PUBLICATION

IRS Issues Proposed Regulations Addressing 501(c)(3) Hospital Requirements

July 19, 2012

The Internal Revenue Service (IRS) recently issued detailed proposed regulations addressing certain requirements that tax-exempt hospitals must adopt in order to maintain their status under Section 501(c)(3) of the Internal Revenue Code (Code). The overarching policy of the proposed regulations is (i) to ensure that financially needy patients have access to health care at charitable hospitals and (ii) to protect patients at charitable hospitals from aggressive debt collection practices.

Background

The Patient Protection and Affordable Care Act (Affordable Care Act) enacted in 2010 created Section 501(r) of the Code. Section 501(r) established certain requirements that a Section 501(c)(3) hospital must meet in order to maintain the tax exempt benefits that accompany the 501(c)(3) designation. Section 501(r) provided three important requirements:

- Written Policies Related to (i) Financial Assistance and (ii) Emergency Medical Care
- Limitation on Charges
- Billing and Collection Requirements

On June 22, 2012, the IRS released proposed regulations for publication in the June 26, 2012 Federal Register. These proposed regulations will now receive increased review after the June 28, 2012 Supreme Court's ruling upholding the vast majority of the Affordable Care Act.

Section 501(r)(4): Financial Assistance Policy and Emergency Medical Care Policy

Financial Assistance Policy: Pursuant to Section 501(r)(4) of the Code, a Section 501(c)(3) hospital's financial assistance policy (FAP) must include the following five items:

- Eligibility criteria for financial assistance, and whether such assistance includes free or discounted care;
- The basis for calculating amounts charged to patients;
- The method for applying for financial assistance;
- In the case of an organization that does not have a separate billing and collections policy, the actions the organization may take in the event of nonpayment; and
- Measures to widely publicize the FAP within the community serviced by the hospital facility.

The proposed regulations have interpreted these five requirements as follows:

Eligibility Criteria and Basis for Calculating Amounts Charged: The FAP must include the discounts and free care available, how the discounts will be applied and how patients may become eligible. Additionally, a statement must be included that the patient will not be charged more for emergency care or other medically necessary care than individuals with insurance.

Notably, the FAP does not require specific criteria such as a certain amount of free or reduced care. Instead, the proposed regulations require the FAP to be available and to specify how a patient can receive the financial assistance.

The following example is provided in the proposed regulations of a FAP satisfying the eligibility criteria for financial assistance and the basis for calculating amounts charged to patients:

A FAP contains a statement that no FAP-eligible patients will be charged more for emergency or other medically necessary care than amounts generally billed to individuals who have insurance coverage and applies the following discounts based on a patient's family income as a percentage of the federal poverty level.

Family Income as Percentage of Federal Poverty Level	Discount Off of Gross Charges
>y% to x%	50%
>z% to y%	75%
≤z%	100%

Method for Applying for Financial Assistance: The FAP must describe how a patient can apply for financial assistance, including the required documentation necessary.

Actions that may be taken in the event of nonpayment: The hospital's FAP or a separate written billing and collection policy must describe (i) the actions the hospital may take to obtain payment, (ii) the time limits before the hospital will attempt to obtain payment and the reasonable efforts the hospital will make to determine whether a patient is FAP-eligible, and (iii) the department within the hospital with the final decision-making authority to determine whether an individual is FAP-eligible and whether extraordinary collection actions can be engaged in to seek repayment.

Widely Publicizing the FAP: The following steps should be taken to ensure the FAP is widely publicized:

- The FAP, the application for financial assistance and a plain language summary should be made available on the hospital's website.
- The FAP, the application for financial assistance and a plain language summary should be made available by mail and in paper form in public locations in the hospital in both English and the primary language of any population with limited proficiency in English that account for at least 10% of the residents.
- Information about the FAP should be conspicuously placed to attract a visitor's attention.
- Residents of the community served by the hospital should be informed and notified in a manner reasonably calculated to reach the members of the community who are most likely to require financial assistance.

Emergency Medical Care Policy: Pursuant to the FAP, the hospital must provide, without discrimination, care for emergency medical conditions regardless of whether the patient is FAP-eligible. Because hospitals must already follow the Emergency Medical Treatment and Active Labor Act (EMTALA), setting forth EMTALA in a written policy satisfies this requirement.

Additionally, the FAP must prohibit the hospital from engaging in actions to discourage emergency medical care such as requiring payment prior to emergency medical care or permitting debt collection activities in the emergency department.

