IRS Issues Proposed Regulations for Charitable Hospitals to Meet New Section 501(r) Requirements

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SUMMARY

In its Proposed Regulations, the IRS covers most of the new requirements for charitable hospitals under Section 501(r) including financial assistance policies, limitations on charges, billing and collections and emergency care policies. It also provides some guidance on the definitions of "hospital facility" and "hospital organization." It does not provide additional guidance regarding community health needs assessment, although interim guidance was provided in Notice 2011-52.

BACKGROUND

The Patient Protection and Affordable Care Act of 2010, as amended ("ACA") added new section 501(r) to the Internal Revenue Code ("Code") which imposes additional requirements on hospital organizations in order to be exempt under section 501(c)(3) of the Code. The new law requires charitable hospitals to conduct a community health needs assessment ("CHNA") every three years and adopt an implementation strategy to address those needs. They also require the hospital to maintain a financial assistance policy, limiting charges to those eligible for financial assistance and requiring reasonable efforts to determine an individual’s eligibility for financial assistance before engaging in extraordinary collection actions, and an emergency care policy. The Proposed Regulations provide guidance on all of those requirements except for the CHNA.

DEFINITION OF "HOSPITAL" AND "HOSPITAL ORGANIZATION"

The Proposed Regulations define a "hospital facility" as a facility that is required by a state to be licensed, registered or similarly recognized as a hospital. The Proposed Regulations also provide that a single hospital facility may be operated in multiple buildings as long as it is operated under a single license. Future guidance will address whether operations in a single building under more than one state license are treated as one or more hospital facilities. The Proposed Regulations do not provide much clarity regarding the definition of a "hospital organization," other than to say that it means an organization described in section 501(c)(3) that operates one or more hospital facilities.

FINANCIAL ASSISTANCE POLICY ("FAP")

The statute states that a hospital must have a written financial assistance policy which includes: (1) eligibility criteria for financial assistance and whether such assistance includes free or discounted care, (2) the basis for calculating amounts charged to such patients, (3) the method for applying for financial
assistance, (4) in the case of an organization that does not have a separate billing and collection policy, the actions the organization may take in the event of nonpayment, and (5) measures to widely publicize the policy within the community to be served by the organization.

The following are some of the highlights of the Proposed Regulations.

**Eligibility Criteria.** No particular criteria are required, but the FAP must specify the financial assistance available (discounts and free care) and all eligibility criteria for each level of assistance. If the FAP provides for a discount, it must specify the amount to which the discount applies. The FAP must also state that an eligible individual will not be charged more than the "amount generally billed" ("AGB"), as discussed below, and the method by which the AGB was determined.

**Method for Applying Financial Assistance.** The FAP must describe how an individual may apply for assistance. The FAP or the application for financial assistance must describe the information and documentation required and contact information to be used to obtain assistance with the application process.

**Actions that May be Taken in the Event of Non-Payment.** The FAP, or a separate written billing and collection policy, must describe the actions the hospital may take to obtain payment for a bill, including any extraordinary collection actions ("ECA"), as discussed below. The FAP or policy must include a description of the process and timeframes for those actions, including any reasonable efforts to determine eligibility for financial assistance. Finally, the policy must describe who has the final authority to determine if the hospital has made "reasonable efforts" to determine whether the individual is eligible for financial assistance and may therefore engage in ECA against the individual.

**Widely Publicizing the FAP.** The FAP must include the following four (4) types of measures to widely publicize the FAP. The hospital may either summarize the measures in the FAP or explain in the FAP how to obtain a free summary of the measures. The four measures are:

1. Make proper copies of the FAP, the FAP application and a plain language summary available upon request, without charge, both in public locations in the hospital and beyond. The documents must be in English and in the primary language of any group that constitutes more than 10 percent of the residents of the community served by the hospital.

2. Inform visitors about the FAP through a conspicuous public display at the hospital.

3. "Inform and notify" members of the community about the FAP in a manner reasonably calculated to meet the needs of those members of the community most likely to require financial assistance.

4. Post on its website or on a website established and maintained by another entity complete and correct versions of the FAP, the FAP application form and a plain language summary of the FAP, both in English and in the primary language of groups that constitute more than 10 percent of the residents of the community. A person with Internet access must be able to download, view and print a hard copy of the documents without special hardware or software.

Preston J. Quesenberry, the principal draftsman of the proposed regulations and a senior technical reviewer in the Exempt Organizations Branch of the IRS Office of Chief Counsel told attorneys attending the American Health Lawyers Association’s annual meeting on June 25, 2012 the IRS is aware that some hospitals have developed systems by which patients are presumed eligible for the institution’s FAP. Quesenberry stated the IRS is interested in examples that are effective and potentially more efficient than the eligibility process outlined in the Proposed Regulations.

