The Nuts and Bolts of the 501(r) Regulations

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Goals

• Understand requirements of Code Section 501(r) and corresponding Final Regulations
• Obtain tools for effectively preparing and reviewing key documents and establishing necessary procedures
• Develop and implement strategies that ensure compliance while promoting the hospital’s charitable purposes and other business objectives
Code Section 501(r) Overview

- Four new duties for Code Section 501(c)(3) hospitals under Affordable Care Act:
  - Community Health Needs Assessment (CHNA)
  - Financial Assistance Policy (FAP)
  - Limitation on Charges (AGB)
  - Billing and Collection Requirements (ECA)
The Rest of the Law

• Potential sanctions for noncompliance include financial penalties, tax on hospital activities, and even loss of Code Section 501(c)(3) status

• Other requirements imposed with Code Section 501(r)
  – Expanded annual reporting obligations through Form 990 (including filing audited financial statements)
  – IRS review of and reporting to Congress about tax-exempt hospitals
Regulations and Other Guidance

• Final Regulations issued December 31, 2014
• Prior Significant Guidance:
  – Notice 2010-39 (solicit comments)
  – Notice 2011-52 (CHNAs)
  – 2012 Proposed Regulations (FAPs, AGB, and ECAs)
  – 2013 Proposed Regulations (CHNAs and failures)
  – 2013 Final and Temporary Regulations (reporting CHNA violations)
  – Notices 2014-2 (reliance) and 2014-3 (correction)
• Subsequent Guidance
  – Revenue Procedure 2015-21
  – Informal comments from IRS personnel
• Additional Formal Guidance to Come(?)
Who Must Comply?

- Any “hospital organization,” meaning any Code Section 501(c)(3) organization that operates a “hospital facility”
- A “hospital facility” is any facility “required by state law to be licensed, registered, or similarly recognized as a hospital”
- Special situations:
  - Hospital systems
  - Government hospitals
  - Disregarded entities and partnerships
When Must Hospitals Comply?

- Full compliance mandatory by start of first tax year beginning after December 29, 2015

<table>
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<tr>
<th>Date Organization’s Tax Year Begins</th>
<th>Deadline for Full Compliance with Final Regulations</th>
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<tr>
<td>January 1</td>
<td>January 1, 2016</td>
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<tr>
<td>April 1</td>
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<td>July 1</td>
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- Until then, must follow “reasonable interpretation” (e.g., Proposed Regulations or Final Regulations)
General Compliance Tips

• Establish 501(r) compliance team to coordinate efforts across various departments
  – Finance (including billing and collections)
  – Community benefit
  – Legal
  – Liaison to senior leadership

• Establish compliance timeline

• Identify, review, and revise key documents

• Evaluate and enhance hospital procedures

• Obtain additional information at Hall Render’s 501(r) compliance website: www.hallrender.com/501r
CHNAs – Statutory Basics

• Code Section 501(r)(3)
• Each hospital facility must conduct a CHNA at least once every three years
• Hospital facility also must adopt an implementation strategy for meeting the community health needs identified through the CHNA
CHNAs – Statutory Basics

• Little additional detail in Code
  – Must take into account input from persons representing broad interests of community served, including public health experts
  – Must make widely available to public

• New Code Section 4959 imposes $50,000 penalty for failure to comply
CHNAs – What Changed?

- Gradual shifts and subtle changes from Notice 2011-52 to 2013 Proposed Regulations to Final Regulations
- Support “building upon” prior CHNAs
- Encourage collaboration among related and even unrelated hospitals
- Give hospitals discretion (but not requirement) to consider additional input and information
- Allow additional time to adopt implementation strategy
- Provide clarity regarding newly created or acquired hospitals and newly terminated or transferred hospitals
CHNAs – Timing

• Hospital organizations were given three full tax years from enactment of ACA to complete their first CHNAs

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• Each hospital organization should have completed its first CHNA and should start (or prepare to start) its second
CHNAs – Conducting a CHNA

• Five steps for conducting a CHNA:
  1. Define community served
  2. Assess community’s health needs
  3. Solicit and take into account required input
  4. Document CHNA in written report adopted by authorized body
  5. Make CHNA report widely available (accomplished by posting conspicuously on website)
CHNAs – Whose Input Needed?

