

Tax News & Views Health Care Edition

Final regulations under Section 501(r) for charitable hospital organizations



Overview

On December 31, 2014, final regulations (T.D. 9708) were released to provide guidance regarding the requirements for charitable hospital organizations under Internal Revenue Code (IRC) § 501(r).

Background

The Patient Protection and Affordable Care Act (ACA), Public Law 111-148 (124 Stat. 119 (2010)), enacted IRC § 501(r) on March 23, 2010. IRC § 501(r) requires a charitable hospital organization to meet the requirements related to the community health needs assessment (CHNA) (IRC § 501(r)(3)), financial assistance policy (FAP) (IRC § 501(r)(4)), limitations on charges (IRC § 501(r)(5)), and billings and collections policies and practices (IRC § 501(r)(6)).

The statutory requirements of § 501(r)(4)-(6) apply to taxable years beginning after March 23, 2010. The statutory requirements of § 501(r)(3) apply to taxable years beginning after March 23, 2012. A hospital organization has had to comply with the statutory requirements of § 501(r) since these applicability dates.

On June 26, 2012, the Department of Treasury (Treasury) and the Internal Revenue Service (IRS) published proposed regulations regarding the requirements of § 501(r)(4) through 501(r)(6) relating to FAPs, limitation on charges, and billing and collections.

On April 5, 2013, Treasury and the IRS published proposed regulations regarding the CHNA requirements, related excise tax and reporting obligations, and the consequences for failing to meet the requirements of § 501(r).

These final regulations amend and adopt the proposed regulations. The final regulations provide hospitals with specific guidance, including key definitions, as to how to comply with the statutory requirements of § 501(r). Due to this level of detail, hospital facilities will need to review policies to make sure they contain each of the required elements noted in the final regulations.

Effective date of regulations

The final regulations are effective as of December 31, 2014.

Applicability date of final regulations under Section 501(r)

The final regulations under Section 501(r) apply to a hospital facility's taxable year beginning after December 29, 2015. This will give all hospital facilities at least a year to come into compliance with the final regulations.

For taxable years beginning on or before December 29, 2015, a hospital facility may rely on a reasonable, good faith interpretation of Section 501(r) including continued reliance on both the 2012 and 2013 proposed regulations.

Final Regulations

The final regulations provide guidance on the requirements described in § 501(r), the entities that must meet these requirements, and the reporting obligations relating to these requirements. This article will focus on the final regulations relating to FAPs, limitation on charges, and billing and collections. Stay tuned for future articles discussing the CHNA requirements and the consequences for failing to meet the requirements of § 501(r).

Definitions

The final regulations clarify and adopt a number of critical definitions. Consistent with the 2013 proposed regulations, the final regulations define a "hospital organization" as an organization recognized (or seeking to be recognized) as described in § 501(c)(3) that operates one or more hospital facilities. A "hospital facility" is a facility that is required by a state to be licensed, registered, or similarly recognized as a hospital. Further, the final regulations state that "multiple buildings operated under a single state license are considered a single hospital facility." The term "state" in this context includes only the 50 states and the District of Columbia and does not include any U.S. territory or foreign country.

The final regulations clarify that multiple, separately licensed facilities that are housed in one building will be treated as separate "hospital facilities." However, the regulations provide some administrative relief by allowing such facilities to adopt joint policies and conduct joint CHNAs.

"Operating a hospital facility" includes operating the facility through the organization's own employees or contracting out to another organization to operate the facility. For example, if an organization hires a management company to operate the facility, the hiring organization is considered to operate the facility.

The final regulations provide clarification regarding the "operation of a hospital facility" through a partnership

or disregarded entity. An organization "operates a hospital facility" if it is the sole member or owner of a disregarded entity that operates the hospital facility. In addition, an organization "operates a hospital facility" if it owns a capital or profits interest in an entity treated as a partnership for federal tax purposes that operates the hospital facility. The definition includes any ownership interest that is held either directly or indirectly through one or more lower-tier entities.

An exception is made for certain partnership arrangements if the organization does not have sufficient control over the operation of the hospital facility to ensure the furtherance of an exempt purpose and therefore treats the activity as an unrelated trade or business. In such cases, the organization will not be deemed to "operate a hospital facility."

