KPMG
cutting through complexity

The Final Section 501(r) Regulations

Oregon HFMA Winter Conference

February 19, 2016

Notice

The following information is not intended to be “written advice concerning one or more Federal tax matters” subject to the requirements of section 10.37(a)(2) of Treasury Department Circular 230.

The information contained herein is of a general nature and based on authorities that are subject to change. Applicability of the information to specific situations should be determined through consultation with your tax adviser.

Agenda

- Section 501(r) Introduction
- Effective Date
- Community Health Needs Assessment
- Revenue Cycle
  - Financial Assistance Policy
  - Limitations on Charges
  - Billing and Collection

Background

History

- Prior to 2010, no statutory or regulatory provisions contained tax-exemption requirements specific to hospitals
- Rev. Rul. 56-185
- Rev. Rul. 69-545
- 1991 House Ways & Means Committee Hearings
- State and local tax and regulatory activity
- Class-action lawsuits
- Schedule H, *Hospitals* (Form 990)

Section 501(r)

- Section 501(r) added by Affordable Care Act of 2010
- Impact:
  - Biggest change in hospital tax exemption requirements since 1969
  - First statutory requirements specifically applicable to tax-exempt status of hospitals

General requirements of section 501(r)

- Each hospital operated by section 501(c)(3) organization must meet requirements governing:
  - Community health needs assessments (“CHNAs”)
  - Financial assistance policies (“FAPs”) and emergency medical care policies
  - Limitations on charges
  - Billing & collection processes
- Penalties
  - Loss of tax-exempt status – for hospital or organization operating hospital
  - $50,000 excise tax for failure to meet CHNA requirements

Related provisions

- IRS required to review information about hospital's community benefit activities at least once every 3 years
- Treasury Secretary, in consultation with HHS Secretary, to annually report to Congress:
  - With respect to private tax-exempt, taxable, and governmental hospitals:
    - Charity care
    - Bad debt expenses
    - Unreimbursed costs of means-tested government programs
    - Unreimbursed costs of non-means tested government programs
  - With respect to private, tax-exempt hospitals: costs incurred for community benefit activities
- Must report, after 5 years, study of trends

Sen. Grassley's take on section 501(r)

- "The Chairman's mark of health care reform legislation includes a proposal from Sen. Chuck Grassley, ranking member of the Committee on Finance, to improve the community service, transparency and billing practices of non-profit hospitals."
- "For now, there's no minimum percentage requirement for charity care and community benefit in this bill. That requirement needs more study… The Internal Revenue Service and the Centers for Medicare and Medicaid Services will collect data that I and others will monitor to ensure that non-profit hospitals are doing charitable work commensurate with their financial resources."

Source: September 17, 2009 Press Release on S. 1796, *America's Healthy Future Act of 2009*

Guidance

- July 2011: Notice 2011-52 on CHNAs
- June 2012: Proposed regulations on other requirements of section 501(r)
- April 2013: Proposed regulations on CHNAs
- December 2014: Final regulations
- March 2015: Rev. Proc. 2015-21 on correcting and disclosing failures
- June 2015: Notice 2015-46 on list of providers in FAP

Effective date of final regulations

- Final regulations generally effective for tax years beginning after December 29, 2015
  - For December 31 taxpayers: **January 1, 2016**
  - For June 30 taxpayers: **July 1, 2016**
- Until effective date:
  - Any reasonable interpretation of section 501(r) permitted
  - Deemed compliant if follow final or proposed regulations
- Some related reporting requirements have already taken effect or will take effect sooner

Consequences of failure to satisfy section 501(r)

- Loss of hospital organization's tax exempt status
- Hospital organization operating multiple hospital facilities: hospital facility failing to meet requirements may become taxable
- Section 4959 excise tax (applies to failures to meet CHNA requirements)
- Exceptions:
  - Failures that are not willful or egregious and are corrected and disclosed (does not apply to section 4959 excise tax)
  - Minor omissions that are either inadvertent or due to reasonable cause and are corrected

