NOT-FOR-PROFIT 501(c)(3) STATUS HINGES ON NEW FINANCIAL ASSISTANCE REGULATIONS

UPDATES ON THE 501(r) TAX REGULATIONS

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A New Era in Healthcare Compliance

Prior to the passage of the Patient Protection and Affordable Care Act (PPACA), the tax exemption standard for nonprofit hospitals was based on a “community benefit” standard set forth by the Internal Revenue Service (IRS) in Revenue Ruling 69-545. The Ruling laid out the facts and circumstances test containing multiple factors for determining community benefit. Prior to this standard, nonprofit hospitals were held to more narrow “charity care” standards set out in 1956. While those standards have been modified somewhat over the years, at no point since those respective decisions, until now, was a set of required action steps mandated that would serve as a bright line test to determine continued tax-exemption for a 501(c)(3) hospital. While charity care remains a key component in maintaining exemption to date, 501(r) provides the most defined, prescriptive and comprehensive set of requirements that a 501(c)(3) hospital has received to maintain tax exempt status. Section 501(r) provides the industry, for the first time, such requirement of action.

SNAPSHOT: ACTIONS NEEDED TO PROTECT 501(C)(3) STATUS

- ENSURE ASSISTANCE IS MADE WIDELY AVAILABLE: Prescriptive Rules Will Require A ‘Tick And Tie’ Accountability For Of A Multitude Of Requirements
- INTEGRATE THE LIMIT ON CHARGES REQUIREMENTS FACILITY WIDE: Intra-Facility Coordination Will Be Required To Ensure Gross Charge Violations Do Not Occur
- ASSESS BILLING AND COLLECTION PROCESSES: Coordination With Third Party Debt Collection Vendors Will Be Required To Ensure Patients Eligible For Financial Assistance Are Not Negatively Affected By Collection Efforts

PRIOR REQUIREMENTS UNDER REV. RUL. 69–545

While Section 501(r) does in fact add to the Internal Revenue Code four clearly defined requirements for 501(c)(3)hospitals, the new Code section does not remove the requirement to comply with community benefit standards set forth years ago in Rev. Rul. 69-545—rules designed to ensure that a tax-exempt hospital operates to serve a public interest rather than a private one. Where adherence to Section 501(r) is generally more prescriptive in nature, the guidance under Rev. Rul. 69-545 tends to be more subjective and has been the focus of much debate and deliberation over the years.

The community benefit factors included in Rev. Rul. 69-545 are:

1) Operation of an emergency room open to all members of the community without considering ability to pay;
2) Being governed by a governing body primarily composed of independent community members;
3) Use of surplus revenue for facilities improvement, patient care, and medical training, education, and research;
4) Provision of inpatient hospital care for all people in the community able to pay, including those covered by Medicare and Medicaid, and
5) Maintaining an open medical staff with privileges available to all qualifying physicians.

Perhaps the strongest evidence that these five factors continue to hold relevance in today’s healthcare industry is that when the IRS revised the Form 990 in 2008, each of these factors found a place within a question, a schedule, or a required disclosure.

This revenue ruling was actually meant to augment an older standard—the “charity care” standard set forth in Rev. Rul. 56-185. This precursor to the community benefit standard included hallmark characteristics of the healthcare industry such as the inability to deny treatment to indigent patients in need, the right to furnish services at reduced rates and below cost, the ability to set aside earnings for capital improvements, and limitations on private use of facilities by physicians, surgeons, etc. While the charity care standard of 1956 was made generally obsolete by the community benefit standard in 1969, echoes of its principles ring loudly in arguments made in recent years by Congressional leadership.

MOMENTUM LEADING TO THE PASSAGE OF SECTION 501(R)

While the evolution of tax-exempt hospital requirements may be traced back many decades, one easily notes the increase in scrutiny and attention brought to the industry within the last eight to 10 years due primarily to Congressional leaders such as Senator Charles Grassley, R-Iowa.

Earlier versions of the bill from the Senate Finance Committee contained minimum required levels of charity care; however the bill did not specify at that time what the minimum would be, and the provision was eventually stricken from the final bill. It is the only substantive change between the Senate Finance Committee version
and the final version. However it is important to note the Congressional Momentum behind 501(r) as verbalized on numerous occasions by Senator Grassley:

“...there is often no discernible difference between the operations of taxable and tax-exempt hospitals.”
“Tax-exempt hospitals don’t have many measures of accountability for their special status.”