The final regulations clarify the extent to which § 501(r) requirements apply to hospital-owned physician practices providing care in the hospital. Whether or not § 501(r) applies to such practices depends upon how such entities are classified for federal tax purposes. A taxable corporation providing care in the hospital facility is not subject to § 501(r). A disregarded entity or partnership owned by the hospital and providing emergency or medically necessary care generally will be subject to § 501(r). The final regulations define such entities as "substantially-related entities."

Finally, the final regulations require government hospital organizations that have been recognized as tax-exempt organizations under § 501(c)(3) (so-called "dual status" entities) to comply with the requirements of § 501(r). However, Treasury notes that dual status entities may voluntarily request to terminate their § 501(c)(3) status under Revenue Procedure 2014-4. Treasury also states that the applicability of § 501(r) to dual status entities does not change their Form 990 filing requirement and such entities may continue to rely on an exemption from filing if granted under Revenue Procedure 95-48.

Financial Assistance Policy

IRC § 501(r)(4) requires a hospital organization to establish a written FAP for each hospital facility. The FAP must apply to, at a minimum, all emergency and other medically necessary care provided by the hospital facility. The final regulations provide additional detail regarding the specific information that a hospital facility must include in its FAP.

Hospital facilities will have at least one year to come into compliance with the final regulations.

Ambulatory surgery centers and skilled nursing facilities located in states that license them as hospitals will need to comply with the requirements of the final regulations.

An organization "operates a hospital facility" if it owns an interest in a partnership or disregarded entity that operates the hospital facility.

The FAP must include:

1. Eligibility criteria for financial assistance and whether such assistance includes free or discounted care,
2. The basis for calculating amounts charged to patients (including the manner in which the amounts generally billed (AGB) is determined),
3. The method for applying for financial assistance,
4. In the case of a hospital facility that does not have a separate billing and collections policy, the actions that may be taken in the event of nonpayment,
5. If applicable, any information obtained from sources other than an individual seeking financial assistance that the hospital facility uses, and whether and how it uses prior FAP-eligibility determinations to presumptively determine that the individual is FAP-eligible,
6. A list of any providers, other than the hospital itself, delivering emergency or medically necessary care in the hospital facility that specifies which providers are covered by the hospital facility's FAP and which are not.

The final regulations provide that the following information must be included in a financial assistance policy:

Eligibility criteria for financial assistance and whether such assistance includes free or discounted care --

The FAP must specify the eligibility criteria and state all discounts and free care which are available. The policy must specify the amounts (such as gross charges) to which any discount percentages would be applied. In addition, the FAP must state that following a determination of eligibility, an FAP-eligible individual will not be charged more than AGB for emergency or other medically necessary care.

The basis for calculating amounts charged to patient --

The policy must describe which of the permitted methods is used to determine AGB. If the hospital facility uses the look-back method to determine AGB, the policy must either state the AGB percentages and describe how they were calculated or explain how the public may obtain this information free of charge.

The method for applying for financial assistance --

The FAP must describe the financial assistance application process. Either the FAP or the application form must include a list of any required information or documentation to be submitted with the application. The FAP must include specified contact information, including telephone number and physical location, for the hospital facility office or department that can assist with the application process. If the hospital facility does not provide assistance with applications, the FAP must include contact information of at least one nonprofit or government agency that is an available source of assistance with the process. The final regulations clarify that a hospital facility may not deny financial assistance based on an applicant's failure

to provide information unless that information is clearly described in the FAP. However, a hospital may grant financial assistance even if the applicant fails to fully provide information and may, for example, rely on other evidence of eligibility or an attestation by the applicant.

The actions the hospital facility may take in the event of nonpayment --

The FAP must describe certain collection actions that the hospital may pursue, either (a) within the FAP or (b) by reference in the FAP to the hospital facility's separate billing and collection policy (including how to obtain a free copy of the separate policy). The FAP, or separate billing and collection policy, must state any actions that may be taken to obtain payment, including any extraordinary collection actions; a description of the process and time frame to determine if an individual is eligible for financial assistance; and a description of the office or department with responsibility for determining if reasonable efforts have been made to assess the patient's eligibility.

