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IRS Issues Final Regulations for Charitable Hospitals

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The Affordable Care Act ("ACA"), which was enacted in 2010, added Section 501(r) to the Internal Revenue Code (IRC). Section 501(r) imposes additional requirements for hospital facilities of hospital organizations that are exempt under IRC Section 501(c)(3) (i.e., Section 501(r) does not repeal or modify current exemption requirements). Final regulations were issued on December 29, 2014, which provide some clarification of the previously issued proposed regulations. Importantly, the final regulations provide a delayed effective date—hospitals must comply with the final regulations beginning on the first day of their first tax year beginning after December 29, 2015. For tax years prior to December 29, 2015, a hospital facility may rely on a reasonable, good faith interpretation of 501(r).

The following discussion provides added detail regarding the clarifications and revisions in the final regulations (Section I) and concludes with proposed action steps for tax-exempt hospital organizations (Section II).

I. Overview: Clarifications and Revisions in the Final Regulations.

Hospital Organizations and Facilities:

The final regulations define a hospital facility as "a facility that is required by a state to be licensed, registered or similarly recognized as a hospital." A hospital facility includes a facility operated through a disregarded entity. Multiple buildings under one state license constitute a single hospital facility. In addition, operations in a single building under more than one state license constitute multiple hospital facilities. Although the Section 501(r) requirements apply on a facility by facility basis, it should be noted that the facilities can collaborate in certain of the 501(r) requirements so long as the collaboration is appropriate (e.g., the facilities may have the same FAP). Such collaboration alleviates the Section 501(r) compliance burden. Finally, governmental hospitals that are (or want to be) recognized by the IRS as exempt under Section 501(c)(3) are subject to the requirements of Section 501(r). A governmental hospital that wants to avoid the application

of Section 501(r) can terminate its 501(c)(3) status using the procedures provided in Revenue Procedure 2014-4.

Section 501(r) does not apply to taxable operations or organizations, so a hospital organization does not have to meet the Section 501(r) requirements with respect to any activities that constitute an unrelated trade or business described in Section 513 with respect to the hospital organization. Similarly, a hospital facility does not have to meet the Section 501(r) requirements with respect to taxable corporations that provide care in the facility, even if the corporation is wholly or partially owned by the hospital organization (e.g., physicians' practices).

A hospital organization "operates" a hospital facility if it owns a capital or profits interest in a partnership or LLC that operates the facility. Thus, a hospital organization cannot avoid the application of Section 501(r) through one or more lower-tier entities treated as partnerships. The governing body of a partnership or disregarded entity is an "authorized body" of its hospital facility, but a committee of such a governing body may also be an authorized body to the extent permitted under state law.

Failure to Meet the Section 501(r) Requirements:

The final regulations provide that an error or omission will not be considered a "failure" to meet a Section 501(r) requirement or jeopardize a hospital facility's exemption (and disclosure will not be required) so long as the error or omission is minor, inadvertent or due to reasonable cause; and the hospital facility promptly corrects the omission or error. The final regulations add a requirement that the facility establish practices or procedures reasonably designed to promote and facilitate Section 501(r) compliance. So long as a failure to meet a Section 501(r) requirement is not willful or egregious and the facility corrects and discloses the error, the failure should be excused. The final regulations also provide that failure by a hospital facility to meet its community health needs assessment (CHNA) requirement is not subject to the $50,000 Section 4959 excise tax if its error or omission was minor and either inadvertent or due to reasonable cause, and it promptly corrected the error or omission. Again, no disclosure is required.

The final regulations clarify that noncompliance will not necessarily result in the operation of the facility to be considered an unrelated trade or business as described in Section 513; however, the income of the facility will be subject to corporate income tax as "noncompliant facility income." This taxable noncompliant facility income is not considered UBI, so it should not impact tax exempt bonds used to finance the noncompliant hospital facility.

The IRS has recently issued additional guidance regarding correction and disclosure procedures for hospital organizations to follow so that certain failures to meet the requirements of Section 501(r) will be excused. *See* Rev. Proc. 2015-21.

Community Health Needs Assessment (CHNA):

Consistent with the earlier proposed regulations, the final regulations maintain that for any year a hospital operates a hospital facility, it must: (1) "conduct" a CHNA in the current taxable year or in either of the two preceding years; and (2) an authorized body of the hospital facility must adopt an implementation strategy to meet the community

health needs identified in the CHNA. In order to conduct a CHNA the regulations say that a hospital facility must complete the following steps:

1. Define the community it serves
2. Assess the health needs of that community
3. Solicit and take into account input received in its assessment from persons who represent the broad interests of that community (including those with special knowledge or expertise in public health)
4. Document the CHNA in a written report
5. Make the CHNA report widely available to the public

The implementation strategy must be adopted on or before the fifteenth day of the fifth month after the end of the taxable year during which hospital facility completed its CHNA (i.e., completed the above five steps). This is a change from the proposed regulations, which had required adoption of the implementation plan by the end of the taxable year in which the facility completed its CHNA.