SECTION 501(R) AND 990 SCHEDULE H

There is a strong correlation between Section 501(r) and the Form 990 Schedule H. Both were written by groups of people within the executive and legislative branches that have been working together for some time to push the new legislation through passage. For this reason, it is understandable when studying Schedule H, Part V, Section B that one may assume the schedule has been updated and that the instructions to the schedule reflect current law. This is not correct as of the 2012 version of the form. As of this writing, the IRS has not updated its Form 990 Schedule H to reflect the regulations under Section 501(r). The schedule and its instructions will be updated to reflect official guidance under Section 501(r) when final regulations are published in the Federal Register.

While Section 501(r) and the accompanying regulations have gone through multiple revisions, the questions and information in 990 Schedule H have remained static for several years. This means that 990 Schedule H filers cannot rely on any guidance provided in the instructions to the schedule to be representative of the law under Section 501(r). Nevertheless, 501(c)(3) hospital facilities are required to comply with the provisions of Section 501(r) as the applicable effective dates pass, and the failure of Schedule H to request information about a particular area is not license to ignore the underlying statute.

Focus on Nonprofit Hospitals

It is important from the outset to clarify who is subject to the requirements of Section 501(r). From a legal entity standpoint, Section 501(r) applies to incorporated or unincorporated associations that are exempt from income tax under Section 501(c)(3) as “hospital organizations,” which for the purpose of these provisions are defined as organizations that operate one or more “hospital facilities.” A hospital facility is defined as a facility that is required by a state to be licensed, registered, or similarly recognized as a hospital. Multiple buildings operated under a single state license are treated as a single facility. The definition does not apply to facilities located outside of the 50 states and the District of Columbia, nor does it apply to facilities in US possessions or territories. Section 501(r) requires that if a single tax-exempt organization operates more than one hospital facility, each facility must separately meet the requirements (discussed below).

Defining a hospital facility within this context is not as cut and dry as it might initially seem. Certainly reference to state law is a convenient and, on its face, less burdensome way to settle a definition; however, a comparison of licensing statutes across the nation reveals that the definition of “hospital” and what type of facility would be required to be licensed as one varies quite a bit. States such as North Carolina use a narrow definition, excluding many organizations from licensure due to a requirement to provide access for patient stays greater than 24-hours, among other requirements. “Hospital” as defined in New York, for example, can include practically any facility in which a physician supervises patients other than a sanitarium. Some commenters have remarked that using varying state definitions could lead to unequal application of Federal law. The IRS has not commented on how this unintended potential consequence of the statute affects its data collection on hospitals, but it is a factor that the industry should not overlook.

Note that the definition includes the word “operates.” Operating a hospital facility, for the purpose of Section 501(r), has been clarified to include the following organization and management structures:

- A hospital facility operated by an organization’s own employees,
- A hospital facility operated by contracting out the operations to another organization, such as a management company,
- A hospital facility operated by a single-member LLC to which the hospital organization exempt under Section 501(c)(3) is the sole member, and
- A hospital facility operated by a joint venture, LLC, or similar pass-through construct unless one of the following exceptions apply:
  - The organization does not have sufficient control over the hospital facility to ensure that the operation furthers an exempt purpose described in Section 501(c)(3), and thus treats the operation as an unrelated trade or business under Section 513(a), or
  - The organization has at all times since March 23, 2010 (the passage of PPACA) been organized and operated primarily for educational or scientific purposes and has not engaged primarily in the operation of a facility, and pursuant to an agreement dated prior to the passage of PPACA, does not own...
more than 35% of the capital or profit interest in the partnership, does not own a general or similar partner interest, and does not have sufficient control to ensure the facility complies with the requirements under Section 501(r).

Addressing the matter of how hospital facilities operated through joint ventures should be treated was very high on the list of questions from the industry when Section 501(r) was passed in 2010. The IRS was, in the beginning, insistent that hospitals operated within joint ventures to which a Section 501(c)(3) organization was a partner be required to comply with Section 501(r) in most if not all cases. In response to public outcry, the IRS developed an interesting “gotcha” provision stating that joint venture hospitals would not have to comply with Section 501(r) so long as they are treated as an unrelated trade or business and, thus, subject to corporate tax rates. The IRS was a bit more lenient with tax-exempt organizations that are not themselves healthcare organizations, but happened to own some minority share in a joint venture hospital, providing that such a hospital would not have to comply with Section 501(r); basically, because the parent organization(s) in that scenario do not derive their tax exemption principally from the operation of a hospital facility.