To ensure that patients and families are aware of potential assistance through the FAP, the hospital facility must publicize the policy in a variety of ways throughout the community. The FAP, application form and a plain language summary must be available on a website. Individuals must be able to access, download, view and print a copy of the documents from the website without requiring special computer hardware or software. The hospital facility must also make paper copies of all three documents available upon request and free of charge both by mail and in public locations in the hospital, including, at a minimum, the emergency room and admissions areas. All FAP documents must be available in English. In addition, documents must be provided in the primary language of any populations with limited English proficiency that constitute the lesser of 1,000 individuals or 5% of the community served. The hospital facility must provide the direct website address to the FAP upon request.

Each hospital facility must inform visitors about the FAP through conspicuous public displays, such as signs and brochures, at a minimum, in the emergency room and admissions areas. The hospital must also offer a paper copy of the plain language summary to patients as part of the intake or discharge process and must include a conspicuous written notice on billing statements regarding the FAP.

To ensure that information reaches those members of the community who are mostly likely to require financial assistance, a hospital facility must distribute financial assistance information to local public agencies and nonprofits assisting low-income populations. In addition to providing copies of the full policy, a hospital

FAP requirements #5 and 6 have been added in the final regulations.

The final regulations change the translation requirement to populations with limited English proficiency that constitute the lesser of 1,000 individuals or 5% of the community.

facility is allowed to use summaries of the FAP to reach additional patient populations. A hospital facility will also have the option of providing certain information, which may be subject to frequent change, separately from the FAP so as to reduce the number of times the FAP needs to be updated and re-released. The FAP must explain how the public can readily access this additional information free of charge.

In the proposed regulations, hospitals were required to list in the FAP all the ways it widely publicized financial assistance information. However, the final regulations eliminate this documentation requirement. Rather than including a list in the FAP, the hospital is only required to implement the measures to widely publicize the FAP in the community it serves.

Emergency Medical Care Policy

IRC §501(r)(4)(B) requires a written emergency medical care policy (EMCP) requiring the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the FAP. The final regulations provide that a hospital facility's EMCP will meet this requirement if it requires the hospital facility to provide for the emergency medical conditions that it is required to provide under existing federal law such as the Emergency Medical Treatment and Labor Act (EMTALA). For hospital facilities that do not have a dedicated emergency department, an example in the final regulations provides that such hospital facility also must establish a written EMCP that addresses how it appraises emergencies, including compliance with EMTALA. The hospital facility's EMCP must prohibit the hospital facility from discouraging individuals from seeking emergency medical care, such as by demanding payment prior to treatment or by permitting debt collection practices that interfere with emergency medical care.

Limitation on Charges

IRC §501(r)(5) requires a hospital facility to limit the amounts charged for emergency or other medically necessary care it provides to a FAP-eligible individual (whether underinsured or uninsured) to not more than the amounts generally billed (AGB) to individuals with insurance covering that care. For all other medical care (i.e. non-emergency and non-medically necessary care) provided to a FAP-eligible individual, the hospital facility must charge something less than gross charges. Essentially, at least some discount must be applied to all charges to a FAP-eligible individual, whether they are underinsured or uninsured. Consistent with the proposed regulations, the final regulations provide two methods for determining AGB.

Meaning of Charged

A FAP-eligible individual is considered to be "charged" only the amount he or she is personally responsible for paying, after all deductions, discounts, and insurance reimbursements have been applied.

Amounts Generally Billed

The two methods for determining AGB for charges for emergency or other medically necessary care include: (i) the "look-back" method, or (ii) the "prospective" method. A modification in the final regulations permits hospitals to change their chosen method at any time, as long as the FAP is updated first to identify the new method used.

Look-Back Method

The "look-back" method requires a hospital facility to calculate an AGB percentage at least annually based on actual claims. Within 120 days of the end of the 12-month period used to make the calculation, the hospital facility must begin applying the AGB percentage to gross charges for the care provided to an FAP-eligible individual. Note, while the proposed regulations called for a 45 day implementation window, the final regulations allow for 120 days.

