

Time to Freshen Up Your Charity Care Policies: Treasury and IRS Issue Final 501(r) Regulations

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Among the many new requirements of the Patient Protection and Affordable Care Act of 2010 (“Affordable Care Act” or “ACA”)¹ are amendments to the Internal Revenue Code (“IRC”) that formalize and impose some uniformity in the manner in which IRC Section 501(c)(3) hospitals assess the need for, and provide community benefit in exchange for, their tax-exempt status. Specifically, the ACA requires “hospital organizations” to:

- (i) conduct a community health needs assessment (“CHNA”) and adopt an implementation strategy for addressing community health needs so identified at least once every three years (IRC Section 501(r)(3)),
- (ii) establish written financial assistance and care for emergency medical conditions policies satisfying certain criteria (IRC Sections 501(r)(4) – (r)(5)), and
- (iii) make reasonable efforts to determine whether an individual is eligible for such financial assistance before engaging in “extraordinary collection actions” (“ECAs”) to collect fees for services provided (IRC Section 501(r)(6)).

On December 31, 2014, the U.S. Department of the Treasury (“Treasury”) and the Internal Revenue Service (“IRS”) published in the *Federal Register* final regulations implementing the above Section 501(r) requirements (“Final Regulations”).² The proposed 501(r) regulations promulgated by Treasury and the IRS on June 26, 2012, and April 5, 2013 (collectively, “Proposed Regulations”),³ formed the basis of the Final Regulations. Because compliance with the Section 501(r) requirements is a condition for maintaining Section 501(c)(3) status and the Final Regulations significantly modify

¹ Public Law 111-148 (124 Stat. 119 (2010), enacted March 23, 2010).

² 79 Fed. Reg. 78954 (Dec. 31, 2014), available at <https://www.federalregister.gov/articles/2014/12/31/2014-30525/additional-requirements-for-charitable-hospitals-community-health-needs-assessments-for-charitable>.

³ See 77 Fed. Reg. 38148 (June 26, 2012); 78 Fed. Reg. 20523 (April 5, 2013).

key provisions of the Proposed Regulations, hospitals would be well served to review the Final Regulations at this point. The Section 501(r) charity care requirements, in particular, continue to receive intense scrutiny. For example, U.S. Senator Charles Grassley, in one of his first acts as Chair of the Senate Judiciary Committee, sent an extensive information request on January 16, 2015, to a hospital regarding its debt collection practices, suggesting significant deficiencies in its approach to debt collection.⁴

Some of the provisions of the Proposed Regulations, particularly those governing collection practices, were both burdensome and controversial, and the Final Regulations temper a number of these requirements. On the other side, a few of the changes expand the hospital's obligations. This Client Alert addresses some of the more significant differences between the Proposed Regulations and Final Regulations governing charity care programs.

Background

Although the Section 501(r) provisions were generally effective upon passage of the ACA (i.e., for taxable years beginning after March 23, 2010),⁵ the Act contained little guidance regarding what would constitute compliance. On June 26, 2012, Treasury and the IRS published a notice of proposed rulemaking ("NPR") regarding the requirements of Sections 501(r)(4) – (r)(6); on April 5, 2013 they jointly published an NPR regarding the CHNA requirements of Section 501(r)(3) and the consequences for failing to meet the Section 501(r) requirements. In January 2014, Treasury and the IRS confirmed that hospitals could rely on the 2012 and 2013 NPRs for compliance with the statute, pending promulgation of final regulations or other guidance.⁶ Under the Final Regulations, hospitals may continue to rely on the 2012 and 2013 NPRs as reflecting a reasonable, good faith interpretation of Section 501(r) until the first taxable year beginning after December 29, 2015. However, because many of the provisions of the Final Regulations are less onerous than those found in the Proposed Regulations, we believe that Section 501(c)(3) hospitals should review their charity care policies in light of these changes.

Charity Care Policy Changes⁷

Third-Party Providers: Under the ACA, a hospital meets the requirements of Section 501(r)(4) only if it establishes a written financial assistance policy ("FAP") that applies to all emergency and other medically necessary care it provides. Recognizing that hospital patients are often seen and separately billed by third-party providers, including private physician groups, in the hospital facility, the Final Regulations add the requirement that

⁴ Senator Grassley's letter is available at <http://www.grassley.senate.gov/sites/default/files/news/upload/CEG%20to%20Mosaic%20%28charitable%20hospital%20requirements%29%2C%20-16-15.pdf>.

⁵ IRC § 501(r)(3), relating to the CHNA, applies to taxable years beginning after March 23, 2012.

⁶ Notice 2014-2 (2014-3 IRB 407) (January 13, 2014).