Section 501(r) is technically also applicable to any other organization which the IRS determines “has hospital care” as its principal function or constitutes the basis for its exemption under Section 501(c)(3)\(^8\), although the specifics of how the IRS will come to such a conclusion has yet to be determined. The Service has indicated that the use of such criteria will be prospective only after notice is given and an opportunity for comment has passed. Finally, a subject of much discussion is how the IRS will apply the provision of Section 501(r) that requires hospital organizations operating multiple hospital facilities to meet compliance on a facility-by-facility basis. The immediate question is, “What happens when one or more hospital facilities within a hospital organization fails to comply with Section 501(r), but one or more other facilities comply?” Guidance from the IRS has suggested that it does not seek to revoke an entire organization’s tax-exempt status for the failures of one or more facilities within a group. The Proposed Regulations indicate that should a hospital facility within a larger organization fail to qualify under Section 501(r)—and the hospital facility does not qualify under any of the small and unintentional failure exceptions discussed in the regulations—the non-compliant facility will be subject to tax for that year under Section 11 of the Internal Revenue Code.\(^9\)

Of particular concern is how Section 501(r) applies to the so called “dual status” hospitals—hospital organizations that are affiliated with a governmental entity and could qualify for tax-exemption under a different section of the Code than 501(a), but for whatever reason have earned such an exemption. The two most common causes of this problem are hospitals that once needed an exemption under Section 501(c)(3) but over the course of their existence became aligned with a governmental entity, and governmental hospitals that obtained exemption under Section 501(c)(3) to take advantage of sponsoring a 403(b) pension plan for employees. Because the IRS will waive the Form 990 filing requirement for governmental hospitals, it is not always clear whether a governmental hospital is a dual status hospital.

Organizations that are unsure regarding their potential dual status should contact the IRS for confirmation.

Hospitals can utilize the IRS’ Master File to help make this determination. The site is a bit clumsy to navigate, but it does provide good insight into the IRS’s classification of all 501(c)(3)’s. Section 501(r) makes no mention one way or the other about its applicability to dual status hospitals; however legal commentators assert that absence of special mention likely means that dual status hospitals are required to comply. The IRS has, in its most recent summary of Proposed Regulations, stated that no special exception from Section 501(r) has been considered for dual status hospitals, however comments for alternative methods of compliance are welcomed.

Financial Assistance Policy

While it has long been a requirement of nonprofit hospitals to have in place a financial assistance policy (also referred to as a “charity care policy”) providing guidelines on discounts for indigent and low-income patients, it has not been until the passage of Section 501(r) that Congress provided details on this requirement.\(^10\) Tied in with a public charity’s exempt purpose to provide assistance to certain identified charitable classes of persons, it is through the requirements of Section 501(r) that an organization can demonstrate that its charitable care is applied consistently and without favoritism or prejudice to the charitable class that it has identified. 501(r) does not mandate a minimum profile of an individual who is eligible for financial assistance.

Key to the following discussion is that while the statute requires that a hospital facility’s financial assistance policy be in writing and adhere to points listed below, at no point has Congress mandated a minimum level of care provision, minimum eligibility criteria, or procedures for application. Rather, it is intended that when all of this information is in writing and widely available to a hospital facility’s community, it is the hospital facility that will determine whether the parameters of financial assistance are reasonable and truly serve as a benefit to the community. One could reasonably determine that the healthcare industry and our local communities will drive this determination.
There are five elements of a Financial Assistance Policy (“FAP”):

1) Eligibility criteria for financial assistance and whether assistance includes free or discounted care, or both. The criteria included in the FAP should encompass all financial and non-financial factors the hospital facility will take into account when determining eligibility for financial assistance. If a facility is found to use factors not specified in its published policy, it could be found to be non-compliant with the statute. The statute does not provide for a minimum level of free or discounted care, nor minimum criteria for eligibility—those decisions remain under the discretion of the hospital facility’s governing body.

2) The basis for calculating amounts charged to eligible patients. The statute makes clear that a hospital facility cannot charge persons eligible for financial assistance gross charges, also called “chargemaster rates.” A reduction from gross charges must take place, and that calculation should be specifically stated in the FAP. The policy should contain the following statement, discussed in detail below:

   “Following a determination of financial assistance eligibility, an individual will not be charged more than an amount generally billed for emergency or other medically necessary care.” The policy should state the permitted methods by which the facility computes and defines “amounts generally billed,” also discussed below.

