



## Health Care **ADVISORY** ■

**JANUARY 30, 2015**

### IRS Final Rule: Additional Requirements for Charitable Hospitals

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On December 31, 2014, the Internal Revenue Service (IRS) published a final rule entitled “Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return.” The final rule establishes regulations regarding the requirements described in Section 501(r) of the Internal Revenue Code (IRC), the entities that must meet these requirements, reporting requirements under Section 6033 and the consequences for failing to satisfy the IRC Section 501(r) requirements. The regulations generally apply to taxable years beginning after December 29, 2015, unless otherwise noted below.

#### **Background**

The Affordable Care Act (ACA) added Section 501(r) to the IRC. On June 26, 2012, the IRS issued a notice of proposed rulemaking (NPRM) that contained proposed definitions (26 C.F.R. §1.501(r)-1) and regulations regarding financial assistance policies (FAPs) and emergency medical care policies (26 C.F.R. §1.501(r)-4), limitations on charges (26 C.F.R. §1.501(r)-5) and billings and collections requirements (26 C.F.R. §1.501(r)-6). On April 5, 2013, the IRS issued an NPRM proposing regulations regarding requirements related to Community Health Need Assessments (CHNA) (26 C.F.R. §1.501(r)-3), related reporting obligations under Section 6033 (26 C.F.R. §1.6033-2), the excise tax under Section 4959 (53 C.F.R. §53.4959-1) and the corrections process and consequences for failing to meet any of the 501(r) requirements (26 C.F.R. §1.501(r)-2). On August 15, 2013, the IRS issued final and temporary regulations and a cross-reference NPRM that provided guidance on the requirement that a return accompany payment of the Section 4959 excise tax for failure to meet the CHNA requirements.

On December 30, 2013, the agency released Notice 2014-2 and Notice 2014-3. Notice 2014-2 confirmed that tax-exempt hospital organizations could rely on the June 26, 2012, and April 5, 2013, proposed rules pending the publication of final regulations or other applicable guidance. Notice 2014-3 contained proposed correction and disclosure procedures under which certain failures to meet Section 501(r) requirements would be excused.

The December 31, 2014, final rule amends and adopts the 2012 and 2013 NPRMs, removes the 2013 temporary final regulations and adopts as amended the proposed regulations that cross-referenced the text of those temporary final regulations. The final rule also clarifies that a hospital organization may continue to rely on both the June 26, 2012, and April 5, 2013, proposed regulations until the hospital organization’s first taxable year beginning after December 29, 2015.

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## Definition of Hospital Organization and Hospital Facility (26 C.F.R. §1.501(r)-1)

The final regulations codify the definitions applicable to certain hospital organizations and hospital facilities that wish to maintain a tax-exempt status. Consistent with the proposed rule, the final regulations define a “hospital organization” as an organization recognized, or seeking to be recognized, as described in IRC §501(c)(3) and that operates one or more hospital facilities. This includes government hospital organizations, though such organizations are not required to file a Form 990 or include any CHNA-related information with a Form 990, if filed.

The final rule amends the proposed definition of “operating” a hospital facility. Under the final rule, an organization operates a hospital facility if it: (1) operates the facility through the organization’s own employees or the contracted employees of another organization; (2) is the sole member or owner of a disregarded entity<sup>1</sup> that operates the facility; or (3) owns a capital or profits interest in an entity treated as a partnership for federal tax purposes that operates the hospital facility. The final rule adds that an organization is considered to own a capital or profits interest in an entity treated as a partnership for federal tax purposes if it owns such an interest directly or indirectly through one or more lower-tier entities that are treated as partnerships for federal tax purposes. The final rule also clarifies that a hospital organization is not required to meet the requirements of Section 501(r) with respect to any hospital facility it is not “operating” within the meaning of that defined term. The final rule maintains the “grandfather rule” as set forth in the 2013 proposed regulations. Under the grandfather rule, an organization will not be considered to operate a hospital facility even if it owns a capital or profits interest in an entity that is treated as a partnership for federal tax purposes and which operates the hospital facility, provided the organization has met certain conditions since March 23, 2010.<sup>2</sup>

The final rule defines a “hospital facility” as a facility that is required by the state to be licensed, registered or similarly recognized as a hospital. Though permitted under the statute, the final rule does not identify any additional categories of organizations or facilities that would be covered by these regulations. The final regulations provide that multiple buildings operated by a hospital organization under a single state license are considered to be a single hospital facility. However, the final rule amends the proposed rule to provide that if a hospital facility consists of multiple buildings operating under a single state license, but the buildings serve different geographic areas or populations, the community served by that hospital facility is the aggregate of those areas or populations.

