be treated as tax-exempt for purposes of federal income tax under Section 501(c)(3). A hospital organization is defined as an organization that operates one or more hospital facilities, defined as licensed by the state as a hospital. Multiple buildings operated by a hospital under a single state license are considered a single hospital facility, even if serving different geographic areas or populations.

Section 501(r) did not provide an exemption for government hospitals that also have section 501(c)(3) status, so these hospitals need to comply with the final rule, including making their CHNA reports and financial assistance policies widely available on a website (even though they are not required to file IRS Form 990). A governmental hospital that does not want to comply with the requirements may submit a request to voluntarily terminate their section 501(c)(3) recognition.

The final rule provides clarification regarding organizations that own capital or profit interest in hospital facilities. Also, in response to a question regarding applicability to hospital-owned physician practices, the final rule responds that it depends on how the entity is classified for federal tax purposes. If it is a separate taxable corporation, it would not need to comply; but if it is disregarded as separate from the hospital for federal tax purposes, than it is considered as part of the hospital and must comply. If emergency or medically necessary care is provided in a hospital by a partnership which the hospital has a capital or profits interest, and it is not an unrelated trade or business with respect to the hospital organization, the entity needs to comply. Please note that the requirements pertaining to financial assistance policies discussed later in this document include a specific discussion about emergency room physician practices and whether they are covered by the hospital's financial assistance policy.

Various requirements need to be adopted by an "authorized body," defined as the board, a committee of or one authorized by the board. The rule allows that a single individual may constitute either a committee of the governing body or a party authorized by the governing body to act on its behalf.

Failure to Satisfy Section 501(r) Requirements
The rule includes a discussion regarding errors that might occur even if appropriate policies and safeguards are in place. It allows that a hospital's failure to meet one of the requirements that is neither willful nor egregious would be excused if the hospital makes the correction and then makes disclosure. An option for correction without disclosure will be available if the omission or error is minor and either inadvertent or due to reasonable cause. The IRS states that all relevant facts and circumstances will be considered in

determining whether to revoke a hospital's tax-exempt status. If a hospital fails to meet the CHNA requirement and is assessed a tax, it would not, by itself, affect the status of tax-exempt bonds.

Community Health Needs Assessment (CHNA)
As provided in the ACA, hospitals must conduct a CHNA every three years and an authorized body of the hospital must adopt an implementation strategy to meet the health needs identified in the CHNA. The rule provides further guidance for hospitals that are new, newly acquired or newly subject to 501(r).

Conducting a CHNA – The final rule requires the solicitation and consideration of input from persons representing the broad interests of the community each time with each CHNA, even if the CHNA builds upon a previously conducted CHNA. The CHNA must include the following:

- Community Served – Hospitals have broad flexibility to define the communities they serve or intend to serve, taking into account all relevant facts and circumstances, provided they do not exclude medically underserved, low-income or minority populations.
- Assessing Health Needs – A list of examples of significant health needs a hospital may consider in the CHNA is expanded. Hospitals have flexibility to choose how to prioritize the health needs, but must take into account community input both in identifying and prioritizing significant health needs. The CHNA must identify resources potentially available to address significant health needs.
- Input from the Community – The CHNA must take into account input from at least one state, local, tribal, or regional governmental public health department; members of medically underserved, low-income and minor populations or those representing those populations; and written comments received on the most recently conducted CHNA and implementation strategy. Hospitals that solicited, but could not obtain this input, must document their reasonable efforts to do so in the CHNA. Hospitals may choose to post a draft CHNA for public comment without triggering the start of a hospital's next three-year CHNA cycle. Hospitals can develop their own system for receiving and tracking written comments from the community.
- Documentation of a CHNA – A hospital must document in its CHNA report that it is adopted by an authorized body of the hospital and include the following:
    - Definition of the community served and how it was determined;
    - Process and methods used to conduct the CHNA;
    - How community input was taken into account;
    - Prioritized description of the significant health needs identified and how determined;
    - Potential resources to address the significant health needs; and
    - Evaluation of the impact of any actions taken to address significant health needs from prior CHNAs.