To calculate AGB using the "look-back" method, the hospital facility divides:

1. The sum of all claims for emergency and other medically necessary care that have been allowed by health insurers from either:
 - Medicare fee-for-service,
 - Medicare fee-for-service and all private health insurers, OR
 - Medicaid, either alone or in combination with the insurers described above,
2. By the sum of the associated gross charges related to those claims.

The hospital facility may use one average AGB percentage of gross charges for all emergency and other medically necessary care rendered at a given hospital facility. Alternatively, multiple AGB percentages may be calculated based on separate categories of care, such as inpatient and outpatient care or care provided by different departments.

Determining AGB percentages for more than one hospital facility

In general, a hospital organization must calculate AGB percentages separately for each hospital facility. However, if hospital facilities are covered under the same Medicare provider agreement, the organization may calculate one AGB percentage based on the claims and gross charges for all such facilities and implement the AGB percentage across all such hospitals.

Amounts generally billed are required to be calculated on a facility by facility basis.

Amounts generally billed are required to be calculated at least annually and must be fully implemented within 120 days of the calculation.

Prospective Medicare or Medicaid Method

As an alternative to the “look-back” method, a hospital facility may use the “prospective Medicare or Medicaid” method, which is based on the billing and coding process the hospital facility would use if the FAP-eligible individual were a Medicare fee-for-service or Medicaid beneficiary. AGB for the care is then the total amount Medicare or Medicaid would allow for the care (including both the amount reimbursed by Medicare or Medicaid and the amount the beneficiary would be responsible for paying in the form of co-payments, co-insurance and deductibles).

Gross Charges

A hospital facility must charge a FAP-eligible individual less than gross charges for any medical care covered under the hospital facility’s FAP. Gross charges are defined as a hospital facility’s full, established price for medical care that the hospital facility consistently and uniformly charges patients before applying contractual allowances, discounts, or deductions. While IRC § 501(r)(5) simply “prohibits the use of gross charges,” the final regulations clarify that a billing statement issued to a FAP-eligible individual may state gross charges as the starting point before applying various allowances, discounts and deductions “provided that the actual amount the individual is personally responsible for paying is less than the gross charges for such care.”

Safe Harbor

The final regulations also set forth a safe harbor for certain situations where more than AGB is charged. A hospital facility will be deemed to meet the requirements of § 501(r)(5) even if it charges more than AGB for emergency or other medically necessary care (or gross charges for any medical care) provided to a FAP-eligible individual if:

- The charge in excess of AGB was not made as a pre-condition of providing medically necessary care,
- The FAP-eligible individual has not submitted a complete FAP application to the hospital facility for the care, and
- If the individual subsequently submits a complete FAP application and is determined to be eligible, the hospital refunds any amount the individual has already paid for the care that exceeds their personal responsibility.

Billing and Collection Practices

IRC §501(r)(6) requires that a hospital facility not engage in “extraordinary collection actions” (ECAs) against patients before having made reasonable efforts to determine if the person qualifies for financial assistance. The final regulations §1.501(r)-6 define extraordinary collection actions and identify various notification requirements.

ECAs are actions taken against an individual related to obtaining payment for care covered under the hospital facility’s FAP policy that:

1. require legal or judicial process (including but not limited to):
 - liens on property
 - foreclosure on real property
 - property
 - commencing civil action
 - causing arrest
 - subjection to a writ of body attachment
 - garnishing wages,
2. involve selling the debt to another party,
3. report adverse information about the individual to credit agencies, OR
4. defer or deny, or require a payment before providing, medically necessary care because of an individual’s nonpayment of one or more bills for previous care.

Reasonable efforts are made when the hospital facility notifies the individual about its FAP during the notification period AND properly addresses an incomplete or complete FAP application received. The notification period begins on the first date of care and ends on the 120th day after the hospital facility provides the individual with the first “post-discharge” billing statement for the care. The application period begins on the date the care is provided and ends on the 240th day after the hospital facility provides the individual with the first “post-discharge” billing statement for the care. A billing statement is considered “post-discharge” if it is provided to an individual after the care is provided and the individual has left the hospital facility.

