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IRC Section 501(r) Requires Tax-Exempt Hospitals Make Modifications by December 29, 2015

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The largest change to tax exemption for hospitals in more than 40 years—under Section 501(r) of the Internal Revenue Code—will become mandatory for hospitals for tax years beginning after December 29, 2015.

The long-awaited final regulations, which took nearly five years to complete, largely mirror and clarify the proposed regulations, with minor modifications, and are consistent with changes affecting the health care industry overall.

In short, this change puts an increased emphasis on preventative care and encourages hospitals to adopt a holistic approach in providing community services, all the while evaluating their impact on the community. Hospitals will be required to be more transparent with their patient populations by detailing their fees, their financial assistance policies, and their billing and collections policies. This information also will need to be provided in multiple languages to reflect their community populations.

While the final regulations largely resemble the proposed regulations, there are differences and clarifications pertinent to tax-exempt hospitals. Here are some of the key differences:

501(r)(3): Community Health Needs Assessment

The scope of the community health needs assessment (CHNA) was expanded to include a need to prevent illness; ensure adequate nutrition; and address social, behavioral, and environmental factors that influence health in the community. Highlights of other CHNA requirements and changes include:

- **Form 990.** The deadline to submit the CHNA and the implementation strategy, which reports implementation needs to the IRS, was changed to the nonextended due date, or the 15th day of the fifth month after year-end (as opposed to the same taxable year the CNHA is completed) which is the same due date as Form 990. The implementation strategy should be reported to the IRS by attaching to Form 990.

- **Evaluations.** This requirement evaluates a hospital's actions to address significant health care needs identified in the previous CHNA.

- **Joint assessment.** Hospitals may work together—and save costs—to prepare a joint CHNA and implementation strategy if they have identical or overlapping communities.

- **Hospital transfers.** The transferred hospital doesn't have to meet the requirements of 501(r) in the year of the transfer.

- **Newly acquired hospitals.** These aren't exempt; the CHNA timing resets as a short taxable year of less than 12 months and is considered a full taxable year for 501(r) purposes.

501(r)(4): Financial Assistance Policies

The final statutes for hospital financial assistance polices (FAPs) were loosened a bit compared with the strict requirements in the proposed regulations. Hospitals will likely want to include as many discounts as possible in the FAP unless it's impractical or improbable. Details for FAPs include:

- **Summaries.** FAPs must include plain-language summaries and be widely available with a list of service providers indicating who is covered and who isn't. Notice 2015-46 further clarifies this requirement.

- **Emergency Rooms.** Hospitals must require that third-party emergency care providers operate consistently with the FAP for care provided in the hospital's emergency room and the list of service providers must include both the physician and his or her service, otherwise the emergency room won't satisfy the emergency room factor in the community benefit standard test, according to Rev. Rul. 69-545.

- **Online presence.** FAPs must be made available on hospital Web sites.

- **Translations.** Hospitals must have FAPs translated into primary languages of the community the hospital serves if the population of limited English proficiency constitutes 5 percent or 1,000 people, whichever is less in the community it serves.

- **Assistance eligibility.** FAPs must include eligibility criteria for financial assistance, whether such assistance includes free or discounted care, and the method for applying for financial assistance.

- **Determining eligibility.** Hospitals may use the service date, the application date, or some other date to assess eligibility. Providing assistance outside FAP is permitted.

- **Nondiscriminatory care.** Hospitals must provide nondiscriminatory care for emergency medical conditions to individuals regardless of their FAP eligibility.

- **Payments.** FAPs should detail the basis for calculating amounts charged to patients and the collection actions a hospital may take against a patient in the event of nonpayment (unless the hospital has a separate written policy addressing billing and collection practices).

- **Mailed summaries.** Hospitals are required to include plain-language summaries in only one postdischarge mailing as long as a "conspicuous written notice" is in every bill issued during the 120-day postdischarge period, along with a phone number and Web site link to FAP documents.

501(r)(5): Limitation on Charges

Hospitals must discount the amounts they charge patients eligible for assistance under their FAP, according to 501(r)(5). FAP-eligible individuals must pay no more than the amounts generally billed (AGB) to insured patients for emergency or other medically necessary care, and must pay less than gross charges for other medical care covered by the FAP.

Two options are provided for calculating AGB:

- The Medicare prospective

- The look-back method

Under the final regulations, hospitals are able to:

- **Calculate.** Base AGB on Medicaid rates, either alone or in combination with data from Medicare and from all private health insurers. Representative samples are not allowed.

- **Timing.** Change their AGB calculation at any time, although hospitals may use only one method at a given time. Hospitals can take 120 days to calculate AGB but must begin applying them within that timeframe. The FAP should be updated prior to implementing this change.

- **Flexibility.** Select different AGB calculation methods for each facility if operating multiple facilities.

501(r)(6): Billing and Collection Policies

Hospitals are allowed to employ

extraordinary collection actions (ECAs) to protect the use of its charitable assets, but only after it determines, using "reasonable efforts," an individual's FAP-eligibility, according to 501(r)(6). If a hospital never intends to initiate ECAs, then there's no need to satisfy reasonable efforts requirements.

While hospitals may still provide the most generous assistance to presumptive FAP-eligible individuals, hospitals are allowed flexibility in determining if an individual qualifies for less than the most generous assistance under its FAP, which is based on information other than provided by the individual or based on a prior determination.

The final regulations allow FAP-eligibility determinations to be postponed to give hospitals time for Medicaid applications and determinations. Hospitals must create ECA Initiation Notices and provide them to patients against whom they intend to engage in ECAs, whether or not a completed FAP application has been received.

Compliance

In order to be compliant with the new regulations, hospitals are required to adjust their practices and policies. Those organizations that didn't revise existing policies in preparation when these changes were first proposed five years ago will require significant updating, particularly when it comes to billing and collection policies. Fortunately, most tax-exempt hospitals have prepared for these changes and will only need to make slight modifications to fully comply for tax years after December 29, 2015.

Tax-exempt hospital facilities that fail to comply with Section 501(r) requirements risk revocation of its tax-exempt status. If a hospital fails to properly conduct and implement CHNA, the facility is subject to an excise tax of $50,000.

However, the IRS clarified that minor omissions and errors with respect to 501(r) won't be considered a failure to meet the requirements of 501(r) if it's inadvertent or due to reasonable cause, and the hospital facility corrects the omission or error promptly after its discovery.

The final regulations are effective for tax years beginning after December 29, 2015. All tax-exempt hospitals will be required to be compliant and therefore have some level of changes that need to be implemented in the next year. Additionally, hospitals that last conducted their CHNA in fiscal year 2012 and will be conducting their second during 2015 will need to determine whether to rely on the proposed regulations, the final regulations, or another reasonable interpretation.

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