The process and methods section should describe the data and other information used in the assessment, as well as the methods of collecting and analyzing this data and information, identifying any party with whom the hospital collaborated or contracted for assistance in conducting the CHNA. The final rule allows hospitals to rely on data collected or created by others and to cite the data sources rather than describe the data collection methods.

Collaboration on CHNA reports – Hospitals are permitted to collaborate with other organizations, and sections of their respective reports may be substantively the same. Collaborating hospitals that define their communities as the same ones may conduct and issue joint CHNAs, but the rule also allows a hospital to identify a significant health need that is more localized. The rule clarifies that joint CHNA reports must contain all of the same basic information that separate CHNAs must contain. It permits hospitals with different but overlapping communities to collaborate in conducting a CHNA and to include substantively identical portions in their separate CHNA reports if appropriate. This also allows joint and/or substantively identical sections of reports with public health departments.

- Widely Available to the Public – Hospitals must post their CHNA reports on a website and make a paper copy available for public inspection upon request without charge for two subsequent CHNA reports.

Implementation Strategies – The implementation strategy is a written plan that describes how the hospital plans to address or not address each significant health need identified in the CHNA. Additional needs identified through other means may be included. Hospitals must take into account comments on previously adopted implementation strategies when conducting subsequent CHNAs. The implementation strategy needs to be attached to the Form 990 or include the URL of the web page where it is posted.

- Description of Needs Addressed/Not Addressed – The implementation strategy must describe the actions the hospital intends to take, the anticipated impact, and an evaluation of the impact of actions taken since the preceding CHNA; identify the programs and resources plan to be committed to address the need; and describe any planned collaboration with other organizations to address the need. Additional examples of health needs that could be identified are provided, such as illness prevention, adequate nutrition, and social, behavioral and environmental factors influencing community health. Examples of reasons a hospital may not address an identified need may include resource constraints, lack of expertise, low priority assigned to the need, lack of identified effective interventions, and if the need is being addressed by others.
- Joint Implementation Strategies - Joint implementation strategies are allowed if the following conditions are met: clearly identify as applying to the hospital; identify the hospital's particular role and responsibilities in taking described actions and

resources the hospital will provide; and a summary that helps easily locate those portions of joint strategy that pertain to the hospital.

- Due Date – Implementation strategies need to be adopted by the authorized body on or before the 15th day of the fifth month after the end of the taxable year (same deadline as Form 990 without extension) in which the hospital finishes conducting the CHNA. This deadline remains even if the hospital receives an extension to file the 990.

Reporting Requirements - Hospitals must provide the following with its annual Form 990: a description of how it is addressing the health needs identified for each hospital operated or the reasons if not addressed; audited financial statements; and the amount of excise tax imposed during the taxable year.

Financial Assistance Policies (FAP)

Hospitals must have a written policy

- That applies to all emergency and other medically necessary care provided by the hospital;
- That is widely publicized; and
- Includes the eligibility criteria for financial assistance (FA), basis for calculating amounts charged to individuals, method for application, actions for nonpayment (if not in separate policy), sources for determinations is other than FAP application, and a list of providers delivering care in the hospital and whether they are covered under the FAP or not.

Eligibility Criteria and Application

The FAP must specify:

- All FA available under the FAP (discounts, free care or other);
- Eligibility to qualify for each discount, free care or other;
- Method to determine "amounts generally billed" (AGB) to those with insurance, and what the percentage discount would be or how the public can obtain the percentage; and
- That an FAP-eligible individual will not be charged more than AGB for emergency or other medically necessary care.

The final rule requires the FAP to "list the providers, other than the hospital facility itself, delivering emergency or other medically necessary care in the hospital facility and to specify which providers are covered by the hospital facility's FAP (and which are not)". If a hospital outsources the operation of the emergency room to a third party, and the care provided by the third part is not covered under the hospital's FAP, the hospital is not considered to operate an emergency room for purposes of the factors considered in Revenue Ruling 69-545 that gives examples illustrating whether a nonprofit hospital is operated to serve a public interest.