Separate hospital facilities operating within the same building under multiple state licenses may have identical FAPs and other policies established for them or share one policy document, provided the information in the policy (or policies) is accurate for all covered facilities. Hospital facilities within the same building – as well as separate hospital facilities participating in an Accountable Care Organization (ACO) – may jointly comply with many of the requirements outlined below. Any joint policy must clearly state that it is applicable to each facility.

The final rule also clarifies that the applicability of these final regulations to hospital-owned physician practices or other entities providing care in a hospital facility “depends upon how the entities are classified for federal tax purposes.” Additionally, the final rule adds a new term, “substantially-related entity,” to refer to an entity that is treated as a partnership for federal tax purposes, in which a hospital organization owns a capital or profits interest and that provides, in a hospital facility operated by the hospital organization, emergency or other medically necessary care that is not an unrelated trade or business with respect to the hospital organization.

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<sup>1</sup> The IRS explains that, “Section 301.7701-2(c)(2)(i) provides that generally, except as otherwise provided, a business entity that has a single owner and is not a corporation under §301.7701-2(b) is disregarded as an entity separate from its owner.” T.D. 9554, 2011-50 I.R.B. 843.

<sup>2</sup> The two conditions: (1) at all times since March 23, 2010, the hospital organization has been organized and operated primarily for educational or scientific purposes and has not engaged primarily in the operation of one or more hospital facilities; and (2) pursuant to a partnership arrangement (and any side agreements) entered into before March 23, 2010, the hospital organization has not owned more than 35 percent of the capital or profits interest in the partnership, has not owned a general partner or similar interest and has not had sufficient control over the operation of the hospital facility to ensure that the facility complies with the requirements of Section 501(r).

Finally, the regulations clarify the definition of an “authorized body” of a hospital facility to provide that such body may include the governing body of an entity that operates the hospital facility and is disregarded or treated as a partnership for federal tax purposes. Therefore, under the final rule, either the governing body (or committee or other authorized party) of a hospital organization or of the disregarded entity or partnership may be considered the authorized body of the hospital facility. Such authorized body must adopt both the CHNA report and the financial assistance policy for the facility.

### **Penalties for Failure to Comply (26 C.F.R. §1.501(r)-2 and 53 C.F.R. §53.4959-1)**

If a charitable hospital fails to meet one or more of the requirements set forth under the statute and final regulations, the hospital may have its tax-exempt status revoked and/or be subject to taxation. Revocation of an organization’s 501(c)(3) status would be effective as of the first day of the taxable year in which the failure occurs. The IRS will consider the following factors in determining whether to revoke an organization’s 501(c)(3) status: the existence and nature of previous failures; the size, scope, nature and significance of the failure(s); for an organization with multiple facilities, the number, size and significance of the facilities that have failed to meet the applicable requirements relative to those in compliance; the reason for the failure(s); the existence (prior to the failure(s)) of policies and procedures reasonably designed to promote and facilitate overall compliance; whether such policies and procedures had been routinely followed; whether other safeguards are put in place that are reasonably calculated to prevent similar failure(s) from occurring in the future; whether the failure(s) was corrected promptly; and whether the organization implemented safeguards or promptly corrected any failure(s) before the IRS commissioner discovered them.

The final rule provides that if a hospital commits an omission with respect to CHNA or FAP requirements, or an error with respect to *any* of the requirements established under Section 501(r), the IRS will not consider such error or omission to be a “failure” if the error or omission was minor and either inadvertent or due to reasonable cause<sup>3</sup> and the hospital facility promptly corrected such omission or error by, in part, establishing practices or procedures designed to achieve overall compliance with the 501(r) requirements. In such case, the hospital would retain its tax-exempt status. Unlike the proposed rule, the final rule does not require public disclosure of such minor errors or omissions. The final rule also clarifies the definitions of “inadvertent” and “reasonable cause” and notes that, as more experience is gained on this issue, the IRS will consider issuing further guidance on both terms.

