Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; … – Final Rule

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On December 31, 2014, the Internal Revenue Service (IRS) published Final Rules implementing the “Additional Requirements for Charitable Hospitals” provisions of the Affordable Care Act (ACA), codified in Internal Revenue Code section 501(r). These rules impose requirements on tax-exempt hospitals relating to community health needs assessments (CHNAs), financial assistance policies (FAPs), and hospital charges, billing, and collection practices. Proposed IRS rules addressing Code section 501(r) requirements have been pending since 2012 and 2013.

Key highlights of the Final IRS Rules include the following:

- Clarify when care provided in a hospital facility by a joint venture is subject to compliance with the Section 501(r) requirements. Reg. §1.501(r)-1
- Provide that the IRS will consider all relevant facts and circumstances in determining whether to revoke §501(c)(3) status for failure to meet one or more requirements of Section 501(r), including whether the hospital had established practices and procedures reasonably designed to promote compliance with the rules. Reg. §1.501(r)-2
- Impose a new requirement that a CHNA report include an evaluation—as opposed to a “plan to evaluate”—of the impact of any actions taken by a tax-exempt hospital to address significant health needs identified in the hospital’s most recent CHNA. Reg. §1.501(r)-3
- Retain the three-year CHNA cycle, but provide tax-exempt hospitals more time following the completion of a CHNA to adopt an implementation strategy. Reg. §1.501(r)-3
- Require hospitals to provide written translations of FAP documents in the language spoken by each Limited English Proficiency language group that constitutes the lesser of 1,000 individuals, or 5 percent of the community served by the hospital facility or the population likely to be affected or encountered by the hospital facility. Reg. §1.501(r)-4
- Clarify that debt collection activities in a hospital emergency room are prohibited only if they could interfere with the provision of emergency medical care (in contrast to payment activities that do not interfere with care, such as the collection of co-pays after stabilization or after discharge). Reg. §1.501(r)-4
- Allow hospitals to change the method initially chosen for calculating the Amount Generally Billed (AGB) and clarify that the AGB limitation is applicable only to the amount the individual is personally responsible for paying after all reimbursement from the insurer has been applied. Reg. §1.501(r)-5
- Streamline and simplify the procedure that must be followed before initiating “extraordinary collection activities,” such as reporting a debt to a collection agency, selling it to a third party, or garnishing wages. Reg. §1.501(r)-6

The IRS Final Rules allow hospitals a transition period of at least a year to come into full compliance with the changes contained in the regulations. The Final Regulations apply to taxable years beginning after December 29, 2015. For taxable years beginning before that date, the Final Regulations provide that a hospital facility may rely on a reasonable, good faith interpretation of section 501(r).

Attached is a comprehensive summary prepared by VHA’s outside tax counsel--Kathleen Nilles and Ken Parsons of Holland & Knight--that details how the recently released Final Regulations change prior administrative IRS guidance on how the new Section 501(r) provisions will be administered and interpreted. If you have any questions, please contact Cidette Perrin at VHA at cperrin@vha.com.
Background: Overview of Tax-Exempt Hospital Provisions in the Affordable Care Act

The Affordable Care Act, enacted in 2010, added new statutory requirements that must be met by all hospitals seeking or maintaining exemption from federal income tax and other tax benefits as Section 501(c)(3) organizations ("charitable hospitals"). These requirements are now largely contained in Section 501(r) of the Internal Revenue Code ("Code"). In addition, the Act added a penalty excise tax (Code Section 4959) to help enforce the requirements and imposed reporting and disclosure requirements on all Section 501(c)(3) hospitals filing the annual information return known as IRS "Form 990."

The requirements are entitled, "Additional Requirements for Section 501(c)(3) Hospitals," and the legislative history makes it clear that the requirements are in addition to, and not in lieu of, the requirements otherwise applicable to charitable hospitals. As detailed below, Code Section 501(r)(1) imposes the following requirements on all charitable hospitals:

- prepare a community health needs assessment ("CHNA") every three years;
- adopt a financial assistance policy ("FAP");
- abide by a limitation on charges for medical care when such care is provided to those qualifying for financial assistance; and
- refrain from engaging in "extraordinary" collection efforts before making reasonable attempts to determine whether a patient qualifies for financial assistance.

The statutory requirements are generally effective for taxable years beginning after March 23, 2010. The CHNA requirement is effective for taxable years beginning after March 23, 2012.

Release of Final IRS Regulations

On December 29, 2014, the Internal Revenue Service released Final Rules on all of the requirements under the Affordable Care Act applicable to charitable hospitals, including their conduct of CHNAs, adoption of FAPs, limitation of medical care charges and collection procedures (the "Final Regulations"). The Final Regulations finalize three sets of Proposed Rules and other IRS administrative guidance.

The Final Regulations apply to a charitable hospital's first taxable year beginning after December 29, 2015, which will give all hospitals at least a year to comply with the new rules. For taxable years beginning on or before December 29, 2015, hospitals may rely on a reasonable and good-faith interpretation of Section 501(r). A charitable hospital will be deemed to have operated in accordance with this standard if it complies with either the Proposed Regulations or the Final Regulations, or a combination of both.

Administrative Guidance Released Prior to Final Regulations

This comprehensive summary details how the recently released Final Regulations change prior administrative IRS guidance on how the new provisions will be administered and interpreted. Prior to the publication of the Final Regulations on December 31, 2014, several pieces of IRS guidance had been released:

- IRS Notice 2010-39 (May 27, 2010) (a general overview of the new requirements and solicitation of public comment on CHNA and certain other issues).
- IRS Notice 2011-52 (July 7, 2011) (additional guidance relating to CHNA implementation and certain definitional issues).
- Proposed Regulations released June 22, 2012 (the "2012 Proposed Regulations") regarding
the implementation of charity care (financial assistance), emergency care, billing and collection policies.

- Proposed Regulations released April 5, 2013 (the "2013 Proposed Regulations") regarding the CHNA requirements under Section 501(r)(3) and other related issues.
- Final and Temporary regulations published August 15, 2013 regarding the requirement that a return accompany payment of the section 4959 excise tax for failure to meet the CHNA requirement.
- Notice 2014-2 (December 30, 2013) to confirm that hospital organizations could rely on both the 2012 Proposed Regulations and the 2013 Proposed Regulations, pending the publication of Final Regulations or other applicable guidance.
- Notice 2014-3 (December 30, 2013) soliciting public comments on a proposed revenue procedure that provides correction and reporting procedures under which certain failures to meet the requirements of section 501(r) will be excused. The IRS plans to finalize the guidance proposed in Notice 2014-3 in the near future.

I. Definition of "Hospital" Covered by the Rules

§1.1 Statutory Definition of Applicable Hospital Organizations and Facilities

Section 501(r)(2) sets forth the standards for determining whether an organization seeking to maintain or establish its status as an organization "described in section 501(c)(3)" is subject to the requirements. Section 501(r)(2)(A) states that the requirements apply to

- An organization that operates a facility which is required by a State to be licensed, registered, or similarly recognized as a hospital, and
- Any other organization that the Secretary of the Treasury determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption under Section 501(c)(3).

In addition, Section 501(r)(2)(B) clarifies that each hospital facility, if a Section 501(c)(3) health care organization operates more than one, must meet the requirements of Section 501(r). It further states that the organization will not be treated as "described in [Section 501](c)(3) with respect to any such facility for which such requirements are not separately met."

§1.2 Preliminary IRS Guidance Regarding Applicable Organizations and Facilities

The 2012 Proposed Regulations defined a hospital organization as "an organization recognized or seeking to be recognized as described in section 501(c)(3) that operates one or more hospital facilities, including a hospital operated through a disregarded entity" (i.e., an entity the separate of existence of which is disregarded for federal income tax purposes). The 2012 Proposed Regulations defined a hospital facility as "a facility that is required by a state to be licensed, registered, or similarly recognized as a hospital." In the preamble to the 2012 Proposed Regulations, the IRS confirmed that governmental hospitals are subject to the statutory requirements if they have sought and received recognition under Section 501(c)(3).