Hospitals are allowed to have discounts (e.g., self-pay) outside of their FAP, and therefore outside of the amounts generally billed requirement, but such discounts are not allowed to be reported as financial assistance on Schedule H of Form 990 nor for purposes of whether a hospital is considered under section 501(c)(3).

The FAP must describe how an individual applies for financial assistance (FA) and what information or documentation must be submitted as part of the application. FA may not be denied based on lack of information if such information was not required in the FAP or FAP application form. Hospitals are able to include statements in the FAP pertaining to an individual's obligation to cooperate. Hospitals may grant FA based on evidence other than that obtained through a FAP application, but need to describe in its FAP such sources and whether and under what circumstances it uses prior FAP-eligibility determinations for presumptive determinations. Hospitals are able to obtain information from an individual orally for FAP application purposes.

Hospitals that are part of a system may have identical FAPs, billing and collections policies and/or emergency medical care policies (or one joint policy document) as long as it is clear it applies to each hospital. Also note that individual hospitals may have differing AGB percentages.

<u>Actions for Non-Payment</u>
The FAP needs to include:

- Actions that may be taken in the event of non-payment if the hospital does not have a separate established billing and collections policy. Established means the policy has been adopted by the governing body or party authorized by the governing body.
- The process and time frames the hospital uses in taking actions including the reasonable efforts it will make to determine whether an individual is FA-eligible before taking extraordinary collection actions (ECAs). The FAP must state if the actions for nonpayment are described in a separate policy and explain how the public may readily obtain access to a free copy.
- The office, department, committee, or other body with the authority to determine that reasonable efforts have been made to determine FAP-eligibility before ECAs are taken.

<u>Widely Publicizing the FAP</u>
For the FAP to be considered "widely available," a hospital must:

- Make the FAP, application form and plain language summary of the FAP prominently available on a website.
- Make paper copies of the FAP, application form and plain language summary available for free upon request in the emergency room and admissions area as well as by mail.

- Notify and inform the community in a way calculated to reach those most likely to need FA. The rule preamble states this means to affirmatively reach out to community members to notify and inform, and provides examples of how this could be accomplished.
- Notify and inform individuals receiving care at the hospital about FAP by:
    - Offering a paper copy of the plain language summary as part of the intake or discharge process;
    - Including a conspicuous written notice on billing statements about the availability of FA with phone numbers of contacts that can provide information and the website where copies of the FAP, application and plain language can be obtained; and
    - Setting up conspicuous displays in public locations including the emergency room and admissions area.
- Accommodate all significant populations that have limited English proficiency by translating the FAP, application form and plain language summary into the primary languages spoken by each language group that constitutes the lesser of 1000 individuals or 5% of community served or likely to be encountered.
- The plain language summary must include contact information (including physical location) of a source of assistance with FAP application, which can be either the hospital itself or a different organization.

<u>Emergency Medical Care Policy</u>
A hospital is required to have a written policy that that hospital provides, without discrimination, care for emergency medical conditions to individuals, regardless of whether they are FAP-eligible. It must prohibit engaging in actions that discourage individuals from seeking emergency medical care, such as demanding that ER patients pay before receiving treatment or permitting debt collection activities that interfere with the provision of the care. The rule provides that a hospital in compliance with EMTALA (see CMS Memorandum S&C-14-06 issued Dec. 13, 2013 for further information on prohibited activities) will likely not be engaging in activities prohibited under the law. Clarification is provided that this does not prohibit all payment activities in the ER, such as collection of co-pays after stabilization or discharge. This required written policy may be included within the same document as the FAP or in an already existing document related to emergency medical care.

Limitation on Charges – Amounts Generally Billed (AGB)

Hospitals are required to limit the amount charged to a FAP-eligible individual for emergency or other medically necessary care to not more than the amount generally billed to those with insurance and limited to less than gross charges for all other medical care covered under the FAP.