3) The method for applying for financial assistance. The FAP must describe how an individual may apply for financial assistance. Similar to the provision above to fully disclose all eligibility criteria, the facility’s FAP should include all the information and documentation it requires an individual to submit as part of his or her application for assistance. Financial assistance may not be denied based on the omission of information or documentation if those items are not specifically required by the policy or the policy’s application form. Many hospital facilities choose to use a separate application form that contains an abbreviated summary of requirements—care should be taken that a full copy of the policy is available through the same channels as the summary application.

4) In the case of an organization that does not have a separate billing and collections policy, the actions the organization may take in the event of nonpayment. Prior to the release of the statute, many hospitals had a separate billing and collections policy. In such an event, the requirements of Section 501(r) relating to the actions an organization may take in the event of nonpayment apply to separate policies as well as those nested within the greater financial assistance policy. The Service has indicated that it expects to specifically require detailed inclusion in the FAP of any extraordinary collection actions (ECA’s) that a hospital facility has authorized to collect a debt. The policy must disclose the process and time frames the hospital facility or other authorized party will use in taking collection actions, including any reasonable efforts to determine whether an individual is eligible for financial assistance. The billing and collections policy, regardless of form, should be made available to the public free of charge both on a website and upon request.

5) Measures to widely publicize the FAP within the community served by the hospital facility. The IRS has entertained many comments on various ways to publicize a FAP. While many commenters seem to wish to mandate certain methods by which to do it, others argue that requirements should be left broad enough to provide flexibility for differing situations and that the regulations merely set out principles. Ultimately, the IRS required the methods discussed below in the Proposed Regulations. Please note that the statute requires not only that a hospital facility adopt these methods, but also that the method be summarized and included as part of the FAP itself. The required methods include:

   - The hospital facility must make paper copies of the policy, the application form, and a plain language summary of the policy available upon request and without charge, both for distribution in public locations in the facility and by mail. The copies should be available in English and in any other language that is 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.

   - The policy must include the measures the hospital will take to inform and notify visitors to the facility about the policy through conspicuous public display or other measures calculated to attract the attention of visitors. This may include placards and brochure kiosks providing basic information and contact details.
− The policy must include measures the facility will take to inform and notify members of the community served by the hospital facility about the policy in a manner reasonably calculated to reach those members of the community who are most likely to require financial assistance. To clarify, this type of public notification does not require disbursing the full details of the policy—rather, a summary of the policy is acceptable, along with information for enabling follow through by members of the community.

− The policy must be placed conspicuously on the hospital facility’s website, or if the facility does not have one, the website of the facility’s corporate parent, system, or other organizational leader. Care must be taken that the policy is both easily accessed (without special software, passwords, fees, or the disclosure of personal information) and kept current. Language requirements discussed above for paper copies apply similarly to online requirements.

Initially, the requirements created a controversy for hospital facilities that did not possess accommodations capable of addressing emergency situations, such as rehabilitation hospitals. A plain language reading of the Code Section suggests that in order to comply with Section 501(r), all hospital facilities must have “A written policy requiring the organization to provide, without discrimination, care for emergency medical conditions…” Fortunately, the IRS addressed the issue in the Proposed Regulations by providing an example of how a hospital facility without an emergency department can comply with the requirement. It appears from the examples provided that it is sufficient for such an organization to establish a written emergency medical care policy that addresses how it appraises emergencies, provides initial treatment, and refers or transfers an individual to another facility, when appropriate, in a manner that complies with the Emergency Medical Treatment and Active Labor Act (EMTALA).

Another potential concern raised by this requirement is that the term “care” is undefined. Certainly many critics have quickly noted the cross-reference within the Code section tying the requirement to EMTALA, but that reference only defines

Keeping in mind that each facility is subject to and evaluated for Section 501(r) on its own, hospital organizations with multiple facilities should carefully determine whether they should use one blanket policy or various customized ones.