Notification is generally met if the hospital facility:

- Provides at least one written notice that
 - Indicates financial assistance is available for eligible individuals,
 - Identifies the ECAs the hospital facility intends to initiate to obtain payment for care, AND
 - States a deadline after which such ECAs may be initiated that is no earlier than 30 days after the date that the written notice is provided,
- Distributes a plan language summary of the FAP with the written notice, and
- Makes a reasonable effort to orally notify the individual about the FAP.

The definition of ECA #4, regarding denial of care due to nonpayment, was added as part of the final regulations.

Notification period = 120 days

Application period = 240 days

A hospital may satisfy the notification requirements (listed above) simultaneously for multiple episodes of care and notify the individual about the ECAs the hospital facility intends to initiate to obtain payment for multiple outstanding bills for care. However, the hospital facility must refrain from initiating the ECAs on the aggregate bill until 120 days after it provided the first post-discharge billing statement for the most recent episode of care included in the aggregation.

If an individual submits a complete or incomplete FAP application during the application period, the hospital facility is deemed to have met its notification requirement. In order to meet its reasonable cause requirements, the hospital facility will still have to properly respond to complete and incomplete FAP applications received (discussed below).

When no FAP application is submitted, a hospital facility satisfies its reasonable efforts as long as it has completed all required notification steps. The hospital facility may engage in ECAs against the individual but must cease these actions if during the remainder of the application period the patient submits a FAP application.

Incomplete FAP Applications

If an individual submits an incomplete FAP application during the application period, a hospital facility must suspend ECAs against the individual until either the individual completes the FAP application or until the individual has failed to respond to requests for additional information within a “reasonable period of time.” The hospital facility must also provide written notice that describes what additional information is required to complete the FAP application, and includes contact information for assistance with the application process.

If an individual, who initially completes an incomplete FAP application, later submits a complete FAP application by the completion deadline, the individual is considered to have submitted a complete FAP application during the application period. The hospital facility will then need to determine whether the individual is FAP-eligible by meeting the requirements for a complete FAP application (to be discussed below). If an individual who initially completes an incomplete FAP application never files a complete application by the completion deadline, then the hospital facility has met its notification and reasonable efforts requirements and may initiate or resume ECAs against the individual(s).

Complete FAP Applications

If an individual submits a complete FAP application during the application period, the hospital facility meets its reasonable efforts requirement if it suspends any ECAs taken against the individual, makes and documents a determination as to whether the individual is FAP-eligible, notifies the individual in writing of the eligibility determination and the basis for the determination, AND

(assuming the individual is FAP-eligible) does the following:

- for discounts other than “free” care: provides a billing statement that indicates the amounts the individual owes as a FAP-eligible individual and shows or describes how the determination was made and how to get information regarding AGB,
- refunds any excess payments made by the patient prior to them being FAP-eligible, unless the refund is less than \$5,
- takes reasonable available measures to reverse any ECAs taken against the individual.

If the hospital facility has not violated anti-abuse rules and makes a determination based on complete FAP applications, then it has made reasonable efforts to determine the FAP-eligibility and may initiate or resume ECAs against the individual if they are not paying. If the hospital facility relies on information it has reason to believe is unreliable or incorrect or obtains the information from the individual under duress or using coercive practices, then it will not be considered to have met the reasonable efforts requirements for determining FAP-eligibility. For purposes of the above statement, a coercive act includes denying care or treatment until the individual provides the information requested.

Presumptive FAP-eligibility determinations

A hospital facility will have made reasonable efforts if it determines that the individual is eligible for the most generous assistance allowed under the FAP based on information other than that provided by the individual as part of a complete FAP application (i.e. if the hospital facility provides the highest level of payment discount to a person, they have met all requirements of reasonable efforts as it relates to that patient).

A hospital may also presumptively determine that an individual is eligible for less than the most generous assistance available under the FAP based on information other than that provided by the individual or based on a prior FAP-eligibility determination. Such presumptive determination only constitutes “reasonable efforts” if the hospital meets the following three conditions:

1. notify the individual regarding the basis for the presumptive FAP-eligibility determination and the way he or she may apply for more generous assistance,
2. give the individual a reasonable period of time to apply for more generous assistance before initiating ECAs,
3. process any complete FAP application that the individual submits by the end of the application period.