- The AGB can be determined under: a look-back method that includes all claims of

- Medicare fee-for-service;
- Medicare plus all private health insurers;
- Medicare, private insurance and Medicaid claims; or
- Medicaid alone.

Alternately, a prospective method may be utilized that includes using the billing and coding process the hospital would use if the FAP-eligible individual were a Medicare fee-for-service patient or a Medicaid patient, and setting the AGB at what would be the total amount Medicare or Medicaid would allow for the care, including the patient's personal responsibilities.

Medicaid managed care claims are considered Medicaid, but Medicare Advantage claims are considered as private health insurance.

- The calculation under the look-back method divides total claims paid in full by the gross charges associated with those claims. Hospitals can do this on an aggregate basis for all emergency and medically necessary care or by categories such as inpatient, outpatient or departmental.
- Paid in full is defined as the amount "allowed" by health insurers during the prior 12-month period. This includes both the amount to be reimbursed by the insurer and the amount owed by the individual, regardless of whether actually paid and disregarding any discounts applied to their portion.
- Claims to be counted are based on whether the claim is allowed during the prior 12-month period, not whether the care was provided during that time.
- Hospitals may include all claims, not just emergency and medically necessary care, in the calculation, but the IRS assumes there would not be a significant difference.
- Hospitals are allowed to include value-based care claims if they can reasonably allocate a capitated payment by an insurer to care received by particular individuals during the period, and has tracked gross charges for that care. The IRS also will continue to consider alternative methods for determining AGB.

- The AGB applies to any FAP-eligible individual, both insured and uninsured, but the amount charged is only the amount the individual is personally responsible for paying, after all deductions and discounts have been applied and less any amounts reimbursed by insurers. So the AGB limit for an FAP-eligible insured individual (what they are responsible for paying) is no more than the AGB after all reimbursements by the insurer have been made. Hospitals are allowed to charge an individual less than AGB.
- Hospitals may change the method used to determine AGB at any time, but must update its FAP to describe the method prior to implementing it. Hospitals within a system may choose different methods.
- Hospitals must calculate the AGB based on individual hospital claims and charges and not system-wide, unless multiple hospitals are covered under the same Medicare provider number.

- Hospitals have up to 120 days after the end of the 12-month period used in calculating the AGB percentage to begin applying the new percentage. The FAP must be updated to reflect new AGB percentages.
- The prohibition of gross charges applies only to FAP-eligible individuals.
- There is a safe harbor for hospitals that charged more than AGB to a FAP-eligible individual if the hospital refunds any amounts paid in excess of the amount the individual should have paid under the FAP and they submit an application.

Billing and Collections

This section was modified from the proposed rule to require fewer specific requirements during the 120-day notification period, but includes specific notices to individuals 30 days prior to specific collection actions. The 240-day period remains as the timeframe in which a hospital must accept and process an application for financial assistance. It also stipulates that hospitals must widely publicize the availability of financial assistance (see above section regarding widely publicizing the FAP).

Hospitals are prohibited from engaging in extraordinary collection actions (ECAs) to obtain payment before making reasonable efforts to determine whether the individual is FAP-eligible for care. This is only applicable to individuals and not applicable to third-party payers. "Reasonable efforts" requires certain notifications and waiting for at least 120 days after the first post-discharge billing statement before initiating ECAs.

<u>Extraordinary Collection Actions (ECAs)</u>
ECAs are defined as actions that:

- Involve selling an individual's debt to another party;
- Involve reporting adverse information about an individual to a consumer credit reporting agency or bureau;
- Involve deferring or denying or requiring payment before providing medically necessary care because of nonpayment for prior bills covered under the hospital's FAP (considered an ECA due to the past-due bills, not the current care sought);
- Require a legal or judicial process, such as:
    - Placing a lien on an individual's property. However, liens against proceeds of settlements, judgments or compromises arising from a suit against a third party will not be considered an ECA;
    - Foreclosing on an individual's real estate property;
    - Attaching or seizing a bank account or other personal property;
    - Commencing a civil action against an individual;
    - Causing an individual's arrest;
    - Causing an individual to be subject to a writ of body attachment; or
    - Garnishing an individual's wages.