The 2013 Proposed Regulations further clarified that a Section 501(c)(3) hospital organization would be considered to be "operating a hospital facility " whether it does so through its own employees or by contracting out the operations to another organization, such as a management company. The 2013 Proposed Regulations also treated a hospital joint venture as operated by the 501(c)(3) partner unless the partner does not have control over the operation of the hospital
sufficient to ensure that it furthers an exempt purpose, and thus treats the operation of the hospital facility as an unrelated trade or business.

§1.3 Changes in the Final IRS Regulations Relating to the Definition of Applicable Hospital Organizations and Facilities

a. General Definition. The Final Regulations made no changes to the general definition of applicable hospital facilities and organizations. The IRS did not identify any additional categories of facilities that should be treated as hospitals other than those facilities required to be licensed by a state as a hospital.

b. Multiple Buildings under Single Hospital License. As in the 2012 Proposed Regulations, only one CHNA is required in this situation. The Final Regulations clarify, however, that if the separate buildings service different communities, the licensed hospital organization may devote separate chapters of its CHNA report to each building.

c. Single Building under Multiple State Licenses. The Final Regulations maintain the rule that each separately licensed "facility" must conduct its own CHNA even if there are multiple facilities within the same building, but the regulations clarify that the building's separately licensed facilities may conduct a joint CHNA and adopt a joint implementation strategy.

d. Government Hospital Organizations. The Final Regulations maintain the rule that government hospitals that have sought exemption under Section 501(c)(3) are subject to the Section 501(r) requirements, including CHNA rules and billing and collection requirements. The preamble to Final Regulations simply notes that government hospitals that do not wish to comply can submit a request to IRS to voluntarily terminate their Section 501(c)(3) recognition under a recently issued Revenue Procedure.

e. Accountable Care Organizations. The Final Regulations decline to provide any special rules for separate entities cooperating in accountable care organizations (ACOs), but the preamble to the Final Regulations notes that such organizations may conduct a joint CHNA.

f. Operating a Hospital Facility (including Through a Joint Venture). The Final Regulations clarify that a hospital is considered to own a capital or profits interest in a hospital facility if it owns such an interest "directly or indirectly through" one or more lower-tier entities treated as partnerships for tax purposes or through a so-called "disregarded entity" (e.g., a single-member LLC that has not elected to be treated as a corporation).

The Final Regulations also contain a new and more expansive definition of when a hospital is not required to meet the requirements of Section 501(r), which includes:

(1) any hospital facility it is not "operating,"
(2) any facility it operates that is not required to be licensed by the state as a hospital, and
(3) any activities that constitute an "unrelated trade or business" (as described in Code Section 513) with respect to the hospital organization.

Similar to the Proposed Regulations, the definition of "operating" a hospital facility turns, in the case of a hospital operated by a joint venture, on whether the tax-exempt partner has sufficient control over the hospital facility to further an exempt purpose and thus treats the operation of the facility as related or an unrelated trade or business.
g. Providing Care in a Hospital Facility Through Hospital-Owned Entities. In the preamble to the Final Regulations, the IRS noted that it received numerous comments related to the provision of care within the hospital by various hospital-owned entities, such as hospital-owned physician practices. The preamble clarifies that whether such organizations are subject to the Section 501(r) requirements will depend on how the separate entities are classified for tax purposes:

- If the entity is classified as a separate taxable corporation, then no Section 501(r) compliance would be required.
- If the entity is a disregarded entity that is wholly owned by the exempt hospital organization, then Section 501(r) compliance would be required.
- If the entity is treated as a partnership, then Section 501(r) compliance will depend on whether the provision of medical care by that entity is treated as a related or unrelated trade or business.

In connection with the third scenario, the Final Regulations include a new defined term—a "substantially related entity," which is defined as an entity (whether a partnership or disregarded entity) that provides in a hospital facility operated by the hospital organization "emergency or other medically necessary care that is not an unrelated trade or business" with respect to the hospital organization.

h. Definition of Authorized Body. The Final Regulations amend the rules to include the governing body of a joint venture that operates a hospital facility in the definition of an "authorized body" under the regulations. This change will allow a hospital participating in a joint venture to seek approval of certain documents (such as a CHNA report) by either the hospital's board or the joint venture's board.

II. Failure to Satisfy Section 501(r)—Procedures for Correction

§2.1 Statutory Rules Related to Section 501(r) Compliance Failures

In order to qualify as exempt from tax under Section 501(c)(3), Section 501(r)(1) requires a hospital organization to meet the requirements related to CHNAs, FAPs, limitation on charges, and billing and collection. Accordingly, compliance failures could result in disqualification or revocation of Section 501(c)(3) status. In addition, the Affordable Care Act added a penalty excise tax to help enforce the CHNA requirements. Code Section 4959 imposes a $50,000 excise tax upon each hospital facility that fails to meet the CHNA requirements.

§2.2 Preliminary IRS Guidance on 501(r) Compliance Failures and Correction Procedures

The 2013 Proposed Regulations provided that a hospital facility's omission of required information from a FAP or a CHNA report or error with respect to the implementation or operational requirements of Section 501(r) would not be considered a failure to meet a requirement of Section 501(r) if:

- Such omission or error was minor, inadvertent, and due to reasonable cause; and
- The hospital facility corrected such omission or error as promptly after discovery as is reasonable given the nature of the omission or error.
The Proposed Regulations also provided that a hospital facility's failure to meet one or more of the above requirements that is neither willful nor egregious would be excused if the hospital facility corrects and makes disclosure in accordance with IRS guidance. The Proposed Regulations stated, however, that a hospital facility may, in the discretion of the IRS, be subject to an excise tax under Section 4959 for a failure to meet the CHNA requirements, notwithstanding the hospital facility's correction and disclosure of the failure in accordance with the relevant procedures. Notice 2011-52 clarified that IRS intends to apply the Section 4959 excise tax separately with respect to each hospital facility's failure to meet the requirements. Thus, if a hospital organization operates two hospital facilities that fail to meet the requirements, it would be subject to a total excise tax of $100,000 ($50,000 for each facility).

The Proposed Regulations provided rules to allow the maintenance of tax exemption where a hospital organization operates multiple hospital facilities, and not all of its facilities are willfully or egregiously noncompliant. Under these rules, if a hospital organization that operates more than one hospital facility fails to meet one or more of the requirements with respect to a hospital facility during the taxable year, the income derived from the noncompliant hospital facility will be subject to the regular corporate income tax rates in Code Section 11. In determining whether to revoke Section 501(c)(3) status as a result of a failure to meet one or more requirements of Section 501(r), the Proposed Regulations provided that the IRS will consider all relevant facts and circumstances.

§2.3 Changes in Final IRS Regulations on 501(r) Compliance Failures and Correction Procedures

a. Minor Omissions and Errors. The Final Regulations retain the general approach in administrative guidance to minor and inadvertent omissions and errors that are due to reasonable cause. If promptly corrected upon discovery, such errors should not result in sanctions. The Final Regulations also contain the following changes and clarifications to the rules related to minor omissions and errors:

- Rather than requiring an error or omission to be minor, inadvertent, and due to reasonable cause, the Final Regulations only require that the error or omission be minor and either inadvertent or due to reasonable cause.
- In the case of multiple omissions or errors, the omissions or errors are considered minor only if they are minor in the aggregate.
- The fact that the same omission or error has occurred and been corrected previously is a factor tending to show that an omission or error is not inadvertent.
- A hospital facility's establishment of practices or procedures (formal or informal) reasonably designed to promote and facilitate overall compliance with the Section 501(r) requirements prior to the occurrence of an omission or error is a factor tending to show that the omission or error was due to reasonable cause.
- Correction of minor omissions or errors must include establishment (or review and, if necessary, revision) of practices or procedures that are reasonably designed to achieve overall compliance with the requirements of Section 501(r).

b. Excusing Certain Failures if a Hospital Facility Corrects and Makes Disclosure. The Final Regulations retain the rule that a hospital facility's failures that are neither willful nor egregious will be excused if the hospital facility corrects and makes disclosure of the failures. The Final Regulations include the following clarifying changes:

- Correction and disclosure of a failure is a factor tending to show that an error or omission
was not willful.