Receipt of a signed waiver from the individual stating that the individual does not wish to apply for assistance under a FAP or to receive the information required does not constitute a determination of FAP-eligibility and doesn’t satisfy the requirements that the hospital facility make reasonable efforts to determine if that person is FAP-eligible.

A signed patient waiver refusing an FAP application does not satisfy the “reasonable efforts” requirement.

Agreements with Other Parties

If a hospital facility refers or sells debt to another party during the application period, reasonable efforts are deemed to be made if the hospital first obtains a legally binding written agreement from the other party that:

- The party will refrain from ECAs against individual until the hospital facility has met reasonable efforts requirements
- Party will suspend ECAs against individual if they submit a FAP application during the application period
- If individual submits FAP application during application period and the hospital facility determines they are FAP-eligible, other party will do the following in a timely manner:
 - Adhere to procedures in the agreement to ensure that the individual does not pay, has no obligation to pay, more than he/she is required to pay under the FAP,
 - Takes reasonable measures to reverse any ECAs taken against individual, AND
 - Obtain written agreement from any sub-parties to which the debt was referred or sold that the sub-party is adhering to the above requirements as well.

Clear and Conspicuous Placement

A hospital facility may print any of the required notices listed above on a billing statement or along with other descriptive or explanatory materials as long as the required information is conspicuously placed and of sufficient size to be clearly readable.

Board Approval of Policies Required

The FAP, EMCP, and billing and collection policy must be adopted by an authorized body of the hospital facility. An “authorized body of a hospital facility” includes 1) the governing body of the hospital organization, or 2) a committee of, or other party authorized by, the governing body to the extent permitted under state law. The final regulations also add that an “authorized body” may include the governing body of an entity that is disregarded

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or treated as a partnership for federal tax purposes that operates the hospital facility or a committee of, or party authorized by, that governing body. The preamble to the regulations clarifies that a single individual may constitute either a committee or authorized party provided that state law allows a single individual to act in either capacity. The hospital facility must also be able to show that each policy has been implemented and consistently carried out within the organization

Concluding Thoughts

Each of the hospital facility’s policies, processes, and procedures related to IRC § 501(r) requires involvement from the governing body as well as employees involved in providing emergency medical care, financial assistance, and billing and collections. Hospitals will have at least one year to come into compliance with the final regulations, however hospitals should use the transition period to assess their current compliance with the final regulations and begin implementing any policy or procedural changes as necessary. The consequences of failing to meet one or more of the requirements of §501(r) range from correction and disclosure of the error to the IRS and the public on Form 990 to loss of tax-exempt status. Undoubtedly, loss of tax-exempt status for a hospital facility will have other tax implications, including, but not limited to property tax, sales and use tax, employment tax and could affect the status of outstanding tax-exempt bonds.

Additional Information

Refer to the Appendix for a list of significant changes that were made from the proposed to the final regulations. Stay tuned for future articles discussing the final regulations regarding CHNA requirements and the consequences for failing to meet the requirements of § 501(r).

For specific questions regarding the final regulations under Section 501(r), please contact a Deloitte Tax professional.