- Whose input must be solicited and taken into account?
  - At least one state, local, tribal, or regional governmental public health department with knowledge or expertise relevant to community’s health needs
  - Members of medically underserved or similar populations in the community or individuals serving or representing such populations
  - Written comments received on hospital facility’s most recently conducted CHNA and implementation strategy
CHNAs – Elements of CHNA

• Six required elements of a CHNA:
  1. Definition of community served and description of how determined
  2. Description of process and methods used to conduct CHNA
  3. Description of how hospital solicited and took into account input received from persons who represent broad interests of community served
CHNAs – Elements of CHNA

• Six required elements of a CHNA (continued):
  4. Prioritized description of significant community health needs identified through CHNA along with description of process of identifying needs as significant and prioritizing among needs
  5. Description of resources potentially available to meet needs
  6. Evaluation of impact of any actions taken since last CHNA to address significant health needs identified through last CHNA [new requirement]
CHNAs – Implementation Strategy

• For each significant health need identified through the CHNA, implementation strategy must:
  – Describe how the hospital facility plans to address the health need; or
  – Identify the health need as one the hospital facility does not intend to address – and explain why

• Hospital facility must adopt implementation strategy by fifteenth day of fifth month of year after CHNA is adopted
CHNAs – Compliance Cycle

1. Plan
2. Gather and Analyze
3. Report
4. Implement and Evaluate
CHNAs – Implement and Evaluate

• Focus hospital energies upon advancing implementation strategy
• Obtain “CHNA Audit” to confirm how effectively prior document and process will satisfy new requirements
• Ensure effective process for receiving comments
• Confirm “conspicuous” posting of CHNA on website
• Review other CHNAs (e.g., competitors)
• Consider collaboration
CHNAs – Best Practices

• Ensure awareness of new (and old) Code Section 501(r) requirements
• Develop process for next CHNA based on CHNA audit (team, timeline, input, secondary data, etc.)
• Coordinate CHNA process with other areas
  – Form 990 reporting
  – Financial assistance
FAP – Statutory Basics

• Code Section 501(r)(4)
• Adopt a written FAP that includes:
  – Eligibility criteria (and whether free or discounted care)
  – Basis for calculating amounts charged to patients
  – Method for applying for financial assistance
  – If no separate billing and collections policy, actions that may be taken in the event of nonpayment
  – Measures to widely publicize policy within community
• Adopt a written policy relating to emergency medical care
FAP – What Changed?

• Added new requirements
  – FAP must apply to substantially related entities (SRE)
  – FAP must list all providers of emergency and MNC and indicate whether or not FAP applies
  – FAP must describe information sources to be used to make presumptive FAP-eligibility determinations

• Multiple changes for widely publicizing the FAP
  – When and where plain language summary (PLS) is provided
  – Limited English proficiency (LEP) groups
  – No longer required to list measures in the FAP

• Discounts that are not FAP-based no longer must be listed
FAP – What Is Covered?

• FAP must apply to all emergency and other medically necessary care (MNC) provided by hospital facility
  – Must include care provided by a substantially related entity
    • Partnerships
    • Disregarded entities
    • Other entity types?
  – MNC can be (1) defined by state law, including Medicaid definition; (2) generally accepted standards of medicine in the community; or (3) based on the examining physician’s determination
FAP – How to Widely Publicize

• FAP must be “widely publicized”
  – FAP, FAP application, and PLS posted to a website
  – Paper copies must be available upon request, without charge, by mail and in public locations (ER and admissions areas)
  – Notify/inform community in a manner reasonably calculated to reach members most likely to require assistance
  – Notify/inform patients about the FAP
    • Offer PLS as part of intake or discharge
    • Conspicuous written notice on billing statement
    • Conspicuous public displays (ER and admissions areas)
  – Translate for populations that have limited English proficiency
    • Lesser of 1,000 individuals; or
    • 5% of community served or population to be affected/encountered
FAP – Contents