⁷ This Client Alert focuses on the changes to the regulations implementing Sections 501(r)(4) – (6), governing charity care policies. Requirements governing the CHNA process, as well as the numerous charity care policy requirements not changed in the Final Regulations, while not discussed here, should nonetheless be addressed by all Section 501(c)(3) hospitals.

each FAP (i) list the providers that deliver emergency or other medically necessary care in the hospital facility, and (ii) specify which providers are and are not covered by the FAP. The FAP must also apply to entities delivering such care in which the hospital has certain ownership interests. If the FAP does not apply to a third party operating a facility's emergency department, the hospital may lose the ability to consider the operation of its emergency room for purposes of the 501(c)(3) public interest test.

Eligibility Criteria: The Proposed Regulations would have required hospitals to include in the FAP the eligibility criteria for all of the discounts, free care, and other levels of assistance provided by the facility. However, the Final Regulations recognize that not all discounts will necessarily be based upon ability to pay, such as discounts for self-pay and out-of-state patients and discounts mandated under state law, and so specify that the FAP need only describe discounts that are expressly part of the FAP. The Final Regulations also provide that discounts not encompassed by the FAP may not be reported as financial assistance on Schedule H of the hospital's Form 990, thus reducing the dollar amount of community benefit that can be claimed by the hospital, nor may they be considered community benefits under the Affordable Care Act.

In response to public comments submitted after publication of the Proposed Regulations, Treasury and the IRS also declined to require any specific eligibility criteria for a hospital's FAP, leaving intact the flexibility that the Proposed Regulations gave to Section 501(c)(3) hospitals to determine the criteria under which patients would be eligible for financial assistance and the level of that assistance.⁸

Documentation of Eligibility: The Proposed Regulations require the FAP to describe the information or documentation that may be required as part of a patient's application for financial assistance. However, the Final Regulations make it clear that a hospital may grant financial assistance under the FAP even if an applicant fails to provide such information. In addition, the Final Regulations amend the definition of a "FAP application" to clarify that it includes information not only provided in writing, but also information provided orally. The Final Regulations also allow the hospital to base its eligibility determination upon information other than that provided by the patient, as well as on a prior FAP eligibility determination. In order to do so, the FAP must describe what other information will be considered, and whether and under what circumstances a prior decision will be used to presumptively determine current FAP eligibility.

Approval of the FAP or Billing and Collections Policy: The Proposed Regulations provided that either the FAP or a separate written billing and collections policy must describe the actions that may be taken in order to obtain payment for medical care. However, the Proposed Regulations specified that only the FAP must be approved by the hospital's governing body. The Final Regulations provide that both the FAP and, if applicable, the separate billing and collections policy be approved by the hospital's board.

⁸ Note, however, that some states, such as New York, do have specific requirements for eligibility standards for financial assistance offered by hospitals.

Publicizing the FAP: The Proposed Regulations required that a description of the efforts undertaken to “widely publicize” the FAP either be included in the FAP or made available in writing. To reduce the documentation burdens associated with the FAP, the Final Regulations eliminated this requirement and require only that the FAP be “widely publicized,” as defined by the Final Regulations.

Availability of the FAP: The Proposed Regulations would have required hospitals to make paper copies of the FAP available upon request and without charge in public locations in the hospital. The term “public locations” was not defined in the Proposed Regulations, nor is it defined in any significant detail in the Final Regulations. However, in response to concerns that this requirement would compel copies of the FAP to be available in *all* public locations of the hospital, the Final Regulations clarify that “public locations” include, at a minimum, the emergency room and admissions areas. In addition, the availability requirement may be satisfied by access through the hospital website, so long as paper is provided unless the individual indicates a preference for an electronic version. The requirement that visitors to the hospital be notified of the FAP through a conspicuous public display or other measures reasonably calculated to attract attention will also be satisfied if notices regarding the FAP are posted, at a minimum, in the emergency room and admissions areas.

Plain Language Summary of the FAP: In line with the requirements geared towards informing patients of the availability of financial assistance, the Proposed Regulations would have required each billing statement sent to a hospital’s patients to include a “plain language summary” of the FAP. The Final Regulations require only that the billing statements include a conspicuous written notice informing the recipient of: (i) the availability of assistance under the FAP;⁹ (ii) a phone number where information regarding the FAP and the application process can be obtained; and (iii) the website address where copies of FAP documents, including the plain language summary, may be obtained.

The Proposed Regulations also provided that the plain language summary must be provided to patients “before discharge,” which led some to believe that it must be provided upon discharge. The Final Regulations clarify (i) that the summary may be offered, rather than provided, to patients; and (ii) that this may be done as part of either the intake or discharge process. The substitution of “offer” for “provide” allows individuals to (i) refuse to take a copy because they know that they are ineligible, or (ii) indicate that they will access it electronically. The Final Regulations also require the summary to contain information about how to apply for financial assistance, as well as contact information (the phone number *and* physical location¹⁰) of either the hospital office or department that will provide assistance with the FAP application process, or of at least one community organization or government agency that will do so.