- A hospital facility failing to meet the CHNA requirements "will" (rather than "may, in the discretion of the IRS") be subject to an excise tax under Section 4959, notwithstanding its correction and disclosure of the failure. As provided in Notice 2011-52, the excise tax applies separately with respect to each hospital facility, meaning a hospital organization could be subject to multiple $50,000 penalties. However, a minor omission or error related to the CHNA requirements that is corrected will not give rise to an excise tax under Section 4959.

c. Facts and Circumstances Considered in Determining Whether to Revoke 501(c)(3) Status. Consistent with the Proposed Regulations, the Final Regulations provide that the IRS will consider all relevant facts and circumstances when determining whether revocation of Section 501(c)(3) status is warranted as a result of a failure to meet one or more requirements of Section 501(r). The relevant facts and circumstances include the size, scope, nature, and significance of the organization's failure, as well as the reason for the failure and whether the same type of failure has previously occurred. The IRS will also consider whether the hospital organization had, prior to the failure, established practices or procedures (formal or informal) reasonably designed to promote and facilitate overall compliance with the Section 501(r) requirements; whether such practices or procedures were being routinely followed; and whether the failure was corrected promptly.

d. Taxation of Noncompliant Hospital Facilities. The Final Regulations retain the facility-level tax for a hospital organization operating more than one hospital facility that fails to meet one or more of the requirements of Section 501(r) separately with respect to a hospital facility during a taxable year. The Final Regulations clarify, however, that application of the facility-level tax will not, by itself, result in the operation of the noncompliant hospital facility being considered an unrelated trade or business under Code Section 513. By way of example, the Final Regulations state that the application of the facility-level tax will not, by itself, affect the tax-exempt status of bonds issued to finance the noncompliant hospital facility.

III. Community Health Needs Assessments

§3.1 Statutory Requirement to Conduct a CHNA and Adopt an Implementation Strategy

Section 501(r)(3)(A) provides that hospitals must conduct a CHNA every three years and adopt an implementation strategy to meet the identified needs. Further, Code Section 501(r)(3)(B) requires that the CHNA

- take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and
- [be] made widely available to the public.

Failure to conduct a CHNA every three years may result in a penalty of up to $50,000. Further, the penalty can be assessed for each successive year in which a hospital does not complete a CHNA.

§3.2 Preliminary IRS Guidance Regarding the CHNA and Implementation Strategy Requirements

a. General Rule--Timing Issues. The 2013 Proposed Regulations provided that a hospital organization meets the requirements of Section 501(r)(3) in any tax year for a hospital facility it
operates only if the hospital facility has conducted a CHNA in that tax year or in either of the two immediately preceding tax years. Also, an authorized body of the hospital facility is required to have adopted an implementation strategy to meet the community health needs identified through the CHNA by the end of the tax year in which the hospital facility conducts the CHNA.

b. **Conduct of a CHNA--Five Key Steps and Completion Date.** Under the 2013 Proposed Regulations, in order to "conduct" a CHNA, a hospital facility must complete all of the following five steps:

- Define the community it serves;
- Assess the health needs of that community;
- In assessing community health needs, take into account input from persons who represent the broad interests of that community, including those with special knowledge or expertise in public health;
- Document the CHNA in a written report that is adopted by an authorized body of the hospital facility; and
- Make the CHNA report widely available to the public.

Further, the Proposed Regulations clarified that a hospital facility will be considered to have "conducted" a CHNA on the date it has completed all of the steps, including making the report widely available to the public.

c. **Community Served by a Hospital Facility.** The Proposed Regulations, like IRS Notice 2011-52, allowed hospitals to take into account all of the relevant facts and circumstances in defining the community they serve. Under the Proposed Regulations, specific facts and circumstances may include the geographic area served by the hospital facility, target populations served (for example, children, women or the aged) and principal functions (for example, focus on a particular specialty area or targeted disease). Also, like IRS Notice 2011-52, the Proposed Regulations cautioned hospitals not to define their communities "to exclude medically underserved, low-income or minority populations" unless they are not part of the hospital facility's target populations or affected by its principal functions.

d. **Assessing Community Health Needs.** The Proposed Regulations indicated that the process of assessing community health needs involves three distinct steps:

- Identifying significant needs of the community;
- Prioritizing those health needs; and
- Identifying potential measures and resources (such as programs, organizations and facilities in the community) to meet those needs.

The Proposed Regulations also stated that "a hospital may use any criteria to prioritize the significant health needs it identifies, including, but not limited to, the burden, scope, severity, or urgency of the health need; the estimated feasibility and effectiveness or possible interventions; the health disparities associated with the need; or the importance the community places on addressing the need."

e. **Consulting with Persons Representing the Broad Interests of the Community.** The Proposed Regulations specified that in order to meet the requirement to take into account input from persons who represent the broad interests of the community, the hospital must consult with:
At least one state, local, tribal or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the hospital's community; and

- Members of medically underserved, low-income, and minority populations in the community served by the hospital facility, or individuals or organizations serving or representing the interests of such populations.

In addition, the Proposed Regulations contained a new requirement that the hospital must also consider "written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy."

Further, the Proposed Regulations defined "medically underserved populations" as "populations experiencing health disparities or at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers."

The Proposed Regulations dropped references in IRS Notice 2011-52 that mandated consultation with public health experts (outside of the public health department context), consumer advocates, community nonprofit organizations and academic experts--although all of these categories were mentioned in the Proposed Regulations as the types of persons with whom a hospital may consult.

**f. Documentation of a CHNA.** The Proposed Regulations spelled out what must be contained in the written CHNA report that each hospital facility must complete and have adopted by its governing body. The required elements of the CHNA report include:

- A definition of the community served and a description of how it was determined;
- A description of the process and methods used to conduct the CHNA;
- A description of how the hospital facility took into account input from persons who represent the broad interests of the community it serves;
- A prioritized description of the significant health needs of the community, along with a description of the process and criteria used in identifying certain health needs as "significant" and prioritizing such significant health needs; and
- A description of the potential measures and resources identified through the CHNA to address the significant health needs.

The Proposed Regulations then further described what level of detail needs to be included in the description of CHNA process and methods, how the hospital obtained input from persons representing broad interests of the community.

**g. Conduct and Documentation of Joint CHNAs.** The Proposed Regulations described how CHNAs conducted jointly or in collaboration with other hospital organizations and facilities must be documented and reported. As a general rule, the Proposed Regulations stated that, while a hospital may conduct its CHNA in collaboration with other organizations and facilities, it must submit its own CHNA report unless it is eligible under IRS regulations to submit a "joint CHNA report."

Under the Proposed Regulations, a joint CHNA report may be issued if:

- Adopted by the authorized body;
- Collaborating hospitals define their community to be the same and conduct a joint CHNA process; and
- The joint CHNA report is clearly identified as applying to the hospital facility.
h. Making a CHNA Widely Available to the Public. The Proposed Regulations stated that a hospital facility's written CHNA report must be "conspicuously posted" on the hospital facility's website, or the hospital organization's website. However, as an alternative, a hospital facility could also post on another entity's website if it does not have a website. In addition, the definition of "widely available" in the Proposed Regulations contained detailed requirements for website posting and document accessibility, including the following:

- Hospitals must provide individuals who ask how to access a copy with the direct website address or URL of the web page on which the CHNA Report is posted;
- Website must clearly inform reader how to download the report;
- Download may not require special equipment or fee; and
- Report must be maintained on the website until two subsequent CHNA reports are made available.

The Proposed Regulations also required making paper copies available for public inspection without charge.

i. Implementation Strategy. The Proposed Regulations defined an "implementation strategy" as a written plan that addresses "significant" community health needs identified through a CHNA for the hospital. Similar to guidance provided in IRS Notice 2011-52, the implementation strategy must both:

- Describe how a hospital plans to meet a health need identified by the CHNA; and
- Describe significant health needs the hospital does not intend to meet and explain why the hospital facility does not intend to meet the health need.