Emergency Medical Care Policy
Merged into the requirement to have a financial assistance policy, Section 501(r)(4)(B) requires a hospital facility to have a written policy stating that it will provide care for emergency medical conditions, without discrimination, to individuals regardless of their eligibility under the financial assistance policy described above. This may surprise some already-existing hospital facilities, as a prior Revenue Ruling had made it clear that the provision of emergency care was not a condition for tax-exempt status under Section 501(c)(3). The Code section defines an emergency medical condition by a cross-reference to Section 1867 of the Social Security Act, commonly referred to as the Emergency Medical Treatment and Active Labor Act (EMTALA). EMTALA defines an emergency medical condition as follows:

- A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in -
  - Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or the unborn child) in serious jeopardy.
  - Serious impairment to bodily functions, or
  - Serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman who is having contractions -
  - That there is inadequate time to effect a safe transfer to another hospital before delivery, or
  - That transfer may pose a threat to the health or safety of the woman or unborn child.

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“emergency medical condition.” While this helps facilities define the situations on which to act, this reference does not help define what actions must be taken. Context of the EMTALA section above makes clear the definition is in respect to the “examination and treatment” of individuals in such situations—the definition of “care” can translate into a much broader concept. Commentators have raised questions over Congress’ intent that all 501(c)(3) hospitals be required to provide care for emergency medical conditions. For example, for a small ancillary hospital, providing a full spectrum of care to all individuals requiring emergency attention could divert essential resources away from other cases, resulting in a lower standard of care across the board—the antithesis of Section 501(r) as a whole.

The IRS made clear in the preamble to the Proposed Regulations that a hospital facility cannot employ techniques that would discourage individuals from seeking emergency medical care, such as requiring payment before treatment or permitting debt collection activity in the emergency department. As a matter of fact, the IRS requires in the Proposed Regulations that the Financial Assistance or Emergency Medical Law policy must explicitly state that such practices are prohibited. 17

At the same time the Proposed Regulations on this topic were being drafted, an event in Minnesota came to light that emphasized the need for such rules. In the fall of 2012, a private collections company engaged by the University of Minnesota’s Medical Center made headlines for “strong-armed billing practices” which violated federal patient-protection laws, putting the hospital at risk of being terminated from Medicare and Medicaid. As reported in the Minnesota Star Tribune, “In the course of the federal review, a manager and 10 registration employees told investigators that [the collections consultant] trained hospital staff members in techniques to maximize revenue collection at the ‘point of service.’” This culminated in a few famous incidents, including a patient in the midst of a heart attack being told she owed a payment for services received so far that day. 18 In a press release about the Proposed Regulations for Section 501(r), Emily McMahon, Acting Assistant Secretary for Tax Policy, stated, “In recent months, we have heard concerns about aggressive hospital debt collection activities, including allowing debt collectors to pursue collections in emergency rooms. These practices jeopardize patient care, and our proposed rules will help ensure they don’t happen in charitable hospitals.” 19

Limitations on Charges

As stated above, Congress has not mandated minimum criteria for financial assistance eligibility from a hospital facility or organization; however, once a patient is found to qualify for that assistance under the facility’s policy, there are limits that such a patient can be charged for any care. The goal is that those without insurance that qualify for assistance be put in generally the same financial position as an individual with insurance or Medicare. This translates to a ceiling on what can be charged to such an individual akin to the net charges that the hospital would receive from an insurer or Medicare for the same procedures. Section 501(r)’s limit on charges contains provisions based around two key details: whether or not the patient in question qualifies for financial assistance under the hospital facility’s policy, and whether the care provided was emergent or medically necessary. The amount a facility is allowed to ultimately charge a patient is a matrix decision contingent on those two factors.

For patients that qualify under the facility’s financial assistance policy, emergency or medically necessary care cannot be billed at more than an amount generally billed (AGB) to individuals who have insurance covering such care. (How to calculate this amount is discussed below.) Even if the care received by these persons is not emergent or medically necessary, the patient cannot be charged gross charges, or chargemaster rates. The level of discount that must be provided in this scenario is not defined by statute. For patients that do not qualify for financial assistance under the facility’s policy, there is no restriction on what the facility may charge for care of any type. (Note, however, that under other provisions of Section 501(r), the provision of this care cannot be halted or interfered with because of collection efforts.)

A simple provision to define and one that will likely not be burdensome to the majority of tax-exempt hospital facilities in the United States—it should be noted that the provision only applies to the “bottom line”, or the charges the patient is required to pay after discounts and reductions. A facility may use gross charges as a starting point for applying reductions, and that starting point may be disclosed to the patient in billing statements.

