AAHAM ONE DAY EDUCATION

Section 501(r) highlights and challenges: Consumer protection meets tax regulation

February 12, 2016

EY

Building a better working world

Disclaimer

- EY refers to the global organization, and may refer to one or more, of the member firms of Ernst & Young Global Limited, each of which is a separate legal entity. Ernst & Young LLP is a client-serving member firm of Ernst & Young Global Limited operating in the US.
- This presentation is © 2015 Ernst & Young LLP. All rights reserved. No part of this document may be reproduced, transmitted or otherwise distributed in any form or by any means, electronic or mechanical, including by photocopying, facsimile transmission, recording, rekeying, or using any information storage and retrieval system, without written permission from Ernst & Young LLP. Any reproduction, transmission or distribution of this form or any of the material herein is prohibited and is in violation of US and international law.
  Ernst & Young LLP expressly disclaims any liability in connection with use of this presentation or its contents by any third party.
- Views expressed in this presentation are those of the speakers and do not necessarily represent the views of Ernst & Young LLP.
- This presentation is provided solely for the purpose of enhancing knowledge on tax matters. It does not provide tax advice to any taxpayer because it does not take into account any specific taxpayer's facts and circumstances.
- These slides are for educational purposes only and are not intended, and should not be relied upon, as accounting advice.

Presenters

- Kathy Pitts
- Ernst & Young LLP
- Birmingham, AL
- kathy.pitts@ey.com
- 205-254-1608

EY

Agenda

- Hospital facilities and partnerships
- Community Health Needs Assessment
- Financial Assistance Policy
- Limitations on charges
- Billing and collection requirements
- Failures, corrections and disclosures
- Schedule H implications

Hospital facilities and partnerships

Hospital facilities

- A hospital organization operating a hospital facility must ensure that each facility meets each Section 501(r) requirement.
- A hospital facility is "a facility required by a state to be licensed, registered or similarly recognized as a hospital"
- Includes:
  - Hospital facilities operated through a disregarded entity
  - Multiple buildings under one state license - a single hospital facility
  - The preamble to final regulations clarifies that operations in a single building under more than one state license constitute *multiple* hospital facilities

EY

Partnerships

- General rule – A hospital organization “operates” a hospital facility if it owns a capital or profits interest in an entity treated as a partnership for federal tax purposes (e.g., joint venture, LLC) that operates the facility, directly or indirectly.
  - Indirect ownership: general rule applies to interests owned indirectly through lower-tier entities treated as partnerships
- The governing body of a partnership or disregarded entity is an “authorized body” of its hospital facility.
  - A committee of such a governing body is also an authorized body to the extent permitted under state law

EY

Instances in which a hospital organization does not have to meet Section 501(r)

- **Unrelated trade or business:** The final regulations clarify that a hospital organization does not have to meet the requirements of Section 501(r) with respect to any activities that constitute an unrelated trade or business described in Section 513
  - Including operation of a hospital facility through a partnership

- **Corporations (physicians' practices):** Preamble clarifies that a hospital facility does not have to meet requirements of 501(r) with respect to taxable corporations (e.g., physicians' practices) that provide care in the facility, even if the corporation is wholly or partially owned by the hospital, because Section 501(r) does not apply.
  - Same rationale would apply to tax-exempt corporations that provide care in the facility but do not operate their own hospital facility

Community Health Needs Assessment (CHNA)

CHNA: defining community served and assessing community health needs

- To conduct a CHNA, hospital facility must:
  - Define community served
    - Regulations provide flexibility in how defined
    - Must describe in CHNA report how defined
  - Identify *and prioritize* significant health needs of community
  - Solicit and take into account input from persons representing broad interests of community, including all of:
    - One public health department or State Office of Rural Health with knowledge or expertise relevant to community's health needs
    - Medically underserved, low-income and minority populations
    - Written comments on its most recent CHNA and implementation strategy
  - Include an evaluation of the *impact of any actions* facility has taken to address *significant health needs identified in prior CHNAs*
  - Documentation is key