The final rule also provides that certain failures may be excused if the hospital facility corrects and discloses them. Specifically, a hospital may be excused from failures that are neither willful (due to gross negligence, reckless disregard or willful neglect) nor egregious, provided the hospital complies with the forthcoming revenue procedure that will finalize procedures for correcting and disclosing such failures. The final rule amends the definition of “egregious” to reflect that the term encompasses only very serious failures, taking into account the severity of the impact and number of affected persons. The IRS may issue future guidance providing examples of failures that are not willful or egregious.

Additionally, under IRC § 4959, as established by the ACA, a charitable hospital that fails to comply with the CHNA requirement would be subject to a \$50,000 excise tax.

### **Community Health Needs Assessment (26 C.F.R. §1.501(r)-3)**

Under the final rule, a charitable hospital must conduct and publish a community health needs assessment (CHNA) at least once every three years. Each charitable hospital must then issue a CHNA report that is widely available to the public and must disclose on its annual tax form the steps the hospital is taking to address the health needs identified in the CHNA.

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<sup>3</sup> This is an amendment to the proposed rule, which would have required an error or omission to meet all three conditions—minor, inadvertent and due to reasonable cause—to not be considered a failure for such purposes.

The final rule provides guidance on the way the CHNA must be conducted, the factors that must be included and the timing of the CHNA. Specifically, the final rule adopts as proposed the requirement that, in conducting a CHNA, a hospital facility must define the community it serves and assess the health needs of the community. The final rule also provides hospital facilities with broad flexibility in defining the community they serve or intend to serve, permitting such facilities to take into account all relevant facts and circumstances, provided the facilities do not exclude medically underserved, low-income or minority populations.

The final rule permits a hospital to determine whether a health need is significant based on facts and circumstances and allows a hospital facility to use “any criteria” to prioritize the significant health needs identified. To clarify the term “health needs,” the final rule expands the examples of health needs to include “not only the need to address financial and other barriers to care but also the need to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community.” The final rule reiterates that these serve as examples only; a hospital facility is not required to identify all such types of health needs in its CHNA. The final rule also amends the proposed regulations to require that a hospital facility take into account community input when both identifying and *prioritizing* significant health needs.

The final rule also adopts as proposed the requirement that a hospital, in conducting each CHNA, solicit and consider input from persons representing broad interests of the community. Specifically, the CHNA report must be developed with the input of persons representing the broad interests of the community, including members (or their representatives) of medically underserved, low-income and minority patient populations in the community served by the hospital. The final rule clarifies that a hospital may update existing CHNAs, rather than begin one anew every three years, subject to this input requirement. The final rule also expressly requires that a hospital facility solicit and take into account input received from a governmental public health department. The final rule clarifies that a hospital facility may rely on data collected or created by others when conducting its CHNA and may simply cite any such data sources, rather than describe the methods of collecting the data. Hospital facilities are also permitted—but are not required—to collaborate with other hospital facilities in conducting a CHNA, even if such hospitals have different, but overlapping, communities.

As noted above, a hospital facility must make widely available a CHNA report that documents its CHNA and is adopted by an authorized body of the facility. The CHNA report must include the hospital’s definition of the community served, a description of the assessment process and methods used, a description of the process and methods used to conduct the CHNA, a description of how the hospital solicited and took into account input (including the organizations providing input and a summary of comments made), a prioritized description of the significant health needs identified (and the process and criteria used to identify them) and a description of the potential resources available to address the needs identified. The final rule removes the proposed requirement that hospitals also include “potential measures” available and clarifies that a hospital facility must also take into account community input when identifying resources potentially available to address such needs. Hospital facilities may post a draft CHNA report for public comment, but are not required to do so. CHNA reports by hospital facilities that collaborate should reflect any material differences in the communities served.