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<th>Emergency Care or Medically Necessary Care</th>
<th>Non-Emergent Care or Non medically Necessary</th>
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<td>Cannot use “gross charges”. Must use AGB or Less</td>
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<td>Cannot engage in collections during care. No limit on billing</td>
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<td><strong>FAP-eligible patients</strong></td>
<td>Cannot bill “gross charges” but may bill above average AGB</td>
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As of this writing, the IRS has been silent on defining “care,” so this is an area that will likely be addressed on a case-by-case basis.
How a hospital facility computes “amounts generally billed” (AGB) is a hotly contested provision of the proposed guidance that has changed several times since Section 501(r) was passed into law. It is interesting to note that prior versions of the bill would have required hospitals to limit their charges to “not more than the lowest amount charged” to patients who have insurance covering such care. Due to antitrust concerns, the provision was revised to allow another method that would not reveal competitively sensitive information to the public. “Amounts generally billed” was the phrase adopted into law, but Congress left it up to the Treasury to define it. Early notions from technical explanations of the Affordable Care Act indicate the intention was once to use an average of the “three best negotiated commercial rates, or Medicare rates.” Trying to strike a compromise between what hospitals might normally get under negotiated insurance rates and Medicare rates proved troublesome, as identifying the “three best” commercial rates was an administrative nightmare.

In the proposed regulations, the IRS revamped the definition of “amounts generally billed” to include two alternatives—the “prospective” method, and the “look-back” method. The prospective method, while likely the easier method to apply on an ongoing basis, would have a hospital facility estimate the amount it would be paid by Medicare and a Medicare beneficiary for the emergency or medically necessary care at issue if the patient were a Medicare fee-for-service beneficiary. To clarify, only Medicare Part A and Part B are allowed for the calculation, and Medicare Advantage (Part C) is, at present, specifically excluded. (For purpose of the proposed regulations, claims paid under Medicare Advantage are treated as claims paid by a private health insurer.)

The look-back method is based on actual past claims paid to the hospital facility by either (1) Medicare fee-for-service only, or (2) Medicare fee-for-service together with all private health insurers paying claims to the hospital facility. The IRS reasoned that it would be much easier for facilities to calculate AGB using all insurer claims rather than the “best three,” and requiring the addition of Medicare fee-for-service claims in the equation served to bring the average back down to the more reasonable levels intended by the drafters of the original Section 501(r) provision.

The look-back method, while potentially complex, is based on a simple formula dividing the sum of all claims for emergency and other medically necessary care that have been paid in full to the facility during a prior 12-month period by the sum of the associated gross charges for those claims. The resulting ratio is the average percentage received by the facility on those types of services for the period, and under this method, provides the minimum discount that must be awarded to patients that qualify for financial assistance. The method must be computed at least every 12 months, but can be computed more often as desired, as long as the calculation always includes a 12-month period in the calculation data. Also, a newly computed AGB ratio must be put into effect with the facility’s financial assistance policy within 45 days after the conclusion of the 12-month period it used to make the computation. Guidance allows that multiple AGB ratio calculations can be made broken down by classes or types of service.

Under either alternative, many hospital organizations will likely have to make changes to their financial assistance policy to adopt one of the above methods and to take steps to keep the calculation updated. Already a question on the Form 990 Schedule H, it is not enough that a hospital facility create and apply discounts to persons qualifying for financial assistance—the facility must be able to prove, through calculation, that the discount provided to the patient qualifying for financial assistance is as good as, or better, than a similarly-treated individual with insurance. The two methods are mutually exclusive and, under current guidance, a facility must choose one and use it consistently to compute AGB in future periods. Whether or not the Service will provide an opportunity to change an established method remains to be seen.

Billing and Collection Restrictions

One of the most visible public perception issues with tax-exempt hospitals has been the negative publicity generated through aggressive collection practices. As is often the case, a few isolated but widely-publicized incidents can rapidly spread to tarnish an entire industry—exactly what happened in the mid 2000’s as a few hospital systems were issuing garnishments, liens on residences, and in the most extreme cases, “body attachments” to collect unpaid accounts. This did not escape the attention of Congress. In particular, Senator Charles Grassley often cited these practices as elements that blurred the line between for-profit and not-for-profit healthcare organizations.