The final regulations further broaden the scope of what is required in the CHNA as they require that a hospital facility not only identify the health needs of the community but also "prioritize" those needs. The CHNA must describe the process and criteria used by the hospital facility in making its assessment. The CHNA must also identify potential resources to address health needs, but the final regulations clarify that the resources of the hospital facility itself can be included as a potential resource. The term "health needs" is also broadened in the final regulations; as a result, Form 990 reporting is likely to be impacted as items previously considered "community building" may now be considered "community benefit." In preparing its CHNA, a hospital facility must take into account input from persons representing broad interests of the community. Input from at least one state, local, tribal or regional governmental public health department official with knowledge, information or expertise relevant to the health needs of that community, members of medically underserved, low-income, and minority populations in the community or individuals or organizations serving or representing these interests is required, and finally written comments received on the hospital facility's most recently conducted CHNA and recently adopted implementation strategy should be taken into account.

A CHNA report must contain the following:

1. A definition of the community served by the hospital facility and a description of how the community was determined
2. A description of the process and methods used to conduct the CHNA
3. A description of how the hospital solicited and took into account the input it received
4. A prioritized description of the significant health needs identified through the CHNA
5. A description of the resources available to address the significant health needs identified in the CHNA
6. An evaluation of the impact of any actions that were taken, since the hospital finished conducting its immediately preceding CHNA to address the significant health needs identified in the hospital facility's prior CHNAs.

A hospital facility must document its CHNA in a report adopted by an authorized body of the hospital facility. The final regulations clarify that a hospital may rely on data created by others in conducting its CHNA and can merely cite the source of its data rather than providing specific detail. In addition, the final regulations continue to allow joint CHNA

reports but the joint reports must contain the six items described above. Collaborating hospital facilities must make their reports widely available to the public, but they do not have to do so on the same day.

A hospital facility's implementation strategy to address significant health needs requires that the hospital facility describe the actions it intends to take to address each significant health need identified in the CHNA, or specifically state the hospital facility will not address a certain significant need and state why such need will not be addressed. The hospital facility must also describe the anticipated impact of its actions and its plan to evaluate the impact of any actions taken since it conducted its immediately preceding CHNA. A hospital facility must identify the programs and resources it plans to commit to address the health need. Finally, the hospital facility must describe any planned collaboration with other facilities or organizations in addressing the health need.

The final regulations provide that a new hospital organization must meet the CHNA requirements by the last day of the second taxable year beginning after the later of (1) the effective date of its IRS exemption determination or (2) the first date on which its hospital facility was licensed or registered by its state as a hospital. It is important to note that a short taxable year is treated as a taxable year for meeting the CHNA requirements. If a hospital organization ceases operation of, or transfers all ownership interest in, a hospital facility before the end of a tax year, it is not required to meet the CHNA requirements with respect to that facility for that tax year.

Financial Assistance Policy (FAP):

Each hospital facility must establish a written FAP that applies to all emergency and other medically necessary care provided by the hospital facility. The final regulations added that the FAP must apply to such care provided in the hospital facility by a "substantially-related entity," which can be a partnership owned in part by, or a disregarded entity wholly owned by, the organization operating the facility. However, if the substantially related entity is an unrelated trade or business (i.e., taxable) then Section 501(r) does not apply to care provided by the substantially-related entity.

The final regulations clarify that the FAP must describe only the financial assistance (including discounts and free care) available under the FAP. Hospital facilities may offer discounts outside of the FAP (e.g., self-pay, out of state patients, etc.). However, the discounts outside the FAP are not considered a community benefit reportable on Form 990 Schedule H.

The FAP must specify the eligibility criteria an individual must satisfy to receive financial assistance. The final regulations provide that an individual's eligibility can be determined based on information other than that provided by the individual. For example, an individual's prior FAP determination can be used to make a presumptive current determination. Information from other sources must be included in the FAP and if the facility uses prior FAP eligibility determinations it must explain under what circumstances it presumptively determined FAP eligibility.

The final regulations clarify that a hospital facility must widely publicize the FAP, the FAP application form, and plain language sum-

mary of the FAP in the community it serves. These items should be available on the hospital facility (or hospital organization)'s website. A hospital facility may provide the FAP, FAP application and plain language summary to a person electronically upon request; but absent such request, the items must be provided via paper copy.