A hospital facility must also prepare an implementation strategy to meet the needs identified. The implementation strategy must be adopted by the facility and reported to the IRS, either as an attachment to Form 990 or by providing the URL of a web page where it is available to the public. The final rule provides additional time for hospital facilities to adopt an implementation strategy, establishing the deadline for adoption as the fifteenth day of the fifth month after the end of the taxable year in which the CHNA was completed. The final rule clarifies that an implementation strategy may describe the interventions designed to prevent illness or address factors that influence community health and permits hospital facilities to explain their reasons for not addressing a significant health need identified. It also adopts as proposed the provision allowing for joint implementation strategies across multiple hospital facilities and organizations, subject to the requirements set forth. The final rule also addresses requirements for new hospital organizations, mergers and acquisitions, and transferred or terminated hospital facilities.

## **Disclosure of Financial Assistance and Emergency Medical Care Policies (26 C.F.R. §1.501(r)-4)**

Each hospital must establish and widely publicize a financial assistance policy (FAP) that clearly describes the eligibility criteria for obtaining financial assistance and the method for applying. The FAP must apply to all emergency and other medically necessary care provided by the hospital facility, including all such care provided in the hospital by a substantially related entity (i.e., a partnership for tax federal purposes). The FAP must be adopted by an authorized body and implemented by the facility.

### **The FAP must include each of the following elements:**

- ***Eligibility criteria for financial assistance and whether such assistance includes free or discounted care.*** The FAP must specify all financial assistance (including all discounts and free care) available under the FAP and the amounts (e.g., gross charges) to which any discount percentages will apply. The FAP must also specify the eligibility criteria that an individual must satisfy to receive each rate of discount, free care or other level of assistance available under the FAP.
- ***The basis for calculating amounts charged to patients.*** The FAP must outline the method used by the hospital facility to determine amounts generally billed (AGB) to individuals who have insurance covering emergency or other medically necessary care. The FAP must specify the AGB percentages used and describe how they were calculated. Alternatively, the FAP may explain how members of the public can obtain such percentages and provide an accompanying description of the calculation in writing, free of charge. The FAP must indicate that a FAP-eligible individual will not be charged more than AGB for emergency or medically necessary care. The final rule also notes that not all discounts a hospital offers are “financial assistance”; the regulations only require the FAP to describe discounts “available under the FAP” rather than all discounts *offered*. Discounts that are not specified in the FAP will not be considered community benefit activities.
- ***The method for applying for financial assistance.*** The FAP must describe how an individual may apply for financial assistance under the FAP and must include (or the application must include) a description of the information and documentation that the hospital facility may require as part of the application process. The FAP must also include contact information, including the telephone number and physical location, for the hospital facility office or department that can provide information about and assistance with the FAP application process. If the hospital does not provide assistance, the FAP must include contact information for at least one nonprofit or government agency that does.
- ***Actions that may be taken in the event of nonpayment.*** The FAP (or a separate billing and collections policy) must describe any actions that the hospital or other authorized party may take to obtain payment for care, including any extraordinary collection actions. The FAP (or a separate billing and collections policy) must also describe the process and timeframes used to take such actions and the reasonable efforts that will be made to determine FAP eligibility before taking them. The FAP (or a separate billing and collections policy) must also identify the office, department, committee or other body with the final authority for determining whether the hospital has made reasonable efforts to determine whether an individual is FAP-eligible. If the hospital has a separate billing and collections policy, the FAP must state that the actions taken in the event of nonpayment are described therein and explain how a free copy may be obtained.
- ***Information obtained from sources other than an individual seeking financial assistance that the hospital facility uses to presumptively determine eligibility.*** If applicable, this section of the FAP must also include whether and under what circumstances the hospital facility uses prior FAP eligibility determinations for this purpose.
- ***A list of any providers, other than the hospital facility itself, delivering emergency or other medically necessary care in the hospital facility.*** The final rule newly requires that this list identify which providers are covered by the FAP and which are not.



The FAP must be widely publicized by a hospital. To be widely publicized, the FAP, the FAP application and a plain language summary of the FAP must be published on a website and available in paper copies without charge (both by mail and in public locations in the hospital facility (e.g., the emergency room and admissions areas)). The final rule also requires a hospital facility to “notify and inform” members of the community served by the hospital about the FAP in a manner “reasonably calculated” to reach those most likely to require financial assistance.