In the case of needs that the hospital plans to meet, the Proposed Regulations provided that the implementation strategy must describe the actions the hospital intends to take, the anticipated impact of these actions, and a plan to evaluate such impact. It must also identify the programs and resources the hospital plans to commit, as well as any planned collaborations with other facilities. In the case of needs that the hospital does not intend to meet, the Proposed Regulations stated that the brief explanation of the reason may include mention of resource constraints, the existence of other facilities or organizations addressing the need, the hospital's lack of experience or competency, the community's low prioritization of the need, or the lack of effective interventions to address the need.

j. Collaborative and Joint Implementation Strategies. The Proposed Regulations encouraged collaboration among hospitals, agencies and health departments in the development of Implementation Strategies, but generally required each hospital to separately document its implementation strategy in a separate written plan tailored to the particular hospital, taking into account its specific programs and resources.

However, the Proposed Regulations provided that hospitals with joint CHNA reports (as described above) may also adopt joint implementation strategies so long as they:

- Are clearly identified as applying to the specific hospital facility;
- Clearly identify the hospital facility's particular role in taking action, as well as the programs and resources the hospital plans to commit; and
- Include a summary or other tool that helps the reader locate those portions of a joint implementation strategy that relates to a particular hospital facility.
k. *How and When an Implementation Strategy is Adopted and Reported.* The Proposed Regulations stated that an implementation strategy is "adopted" on the date it is approved by an authorized governing body of the hospital organization. The Proposed Regulations also stated that the hospital's implementation strategy must be adopted "by the end of the same taxable year in which the hospital conducts the CHNA."

Under the Proposed Regulations, a tax-exempt hospital organization must attach to its annual Form 990 the most recently adopted implementation strategy for each of its hospital facilities. If, however, the hospital has made such implementation strategies available on its website, it can fulfill this requirement by providing the URL of each relevant webpage.

§3.3 Changes in Final IRS Regulations on CHNA Reports and Implementation Strategies

a. *Conducting a CHNA (Five Key Steps).* The Final Regulations make no changes to the five key steps of conducting a CHNA other than to add that a hospital must "solicit" as well as "take into account" input from persons who represent the broad interests of the community. The significance of this change is explained below.

   i. **Defining the Community Served by the Hospital Facility**

   The Final Regulations delete a sentence in the Proposed Regulations that allowed a hospital facility to define its community to include populations in addition to its patient populations and geographic areas outside of those in which its patient populations reside. The preamble to the Final Regulations explains that this sentence had the potential to cause confusion by implying that the "community served" for CHNA purposes may not actually be the community served by the hospital facility. Like the Proposed Regulations, the Final Regulations do not permit a hospital to define its community in a way that excludes medically underserved, low-income or minority populations, and the preamble to the Final Regulations notes that the term "medically underserved" populations includes populations "at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic language, financial or other barriers."

   ii. **Assessing Community Health Needs**

   The Final Regulations continue the basic rules set forth in the 2013 Proposed Regulations regarding the assessment process, but with respect to the requirement that a hospital "identify measures and resources . . . potentially available to address those health needs," it deletes the term "measures" as having no clear meaning in the context. Further, it also clarifies that the term "resources" applies not only to "organizations, facilities and programs in the community," but also those of the hospital facility itself.

   iii. **Input from Persons Representing Broad Interests of the Community**

   The preamble to the Final Regulations explains that several commenters asked Treasury to address the situation in which a hospital facility, despite its best efforts, is unable to secure input on its CHNA from a required category of persons. In response, the Final Regulations retain the three categories of input that must be sought, but clarify that a hospital facility must "solicit" input from these categories and take into account the input "received." The preamble states that any hospital facility claiming that it solicited, but could not obtain input from one of the required categories of persons, must describe its efforts in the CHNA report.
The preamble further details that Treasury considered, but ultimately did not agree to, suggestions from "numerous commenters" to require hospitals to solicit and take into account public input on the hospital's identification and prioritization of significant health needs or on its definition of what constitutes its "community served."

The preamble also details that Treasury and IRS considered, but ultimately did not agree to any changes in the following three categories of input required to be solicited:

- **Governmental Public Health Departments**—The Final Regulations preserve the flexible approach contained in the Proposed Regulations and do not change the option hospitals have to consult with state, regional, local or tribal public health departments. However, they do add as an additional option the possible consultation with State Offices of Rural Health to satisfy this requirement.

- **Medically Underserved, Low Income and Minority Populations.** Despite requests to expand the categories of persons with whom a hospital is required to consult, the Final Regulations do not expand the populations from whom a hospital is required to solicit input beyond medically underserved, minority and low-income populations. In particular, the Final Regulations decline to create a special category for populations with limited English proficiency (LEP), noting that this category is referenced within the definition of "medically underserved" populations.

- **Written Comments on Hospital's CHNA and Implementation Strategy.** Although some organizations continued to advocate for requiring comments on a draft CHNA report before it is finalized, Treasury declined to adopt this suggestion and maintained the requirement that a hospital take into account only any written comments received from the public on its most recent (prior) CHNA report and Implementation Strategy in conducting and completing its present CHNA.

In addition, Treasury did not agree in the Final Regulations to various suggestions to make any of the additional sources of input that a hospital "may" solicit or take into account mandatory. This broader range of optional sources of input will continue to include health care consumers and consumer advocates, nonprofit and community based organizations, academic experts, local government officials, local school districts, health care providers and community health centers, health insurance and managed care organizations, private businesses and labor and workforce representatives.

Finally, Treasury was asked to respond to numerous comments regarding the potential link between the needs of a hospital facility's community and a hospital's Financial Assistance Policy ("FAP"). Some organizations urged Treasury to require hospitals to use the CHNA process to update the hospital's FAP. While Treasury declined to incorporate that suggestion, the Final Regulations expressly provide that the health needs of a community "may include, for example, the need to address financial and other barriers to accessing care...".

**iv. Documentation of a CHNA**

The Final Regulations make no major changes in this area. However, the Final Regulations clarify that a hospital facility may rely on data collected and created by third parties in conducting its CHNA report, and when it does so, it may simply cite or identify its data sources, and it need not describe the "methods of collecting" the data.
v. Collaboration on CHA Reports

In general, each hospital organization must document its own CHNA in a separate CHNA report. The Final Regulations encourage collaboration by allowing for joint CHNA reports. The Final Regulations also clarify that collaborating hospitals do not have to conduct a joint (or identical) process.

The Final Regulations also clarify that hospital facilities may utilize portions of a public health department’s CHNA if it is conducted consistent with IRS guidelines and other joint CHNA requirements are met.

vi. Making CHNA Report "Widely Available" to the Public

The Final Regulations make no changes to how a CHNA report must be made "widely available" to the public. Despite the requests of numerous commenters, Treasury declined to adopt suggestions that the document be translated into multiple languages and/or made available in multiple locations. The preamble points out that the requirement to "widely publicize" a hospital's FAP implies a greater degree of effort than the requirement to make the CHNA report "widely available."

b. Implementation Strategies

i. Describing how a Hospital Facility Plans to Address a Significant Health Need

The 2013 Proposed Regulations provided that an implementation strategy must, among other things, "describe the actions the hospital facility intends to take to address the health need, the anticipated impact of these actions, and the plan to evaluate the impact…." In response to various comments, the Final Regulations replace the proposed requirement that the implementation strategy describe "a plan to evaluate the impact" with a requirement that the CHNA report include "an evaluation of the impact of any actions that were taken since the hospital facility finished conducting its immediately preceding CHNA to address significant health needs identified in the hospital facility's prior CHNA(s)."

ii. Describing Why a Hospital Facility is not Addressing a Significant Health Need