• FAP must contain certain info:
  – Eligibility criteria and whether assistance includes free or discounted care
  – Basis for calculating amounts charged to patients
  – Application method
  – Description of collections actions (can have a separate billing and collections policy)
  – Alternative info sources to be used for presumptive eligibility determinations (discussed in Billing & Collections)
  – Emergency and MNC provider list for the hospital facility
FAP – Contents

• Eligibility criteria
  – Specify all financial assistance available under the FAP
  – Criteria for each discount and/or level of financial assistance
  – Method for determining AGB
  – Statement that FAP-eligible individual may not be billed more than AGB for emergency or MNC

• Method for applying
  – Describe the process
  – FAP or FAP-application must describe the information and all documentation the hospital facility may require
  – Individuals cannot be denied based on required information not identified in FAP or FAP-application

• Emergency Medical Care Policy
  – EMTALA policy should suffice (beware of debt collection activities)
FAP – Best Practices

• Evaluate Policies and Documents
  – FAP, FAP-application
  – Plain language summary
  – Billing and collections (is it separate from FAP?)
  – AGB explanation
  – Checklist to widely publicize
  – Translations

• Consider system-wide FAP or facility-based FAPs

• Identify who provides emergency and MNC in each hospital facility

• Identify SREs
AGB – Statutory Basics

- Code Section 501(r)(5)
- Limit charges for emergency or other medically necessary care provided to patients eligible for financial assistance under the FAP to not more than the amounts generally billed to patients with insurance (AGB)
- Cannot use “gross charges”
AGB – What Changed?

- AGB data options
  - Added Medicaid
  - Declined to add other private health insurer options
- Allows AGB to be changed at any time – if FAP updated first
- Established “personally responsible” criteria to identify what a FAP-eligible individual is considered to be “charged”
- Clarified that all care subject to FAP (not just emergency and MNC) is also subject to the gross charges limitation
AGB – Defined

• For emergency or MNC, the amount charged is limited to not more than AGB
• For all other care covered by the FAP, the amount charged must be less than gross charges for such care
• “Charged” is the amount a FAP-eligible individual is personally responsible for paying (after applying all deductions, discounts, and insurance)
• Methods: look-back or prospective
AGB – Calculation Methods

• Look-Back Method
  – AGB percentage:
    • 12-month period
    • Begin using within 120 days
    • Calculate at least annually
    • Can use all claims (not limited to emergency and MNC)
  – Data:
    • Medicare fee-for-service
    • Medicare fee-for-service and all private health insurers
    • Medicaid, either alone or in combination

\[
\frac{\text{Sum of Amounts Allowed}}{\text{Sum of Associated Gross Charges}}
\]
AGB – Calculation Methods

• Prospective Method
  – Utilize billing and coding process
  – Data
    • Medicare fee-for-service
    • Medicaid beneficiary
    • Both
  – Set AGB at the amount that would be the total allowed by Medicare/Medicaid

• General requirements – both methods
  – Include insurer’s and insured’s obligations
  – Single AGB or multiple AGBs for different services
  – AGB for each hospital facility (unless single provider agreement)
AGB – Best Practices

• Evaluate options for calculating AGB percentage
  – A lower AGB will restrict FAP flexibility
  – Look-back or prospective
  – Types of payers

• Can you identify MNC?
  – IRS defers to state law
  – May be easiest to count all care (not just emergency and MNC)
ECAs – Statutory Basics

- Code Section 501(r)(6)
- Hospital may not engage in ECAs before making reasonable efforts to determine if individual is eligible for assistance under FAP
ECAs – What Changed?