The regulations provide that a measure taken by a hospital will be considered to “notify and inform” the community or patients about the FAP if it “notifies the reader or listener that the hospital facility offers financial assistance under a FAP and informs him or her about how or where to obtain more information” or copies of the FAP, the FAP application and a plain language summary. A measure to publicize the FAP will be “reasonably calculated” to notify and inform the community based on the facts and circumstances, including primary languages spoken and other attributes of the community and hospital facility. The final rule also permits a hospital facility to provide any document electronically (by email or website), according to individuals’ preferences. The final rule expands the translation services requirements for the FAP to align with other federal program requirements (e.g., Medicaid).

A hospital must also establish a written policy for a hospital facility that requires the hospital facility to provide, without discrimination, care for emergency medical conditions. Such care must be provided regardless of whether an individual is FAP eligible. This policy must prohibit the hospital facility from engaging in actions that discourage individuals from seeking emergency medical care, such as demanding that emergency patients pay before receiving treatment. The policy must also require the hospital facility to provide care for emergency medical conditions in accordance with existing and future federal regulations governing standards and certification (Subchapter G of Chapter IV of Title 42 of the Code of Federal Regulations), including (but not limited to) the Emergency Medical Treatment & Labor Act (EMTALA).

### **Limitations on Charges (26 C.F.R. §1.501(r)-5)**

Under the final rule, hospitals may not charge individuals who are eligible for financial assistance more for emergency or other medically necessary care than the amounts generally billed (AGB) to patients with insurance (including Medicare, Medicaid or private insurance). The final rule clarifies that the AGB is a cap and discounts may be greater. For all other medical care covered under the FAP, the hospital must charge FAP-eligible individuals less than the gross charges for such care. It clarifies that a FAP-eligible individual is “charged” for services based only on the amount he or she is personally responsible for paying after all deductions, discounts and insurance reimbursements have been applied. The final rule provides that a hospital facility may use a definition of “medically necessary care” applicable under the laws of the state in which it is licensed or a definition that refers to the generally accepted standards of medicine in the community or to an examining physician’s determination.

A hospital facility must calculate the facility’s AGB for all emergency or other medically necessary care. The final rule provides that a hospital facility may use either the “look-back method” or “prospective Medicare or Medicaid method” to calculate the AGB for emergency or other medically necessary care. The final rule newly permits hospitals to use “any other method specified in regulations or guidance published” by the IRS in the future and permits hospitals to change the method used with no limitation on frequency, but only permits the use of one method at a time by each facility.

The look-back method permits a hospital facility to determine the AGB by multiplying gross charges for the care by one or more percentages of gross charges (AGB percentages). Under the look-back method, a hospital must calculate the AGB percentages at least annually. The AGB percentages are calculated by dividing (1) the sum of the amounts allowed by certain issuer types during a prior 12-month period for all claims or all claims for emergency and other medically necessary care by (2) the sum of the associated gross charges. The 2012 proposed regulations would only include claims “paid in full” and limit the AGB calculation to include only claims paid by Medicare fee-for-service (FFS) and/or private health insurers as primary payers. The final rule, however, includes claims “allowed,” and also permits Medicaid-allowed amounts (either alone or in combination with Medicare FFS or in combination with Medicare FFS and private insurance). As with the proposed

rule, the hospital may also base the AGB percentages on claims allowed by Medicare FFS or Medicare FFS and all private health insurance issuers that pay claims to the facility. The final rule removes the reference to “primary payers” in order to permit hospitals to include the total amount of claims allowed including by secondary payers.

Under the look-back method, a hospital may calculate a single AGB percentage for all emergency and other medically necessary care provided by the facility, or multiple AGB percentages for separate categories of care (e.g., inpatient and outpatient) or for separate items or services. The look-back period method provides hospital facilities until the 120<sup>th</sup> day after the end of the 12-month period used by the facility in calculating the AGB percentages to determine the AGB. The final rule newly permits a hospital facility to determine AGB based on claims allowed for *all* medical care provided during a prior 12-month period and not just those allowed for emergency and other medically necessary care. It also permits a hospital organization to calculate AGB percentages using the look-back method for all facilities that are covered under a single Medicare provider agreement and implement the AGB percentages across all such facilities.