Common terms and collaboration

Key definitions

- Hospital facility: required by a state to be licensed, registered, or similarly recognized as a hospital
- Hospital organization: section 501(c)(3) organization that operates a hospital facility
- Authorized body of hospital facility:
  - Governing body of hospital organization that operates facility or committee of, or other party authorized by, that governing body
  - Governing body of disregarded entity or partnership that operates facility or committee of, or other party authorized by, that governing body
- Establishing FAP and other policies: authorized body has adopted and policy has been implemented (consistently carried out)
- FAP-eligible: defined in regulations but appears to depend on context
- Operating hospital facility:
  - Organization can operate a facility directly or by contract (e.g., management agreement)
  - Organization operates facility if it is sole member of disregarded entity operating facility
  - Organization operates facility if it owns interest in partnership operating facility (exceptions apply)

Widely available on a web site

- Hospital facility conspicuously posts a complete and current version of document on:
  - Hospital facility's web site
  - If hospital facility doesn't have web site, hospital organization's web site
  - Web site established and maintained by another entity (web site of facility or organization must have conspicuously-displayed link to web page where document posted and clear instructions for accessing)
- Individuals with access to the internet can access, download, view, and print a hard copy of the document
  - Without special hardware or software other than readily available free software
  - Without paying an additional fee
  - Without creating an account or having to provide personally identifiable information
- Hospital facility provides individuals who ask with web site address or URL

Collaboration

- Can collaborate on policies and reports
- Can issue joint policies and reports

Community health needs assessment

section 501(r)(3)

In general

- Facility must conduct CHNA at least once every 3 years (i.e., in current taxable year or either of 2 preceding taxable years)
- Authorized body of facility must adopt implementation strategy to meet health needs identified in CHNA on or before 15th day of 5th month following end of taxable year

Examples

Assume taxpayer conducted its first CHNA in its tax year ended 2013 and will conduct its next CHNA in its tax year ending 2016.

Tax Year	CHNA Due Date	Implementation Strategy Due Date
June 30	June 30, 2016	November 15, 2016
September 30	September 30, 2016	February 15, 2017
December 31	December 31, 2016	May 15, 2017

Conducting CHNAs

- Define the community served
- Assess the significant health needs of the community
- Solicit and take into account public input from persons representing the broad interests of the community, including those with specialized knowledge or expertise in public health
- Adopt a written CHNA report
- Make CHNA report widely available to the public

Community Served

- Take into account all relevant facts & circumstances
  - Geographic area
  - Target populations (e.g., children, women, aged)
  - Principal functions (e.g., specialty area or targeted disease
- May not define to exclude medically underserved, low-income, or minority populations
- Must take into account all patients without regard to ability to pay or FAP-eligibility
- For multiple buildings under 1 license, community is the aggregate of all buildings

Assessing Health Needs

- Identify significant health needs using all facts and circumstances
- Prioritize needs using any criteria
  - Examples: burden, scope, severity, urgency, estimated feasibility or effectiveness of interventions, health disparities, or importance to the community
- Identify resources potentially available to address needs (e.g., organizations, facilities, programs – including those of facility)
- Examples include financial & other barriers to care, preventing illness, adequate nutrition, social/behavioral/environmental factors that influence health

Persons Representing Broad Interests of Community

- State, local, tribal, governmental public health department (or equivalent) or SORH (state office of rural health)
  - Knowledge, information, and expertise relevant to needs of community
- Members of medically underserved, low-income, minority populations or individuals or organizations serving or representing such persons and interests
  - "Medically underserved" – populations experiencing health disparities; at risk of inadequate medical care
  - Examples: uninsured or underinsured, geographic, language, financial, other barriers
- Written comments received on most recent CHNA & implementation strategy
- Solicit input
  - Identify and prioritize significant health needs and
  - Identify resources potentially available to address needs

Contents of CHNA report

- Definition of community served and how determined
- Description of process and methods used to conduct CHNA
- Description of how input was solicited and taken into account
- Prioritized description of significant health needs and description of process and criteria used to identify needs as significant and their priority
- Description of resources potentially available to address identified needs
- Evaluation of impact of actions taken to address needs since last CHNA

Process and Methods

- Describes data and other information used in CHNA
- Describes methods of collecting and analyzing data and information
  - Data obtained from external source material may be cited instead
- Identifies any parties with whom collaborated or contracted for assistance in conducting CHNA

Public Input

- Generally summarizes any input provided
  - How
  - Over what time period
  - Names organizations and summarizes nature and extent of input
  - Describes medically underserved, low-income, minority populations being represented by organizations or individuals
- Does not need to identify specific individuals
- If facility solicits input but fails to obtain from any source, report should describe solicitation efforts