Section 501(r)(5): Limitations on Charges

Hospitals must limit that amount charged to FAP-eligible individuals to:

- In the case of emergency or other medically necessary care, not more than the amounts generally billed to individuals who have insurance; and
- In the case of all other medical care, less than the gross charges for any medical care provided to that individual.

Amounts Generally Billed: A hospital may employ one of the following methods to determine the amounts generally billed:

- Look-back Method: Actual claims for the prior 12 months for (i) claims paid by Medicare fee-for-service, or (ii) claims paid by both Medicare fee-for-service and all private health insurers as primary payers.
- Prospective Medicare Method: Estimated amount the hospital would expect to receive from Medicare for the emergency or other medically necessary care provided if the FAP-eligible individual were a Medicare fee-for-service beneficiary.

Safe Harbor: The hospital will be deemed to have satisfied the above requirements if (i) the FAP-eligible individual has not submitted a complete FAP-application as of the time of charge, and (ii) the hospital facility has made and continues to make reasonable efforts to determine whether the individual is FAP-eligible.

Section 501(r)(6): Billing and Collections

Prior to engaging in extraordinary collection efforts, or selling an individual's debts to a collection agency, a hospital must seek to determine whether an individual is FAP-eligible.

Extraordinary Collection Actions: An extraordinary collection action is an action by the hospital, in an attempt to collect payment for a bill of care covered under the hospital's FAP that requires a legal or judicial process, involves selling an individual's debt to another party or involves reporting an individual to credit reporting agency or credit bureau. Actions that require a legal or judicial process include, but are not limited to the following:

- Placing a lien on an individual's property;
- Foreclosing on an individual's real property;
- Attaching or seizing an individual's bank account or any other personal property;
- Commencing a civil action against an individual;
- Causing an individual's arrest;
- Causing an individual to be subject to a writ of body attachment; and
- Garnishing an individual's wages.

Reasonable Efforts: The hospital will have made reasonable efforts to determine whether an individual is FAP-eligible only if the hospital satisfies the following requirements:

- Adequately notifies the individual about the hospital's FAP during a 120-day notification period by doing the following:

  - Distributing a plain language summary of the FAP and offering a FAP application prior to discharge.
  - Including a plain language summary of the FAP with all (and at least three) billing statements and any written communication regarding the bill
  - Informing the individual about the FAP in all oral communications
  - Providing the individual with at least one written notice that describes the extraordinary collection efforts the hospital may take if the individual does not pay the amount due. This notice must be provided 30 days prior to the specified deadline in the written notice.
- If an individual submits an incomplete application during the 240-day application period, the hospital provides the individual with information to aid in the completion of the FAP; and
- If an individual submits a complete FAP application, a documented determination must be made as to whether the individual is FAP-eligible.

Only after satisfying the above requirements may a hospital engage in an extraordinary collection action against an individual. The following example is provided (extraordinary collection action being referenced as "ECA"), in the proposed regulations:

Individual A receives care from hospital facility T on February 1 and February 2. When A is discharged from T on February 2, T gives A its FAP application form and a plain language summary of its FAP. On March 1, April 15, and May 30, T sends A billing statements that include a one-page insert that provides a plain language summary of the FAP. With the May 30 billing statement, T also includes a letter that informs A that if she does not pay the amount owed or submit a FAP application form by June 29 (120 days after the first billing statement was provided on March 1), T may report A's delinquency to credit reporting agencies, seek to obtain a judgment against A, and, if such a judgment is obtained, seek to attach and seize A's bank account or other personal property, which are the only ECAs that T (or any party to which T refers A's debt) may take in accordance with T's billing and collections policy. T does not have any other written or oral communications with A about her bill before June 29. T keeps electronic records showing that it provided a plain language summary and FAP application to A on discharge and included the letter regarding ECAs and the plain language summaries with the billing statements sent to A. A does not submit a FAP application form by June 29. T has made reasonable efforts to determine whether A is FAP-eligible, and thus may engage in ECAs against A, as of June 30.

Waiver Does Not Constitute Reasonable Efforts: The reasonable efforts requirements will not be satisfied by a signed waiver from the individual stating that the individual does not wish to apply for financial assistance.

Summary

Section 501(c)(3) hospitals should evaluate (i) the information provided to patients regarding financial assistance and (ii) billing and collections policies for patients eligible for financial assistance. If you would like to discuss the IRS's proposed regulations under Section 501(r), please contact one of the attorneys within either the Firm's Health or Tax Departments.