Alternatively, a hospital may use the prospective method, which is based on the billing and coding process that it would otherwise use if the FAP-eligible individual were a Medicare fee-for-service or Medicaid beneficiary (the latter option being added under the final rule). Under this method, the hospital would set the AGB for care at the amount the hospital facility determines would be the total amount Medicare or Medicaid would allow, including patient responsibility.

The final rule defines, as proposed, “gross charges” (or the chargemaster rate) to mean a hospital facility’s full, established price for medical care that the facility consistently and uniformly charges patients before applying any contractual allowances, discounts or deductions.

Finally, the regulations establish a safe harbor under which hospital facilities will be deemed to have appropriately limited the amount charged for care, even if the facility does in fact charge more than permitted under this provision, provided the following conditions are met: the charge in excess of AGB was not made or requested as a precondition of providing medically necessary care to the FAP-eligible individual; at the time of the charge, the FAP-eligible individual had not submitted a complete FAP application to the facility or had not otherwise been determined FAP-eligible; and if an application was subsequently completed and the individual determined FAP-eligible, the hospital facility refunds any amount paid by the individual in excess of his or her individual liability under the FAP (unless such difference is less than \$5 or an amount otherwise set forth by the IRS through guidance).

### **Billing and Collection Requirements (26 C.F.R. §1.501(r)-6)**

The final rule prohibits hospital facilities from engaging in extraordinary collection actions (ECAs) until they make reasonable efforts, as amended by the final rule, to determine whether an individual is eligible for assistance under the FAP.

The final rule identifies the following collection activities as ECAs: selling an individual’s debt to another party (subject to certain exceptions); reporting adverse information to a credit bureau or credit reporting agency; deferring, denying or requiring prepayment for medically necessary care because of an individual’s nonpayment of one or more previous bills for prior care; or actions requiring a legal or judicial process (e.g., garnishing wages) with emphasis on those ECAs newly included under the final rule. The final rule provides that ECAs against an individual include ECAs against any other individual who has accepted or is required to accept responsibility for the individual’s hospital bill. Furthermore, a hospital facility will be deemed to have engaged in an ECA (or to have taken steps necessary to make reasonable efforts to determine FAP eligibility for the care provided) against an individual if any purchaser of the debt, debt collection agency or substantially related entity has engaged in these activities.

The final rule also provides that the following three collection activities are *not* considered ECAs: (1) sale of an individual’s debt if, prior to the sale, the hospital has entered into a legally binding agreement with the purchaser of debt in which the parties agree that the purchaser is prohibited from engaging in any ECAs to obtain payment for the care and is prohibited

from charging interest on the debt in excess of the established rate at the time the debt is sold, that the debt is returnable to or recallable by the hospital facility upon a determination of FAP-eligibility, and that, if the individual is determined FAP-eligible, the purchaser, in combination with the hospital, must not seek more than the individual is required to pay; (2) 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 facility provided care; and (3) the filing of a claim in any bankruptcy proceeding.

***Reasonable efforts to determine FAP-eligibility: Presumptive eligibility***

A hospital facility meets the requirement to make reasonable efforts to determine FAP-eligibility if it makes a presumptive eligibility determination based on information other than that provided by the individual or based on prior eligibility. In this situation, if the hospital facility determines that an individual is eligible for assistance that is less generous than the most generous assistance available under the FAP, reasonable efforts are considered to be made only if three conditions are met. First, the hospital facility must notify the individual about the basis for the eligibility determination. Second, the hospital facility must give the individual a reasonable period of time to apply for more generous assistance before initiating ECAs. Finally, if the individual submits a complete FAP application seeking more generous assistance within the application period, the hospital facility must determine whether the individual is eligible for the more generous discount and must and otherwise comply with requirements applicable to complete applications.