The 2013 Proposed Regulations provided that a hospital may provide a brief explanation of its reason(s) for not addressing a significant health need, including, but not limited to "resource constraints" and "relative lack of expertise or competencies" to address the health need. Some groups urged Treasury to not allow hospitals to cite these reasons. However, the Final Regulations preserve the ability of a hospital facility to explain its reasons for not addressing a significant health need (including resource constraints or a lack of expertise), even if those reasons could be mitigated through collaboration.

iii. Joint Implementation Strategies

The Final Regulations adopt the provisions in the 2013 Proposed Regulation allowing hospital facilities to adopt joint implementation strategies so long as the specified requirements are met.

iv. When the Implementation Strategy Must Be Adopted
In response to comments from the hospital community regarding the requirement that an implementation strategy must be adopted within the same taxable year as the hospital’s CHNA is conducted and completed, the Final Regulations allow hospitals an additional 4 and 1/2 months after the close of the taxable year (e.g., until May 15th for a hospital whose taxable year closes on December 31st).

c. Exception for Hospitals that are New, Newly Acquired or Newly Subject to 501(r)

The Final Regulations make no major changes to the special rule for new or newly acquired hospitals. As in the Proposed Regulations, they must meet the CHNA requirements by the last day of the second taxable year beginning after the date, respectively, that the hospital is acquired, placed in service, or newly subject to Section 501(r). However, the Final Regulations and its preamble make the following clarifications with respect to that special rule with regard to the CHNA requirement and its timing:

- The Final Regulations treat mergers the same as acquisitions, meaning the "acquired" hospital activities will have until the last day of the second taxable year beginning after the merger to meet the CHNA requirements.
- New hospital facilities must meet the CHNA requirements by the last day of the second taxable year beginning after the later of the effective date of the determination letter or ruling recognizing the organization as described in Section 501(c)(3) or the first date a facility operated by the organization was licensed, registered, or similarly recognized by its state as a hospital.

In addition, the Final Regulations provide that a hospital is not required to meet the CHNA requirements in Section 501(r)(3) with respect to a hospital facility in a taxable year if the organization transfers all ownership of the facility to another organization or otherwise ceases its operation of the hospital facility before the end of the taxable year. The Final Regulations also clarify that a government hospital that terminates its Section 501(c)(3) recognition by submitting a request pursuant to specified IRS procedures is no longer considered a "hospital organization" subject to the excise tax for failing to meet the CHNA requirements during the taxable year of its termination.

IV. Financial Assistance Policy/Emergency Medical Care Policy

§4.1 Statutory Requirements Regarding Financial Assistance and Emergency Medical Policies

Section 501(r)(4) requires that charitable hospitals have a financial assistance policy and an emergency medical care policy. Under Section 501(r)(4)(A), the financial assistance policy must include

- Eligibility criteria for financial assistance, and whether such assistance includes free or discounted care,
- The basis for calculating amounts charged to patients,
- The method for applying for financial assistance,
- In the case of an organization which does not have a separate billing and collections policy, the actions the organization may take in the event of non-payment, including
collections action and reporting to credit agencies, and

- Measures to widely publicize the policy within the community to be served by the organization.

Under Section 501(r)(4)(B), a hospital organization's emergency medical care policy must be a written policy requiring the organization to provide, without discrimination, "care for emergency medical conditions" (within the meaning of 42 U.S.C 1395dd) to individuals regardless of their eligibility under the financial assistance policy.

§.4.2 Preliminary IRS Guidance Regarding Financial Assistance and Emergency Medical Care Policy Requirements

§.4.2.1 Financial Assistance Policy

The Proposed Regulations spelled out in considerable detail how the statutory requirements for a hospital's financial assistance policy ("FAP") must be implemented. Topics addressed include eligibility criteria, method for applying for financial assistance, and how to meet the requirement to widely publicize a FAP.

a. Eligibility Criteria. Significantly, the Proposed Regulations did not mandate any particular eligibility criteria, but they did impose a number of detailed requirements that a FAP must comply with, such as:

- Specifying the financial assistance, including all discounts and free care, available under the FAP, and
- Specifying all of the eligibility criteria that an individual must meet to receive free or discounted care or another level of assistance.

The Proposed Regulations also required the FAP to state that following a determination of FAP eligibility, an individual will not be charged more than "amounts generally billed" ("AGB") for emergency or other medically necessary care.

b. Basis for Calculating Amount Charged to Patients. In addition, the Proposed Regulations specified that the FAP must either:

- state the percentage of gross charges the hospital facility applies to determine AGB (the AGB percentage) and how the AGB percentage was calculated (i.e., by describing which of the permitted methods the hospital facility used to determine AGB); or
- explain how members of the public may readily obtain this information in writing and free of charge.

If applicable, a FAP must also specify the amounts, such as gross charges, to which any discount percentages specified in the FAP will be applied. See "Limitation on Charges" described in §5 below.

c. Method for Applying for Financial Assistance. With respect to the method for applying for the hospital's financial assistance, the Proposed Regulations specified that a FAP must describe how an individual may establish eligibility for financial assistance under the FAP, including the following:
• Either the hospital facility’s FAP or FAP application form (including accompanying instructions) must describe the information or documentation the hospital facility may require an individual to submit as part of his or her FAP application; and
• The FAP must provide certain contact information that an individual can use to obtain assistance with the FAP application process.

The Proposed Regulations provided that financial assistance may not be denied based on the omission of information or documentation if such information or documentation is not specifically required by the FAP or FAP application form.

d. Actions That May Be Taken in the Event of Nonpayment. The Proposed Regulations specified that, if the hospital does not have a separate billing and collections policy, it must describe in the FAP any actions the hospital facility may take in the event of nonpayment, including:

• Any actions that the hospital facility (or other authorized party) may take to obtain payment of a bill for medical care provided by the facility including, but not limited to, any extraordinary collection actions (“ECAs”);
• The process and time-frames the hospital facility (or other authorized party) will use in taking these actions, including any reasonable efforts to determine whether an individual is FAP-eligible before imposing ECAs; and
• The office, department, committee, or other body with the final authority for determining that the hospital facility has made reasonable efforts to determine whether an individual is FAP-eligible and therefore may engage in extraordinary collection actions against the individual.

The Proposed Regulations further specified that when a hospital has a separate written billing and collections policy, the FAP must state that the actions the hospital facility may take in the event of nonpayment are described in a separate policy and explain how members of the public may readily obtain a free copy of this separate policy.

e. Widely Publicizing the FAP. Under the Proposed Regulations, hospital facilities were required to take the following measures to widely publicize the FAP:

• Make the FAP, the FAP application form, and a plain language summary of the FAP widely available on a website for free;
• Make paper copies of the FAP, the FAP application form, and a plain language summary of the FAP available upon request and without charge, both for distribution in public locations in the hospital facility and by mail;
• The Proposed Regulations further required each of these documents to be made available in English and in the primary language of any populations with limited proficiency in English that constitute more than 10 percent of the residents of the community served by the hospital facility.
• Inform and notify visitors to the hospital facility about the FAP through a conspicuous public display or other measure(s) reasonably calculated to attract the attention of visitors to the hospital facility (such as posting signs and displaying brochures); and
• Inform and notify members of the community served by the hospital facility about the FAP in a manner reasonably calculated to reach those members of the community who are most likely to require financial assistance (such as distributing information sheets to local government agencies and nonprofits).
Hospitals have the option of summarizing these measures in the FAP itself or explaining in the FAP how members of the public may readily obtain a free written summary of these disclosure and accessibility measures.

§4.2.2 Emergency Medical Care Policy

As noted above, Section 501(r)(4)(B) requires charitable hospitals to establish a written policy that requires the hospital to provide, without discrimination, care for emergency medical conditions to individuals, regardless of whether the individuals are eligible for financial assistance under the hospital's FAP.