The billing and collections limitations provided by Section 501(r) are primarily centered on the concept of “extraordinary collection actions” (ECA), and when they are, and are not, allowed. The IRS was left with the last word on what constituted an ECA, and the result was the definition of an ECA as an action that fits one of the following three categories:

1) An action to collect a debt that requires a legal or judicial process;
2) The sale of an individual’s debt to another party; or
3) The reporting of adverse information about an individual to consumer credit reporting agencies or credit bureaus.
The proposed regulations include bullet lists of actions that are described as extraordinary collection actions, but a focus on such a list could easily serve to narrow the definition beyond the intended scope of the statute and provide a false sense of certainty. The restriction on ECAs also applies to relatives and other persons whom have assumed the debt on behalf of a patient that qualifies for financial assistance under the hospital facility’s policy.

It should be noted that the sale of an individual’s debt does not include merely referring collection of the debt to a third party collections agency, as long as the legal right to the debt is not transferred. Another important point to remember—a hospital facility is responsible for the actions taken by third parties in efforts to collect its debts, and any breach of Section 501(r) prohibitions of ECAs by a third party will be attributed to the hospital facility referring the debt.

ECAs are not completely banned in the context of the 501(c)(3) hospital industry—they are allowed after a hospital facility has made reasonable efforts to determine a patient’s eligibility for financial assistance. The IRS has provided a definition of “reasonable efforts” that may require hospital facilities to review their policies to determine adherence. “Reasonable efforts” entail providing a patient with information about the facility’s financial assistance policy for a set period of time, and accepting applications for assistance for a set period of time, all before engaging in any collection action which would constitute an extraordinary collection action.

Taking several comments from the industry, the IRS established a timeframe to which a hospital facility must take certain actions and not engage in ECAs. That timeframe consists of two overlapping windows: a notification period, and an application period. The “notification period” runs from the date care is provided to the 120th day after the first billing statement is provided to the patient. During this window, it is the responsibility of the hospital facility to provide, in all correspondence with a patient, written or oral (i.e. phone calls to/from patients), information about the hospital facility’s financial assistance policy. This includes providing a plain language summary of the policy, providing application forms, and providing contact information for persons that can assist in the application. A summary of the policy must be included with all billing statements during this period, and there must be at least three statements. The 120 day window was calculated by the IRS to coincide with the standard billing window for Medicare bad debt write offs and with the majority of state requirements on bad debt. Also, this length of time was calculated as providing enough time for hospital facilities to work in three billing cycles, plus allow 30 extra days for patients to submit applications for assistance. Besides a summary of the policy, at least once during this cycle, the facility must disclose in writing to the patient the ECAs that it, or another authorized party, will engage to collect the account if the patient does not submit an application for financial assistance.

Following the notification period, the “application period” runs from the date care is provided until the 240th day after the first billing statement is provided to the patient. During this window, the hospital facility is required to accept an application for financial assistance from patients. After the close of the notification window, but during the application window, a hospital facility actually can engage in ECAs; however, should a patient simply submit an application for assistance (complete or otherwise), the facility must immediately cease all ECAs and take all required steps to “undo” any legal actions, credit reporting, or other consequences of the ECA. One can see that a policy of beginning ECAs before the application window has closed can be frustrating and cumbersome to the hospital facility. If the application period concludes with no application submitted by a patient, or if an application that was submitted was determined ineligible under the financial assistance policy’s criteria, the facility may re-engage/resume in ECAs should it so choose. Recall that during the notification window, the facility was required to identify those actions it would take in writing to the patients. Section 501(r) requires that ECAs taken under any circumstance be part of an established and written policy.

As stated above, when an application for assistance is submitted during the application window, all ECAs must cease immediately. If the application is incomplete, the rule still applies, and the facility is required to send, in writing, to the patient a list of the remaining information needed to process the application, along with a list of the ECAs that will begin or resume if the application is not completed within at least 30 days from the date of the notice or the conclusion of the application period, whichever comes last.

These measures, when followed, will establish that a hospital took reasonable efforts to determine the financial assistance eligibility of its patients and establish compliance with Section 501(r)(6). One issue that has not been fully addressed by the IRS in the proposed regulations is how to treat timing of the notification and application periods when patients have prolonged stays that continue through the beginning of a billing cycle. For example, an inpatient stay may keep a patient in the facility past the first date on which a billing statement is provided, thus causing confusion about when to begin counting the days. As of this writing, the IRS is accepting comments on this issue, and is expecting to address the matter in final guidance.
Next Steps

As of the release of this whitepaper, the IRS is working to release the final regulations. The delay of the release is a result, in part, of the IRS’ determination of when the hospitals will be required to comply. The IRS’ overall intent is to allow a reasonable implementation period, however they do consider the proposed regulation period as a time for compliance efforts to begin. We would anticipate that the final ruling on implementation dates will be driven by each hospital’s tax year end, therefore the sector will experience a staggered implementation cycle that will likely begin in 2015 and end in 2016. As we anticipate the release of the final regulations in 2014, there are important steps that should be taken to prepare for compliance.