***Reasonable efforts to determine FAP-eligibility: Notification and processing of applications***

The requirement to make reasonable efforts to determine FAP-eligibility will also be met if the hospital facility notifies the individual about the FAP and refrains from ECAs for at least 120 days, starting from the date of the first post-discharge billing statement for the care. Two additional conditions apply in such a situation. In the case of an individual who submits an incomplete FAP application during the application period, the hospital facility must notify the individual about how to complete the FAP application and give the individual a reasonable opportunity to do so. In the case of an individual who submits a complete FAP application during the application period, the hospital facility must determine whether the individual is FAP-eligible for the care provided.

***Notification requirements: Generally***

The final rule outlines notification requirements that must be met in order to meet the reasonable effort standard. A hospital facility will have notified an individual of the FAP for the purpose of making a reasonable effort to determine FAP-eligibility only if it takes the following steps at least 30 days before first initiating one or more ECA. Notification is made if a hospital facility provides the individual a written notice that indicates financial assistance is available for eligible individuals, identifies the ECAs the hospital facility (or other authorized party) intends to initiate and establishes a deadline after which such ECAs may be initiated, provided such deadline is no earlier than 30 days after the date that the written notice is provided. The hospital facility must also provide the individual with a plain language summary of the FAP (with the written notice) and make a reasonable effort to orally notify the individual about the hospital facility's FAP and how the individual may obtain assistance with the FAP application process.

***Notification requirements: Options in the event of multiple episodes of care***

In the event of a single patient receiving multiple episodes of care, a hospital facility may simultaneously satisfy the notification requirement for such episodes and notify the individual about the ECAs the hospital facility intends to initiate for multiple outstanding bills. However, if a hospital facility aggregates an individual's outstanding bills for multiple episodes of care before initiating one or more ECAs, a hospital must refrain from initiating the ECAs until 120 days after it provided the first post-discharge billing statement for the most recent episode of care included in the aggregation.

***Notification requirements prior to deferring or denying care due to nonpayment for prior care***

Finally, for the purposes of effectuating notification before deferring or denying care due to nonpayment for prior care, a hospital facility must provide the individual with a FAP application form and a written notice indicating that financial



assistance is available for eligible individuals. Such notice also must set forth the deadline, if any, after which the hospital facility will no longer accept and process the individual's FAP application. This deadline must be no earlier than the later of 30 days after the date that the written notice is provided or 240 days after the date the first post-discharge billing statement was provided. If the individual submits a FAP application for the previously provided care by the deadline (or at any time, if the hospital facility does not provide a deadline), the hospital facility must process the FAP application on an expedited basis. Additionally, in such a situation, the hospital facility must still provide a plain language summary of the FAP and make reasonable efforts to orally notify the individual about the hospital facility's FAP and about how he or she may obtain assistance with the FAP application process. The preamble of the final rule also notes that hospital facilities remain subject to the requirements of both the emergency medical care policy they adopt and Subchapter G of Chapter IV of Title 42 of the Code of Federal Regulations, including regulations under EMTALA.

### ***Application processing: Generally***

The final rule outlines requirements that must be met with respect to the processing of applications in order to meet the reasonable effort standard. Specifically, the final rule sets forth requirements for how hospital facilities must handle ECAs if and when an individual completes a FAP application or submits an incomplete FAP application, including anti-abuse provisions and suspensions of applications pending a Medicaid eligibility determination.

### ***Application processing: Requirements for processing incomplete applications***

For incomplete FAP applications submitted during the application period, the hospital facility must suspend any ECAs and provide the individual with a written notice that describes the additional information and/or documentation that must be submitted to complete the FAP application, including contact information. If an individual who has submitted an incomplete FAP application during the application period subsequently completes the FAP application during the application period (or within a reasonable timeframe), the hospital facility must comply with the requirements that apply to completed FAP applications.

### ***Application processing: Requirements for processing complete applications***

When a completed FAP application is submitted during the application period, the hospital facility must in a "timely manner" suspend any ECAs, make a determination as to whether the individual is FAP-eligible for the care and notify the individual in writing of this eligibility determination and the basis for this determination. If the individual is FAP-eligible, the hospital facility must provide an individual eligible for assistance other than free care with a billing statement that indicates the amount he or she owes, how that amount was determined and how the individual can get information regarding the AGB; the hospital facility must refund the individual any amount paid in excess of what he or she is determined to be personally responsible for (unless such excess amount is less than \$5 or an amount set by the IRS); and the hospital facility must take all reasonably available measures to reverse any ECA taken against the individual to obtain payment for the care (with the exception of a sale of debt or the deferral, denial or requirement of payment before care). Reasonably available measures generally include measures to vacate any judgment against the individual, lift any levy or lien on the individual's property and remove from the individual's credit report any adverse information that was reported to a consumer reporting agency or credit bureau.