In the preamble to the 2013 Proposed Regulations, the IRS acknowledged receipt of numerous comments suggesting that this requirement should not be interpreted as imposing any additional requirements other than to set forth the Emergency Medical Treatment & Labor Act ("EMTALA") standards in a written policy. However, the Proposed Regulations did not adopt this approach and additionally required that the written policy

• ...prohibit the hospital facility from engaging in any actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or permitting debt collection activities in the emergency department or in other areas of the hospital where such activities could interfere with the provision, without discrimination, of emergency medical care.

• In the Proposed Regulation's preamble, the IRS further suggested that debt collection activities could jeopardize a hospital facility's compliance with EMTALA as well as with the new tax exemption requirement under Section 501(r)(4)(B) to provide "nondiscriminatory" medical care.

§4.3 Changes in the Final Regulations on FAPs and Emergency Medical Care Policies

Consistent with the Proposed Regulations, the Final Regulations require hospital organizations to establish written FAPs and written emergency medical care policies.

a. Financial Assistance Policies. The Final Regulations provide that a charitable hospital meets the requirements of Section 501(r)(4)(A) only if it establishes a written FAP that applies to all emergency and other medically necessary care provided by the hospital. The Final Regulations also require a hospital's FAP to list the providers, other than the hospital facility itself, delivering emergency or other medically necessary care in the hospital and to specify which providers are covered by the hospital's FAP (and which are not). The Final Regulations make the following additional changes and clarifications:

   i. Eligibility Criteria and Basis for Calculating Amounts Charged to Patients

Like the Proposed Regulations, the Final Regulations do not mandate any particular eligibility criteria and require only that a FAP specify the eligibility criteria for receiving financial assistance under the FAP.

   ii. Method for Applying for Financial Assistance

The Final Regulations expressly state that a hospital facility may grant financial assistance under its FAP even if an applicant fails to provide any or all information or documentation described in the
FAP or FAP application form. Accordingly, a hospital facility may grant financial assistance under its FAP based on evidence other than that described in a FAP or FAP application form or based on an attestation by the applicant. However, the Final Regulations require a hospital facility to describe in its FAP any information obtained from sources other than individuals seeking assistance that the hospital facility uses in order to make FAP-eligibility determination, and whether and under what circumstances it uses prior FAP-eligibility determinations to presumptively determine that individuals are FAP-eligible.

The Final Regulations also amend the definition of "FAP application" to clarify that the term is not intended to refer only to written submissions and that a hospital facility may obtain information from an individual in writing, orally, or both.

iii. Actions That May Be Taken in the Event of Nonpayment

The Proposed Regulations provided that either a hospital facility's FAP or a separate written billing and collections policy established for the hospital facility must describe the actions that the hospital facility may take related to obtaining payment for medical care, including any extraordinary collection actions. The Final Regulations adopt this requirement without major change.

iv. Widely Publicizing the FAP

The Final Regulations continue to require a hospital facility to make the FAP documents available upon request and widely available on a web site and to inform both visitors to the hospital and members of the community about its FAP. However, the Final Regulations eliminate the requirement in the Proposed Regulations that the FAP list the measures taken to widely publicize the FAP in the community it serves. Instead, the Final Regulations only require a hospital facility to implement the measures to widely publicize the FAP.

The Final Regulations retain the requirement that the full FAP must be made widely available on a web site and in paper form upon request in public locations in the hospital. The Final Regulations specify, however, that "public locations" in a hospital facility include, at a minimum, the emergency room and the admissions areas. The Final Regulations also clarify that a paper copy must be provided in response to a request unless the individual indicates he or she would prefer to receive or access the document electronically.

The Final Regulations consolidate all of the requirements that involve notifying patients generally about the FAP under the widely publicizing requirements. As a result, the notification component of reasonable efforts to determine FAP-eligibility (discussed in §6.3 below) is simplified and is focused primarily on those patients a hospital actually intends to engage in extraordinary collection activities.

In addition to notifying patients about the FAP through a conspicuous public display, the Final Regulations also require hospital facilities to widely publicize their FAPs by providing FAP information to patients before discharge and with billing statements. The Final Regulations also amend these requirements in response to comments to the Proposed Regulations:

- Rather than require a full plain language summary with billing statements, the Final Regulations require only that a hospital facility's billing statement include a conspicuous written notice that notifies and informs the recipient about the availability of financial assistance under the hospital facility's FAP and includes the telephone number of the hospital department that can provide information about the FAP and FAP application process. Alternatively, the hospital can provide the contact information of a nonprofit
organization or government agency that the hospital has identified as an available source of such assistance.

- A hospital must offer the plain language summary as part of either the intake or discharge process, rather than "before discharge," which some commenters interpreted as limited to "at discharge." Further, Treasury and the IRS intend that the terms "intake" and "discharge" be interpreted broadly to include whatever processes are used to initiate or conclude the provision of hospital care.

- Recognizing that many patients will have no interest in the FAP summary because they know they will not be eligible under the FAP, a hospital is only required to "offer" (rather than "provide") the FAP summary to patients.

- Information about how to apply for financial assistance must be included in the plain language summary.

- The requirement to translate FAP documents is now coordinated with guidance provided by the Department of Health and Human Services, which provides that written translations of vital documents for each Limited English Proficient (LEP) group that constitutes 5 percent or 1,000, whichever is less. Rather than require translation of FAP documents into the primary language of any Limited English Proficient populations that constitute more than 10 percent of the members of the community served by the hospital facility (as provided in the Proposed Regulations), the Final Regulations adopt the 5-percent/1000 person threshold in HHS guidance.

The Final Regulations retain the requirement to notify and inform members of the hospital's community in a manner reasonably calculated to reach those members who are most likely to require financial assistance from the hospital facility.

b. Emergency Medical Care Policies. In response to comments that the broad language in the Proposed Regulations regarding "debt collection in the emergency department" could be read to prohibit ordinary activities in the emergency room, such as collecting co-payments and asking for insurance information, the Final Regulations clarify that debt collection activities are prohibited only if they interfere with the provision of emergency medical care. The Final Regulations also clarify that multiple hospital facilities may have identical FAPs, billing and collection policies, and/or emergency medical care policies established for them (or even share one joint policy document), provided that the information in the policy or policies is accurate for all such facilities and any joint policy clearly states that it is applicable to each facility. The Final Regulations note, however, that different hospital facilities may have different AGB percentages or use different methods to determine AGB that would need to be reflected in each hospital facility's FAP.

V. Limitation on Charges

§5.1 Statutory Requirements Regarding Billing Policy (Limitation on Charges)

Section 501(r)(5) requires a hospital organization to limit its charges for emergency and other medically necessary care provided to individuals eligible for assistance under the financial assistance policy. Individuals qualifying for financial assistance cannot be charged more than the "amounts generally billed to individuals who have insurance covering such care[]." Further, Section 501(r)(5) prohibits hospitals from using gross charges -- i.e., chargemaster rates -- as a basis for computing the amount to bill individuals covered under the hospital's financial assistance policy.

§5.2 Preliminary IRS Guidance Regarding Billing Policy
The Proposed Regulations clarified that tax-exempt hospitals must limit the amount charged to a FAP-eligible individual to:

- In the case of emergency or other medically necessary care, not more than the amounts generally billed (AGB) to individuals with insurance covering that care; and
- In the case of all other medical care, less than the gross charges for such care.

The Proposed Regulations proposed that hospitals use one of two different methods to calculate AGB and that they continue to use that method once it is selected. The two methods included by the IRS in the Proposed Regulations are described as follows:

- "Look-back" method--i.e., a method based on actual past claims paid to the hospital facility by either (a) Medicare fee-for-service only or (b) Medicare fee-for-service together with all private health insurers paying claims to the hospital facility, or
- "Prospective" method - i.e., a method based on an estimate of the amount the hospital would be paid by Medicare for the emergency or other medically necessary care at issue if the FAP-eligible individual were a Medicare fee-for-service beneficiary.

With respect to the prohibition on gross charges, the Proposed Regulations clarified that it applies only to FAP-eligible individuals, but for those individuals, it applies to any medical care, not just emergency and medically necessary care. At the same time, the Proposed Regulations clarified that it is acceptable to include gross charges on hospital bills as the "starting point" to which various contractual allowances, discounts, or deductions are applied.