Appendix

Summary of significant changes to the final regulations

Regulation	Change to final regulation
Financial Assistance Policy (FAP) – Section 501(r)(4)	
§1.501(r)-4(b)(1)(iii)(F)	The FAP must list the providers (other than the hospital itself) that may deliver emergency or medically necessary care in the hospital facility and specify which providers are covered by the FAP and which are not. For example, in the case of private physician groups or hospital-owned practices providing care in the hospital facility.
Preamble to final regulations	If a hospital facility outsources the operation of its emergency room to a third party and the care provided by that third party is not covered under the hospital facility's FAP, the hospital facility may not be considered to operate an emergency room for purposes of Revenue Ruling 69-545.
Preamble to the final regulations	The FAP is only required to describe "financial assistance" discounts available under the FAP rather than all discounts offered by the hospital facility.
Preamble to the final regulations	The hospital facility may offer patient discounts other than financial assistance, such as self-pay discounts, discounts mandated by state law, and discounts for out-of-state. Such discounts are not required to be listed in the FAP. However, only discounts specified in the FAP may be reported as "financial assistance" on the Form 990, Schedule H "Hospitals" community benefit calculation.
Preamble to the final regulations	The regulations do not mandate specific FAP-eligibility criteria. Each hospital may set their own eligibility criteria that respond to local community needs.
§1.501(r)-4(b)(3)(i)	A hospital facility may grant financial assistance under its FAP notwithstanding an applicant's failure to provide appropriate information or documentation. A hospital facility may grant financial assistance based on evidence other than that described in a FAP or based on an attestation by the applicant.
§1.501(r)-1(b)(13)	The definition of "FAP application" is amended to clarify that the term is not intended to refer only to written submissions and that a hospital facility may obtain information from an individual in writing or orally (e.g. face-to-face meetings or over the phone).
§1.501(r)-4(b)(1)(iii)(E)	A hospital facility must describe in its FAP any information obtained from sources other than individuals seeking assistance that the hospital facility uses, and whether and under what circumstances it uses prior FAP-eligibility determinations, to make a financial assistance determination.
§1.501(r)-4(b)(6)	The requirement to translate documents for certain populations with limited English proficiency applies to both the FAP and the billing and collections policy. The definition of "readily obtainable information" has been amended to explain the translation requirements.
Preamble to the final regulations	The final regulations eliminate the requirement that the FAP list the measures taken to widely publicize the FAP and instead require only that a hospital implement such measures.
§1.501(r)-4(b)(5)(i)(B)	FAP documents must be made available upon request and without charge in public locations. The final regulations define "public locations" as, at a minimum, the emergency room (if any) and the admissions areas.
§1.501(r)-4(b)(7)	The final regulations clarify that making FAP documents "available upon request" may include offering to provide documents electronically in lieu of paper documents.
§1.501(r)-4(b)(5)(i)(D)(2)	Rather than require a full plain language summary with billing statements, the final regulations require only that a billing statement include a conspicuous written notice that notifies the recipient about the availability of financial assistance.
§1.501(r)-4(b)(5)(i)(D)(1)	The final regulations clarify that the requirement to distribute a plain language summary may be satisfied either during the intake or discharge process.
§1.501(r)-4(b)(5)(i)(D)(1)	The final regulations require only that a hospital facility "offer" (rather than "provide") a plain language summary as part of the intake or discharge process. Thus, allowing the patient to decline a copy.
§1.501(r)-1(b)(24)(v)	The final regulations require the plain language summary to include the contact information of a source of assistance with FAP applications but allow for this source to be either the hospital facility itself or another organization such as a nonprofit or government agency.

Regulation	Change to final regulation
Financial Assistance Policy (FAP) – Section 501(r)(4)	
§1.501(r)-1(b)(24)(v)	The plain language summary must include contact information for the office or department that can provide information on the FAP but does not need to name a specific staff person.
§1.501(r)-1(b)(24)(ii)	The final regulations state that the plain language summary must include information about “how to apply” for financial assistance.
§1.501(r)-4(b)(5)(ii)	All FAP documents must be provided in the primary language of any populations with limited English proficiency that constitutes the lesser of 1,000 individuals or 5% of the community served. (Reduced from the 10% threshold which was provided in the proposed regulations.)
§1.501(r)-4(d)(3)	The final regulations clarify that joint policies may be adopted for multiple hospital facilities, provided that the policy clearly state the list of applicable facilities.