If the hospital facility actually determines whether the individual is FAP-eligible for the care based on a complete FAP application and otherwise meets the requirements described above (with respect to processing a complete FAP application), the facility will be found to have made reasonable efforts to determine whether an individual is FAP-eligible if it initiates any ECAs. If these conditions are satisfied, the notification requirements do not also need to be met. Additionally, a hospital facility that believes a FAP applicant may qualify for Medicaid may postpone determining whether the individual is FAP-eligible for the care until after the individual's Medicaid eligibility has been determined.

The final rule also includes an anti-abuse rule for complete FAP applications. Under the anti-abuse provision, a hospital facility may not base its determination that the individual is not FAP-eligible on information that the hospital facility has

reason to believe is unreliable or incorrect or on information obtained from the individual under duress or through the use of coercive practices (e.g., delaying or denying emergency medical care).

***Application processing: Requirements when no application is submitted***

If no FAP application is submitted during the application period, any reasonable effort requirements that are conditioned on an individual's submission of a FAP application will not apply. A hospital facility may therefore initiate one or more ECAs to obtain payment for care, provided the hospital satisfies all other applicable requirements. For example, the IRS provides that unless and until a hospital facility receives a FAP application from an individual during the application period, the hospital facility has made reasonable efforts to determine whether the individual is FAP-eligible for care (and may initiate ECAs to obtain payment for the care) once it has notified the individual about the FAP.

The final rule further provides that if an individual submits a FAP application during the application period, the hospital facility must suspend ECAs. Suspension occurs only if the hospital does not initiate or take further action on any previously initiated ECAs until either the hospital facility has determined whether the individual is FAP-eligible based on a complete FAP application or, in the case of an incomplete FAP application, the individual has failed to respond to requests for additional information and/or documentation within a reasonable period of time.

Under the final rule, a hospital facility may print any written notice or communication required to effectuate such reasonable efforts, including the plain language summary of the FAP, on a billing statement. Such information must be conspicuously placed and of sufficient size to be clearly readable. A hospital facility may also provide electronically any written notice or communication required to effectuate such reasonable efforts, based on an individual's stated preference.

**Additional Disclosure Requirements (26 C.F.R. §1.6033-2)**

The final rule also implements regulations regarding returns that must be filed with the IRS under Section 6033 of the IRC, as amended by the ACA. The 2013 regulations proposed to require that a hospital annually furnish a description of the actions taken during the taxable year to address the significant health needs identified through its most recent CHNA. The final rule retains this and reiterates that a hospital organization must attach to its Form 990 a copy of its audited financial statements for the taxable year. According to the IRS, the final regulations under Section 6033 clarify and confirm compliance with statutory requirements that are already in effect, and therefore the final regulations under Section 6033 apply to returns filed on or after December 29, 2014.

Additionally, the IRS notes separately that the requirements described above are in addition to other consumer protections provided by the ACA. The Centers for Medicare & Medicaid Services (CMS) issued a final rule implementing this provision—Section 2718(e) of the Public Health Service Act (ACA 1001)—in August.<sup>4</sup> CMS's final rule provides that "[e]ach hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act." Hospitals must "either make public a list of their standard charges (whether that be the chargemaster itself or in another form of their choice), or their policies for allowing the public to view a list of those charges in response to an inquiry." CMS further "encourage[s] hospitals to undertake efforts to engage in consumer friendly communication of their charges to help patients understand what their potential financial liability might be for services they obtain at the hospital, and to enable patients to compare charges for similar services across hospitals."

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<sup>4</sup> Centers for Medicare & Medicaid Services, *Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2015 Rates*, final rule, 79 Fed. Reg. 49,853 (Aug. 22, 2014).

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