Separate or Joint CHNAs

- Separate CHNAs
  - May collaborate with others but must document separately unless adopt a joint CHNA
  - May be substantively identical to other CHNAs
- Joint CHNAs
  - Joint report conducted with collaborators
  - Meets all requirements of a CHNA report
  - CHNA report clearly applies to facility
  - All organizations in joint report identify community as same
  - Adopted by authorized body

Implementation strategy

- Written plan that addresses each significant health need identified in CHNA
- Plans to address needs
  - Describes actions facility intends to take to address need and the anticipated impact of such actions
  - Identifies resources that facility plans to commit to address the need
  - Describes planned collaboration with other facilities or organizations
- Why not addressing need
  - Examples: resource constraints; other organizations or facilities are addressing; lack of expertise or competency; low priority; lack of effective interventions

Financial Assistance Policy

section 501(r)(4)

In general

- Hospital facility must establish written FAP
  - Must apply to all emergency and medically necessary care provided by facility or in facility by a substantially-related entity
  - Must be widely publicized
  - Not required to include all discounts offered by facility
  - Regulations do not specify the amount or type of financial assistance that must be provided
- Facility must establish written emergency medical care policy

Contents of FAP and application forms

- Eligibility criteria for each type of assistance
- Whether assistance includes free or discounted care
- Basis for calculating amounts charged to patients
- Information regarding amounts generally billed (AGB)
- Method of applying for financial assistance
- Actions taken in event of nonpayment (if no separate billing and collections policy) or reference to separate policy
- Information and documentation individual may have to provide
- Information obtained from sources other than the applicant and whether and when prior eligibility is taken into account
- Contact information
- List of providers delivering emergency or other medically necessary care that specifies whether or not covered by the FAP

List of Providers in FAP

- FAP must include a list of providers, other than the hospital facility itself, delivering emergency or other medically necessary care in the hospital facility and specify which providers are covered by the hospital facility's FAP and which are not
  - Names of individual doctors, practice groups, or any other entities
  - Name used either to contract with the hospital or to bill patients for care provided
  - Name of department, rather than the specific names of doctors or practice groups, and indicate the services
- If a provider is covered by a hospital facility's FAP in some circumstances but not in others, the hospital facility must describe the circumstances in which the emergency or other medically necessary care delivered by the provider will and will not be covered by the FAP
- May maintain the list of providers in a document separate from the FAP that contains the date on which it was created or last updated
  - FAP must state that the list of providers is maintained
  - FAP must explain how members of the public may readily obtain it free of charge, both online and on paper
- If only change is updating the provider list, no requirement for authorized body to adopt
- Must update at least quarterly

Widely publicizing FAP

- FAP, application, and plain language summary of FAP widely available on website
- Hard copies of FAP, application, and plain language summary available upon request and without charge by mail and in public locations
- Community notified and informed of FAP in manner reasonably calculated to reach most affected individuals
- Patients notified and informed about FAP
  - Paper copy offered as part of intake or discharge process
  - Conspicuous written notice on billing statements
  - Conspicuous public displays in public locations in facility
- FAP, application and plain language summary translated into primary languages of all significant populations with limited English proficiency

Plain language summary

- Must contain:
  - Description of eligibility & assistance available
  - Summary of how to apply
  - URL and physical locations of FAP and application form
  - Instructions to obtain free copies by mail
  - Contact information, including phone and physical location for additional information and for assistance with application (can be facility, government agency or nonprofit)
  - Statement of availability of translations of FAP, application, and plain language summary
  - Statement that FAP-eligible patients may not be charged more than AGB for emergency or medically necessary care
- Must be widely publicized

Emergency medical care policy

- Facility must establish written policy requiring the provision of emergency medical care without discrimination and regardless of whether patient is FAP-eligible
- Policy must prohibit facility from engaging in actions that discourage seeking medical care
  - E.g., demanding payment before treatment or permitting debt collection activities that interfere with provision of medical care
- Policy generally meets requirements if it requires facility to comply with EMTALA and contains the prohibition requirement

Limitation on charges

section 501(r)(5)