⁹ Assistance with FAP applications can be provided by the hospital itself, a community-based organization, or a government agency.

¹⁰ The Final Regulations remove the requirement in the Proposed Regulations that a room number be provided.

Translations of the FAP Documents: The Proposed Regulations would have required that hospitals translate the FAP documents into the language of any limited English proficiency (“LEP”) population exceeding 10 percent of the community served by the hospital. The Final Regulations make this requirement more onerous, lowering the threshold to cover LEP groups consisting of the lesser of 5 percent of the community or 1,000 individuals, consistent with the Department of Health and Human Services’ “safe harbor” for compliance with Title VI of the Civil Rights Act.¹¹ A hospital may use any reasonable method to determine the size of its LEP populations.

Debt Collection Activities: The Proposed Regulations would have required a hospital’s emergency medical care policy to prohibit actions that discourage patients from seeking emergency medical care, such as demanding payments before treatment or permitting debt collection activities in the emergency department or elsewhere where such activities could interfere with the provision of such emergency services. The Final Regulations clarify that they are not intended to prohibit all payment activities, such as requesting insurance information or collecting co-payments, and revise the rules to prohibit only “debt collection activities that interfere with the provision, without discrimination, of emergency medical care,” regardless of where they occur.

CMS guidance issued subsequent to the 2012 NPR makes clear, however, that the Emergency Medical Treatment and Active Labor Act (“EMTALA”) prohibits actions that delay screening and treatment for an emergency medical condition, such as inquiring about payment or insurance status, or from using the registration process to unduly discourage individuals from remaining for further evaluation. Hospital practices for registration of emergency room patients will need to be carefully structured to comply with both EMTALA and the 501(r) requirements.

Billing and Collection: The ACA’s FAP provisions provide that the ACA’s requirements are satisfied only if the hospital does not engage in ECAs¹² before making reasonable efforts to determine whether an individual is FAP-eligible.¹³ The Final Regulations remove from the definition of an “extraordinary collection action” a lien against the proceeds from a patient’s suit against a third party, and they clarify that the sale of an individual’s debt will not be considered an ECA if, prior to the sale, the hospital enters into an agreement regarding the debt, satisfying certain conditions specified in the Final Regulations. On the other hand, the Final Regulations add to the definition of “extraordinary collection action” the deferral or denial of medically necessary care due to nonpayment for care previously provided, or the requirement that previously provided care be paid for before currently medically necessary care will be administered. Special FAP notification requirements apply in these situations. The Final Regulations also contain a presumption that a pre-payment requirement for an individual with outstanding bills is due to nonpayment, unless the hospital can demonstrate the action is based upon other factors.

¹¹ 42 U.S.C. § 200d, *et seq.*

¹² “Extraordinary collection actions” were defined in the Proposed Regulations as actions related to obtaining payment (i) that require a legal or judicial process, (ii) involve selling an individual’s debt to another party, or (iii) involve reporting adverse information to a consumer credit agency or bureau.

¹³ This includes ECAs against any other individual who has accepted responsibility for the patient’s bill.

Notice of Availability of the FAP: The Proposed Regulations would have required a hospital to notify a patient of the FAP within 120 days of the first bill and to process any FAP application submitted within 240 days of that bill. To account for patients who receive care over an extended period of time, the Final Regulations start these two periods on the date of the first post-discharge billing statement. The Final Regulations also provide that if a hospital aggregates an individual's outstanding bills from multiple episodes of care for the purposes of initiating an ECA, the 120-day period runs from the first post-discharge bill for the most recent episode of care. Oral notification about the FAP is now only required to be given to individuals against whom the hospital intends to initiate ECAs, rather than all patients, and the notice need only advise the individual of the ECAs that the hospital intends to initiate, as opposed to all ECAs that might be initiated, as was the case in the Proposed Regulations. The Final Regulations also require the hospital to provide the plain language summary of the FAP to individuals against whom the hospital actually intends to engage in ECAs, instead of all patients against whom it might one day be able to do so. The Final Regulations also eliminate any separate requirement to document notification actions¹⁴ and allow notifications electronically to individuals who express a preference to receive communications in that manner.

Conclusion

As can be readily seen, the charity care requirements of the IRC are extensive and quite complex. Whether or not a hospital's FAP was written or revised with the Proposed Regulations in mind, a thorough review of the FAP, in light of the issuance of the Final Regulations, is now in order.

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*This Client Alert was authored by **Arthur J. Fried**. For additional information about the issues discussed in this Client Alert, please contact the author or the Epstein Becker Green attorney who regularly handles your legal matters.*

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¹⁴ It should be noted that hospitals must nonetheless report whether and how they made reasonable efforts to determine FAP eligibility on the Form 990, and are responsible for maintaining records to substantiate information reported on the 990.

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