- **DRAFT REVISION TO FINANCIAL ASSISTANCE DOCUMENTS** including the policy, application, and plain language summary. The prescriptive requirements of the upcoming regulations will require a ‘tick and tie’ of these requirements. Final regulations likely will not vary significantly from the proposed regulations.

- **PERFORM AN ASSESSMENT REGARDING THE AVAILABILITY** of financial assistance to ensure the ‘widely available’ standard is being met.

- **CALCULATE AGB** (i.e. limit on charges) and how the hospital facility will ensure gross charge violations will not occur. Participate of multiple hospital departments such as billing, financial assistance and others will be necessary.

- **ASSESS BILLING AND COLLECTION PROCESSES** - coordination with third party debt collection vendors will be required to ensure financial assistance eligible patients are not negatively affected by collection efforts or other extraordinary collection actions.

As we anticipate the future of healthcare, we have been provided a fairly detailed vision of the expectations set forth by Congress. These expectations will most likely be the justification of continued tax exempt status and also the subject of public scrutiny.

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1 Rev. Ruling 58-185. Criteria or tests to be met in determining whether a hospital qualifies for exemption from Federal income tax under Section 501(a) of the Internal Revenue Code of 1954 as an organization described in Section 501(c)(3) thereof. Modified by Rev. Ruling 69-545.

2 Senate Finance Committee, “Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options”, May 20, 2009, page 33, “The Committee could consider a policy option that would codify organizational and operational requirements for determining whether a hospital is a charitable organization for purposes of section 501(c)(3) tax-exempt status. Such requirements include, among other things, that section 501(c)(3) hospitals regularly conduct a community needs analysis, provide a minimum annual level of charitable patient care, not refuse service based on a patient’s inability to pay, and follow certain procedures before instituting collection actions against patients.”

3 IRS publications and form instructions are its interpretation of law, and it is generally true that a taxpayer can never rely on them for guidance on tax law, but that fact is always worth reiterating.


5 North Carolina G.S. Section 131E-76(3).

6 Stewart, Katie, and Azman, Darren; “Section 501(r) and Nonprofit Hospital Joint Ventures”; Taxation of Exempts; Sept/Oct 2010.

7 Prop. Reg. Section 1.501(r)-1(c)(2).

8 Sec. 501(r)(2)(A)(ii).

9 Prop. Reg. Section 1.501(r)-2(d).

10 Sec. 501(r)(4).

11 The statute has not defined what it means for a hospital facility to have a “separate” billing and collections policy, and such guidance is expected to come from the IRS in the future. In any event, the Service has made clear that any provisions on billing and collections applied to a subsection of a financial assistance policy shall equally apply to a separate billing and collections policy.

12 Department of the Treasury, Additional Requirements for Charitable Hospitals, Notice of Proposed Rulemaking, REG-130266-11.


14 Rev. Ruling 83-157. A nonprofit hospital that is not required to operate an emergency room where a state or local health planning agency has found that this would unnecessarily duplicate emergency services and facilities that are adequately provided by another medical institution in the community is exempt under Section 501(c)(3) of the Code.

15 Sec. 501(r)(4)(B).


17 Prop. Reg. Section 1.501(r)-4(c)(2).


20 See section 10903 of H.R.3590 (111th Congress, 1st Session (2009)), “Modifications of Limitations on Charges by Charitable Hospitals.”

21 Staff of the Joint Committee on Taxation, Technical explanation of the Revenue Provisions of the “Reconciliation Act of 2010,” as amended, in Combination with the “Patient Protection and Affordable Care Act of 2010” (March 21, 2010), at 82 (technical explanation).

22 The Proposed Regulations under Section 1.501(r)-5(b)(3) contains several examples of how to calculation AGB under the look-back method.


24 Body attachments may be described as an arrest, but issued from a civil court rather than for a criminal reason. Body attachments are not allowed in all states and municipalities.