The final regulations modify the notification requirements that the proposed regulations required facilities to follow to make "reasonable efforts" to determine FAP eligibility before engaging in extraordinary collections actions (ECAs). The final regulations contain the following differences:

1. It is no longer required that a hospital facility send three separate bills that include a plain language summary of the FAP
2. Hospital facilities are required to offer (though not necessarily provide) a plain language summary of the FAP to patients as part of the intake or discharge process
3. The final regulations require a conspicuous notice on all bills that notifies recipients of the availability of financial assistance and that includes contact information for obtaining the FAP and learning about the FAP application process
4. Conspicuous public displays are required that notify and inform patients about the FAP in public locations in the hospital facility, including the emergency room and the admissions areas

The final regulations also clarify that a "FAP application" is not limited to a written submission. A hospital facility can also obtain information from an individual in writing, orally or through a combination of the two.

A FAP's plain language summary must include: (1) a brief summary of how to apply for assistance under the FAP; and (2) contact information for the hospital facility office that can provide assistance with the FAP application process, if one exists; if not, contact information for at least one nonprofit organization or government agency that can provide assistance with the FAP application process must be provided.

One additional modification provided in the final regulations regarding the FAP, FAP application and plain language summary is with regard to the requirement that these items be provided in a language other than English (i.e., limited English proficiency or "LEP"). A hospital facility must provide a translation of these documents if certain community thresholds are met—specifically the final regulations lower the LEP threshold to the lesser of 1,000 individuals or 5% of the community served by the hospital. A hospital facility can use any reasonable method to determine these numbers and percentages and the final regulations eliminate reference to US Census Bureau data as the basis for determination.

The final regulations change the definition of "medically necessary care" to which a FAP (as well as the limitation on amounts generally billed) applies, giving facilities greater flexibility. Hospital facilities can use either: (1) the Medicaid definition of "medically necessary care;" (2) another definition provided by state law; or (3) a definition that refers to generally accepted standards of medicine in the community or to an examining physician's determination. The final regulations require the FAP to list other providers who deliver emergency or other medically necessary care in the hospital facility, and which providers are and are not covered under the FAP. If a hospital facility outsources its emergency room operation to a third party that is

not subject to the hospital 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.

Emergency Medical Care Policy and Shared Policies:

The final regulations state that a hospital facility must provide care, without discrimination, for emergency medical conditions to individuals whether or not they are FAP eligible. An emergency medical care policy may be included in the same document as the FAP, or in a document relating to emergency medical care. The final regulations clarify that multiple hospital facilities can share the same policies, so long as the policies are accurate for each hospital facility and any joint policy states that it is applicable to each hospital facility.

Billing and Collection Requirements:

In general, 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. This rule applies to any ECAs taken by any purchaser of the individual's debt, any debt collection agency to which the hospital facility referred the debt, or any "substantially related entity," as defined above.

The final regulations clarify that a hospital's placement of a lien to collect proceeds of judgments, settlements, or compromises arising from a patient's suit against a third party as a result of injuries for which the facility provided care does not constitute an ECA. ECAs are actions taken by a hospital facility against an individual to obtain payment of a bill for care covered under its FAP, including: (1) selling an individual's debt (subject to exceptions); (2) a "defer or denial ECA" which requires payment on past unpaid bills for FAP related care before providing medically necessary care or to defer or deny such care because of non-payment (with limited exceptions); (3) reporting adverse information about an individual to consumer reporting agencies or credit bureaus; and (4) an action that requires a legal or judicial process (e.g., foreclosures, civil actions, etc.).

A hospital must make "reasonable efforts" to determine if an individual is FAP eligible. A hospital is considered to make reasonable efforts to determine if an individual is FAP eligible if it complies with certain required notification and application periods. The final regulations modify the notification and application periods provided in the proposed regulations.

Under the final regulations, the notification period begins on the date the facility provides the first post discharge billing statement and ends 120 days later. In addition, a hospital facility may aggregate a patient's outstanding bills for multiple occurrences of care; however, the 120 day notification period applies to the most recent occurrence of care in the aggregation.

The final regulation provide that the application period for which the hospital must accept and process a FAP application begins on the date the hospital facility first provides the first post discharge billing statement and ends 240 days later.

Because the final regulations defer the notification and application periods to post dis-

charge periods, so notice is not sent while a patient is still hospitalized.