The Proposed Regulations also provided a "safe harbor" for certain charges in excess of AGB as follows:

A hospital facility will be deemed to meet [the applicable requirements] even if it charges more than AGB for emergency or other medically necessary care (or gross charges for any medical care) provided to a FAP-eligible individual if (1) the FAP-eligible individual has not submitted a complete FAP application as of the time of the charge; and (2) the hospital facility has made and continues to make reasonable efforts to determine whether the individual is FAP-eligible.

If an individual is subsequently found to be FAP-eligible, the Proposed Regulations suggested that any excess charge should be corrected.

§5.3 Changes in the Final Regulations on Limitation on Charges

Consistent with the statute and the Proposed Regulations, the Final Regulations provide that a hospital meets the requirements of Section 501(r)(5) only if it limits the amounts charged for any emergency or other medically necessary care it provides to FAP-eligible individuals to no more AGB.

The Final Regulations retain the look-back method and prospective method to determine AGB. However, the Final Regulations allow Treasury and the IRS to provide for additional methods in future published guidance as circumstances warrant. The Final Regulations also permit a hospital to change the method it uses to determine AGB at any time so long as it updates its FAP to describe the new method prior to implementing it. The Final Regulations make the following additional changes and clarifications to AGB.
• Hospitals may use Medicaid rates in calculating AGB, rather than only Medicare (or Medicare and private health insurers), as provided in the Proposed Regulations.
• The term "Medicaid" includes medical assistance provided through a contract between the state and a Medicaid managed care organization or a prepaid inpatient health plan.
• A FAP-eligible individual is considered to be "charged" only the amount he or she is personally responsible for paying, after all deductions and discounts have been applied and less any amounts reimbursed by insurers. Accordingly, in the case of a FAP-eligible individual who has health coverage, a hospital will not fail to meet the limitation on charges requirements because the total amount the individual and his or her health insurer are required to pay exceeds AGB.
• Hospitals may define the term "medically necessary care" for purposes of their FAPs and the AGB limitation. They may (but are not required to) use the Medicaid definition used in the hospital's state, other definitions provided by state law, or a definition that refers to generally accepted standards of medicine in the community or an examining physician's determination.

With respect charges in excess of AGB, the Final Regulations retain the safe harbor outlined in the Proposed Regulations. However, the Final Regulations eliminate the requirement that the hospital facility make reasonable efforts to determine whether the individual is FAP-eligible. Instead, the safe harbor focuses on remedying the overcharging by requiring that, if an individual submits a complete FAP application and is determined to be FAP-eligible for care, the hospital must refund any excess amounts the individual paid for care (unless less than $5).

VI. Billing and Collection Requirements

§6.1 Statutory Requirements Regarding Collection Policy

Section 501(r)(6) prohibits charitable hospitals from engaging in extraordinary collection actions ("ECAs") before making reasonable efforts to determine whether an individual is eligible for assistance under the hospital's financial assistance policy.

§6.2 Preliminary IRS Guidance Regarding Collections

a. Extraordinary collection actions. The Proposed Regulations classified the following as ECAs:

• Placing a lien on an individual's property;
• Foreclosing on an individual's real property;
• Attaching or seizing an individual's bank account or any 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; and
• Garnishing an individual's wages.

The Proposed Regulations acknowledged all of the above actions as actions that require a legal or judicial process.

In addition, the Proposed Regulations treated the following actions as ECAs:

• Reporting any adverse information about an individual to consumer credit reporting agencies or credit bureaus
Any sale of an individual’s medical debt to a third party

The Proposed Regulations stated that a hospital facility will be deemed to have engaged in an ECA against any individual if it engages in an ECA against any other individual who has accepted or is required to accept responsibility for the individual’s hospital bills. In addition, the hospital facility will be considered to have engaged in an ECA against an individual if any purchaser of the individual’s debt or any debt collection agency or other party to which the hospital facility has referred the individual’s debt has engaged in an ECA against the individual.

b. Reasonable Efforts. Under the Proposed Regulations, a hospital facility will have made "reasonable" efforts to determine whether the individual is FAP-eligible only if the hospital:

(1) appropriately notifies the individual about the FAP during a 120-day "notification" period that begins on the date on which medical care is provided to the individual and ends on the 120th day after the hospital facility provides the individual with the first billing statement for the care;
(2) in the case of an individual who submits an incomplete FAP application during a 240-day "application period," provides the individual with information relevant to completing the FAP application; and
(3) in the case of an individual who submits a complete FAP application, makes and documents a determination as to whether the individual is FAP-eligible (and meets certain other specified requirements).

With respect to the notification prong of the "reasonable efforts" test, the hospital will be deemed to meet this requirement only if it does all of the following:

• Distributes a plain language summary of the FAP and offers a FAP application form to the individual before discharge from hospital;
• Includes a plain language summary of the FAP with all (and at least 3) billing statements for the care and in all other written communications regarding the bill provided during the notification period;
• Informs the individual about the FAP in all oral communications regarding the amount due for the care that occur during the Notification period; and
• Provides the individual with at least one written notice that
  • Informs the individual about the ECAs that the hospital facility (or other authorized party) may take if the individual does not submit a FAP application or pay the amount due by a date that is no earlier than the last day of the notification period, and
  • Is provided to the individual at least 30 days before the deadline specified in the written notice.

If a hospital facility has met all of the notification requirements and the individual has failed to submit a FAP application by the end of the notification period, the hospital facility may engage in ECAs against the individual.

The Proposed Regulations further provided that a hospital facility must still accept and process FAP applications submitted by an individual during a longer "application period" that ends on the 240th day after the hospital facility provides the individual with the first billing statement for the care. In such case, if it turns out that the individual is FAP-eligible, the hospital must seek to correct any ECAs it has undertaken.
The Proposed Regulations provided special rules with respect to many aspects of the above requirements, including:

- What constitutes a plain language summary of the FAP, and what it must include;
- What steps must be taken if an individual submits an incomplete FAP application during the application period (including suspension of ECAs and the provision of written notices);
- What steps must be taken upon receipt of a complete FAP application during the application period (including the refund of excess payments and reversal of ECAs); and
- What protections a hospital must put in place by the hospital when it refers an individual's debt for collection by a third party.

The Proposed Regulations also contained an "anti-abuse" rule. Under that rule, a hospital facility will not be treated as having made reasonable efforts if the hospital facility bases a determination that the individual is not FAP-eligible on information the hospital facility has reason to believe is unreliable or incorrect or on information obtained from the individual under duress or through the use of coercive practices (which the rule defines as including the denial of emergency medical care to an individual until the individual has provided the requested information). Further, the Proposed Regulations specified that a hospital will not be treated as having made reasonable efforts to determine whether an individual is FAP-eligible simply because it has obtained a signed waiver from the individual disclaiming eligibility.

§6.3 Changes in Final IRS Regulations on Collection Policy

a. Extraordinary Collection Actions. Consistent with the statute, the Final Regulations provide that a hospital facility meets the billing and collection requirements of Section 501(r)(6) only if it does not engage in ECAs against an individual to obtain payment for care before making reasonable efforts to determine whether the individual is FAP-eligible for care.