**EMERGENCY MEDICAL POLICY**

A policy that meets the requirements of the Emergency Medical Treatment and Labor Act will generally satisfy that requirement. The Proposed Regulations do add that the hospital must prohibit debt collection activities from occurring in the emergency department or in other hospital areas where such activities could interfere with the treatment of emergency medical conditions.
ADOPTION AND IMPLEMENTATION OF POLICIES

According to the Proposed Regulations:

(1) The FAP and other policies must be adopted by an "authorized body" (e.g., a board, a committee of the board with delegated authority or management executive with such authority).

(2) A policy will have been implemented if it is consistently carried out.

(3) A hospital organization operating multiple hospital facilities must separately establish policies for each hospital facility, although such policies may be identical.

LIMITATION ON CHARGES

The statute requires that the amount charged to individuals eligible for financial assistance not be more than amounts generally billed to individuals who have insurance coverage, and the Proposed Regulations require the hospital to limit the charges to such individuals to less than the gross charges for such care.

Amounts Generally Billed ("AGB")

The Proposed Regulation provides two methods to determine AGB – a "look-back" method based on actual past claims paid to the hospital or a "prospective" method based on the estimated Medicare fee-for-service amount.

*Look-back* Method

Under this method, the hospital has the option of calculating annually the amount paid over the previous 12-month period by all private health insurers and Medicare fee-for-service or only Medicare fee-for-service. The AGB must be calculated within 45 days after the end of the 12-month period.

*Prospective* Medicare Method

Under the prospective method, the hospital may charge the same amount it would be paid by Medicare and the Medicare beneficiary under a fee-for-service arrangement using the same billing and coding process as if the individual were a Medicare fee-for-service beneficiary.

Gross Charges

The Proposed Regulations define "gross charge" (or chargemaster rate) as a hospital’s full, established price for medical care that it consistently and uniformly charges all patients before applying any contractual allowances, discounts or deductions. The Proposed Regulations clarify that the gross charges prohibition contained in the statute applies only to individuals eligible for financial assistance and that it is permissible to show the gross charge on a bill as long as it is not the amount charged.

BILLING AND COLLECTION

The statute requires that a hospital not engage in "extraordinary collection actions" before it has made "reasonable efforts" to determine whether an individual is eligible for financial assistance.

Extraordinary Collection Activities

The Proposed Regulations provide that ECAs include any action taken by a hospital to obtain payment for care covered under the hospital’s FAP that require a legal or judicial process. Such actions include but are not limited to the following:

(1) Reporting to a credit agency
(2) Sale of the debt to another party
(3) Placing a lien on an individual’s property
(4) Foreclosing on an individual’s real property
(5) Attaching or seizing an individual’s bank account or any other personal property
(6) Commencing civil action against an individual
(7) Causing an individual’s arrest
(8) Causing an individual to be subject to a writ of body attachment
(9) Garnishing an individual’s wages

Notably absent from this list are the following:

(1) Referring the debt to a collection agency (where the debt is not sold)
(2) Deferring or denying care based on a pattern of nonpayment, requiring deposits before providing care, or charging interest

The Proposed Regulations do not require approval by a hospital's governing body before engaging in ECAs.

**Reasonable Efforts**

The Proposed Regulations provide that a hospital will have made reasonable efforts to determine whether an individual is eligible for financial assistance if it:

(1) Notifies the individual about the FAP;

(2) In the case of an individual who submits an incomplete application, provides the individual with information to complete the application;

(3) In the case of an individual who submits a complete application, makes and documents a determination as to eligibility.

**Notice Periods**

The Proposed Regulation creates two notice periods:

(1) A "notification period" which begins on the date of service of the care and ends on the 120th day after the hospital provides the individual with the first bill for the care. The hospital must notify the individual of the FAP during this period.

(2) An "application period" which ends on the 240th day after the hospital provides the individual with the first bill for the care. The hospital must accept and process applications during this period.

In order to satisfy the notification component of "reasonable efforts," the Proposed Regulations require a hospital to:

(1) Give a plain language summary of the FAP, and offer an application to the individual before discharge;

(2) Provide the FAP notice with all (and at least three) billing statements and then have at least 30 days after the third billing statement to apply before ECAs are initiated;

(3) Include a plain language summary of the FAP with all billing statements and all other communications regarding the bill during the notification period;

(4) Inform the individual about the FAP in all oral communications regarding the amount due during the notification period; and

(5) Provide the individual with at least one written notice that informs the individual about the ECA that the hospital may take if an application is not submitted or the amount due paid by the last day of the notification period. This notice must be provided at least 30 days before the deadline.

**Other Provisions Related to "Reasonable Efforts"**

In addition to the rules outlined above, the Proposed Regulations also contain a list of requirements for the plain language summary of the FAP and discuss the procedures for handling incomplete applications as well as complete applications, requiring suspension of ECAs in some circumstances. The Proposed Regulations also contain special provisions that apply if the hospital either refers the debt to a collection agency or sells the debt to another party. **Note, however, that a waiver or other signed statement by an individual that he/she does not want to apply for financial assistance or to receive notices will not satisfy the requirement that the hospital make reasonable efforts to determine financial eligibility.**

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