The final regulations also provide that to meet the notification requirements before initiating ECAs, the hospital facility must do the following:

1. Provide at least one written notice disclosing: (1) that financial assistance is available for eligible individuals; (2) the ECAs the facility intends to initiate (rather than all actions that may be initiated as provided in the proposed regulations) against the individual; and (3) the deadline after which such ECAs may be initiated (which can be no earlier than 30 days after the date of the notice)
2. Provide a plain language summary of the FAP with the above notice
3. Made a reasonable effort to orally notify the individual about the FAP and how the individual may obtain assistance with the application process

The proposed regulations provided for the first two requirements above (with the noted modification). The final regulations added the third requirement.

When an individual submits an incomplete FAP application during the application period, the hospital facility must suspend any ECAs for a "reasonable time" and give written notice to the individual that describes the additional information needed to complete the FAP and which also includes certain contact information. The proposed regulations provided that a hospital facility must suspend ECAs until at least 240 days after the date of the first billing statement provided to the individual. The final regulations modify the proposed regulations by eliminating the proposed regulation's fixed time period (i.e., 240 days). The final regulations instead provide that the hospital facility must suspend ECAs until the individual has failed to respond to requests for additional information "within a reasonable period of time."

The final regulations also impose the following additional billing and collection requirements:

1. If a hospital facility presumptively determines that an individual is eligible for less than the most generous assistance available under the FAP, based on a prior FAP eligibility determination or based on information provided by the individual, the hospital facility will satisfy the reasonable efforts standard if it: (1) notifies the individual regarding the basis for its presumptive FAP eligibility determination; (2) explains how the individual may apply for more generous assistance; (3) gives the individual a reasonable amount of time to apply for more generous assistance before initiating ECAs; and (4) processes any complete FAP application the individual submits within the application period.
2. In making reasonable efforts to determine FAP eligibility, a hospital facility may provide any written notice electronically to any individual who indicates he or she prefers to receive written notices electronically.
3. The Preamble clarifies that if a facility receives a complete FAP application and determines the applicant is eligible for free care, it is not required to send that individual a billing statement indicating that the individual owes nothing for the care.
4. The hospital facility must refund amounts paid by individuals who are later determined to be FAP eligible (subject to a limited exception).

Limitations on Charges:

In general, 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 medically necessary care, the amount the hospital facility may charge is limited to an amount that is not more than the amounts generally billed (AGB) for individuals who have insurance covering such care. With regard to all other medical care, the hospital facility must limit its charges to an amount less than its gross charges for such care. The final regulations clarify that the amount "charged" includes the amount a FAP eligible individual is personally responsible for paying, after all deductions and discounts (including those provided under the FAP) and less any amounts reimbursed by insurers. The AGB limitation applies regardless of an individual's insurance status and whether or when the full amount allowed is actually paid. The hospital facility's billing statement may state gross charges as a line item, but discounts and deductions should be shown reducing the amount to be charged to an amount net of such discounts and deductions so the individual is only charged the net amount.

In calculating the AGB, the final regulations retained the two methods provided in the proposed regulations—the "look-back" method and 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. Furthermore, the final regulations say that a hospital facility may change its method of determining its AGB at any time, provided it first updates its FAP to describe the new method it intends to implement. There is no requirement that such change be specifically approved by the hospital organization's board (albeit the hospital's board must approve the FAP). It is also notable that such change can be made "at any time," so changes can potentially be made at any time during a particular tax year. The final regulations also added a provision that allows the IRS and Department of the Treasury to provide additional methods to determine AGB through future published guidance, though no such guidance has yet been issued.

Although the final regulations retained the methods for calculating AGB as provided in the proposed regulations, the final regulations do provide some modifications to the AGB calculation under the "look back" method. The look back method calculates the AGB by multiplying the hospital facility's gross charges for the care provided by one or more AGB percentages. In determining the applicable percentage to use, the numerator is the sum of all claims allowed for emergency and other medically necessary care or the sum of all claims allowed (rather than claims only for emergency and other medically necessary care that have been paid in full, as in the proposed regulations) during the prior twelve month period by looking at: (1) Medicare fee for service; (2) Medicare fee for service and all private health insurers that pay claims to the hospital facility; or (3) Medicaid, either alone or in combination with the insurer(s) described above. This Medicaid provision was added by the final regulations. The denominator is the sum of the associated gross charges for the same claims. The AGB must be calculated at least annually under this method.

Under the "look back" method, the AGB percentage can be a single average percentage of gross charges for all care or for all emergency and other medically necessary care provided by the hospital facility or 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 in the aggregate, and apply the percentage(s) across all of the hospital facilities. While the proposed regulations provided that the hospital facility must begin using the AGB percentage by the 45th day after the end of the twelve month period used to calculate the AGB percentage, the final regulations modify this start date to the 120th day after the end of the twelve month period.