Like the Proposed Regulations, the Final Regulations provide that a hospital facility will be considered to have engaged in ECAs against an individual to obtain payment for care if the hospital facility engages in such ECAs against any other individual who has accepted or is required to accept responsibility for the individual's hospital bill for the care. The Final Regulations contain the following requirements, many of which are substantially similar to the requirements outlined in the Proposed Regulations.

i. Reports to Credit Agencies

The Final Regulations retain the position that reporting to credit agencies is a collection action because, in the IRS' view, it is a tool to collect delinquent debts, and bad credit reports can have extraordinarily detrimental consequences for individuals.

ii. Certain Liens

The Final Regulations expressly provide that hospital liens to obtain the proceeds of settlements, judgments, or comprises arising from a patient's suit against a third party who caused the patient's injuries are not ECAs because they are not collection actions against the patient.

iii. Sale of an Individual's Debt to Another Party
The Final Regulations retain the general rule that debt sales are ECAs because the IRS believes hospitals have less control over a debt once it has been sold and that debt buyers will generally have less information regarding the individual and the debt and more incentive to engage in ECAs before making reasonable efforts to determine whether an individual is FAP-eligible. However, the IRS believes these concerns are mitigated in certain cases in which contractual arrangements with debt buyers both allow hospital facilities to retain control over the debt and benefit patients. Accordingly, the Final Regulations provide that the sale of an individual's debt is not an ECA if, prior to the sale, the hospital facility enters into a legally binding written agreement with the purchaser of the debt containing each of the following four conditions:

1) The purchaser must agree not to engage in any ECAs to obtain payment of the debt;
2) The purchaser must agree not to charge interest on the debt in excess of the federal short term interest rate plus three percentage points at the time the debt is sold (or such other interest rate set by guidance published by the IRS);
3) The debt must be returnable to, or recallable by the hospital facility upon a determination by the hospital facility or the purchaser that the individual is FAP-eligible; and
4) If the individual is determined to be FAP-eligible and the debt is not returned to or recalled by the hospital facility, the purchaser must adhere to procedures specified in the agreement that ensure that the individual does not pay, and has no obligation to pay, the purchaser and the hospital facility together more than he or she is personally responsible for paying as a FAP-eligible individual.

Because debt sales subject to the four conditions above are not considered to be ECAs under the Final Regulations, a hospital facility may make those debt sales without first having made reasonable efforts to determine FAP-eligibility.

iv. Including Additional Actions as ECAs.

The Final Regulations provide that ECAs include a hospital facility deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care.

b. Reasonable Efforts. The Final Regulations retain the general approach in the Proposed Regulations to making reasonable efforts to determine FAP-eligibility. However, the Final Regulations make the following changes designed to reduce the compliance burden on hospital facilities while at the same time ensuring that the reasonable efforts taken to determine whether individuals are FAP-eligible adequately protect patients.

i. Notification and Application Periods

Consistent with the Proposed Regulations, the Final Regulations provide for a 120-day period before hospital facilities may initiate ECAs against patients whose FAP-eligibility is undetermined and a 240-day period during which a hospital facility is required to process any application submitted by the individual. However, the Final Regulations provide that the applicable 120- and 240-day periods start on the date that the first "post-discharge" billing statement is provided, rather than just the first billing statement. (For these purposes, the Final Regulations clarify that a billing statement for care is considered "post-discharge" if it is provided to an individual after the care is provided and the individual has left the hospital facility.) In addition, the Final Regulations provide that hospital facilities must accept and process FAP applications up to 240 days after the first post-
discharge bill, but hospital facilities have the option to accept and process such applications at any
time.

ii. Meeting the Section 501(c)(6) Requirements on an "Episode-of-Care" Basis

The Final Regulations clarify that a hospital facility may satisfy the notification requirements
simultaneously for multiple episodes of care for purposes of notifying the individual about its FAP and potential ECAs. However, if a hospital facility aggregates an individual's outstanding bills for multiple episodes of care before initiating one or more ECAs to obtain payment for those bills, it may not initiate the ECAs until 120 days after it provided the first post-discharge bill for the most recent episode of care included in the aggregation.

iii. Notification Requirements

The Final Regulations make a few changes to streamline the notification component of "reasonable efforts." A hospital facility is required to provide a plain language summary of the FAP to an individual only if and when it sends that individual a written notice about potential ECAs. The Final Regulations also require a conspicuous written notice about the FAP to be included on a hospital facility's billing statement as part of "widely publicizing" the FAP. The Final Regulations replace the oral notification requirement in the Proposed Regulations with a requirement that a hospital facility make a reasonable effort to orally notify an individual about the hospital's FAP and about how the individual may obtain assistance with the FAP application process at least 30 days before the initiation of ECAs against the individual.

iv. Incomplete FAP Applications

Some organizations were concerned that the Proposed Regulations effectively allowed an individual to submit a FAP application form with minimal information on it and thereby automatically defer ECAs for up to 240 days. In response to these concerns, the Final Regulations provide that a hospital facility must suspend ECAs against an individual until either the individual completes the FAP application and the hospital determines whether the individual is FAP-eligible or until the individual has failed to respond to requests for additional information within a reasonable period of time.

v. Complete FAP Applications

Consistent with the Proposed Regulations, the Final Regulations provide that, if a hospital facility receives a complete FAP application from an individual during the application period, the hospital facility will have made reasonable efforts to determine whether the individual is FAP-eligible only if it suspends any ECAs taken against the individual to obtain payment for the care, makes and documents an eligibility determination in a timely manner, and notifies the individual in writing of the determination and the basis for the determination. Because the IRS believes that the reasonableness of the time period required to make an eligibility determination will vary depending upon particular facts and circumstances, the Final Regulations do not adopt a specific period of time in which a hospital facility must make a FAP-eligibility determination. The Final Regulations also do not require a hospital facility to refund any excess amount a FAP-eligible individual has paid for care if such excess amount is less than $5.

vi. Presumptive FAP-Eligibility Determinations Based on Third-Party Information or Prior FAP-Eligibility Determinations
In addition to presumptively determining that an individual is eligible for the most generous assistance available under its FAP (as in the Proposed Regulations), the Final Regulations provide that a hospital facility may presumptively determine that an individual is eligible for less than the most generous assistance available based on information other than that provided by the individual (such as information provided by public and private records) or based on a prior FAP-eligibility determination. However, a presumptive determination that an individual is eligible for less than the most generous assistance available under a FAP only constitutes reasonable efforts to determine FAP-eligibility if the following three conditions are met:

1) The hospital facility must notify the individual regarding the basis for the presumptive FAP-eligibility determination and the way he or she may apply for more generous assistance available under the FAP;

2) The hospital facility must give the individual a reasonable period of time to apply for more generous assistance before initiating ECAs to obtain the discounted amount owed for the care; and

3) The hospital facility must process any complete FAP application that the individual submits by the end of the application period or, if later, by the end of the reasonable time period given to apply for more generous assistance.

The Final Regulations retain the rule that a hospital will not be treated as having made reasonable efforts to determine whether an individual is FAP-eligible simply because it has obtained a signed waiver from the individual disclaiming eligibility.

vii. Reasonable Efforts in the Case of Denying or Deferring Care Based on Past Nonpayment

The Final Regulations include as an ECA the deferral or denial (or the requirement of a payment before providing) medically necessary care because of the individual's nonpayment of one or more bills for previously provided care. Under this circumstance, a hospital facility is not required to provide the oral and written notification about the FAP and potential ECAs at least 30 days in advance of initiating this ECA to have made reasonable efforts to determine the individual's FAP-eligibility. To avail itself of this exception, however, a hospital facility must satisfy each of the following conditions:

1) The hospital facility must provide the individual with a FAP application form (to ensure the individual may apply immediately, if necessary) and notify the individual in writing about the availability of financial assistance for eligible individuals and the deadline, if any, after which the hospital will no longer accept and process a FAP application for the previously provided care at issue. (This deadline must be no earlier than the later of 30 days after the date that the written notice is provided or 240 days after the date that the first post-discharge billing statement for the previously provided care was provided.);

2) The hospital facility must also notify the individual about the FAP by providing a plain language summary of the FAP and by orally notifying the individual about the hospital facility's FAP and about how the individual may obtain assistance with the FAP application process; and

3) If an individual submits a FAP application for previously provided care during the application period, the hospital facility must process the application on an expedited basis to ensure that medically necessary care is not unnecessarily delayed.

viii. Agreements With Other Parties
With minor clarifying revisions, the Final Regulations adopt the rule in the Proposed Regulations related to agreements with other parties. If a hospital facility refers or sells an individual's debt to another party during the application period, the hospital facility will have made reasonable efforts to determine FAP-eligibility only if it first obtains a legally binding written agreement from the other party to abide by certain specified requirements.