Limitations on Charges – Section 501(r)(5)	
§1.501(r)-5(b)(3) and §1.501(r)-5(b)(4)	For either the “look-back” or “prospective” methods, the final regulations allow hospital facilities to base amounts generally billed (AGB) on Medicaid rates, either alone or in combination with Medicare. The proposed regulations did not allow Medicaid rates to be used under either method.
§1.501(r)-5(b)(2)	For purposes of determining charges in excess of AGB, a FAP-eligible individual is considered to be “charged” only the amount he or she is personally responsible for paying, after all deductions, discounts, and insurance reimbursements have been applied.
§1.501(r)-5(b)(1)	A modification in the final regulations permits hospitals to change their chosen AGB method at any time, as long as the FAP is updated first to identify the new method used.
§1.501(r)-5(e)	The final regulations allow hospital facilities to define the term “medically necessary care” for purposes of their FAPs and the AGB limitation.
§1.501(r)-5(b)(3)	Under the “look-back” method, the definition of AGB now refers to claims “allowed” rather than claims “paid in full.”
§1.501(r)-5(b)(3)(v)	The final regulations provide that a hospital facility may include in the calculation of its AGB percentage claims for “all medical care” rather than just the claims allowed for “emergency and other medically necessary care,” if it would be administratively burdensome to sift out such claims.
§1.501(r)-5(b)(3)(vi)	The final regulations do not permit system-wide AGB calculations. However, if hospital facilities are covered under the same Medicare provider agreement, the organization may calculate one AGB percentage based on the claims and gross charges for all such facilities and implement the AGB percentage across all such hospitals.
§1.501(r)-5(b)(3)(iv)	A hospital facility must implement the AGB percentage within 120 days of the end of the 12-month period used to calculate AGB (an increase from the 45 days provided in the proposed regulations.)

Billing and Collection – Section 501(r)(6)	
§1.501(r)-6(b)(3)	The final regulations clarify that any lien that a hospital facility is entitled to assert under state law on the proceeds of a judgment, settlement, or compromise owed to an individual as a result of personal injuries for which the hospital provided care is not an ECA.
§1.501(r)-6(b)(2)	Certain debt sales subject to a legally binding written agreement are not considered an ECA, provided that the agreement meets four requirements as outlined in the regulations.
§1.501(r)-6(b)(4)	The filing of a claim in any bankruptcy proceeding is not an ECA.
§1.501(r)-6(b)(1)(iii)	The final regulations include a new ECA for deferring or denying, or requiring payment before providing, medically necessary care because of an individual’s nonpayment of a bill for previous care.
§1.501(r)-6(c)(3)	The 120-day notification period and 240-day applicable period start on the date that the first “post-discharge” billing statement is provided, rather than just the first billing statement.
§1.501(r)-6(c)(4)(i)	Rather than requiring a plain language summary of the FAP be included with all (and at least three) billing statements, the final regulations require that all billing statements include a “conspicuous written notice” regarding financial assistance and require the distribution of one copy of the plain language summary.
§1.501(r)-6(c)(4)(i)(C)	The final regulations replace the oral notification requirement in the proposed regulations with a requirement that a hospital facility make a reasonable effort to orally notify an individual about the hospital facility’s FAP and how to obtain assistance at least 30 days before initiating ECA’s against the individual.

Billing and Collection – Section 501(r)(6)

§1.501(r)-6(c)(4)(i)(A)	The final regulations amend the requirement regarding the written notice about ECAs to require that the notice state the ECA(s) that the hospital facility (or other authorized party) actually “intends to take,” rather than a description of every ECA a hospital “may” take in the future.
§1.501(r)-6(c)(10)	A hospital facility may provide any of the written billing & collection notices or communications electronically (for example by email) to any individual who indicates he or she prefers to receive the written notice electronically.
§1.501(r)-6(c)(4)(ii)	A hospital may satisfy the FAP notification requirements simultaneously for multiple episodes of care, provided that the hospital refrain from initiating the ECAs on the aggregate bill until 120 days after the first post-discharge billing statement for the most recent episode of care included in the aggregation.
§1.501(r)-6(c)(5)	The final regulations provide that ECAs taken against an individual who has submitted an incomplete FAP application only have to be suspended for a “reasonable period of time,” not a period of at least 240 days from the first post-discharge billing statement.
§1.501(r)-6(c)(6)(i)(C)(1)	If a patient qualifies for “free care” under the FAP, the hospital is required to notify the patient in writing of the eligibility determination, but is not required to send a separate billing statement indicating a \$0 balance. If the patient qualifies for “discounted” care under the FAP, the hospital is then required to provide a billing statement showing the amount due.

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