Finally, a safe harbor is available so that even if a hospital facility charges more than the AGB to a FAP eligible individual, it will meet the Section 501(r)(5) limitation if: (1) the charge in excess of the AGB was not made as a pre-condition of providing medically necessary care to the FAP eligible individual; (2) the FAP eligible individual has not submitted a complete FAP application at the time of the charge; and (3) if the individual subsequently submits a complete FAP application and is determined eligible for the FAP, and the hospital refunds any amounts that the individual paid that exceed the amount the individual is determined to be responsible for paying. The final regulations remove the requirement for the hospital facility to make "reasonable efforts" to determine FAP eligibility as a condition to meeting the safe harbor.

II. Exempt Hospital Action Steps

Although the final regulations provide a rather generous effective date for their application, hospital organizations should begin preparing to comply with the regulations as soon as possible. The regulations are lengthy and complex, so it will likely take quite a lot of time and effort for hospital facilities to be in position to implement the regulations.

Following are some proposed actions that hospital organizations should begin to undertake:

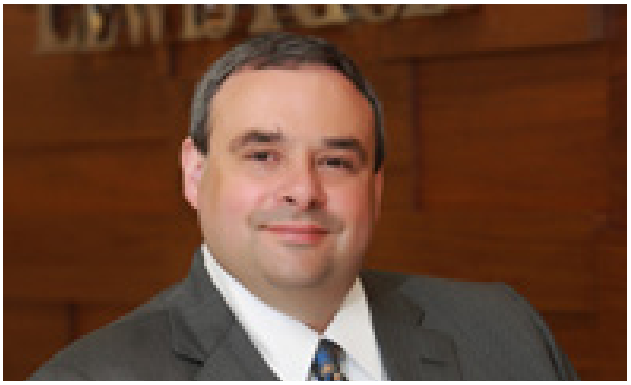
1. **Form a 501(r) implementation team.** If it has not already done so, each hospital organization should form a 501(r) implementation team consisting of management and staff representing the areas that will be affected by the final regulations. Such areas include financial assistance, patient intake a discharge, the emergency room, billing, collections, IT, public relations, community outreach, finance and accounting, legal and compliance, and tax reporting. The hospital will also need to develop training programs for the personnel who will be required to implement Section 501(r). If there are multiple hospital facilities, the implementation team should solicit input and coordinate efforts with representatives of the various facilities.
2. **Hospital facilities should be identified.** The final regulations apply on a facility by facility basis, so it is crucial that the hospital organization accurately identify each hospital facility it either directly or indirectly operates.
3. **Review existing written policies.** A hospital facility must have a written FAP, emergency medical care policy and billing and collection policy. The hospital facility should review each of these in light of the final regulations. A list should be compiled of any providers other than the facility itself, providing emergency or

medically necessary care in the facility and specify which providers are covered by the FAP and which are not.

4. **Hospital facilities should develop a FAP plain language summary as required by the final regulations.**
5. **Review methods available to determine AGB.** As previously discussed, there are certain limitations on billing and collection and the final regulations provide some modification to the calculations that can be used by a hospital facility to determine its AGB.
6. **Determine and review ECAs and develop a process to comply with the final regulations and in particular the "reasonable efforts" requirements.** If hospital facilities use third parties to collect debt, these agreements should be reviewed and modified so that they comply with the ECA requirements.
7. **Review CHNA reporting and implementation strategy.** A hospital facility is required to conduct a CHNA at least once every three years and adopt an implementation strategy with regard to the CHNA. Most hospital facilities have conducted their first CHNA and adopted their first CHNA implementation strategy. The final regulations made changes to the prior CHNA rules, so the hospital facility should take steps to ensure it is complying with the final CHNA provisions, as discussed above.
8. **Consider joint collaboration.** The final regulations allow hospital organizations or facilities to collaborate with others, such as providing for joint FAP, combining facilities for AGB percentages, and joint CHNA reporting.
9. **Review and consider the requirements for making information publicly available.**

The above is not an exhaustive list of actions; nonetheless, hospital organizations should begin taking steps to ensure compliance with Section 501(r). Due to the delayed effective date of the final regulations, it is not anticipated that the IRS will start examinations for compliance with the final Section 501(r) regulations until 2017 or 2018. However, it has been noted that IRS agents have been trained on Section 501(r) and they will be trained on the final regulations.

Lewis Rice LLC is poised to provide assistance to tax exempt hospital organizations through regular consultation or through participation as part of a hospital organization's implementation team. For more information, please feel free to contact one of the listed attorneys or click here.



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