On December 29, 2014, the Internal Revenue Service issued final regulations under Section 501(r) of the Internal Revenue Code clarifying certain requirements applicable to charitable tax-exempt hospitals. The final regulations adopt and amend the proposals contained in REG-130266-11 (June 26, 2012) and REG-106499-12 (Apr. 5, 2013), and also respond to comments made in response to related notices.

Section 501(r), enacted as part of the Patient Protection and Affordable Care Act, Pub. Law 111-148, 124 Stat. 119 (2010), imposed new requirements applicable to charitable tax-exempt hospitals. These requirements include the obligation to perform a community health needs assessment every three years, the obligation to establish written policies on financial assistance and emergency care, and the imposition of certain limitations on billing and collection actions.

In response to comments submitted, the final regulations in many respects ease the burden of compliance in certain areas by offering more flexibility than the proposed regulations. At the same time, the regulations add various new facets that may be an unwelcome surprise for some hospitals that believed they had largely achieved Section 501(r) compliance. The final regulations also outline reporting obligations and the consequences of failure to comply with Section 501(r)’s requirements.

In no particular order of priority, the final regulations are notable in the following respects:

**Generally**

1. A hospital does not need to meet the requirements of IRC Section 501(r) with respect to any activities that are treated as unrelated trade or business activities of the hospital.

**Financial Assistance Policies**

2. In their financial assistance policies (FAP), hospitals do not need to describe the measures that will be taken to widely publicize such policies. The final regulations instead focus on whether such measures are in fact taken, not whether they are fully described in the policy.

3. The final regulations recognize that applications for financial assistance often include not only information set forth by applicants in written form, but also information provided orally through telephone or in-person conversations with hospital personnel.

4. The final regulations formally embrace the concept of presumptive eligibility determinations, i.e., using information from third party sources or from prior eligibility determinations, rather than based on a new application from a particular individual.

5. The requirements of Section 501(r) apply to physician services rendered in the hospital facility if the physician practices are owned directly by the hospital organization (or by an entity disregarded and treated as part of the hospital for tax purposes, or by an entity treated as a partnership in which the hospital holds a capital or profits interest), and not by a separate organization (whether taxable or tax-exempt).

6. Hospitals must include in their FAPs a listing of all providers delivering emergency or medically necessary care in the hospital, specifying which providers are or are not covered by the FAP. This concept is entirely
new, appearing for the first time in the final regulations, and may raise difficult questions for some hospitals.

7. The preamble to the final regulations includes some troubling language regarding hospitals that “outsource” the operation of their emergency departments, stating that, if such outsourced providers are not subject to the hospital’s FAP, the hospital facility may not be deemed to have an open emergency room within the meaning of Rev. Rul. 69-545 (the long-standing guidance establishing the so-called “community benefit” standard of exemption for charitable hospitals). The looming question is whether a hospital that contracts with a private physician group to staff its emergency department would be considered to have “outsourced” its emergency department. Absent clarity on this point, hospitals may seek to require their contracted emergency department groups (and, for that matter, other hospital-based providers) to abide by the hospitals’ FAPs.

8. The final regulations expand the translation requirement to include the primary language spoken by a language group constituting the lesser of 1,000 individuals or 5 percent of the community served by the hospital. The translation requirement applies to the FAP, FAP application, plain-language summary of the FAP, and any separate billing and collection policy.

9. In order to be “established” within the meaning of the final regulations, a hospital’s FAP, billing and collections policy, and emergency care policy must be adopted by an authorized governing body of the hospital and must be carried out consistently thereafter. In the case of hospitals operated through disregarded entities or entities treated as partnerships under tax law, the pertinent governing body may be that of the disregarded entity or partnership on one hand, or that of the hospital that owns the sole interest in the disregarded entity or the capital or profits interest in the partnership on the other.

10. Hospitals may maintain joint policies for multiple facilities, but the pertinent policies must clearly identify every facility to which they apply.

11. Hospitals must offer patients a paper copy of the plain-language summary either as part of the intake process or upon discharge.

12. Notices regarding the availability of financial assistance must be made through conspicuous public displays in public locations throughout the hospital (including, at a minimum, the emergency department and admissions areas).

13. It is not necessary for every billing statement to include a plain-language summary of the hospital’s FAP. Rather, billing statements must include conspicuous written notices regarding the availability of assistance, including the phone number for information and the application process, and a website where copies of the FAP, FAP application and plain-language summary are available.