Filing a claim in a bankruptcy proceeding is not considered an ECA. The final rule makes provision that the sale of debt is not an ECA if prior to the sale, the hospital has a legally

binding written agreement with the purchaser containing four conditions: the purchaser must not engage in ECAs to obtain the debt; no interest is charged in excess of a certain rate; the debt must be returned if the individual is found FAP-eligible; and if FAP-eligible debt is not returned, the purchaser ensures the individual does not pay more than what they would under the FAP.

Notification and Application Periods

A hospital will have notified an individual if at least 30 days before first initiating one or more ECAs, it:

- Provides a written notice that FA is available and identifies the ECA that may be initiated within 30 days;
- Provides a plain language summary of the FAP;
- Makes a reasonable effort to orally notify the individual about FAP and how to obtain assistance with the application process.

Written notification may be made electronically to individuals that indicate they prefer that method. The final rule eliminates any separate requirement regarding documenting notification, but hospitals are responsible for maintaining records to substantiate information required by the Form 990.

Hospitals are free to accept FAP applications for whatever time period they choose, but must accept and process such applications for a minimum of 240 days from the first post-discharge bill. This time period could be longer if the notification process regarding potential ECAs was delayed.

Hospitals may satisfy the notification requirements simultaneously for multiple episodes of care for notifying the individual about FAP and potential ECAs. However, it may not initiate ECAs until 120 days after it provided the first post-discharge bill for the most recent episode of care.

Hospitals must provide written documentation to individuals determined to be eligible for free care, but a zero billing statement is not necessary.

Incomplete and Complete Applications

- Hospitals must suspend ECAs against an individual that submits an incomplete FAP application until either the application is completed and the hospital makes a determination whether they are FAP-eligible, or until a reasonable time period has elapsed during which the individual has not responded with additional information.
- Hospitals must provide notice about potential ECAs and an accompanying plain language summary of the FAP to an individual who has submitted an incomplete application as well as contact information for further assistance with the application process.
- The hospital has made reasonable efforts to determine FAP-eligibility if upon receipt of a complete application it suspends any ECAs and notifies the individual

in writing of the FAP determination. If the individual is FAP-eligible for less than free care, the hospital will provide a billing statement indicating how much is owed, how the amount was determined and how to get further information regarding AGB; provides a refund of any amounts paid in excess of the FAP-determined amount; and takes reasonably available measures to reverse any ECA.

- Receipt of a completed FAP application and the above steps fulfills the notification requirements.
- A hospital may postpone a FAP determination until a Medicaid eligibility determination has been made if the hospital believes they may qualify.
- Obtaining a signed waiver from an individual that they do not wish to apply for FA does not satisfy the reasonable efforts requirement.

Agreements with Other Parties

With the exception of the sale of debt and appropriate steps outlined above, a hospital that sells or refers debt to another party needs to have a legally binding written agreement to ensure no ECAs are taken until the requirements regarding FAP-eligible determinations are followed.

Presumptive Eligibility

- Hospitals are allowed to utilize presumptive eligibility sources to determine an individual is eligible for both free care or for less generous assistance. If eligible for less than the most generous assistance, the hospital must notify the individual regarding the basis for the determination and how they can apply for more generous assistance, provide a reasonable time period to apply for additional assistance and process any complete FAP application by the end of the application period.
- Hospitals may not make a presumptive determination or use a waiver form to determine that an individual is not FAP-eligible.

IHA will develop guidance for hospitals to help navigate the interaction between this rule and Illinois laws (Hospital Uninsured Patient Discount Act and Fair Patient Billing Act). If you have questions, please contact Sandy Kraiss at skraiss@ihastaff.org or 630-276-5522.