- Requiring payment for prior treatment before providing care is an ECA
- New rules regarding sale of debt to third party
- May presumptively determine that an individual is eligible
- Elimination of "notification period" (mostly)
- Numerous differences regarding notification requirements and handling of applications
ECAs – Defined

• What is an ECA?
  – Selling debt to third party (unless exception met)
  – Reporting to credit reporting agency or credit bureau
  – Deferring, denying, or requiring payment before providing medically necessary care due to nonpayment for previously provided care
  – Actions that require legal or judicial process (e.g., commencing a civil action, placing a lien, or garnishing wages)
ECAs – Defined

• What isn’t an ECA?
  – Selling debt to third party if written agreement that:
    • Purchaser is prohibited from engaging in ECA
    • Purchaser cannot charge excessive interest
    • Debt returnable if individual is FAP-eligible
    • If debt of FAP-eligible individual is not returned, individual not
      required to pay more than what FAP requires
  – Asserting lien on personal injury judgment
  – Filing claim in bankruptcy
ECAs – Reasonable Efforts

• 2012 Proposed Regulations required notification period and application period
• Final Regulations eliminate notification period
• Reasonable efforts now require
  – Presumptive eligibility; or
  – Notification and processing of applications
• Must refrain from any ECAs for 120 days from date of first post-discharge statement
ECAs – Presumptive Eligibility

• Hospital may presume individual is eligible based on prior eligibility determination or other outside information (e.g., Medicaid eligibility)

• If presumed eligible for less than most generous assistance, individual must be given notice and opportunity to apply for more generous assistance
ECAs – Notification

• Must notify at least 30 days before initiating ECA

• Required elements:
  – Written notice of availability of financial assistance, specific ECA contemplated, and deadline for ECA
  – Plain language summary of FAP
  – Reasonable effort to give oral notice

• If denying care due to prior nonpayment, must provide FAP application, identify application deadline and process application on expedited basis (if submitted)
ECAs – Handling Applications

• If complete application submitted, must suspend any ECAs, determine eligibility, and notify applicant (including notice of new amount payable, if any)

• If incomplete application submitted, must suspend any ECAs and inform individual how to complete

• If no application submitted, may proceed with ECAs (assuming proper notification given)
ECAs – Best Practices

• Make strategic decisions about what ECAs hospital facility will (and will not) initiate – and under what circumstances
• Review all third party agreements for compliance with Final Regulations and amend as necessary
• Review billing and collections policies and procedures
  – Establish timeline
  – Standardize notifications
  – Monitor practices for compliance
Failures – The Basics

• Statutory
  – Code Section 4959 – Excise tax of $50,000
  – Code Section 501(r)(1) – Other failures implicated loss of exemption

• 2013 Proposed Regulations
  – Revocation reserved for willful or egregious violations
  – Created mechanism for correction of certain errors
  – Provided that organizations with multiple hospital facilities would be evaluated on a facility basis
Failures – What Changed?

- Core concepts remain
- Self correction without disclosure of minor errors
  - Standard is now inadvertent or due to reasonable cause
- Defined “minor,” “inadvertent,” “reasonable cause,” and “egregious”
- Indicated that repeated failures could be problematic
Failures – Correction or Penalty?

• Correction without disclosure
  – Omission or error was minor and either inadvertent or due to reasonable cause
  – Omission and error must be corrected and practices/procedures must be added/reviewed/revised to improve compliance

• Correction with disclosure (Rev. Proc. 2015-21)
  – Failure was neither willful nor egregious
  – Failure must be corrected and disclosed

• Multiple hospital facilities – income tax
  – Failures isolated to a hospital facility will cause such facility to be subject to income tax
  – Income can not be aggregated with other facilities or UBI
  – Will not affect tax-exempt status of bonds

• Revocation
Compliance Summary

CHNA
- CHNA Report
- Implementation Strategy

FAP
- FAP Policy
- FAP Application
- Plain Language Summary
- Emergency Care Policy

AGB
- AGB Calculation
- Explanation of Calculation

ECAs
- Billing and Collection Policy
- Third Party Agreements
- Billing and Collection Procedures
For more information on 501(r) compliance, please visit:
www.hallrender.com/practice_areas/501r_compliance

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