In general

- Hospital facility and any substantially-related entity must limit amounts charged to FAP-eligible individual
  - May not charge more than AGB for emergency or other medically necessary care
  - Must charge less than gross charges (chargemaster rates) for all other care covered by FAP
- Amounts charged are only those amounts for which patient is personally responsible

Look-back method

- AGB percentage: Divide all claims for emergency or medically necessary care allowed by health insurers by gross charges associated with
  - Medicare alone or with private insurers, or
  - Medicaid alone, with Medicare, or with Medicare and private insurers
- Amount “allowed” by heath insurers includes co-pays, deductibles, and amounts paid or reimbursed by insurance
- Multiply hospital facility’s gross charges by AGB percentage
- Compute AGB percentage at least annually over 12 month period
- Apply new AGB percentages by 120th day after 12 month period
- Each hospital facility must compute separate AGBs, unless they share Medicare provider number

Prospective Medicare or Medicaid method

- Determine AGB using the billing and coding process as if the individual were Medicare fee-for-service or Medicaid beneficiary
- AGB is the amount Medicare or Medicaid would allow for the care, including amounts paid or reimbursed and amounts paid by individual as co-payments, co-insurance, or deductibles
- Facility permitted to use Medicare, Medicaid, or both
  - If facility uses both, FAP must describe when Medicaid or Medicare will be used

Gross charges

- Facility must charge FAP-eligible individual less than gross charges for any medical care covered under FAP
- Billing statement may state gross charges provided that amount a FAP-eligible individual is personally responsible for paying is actually less than gross charges

Safe harbor

- Violation of limitation on charges rules okay under safe harbor
  - Charge in excess of AGB was not made or requested as a pre-condition of providing medically necessary care to FAP-eligible individual
  - At the time of the charge, FAP-eligible individual has not submitted a complete FAP application to facility or otherwise been determined to be FAP-eligible
  - If individual subsequently submits complete FAP application and is determined to be FAP-eligible, facility refunds amount individual has paid in excess of the amount owed (unless overcharge is less than $5)

Billing & collection

section 501(r)(6)

In general

- Facility may not engage in ECAs before making reasonable efforts to determine FAP-eligibility
- ECAs include those initiated against any individual who accepted or is required to accept financial responsibility

Extraordinary collection actions

- Selling debt to a third party (generally)
- Reporting adverse information to credit bureaus
- Deferring, denying, or requiring prepayment before providing medically necessary care due to a prior nonpayment relating to FAP-eligible medical care
  - If individual has outstanding bills, presumption is that prepayment is related to such bills unless hospital can demonstrate otherwise
- Actions requiring legal or judicial processes, including
  - Liens
  - Foreclosures
  - Attaching or seizing bank account or personal property
  - Arrest
  - Writ of body attachment
  - Garnishing wages

Extraordinary collection actions – Exceptions

- Certain sales of debt if made pursuant to a legally binding, written agreement with detailed provisions
- Liens on certain judgments, settlements, and compromises arising from personal injuries for which hospital provided care
- Bankruptcy claims

Reasonable efforts

- If FAP-eligibility undetermined
  - Hospital may not engage in ECAs for 120 days from first post-discharge bill
- Special rules apply for
  - Presumptive eligibility
  - Deferring or denying care
  - Incomplete applications
- If application submitted within 240 days of first post-discharge bill, must suspend all ECAs
- Complications and exceptions apply

Reporting & disclosure

Reporting

- Form 990
  - Prepare Schedule H, Part V, Section B
  - Report any excise tax owed under section 4959
  - Attach audited financial statements
- Form 990-T – report and pay noncompliant hospital facility income
- Form 4720 – report and pay section 4959 excise tax

Observations

Observations

- Regulations can be broken into two main pieces:
  - CHNAs
  - Revenue cycle (everything else)
- Three components to section 501(r) compliance (then repeat)
  - Gap analysis
  - Policy writing
  - Implementation
- Revenue cycle provisions are as much about process as they are about policies
- Look for cost/benefit analysis opportunities
- There are requirements in the regulations that seem more difficult to implement every time you think about them
- Unless proposed regulations were followed in minute detail, there is work to do to come into full compliance with the final regulations

Sue Robison, Managing Director
Development and Exempt Organizations
Seattle, WA
Phone: 1.206.913.4492
E-mail: srobison@kpmg.com