14. The 120-day period for notification of the availability of financial assistance commences as of the date of the first post-discharge statement for the care at issue.

Limits on Charges

15. Hospitals providing substantial care to Medicaid beneficiaries may calculate their amounts generally billed (AGB) using Medicaid rates, either alone or in combination with a Medicare fee-for-service and all other private insurers. This will be welcome clarification for children’s hospitals, in particular.

16. Hospitals calculating their AGB based on the lookback method (rather than the prospective method) must look to claims allowed rather than paid in full, and the relevant inquiry includes claims allowed during the measurement period, without regard to when the associated medical care was actually delivered.

17. AGB must be calculated on a facility-specific basis, rather than with respect to a larger healthcare system. However, a single hospital facility may use different AGB approaches with respect to separate service lines or departments, provided that the approaches are described in the hospital’s FAP.

Extraordinary Collection Actions

18. Extraordinary collection actions (ECA) do not include liens filed by hospitals with respect to the proceeds of personal injury judgments, settlements or compromises. Similarly, the term also does not include the filing of claims in bankruptcy proceedings.

19. If a hospital intends to undertake an ECA, it must give at least 30 days’ prior written notice of such intent, with that notice including a plain-language summary of the hospital’s FAP.
20. Hospitals may aggregate multiple episodes of care for purposes of complying with the notification and reasonable efforts standards; however, in that event, the pertinent timelines must be measured with respect to the most recent episode of care at issue.

21. In the case of individuals who have submitted complete applications for assistance, hospitals must notify such individuals in writing regarding the hospital’s determination as to their eligibility for financial assistance.

Community Health Needs Assessments

22. In conducting community health needs assessments (CHNA), the types of health “needs” to be addressed may include those addressing financial and other barriers to access or the needs to prevent illness, to ensure adequate nutrition, or to address social, behavioral and environmental factors that influence health in the community.

23. In their CHNA reports, hospitals must describe generally any input received in the form of written comments from the public, as well as the time period over which such input was provided.

24. Hospitals are not required to publish translated versions of their CHNA reports.

25. Hospitals will have an additional 4 1/2 months following the end of the tax year during which the CHNA is conducted to adopt an implementation strategy to meet the health needs identified in the CHNA; this date corresponds to the due date (without extension) of the hospital’s Form 990 for the tax year during which the CHNA is conducted.

26. Hospital facilities that are newly acquired (including by merger) or placed into service must meet the CHNA requirements by the last day of the second taxable year commencing after the later of the date of acquisition, licensure or recognition of 501(c)(3) status.

27. A hospital organization is not required to meet the CHNA requirements for a tax year as to a particular hospital facility if the organization transfers ownership of the facility to another organization, or otherwise ceases to operate the facility, before the end of the taxable year.

Consuming 62 pages in the December 31 issue of the Federal Register, the final regulations are neither a quick nor easy read. Hospitals likely will find that they need time to digest the content, and may need to frequently refer back to the regulatory detail as questions arise in future application. On a positive note, the IRS has recognized that hospitals will need time to adapt their policies and practices and, accordingly, has provided that the final regulations will become effective for taxable years beginning after December 29, 2015 (i.e., for the 2016 taxable year). Hospitals should not be lulled into complacency, however, as the provisions of the statute itself (IRC Section 501(r)) have been effective for several years now. Moreover, the final regulations note that, prior to the 2016 tax year, hospitals may rely on a reasonable, good faith interpretation of the statutory provisions, which may be demonstrated through compliance with the provisions of the June 2012 proposed regulations. Anecdotally, it appears that many hospitals refrained from full compliance with the proposed regulations in the hope that the IRS would provide greater flexibility in the final version. As such, hospitals should act diligently to incorporate the provisions of the final regulations into their operating policies and procedures.

Finally, even with regulations now in final form, some hospitals may be tempted to skimp on 501(r) compliance based on recent public statements from the General Accounting Office acknowledging that IRS enforcement levels are at historic lows (with only 0.71 percent of charitable organizations subject to audit in 2013). Such hospitals should be mindful, however, that even without the IRS at their doorstep, their compliance with Section 501(r) likely will be tested in various other settings, including in the context of their annual Form 990 filings and audited financial statements, diligence associated with proposed significant transactions, and the borrowing of tax-exempt bond proceeds.

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