CHNA
Implementation strategy

- Authorized body must adopt implementation strategy by 15th day of 5th month after end of taxable year during which CHNA is conducted
- Implementation strategy is required to:
  - Describe actions the hospital intends to take to address each significant health need identified in CHNA, and anticipated impact of those actions, or identify health need as one it does not intend to address and explain why
  - Identify resources it plans to commit to the health need
  - Describe any planned collaboration with others in addressing the health need
- Hospital must document its implementation strategy in a separate written plan, taking into account its specific programs and resources
  - May adopt a joint implementation strategy if it adopted a joint CHNA report

CHNA implications

- CHNA has been "conducted" only after report is adopted by a governing body and made widely available
- Not required to address a minimum number of needs or achieve a particular level of success
- CHNA and implementation strategy:
  - Very public documents, likely to be closely scrutinized
  - Should clearly comply with each requirement
  - For example, include language clearly explaining how community input was *solicited* and taken into account when *prioritizing* health needs
- IRS reviews the community benefit activities of every hospital once every three years and may review the CHNA report
- Tax year in which a second CHNA is needed depends on tax year in which first CHNA was conducted

CHNA frequently asked questions

- Must definition of “community” for CHNA purposes be identical to the definition of “community” for other purposes (e.g., financial assistance policy notice requirements, financial assistance policy translations, Schedule H)?
- What if a calendar-year exempt organization acquires on January 1, 2016, a hospital that last conducted its CHNA for its tax year ending June 30, 2013? By what date must that facility conduct its next CHNA?
- What if the tax year of a joint venture that operates a hospital facility is different from the tax year of the exempt organization partner? Whose tax year determines *when* the hospital facility’s CHNA needs to be conducted?

Financial Assistance Policy (FAP)

EY

FAP regulations – Section 1.501(r)(4)

- Each hospital facility must establish a written FAP that applies to all emergency and other medically necessary care it provides
  - Hospitals have flexibility to define "medically necessary care"
- FAP must describe
  - Method used to determine amounts generally billed (AGB) and how AGB percentage was calculated or refer to another document that includes this information
    - If another document is referred to, that document must be translated into limited English proficiency (LEP) languages and made widely available
  - Collections actions that can be taken for nonpayment or refer to a separate billing and collections policy that includes this information

EY

FAP – listing of outside providers

- FAP must list *providers other than hospital facility* that deliver emergency or other medically necessary care in the facility, and which providers are and are not covered under FAP
- Notice 2015-46:
  - May include name of practice group rather than each doctor in group
  - May reference department or type of service if all care in that department or type of service is or is not covered by the FAP
  - List may be maintained in document outside of FAP if FAP explains how members of public may obtain it free of charge, online and on paper
  - Updates may be made to list without governing body approval
  - Updates must be made at least quarterly to correct “minor errors or omissions”

FAP outside provider list questions

- May a hospital include a provider list hotline number, website link or other description of where/how the provider list may be accessed rather than the actual provider list in the FAP?
- Must the provider list include home health nurses that provide care to patients of the hospital?
- What if all employed radiologists are covered by the FAP, but all non-employed radiologists in the facility are not covered – must all the radiologists be included on the provider list?
- Why did the US Treasury and the IRS add this requirement?

EY

FAP – LEP accessibility and translation

- The FAP, FAP application form and plain language summary must be available in English and in any other language in which LEP populations comprise the lesser of 1,000 individuals or 5% of:
  - community served by the hospital, or
  - population likely to be affected or encountered by the hospital facility
- Rationale: Any reasonable method may be used to determine numbers and percentages.
- Regulations provide flexibility in how a facility defines its community
  - Not required to be identical to community for CHNA purposes
- Regulations provide flexibility in how a facility defines what constitutes an LEP population

FAP – LEP accessibility and translation

- Translations of FAP documents in LEP languages must also be made widely available and regularly updated.
  - Must be placed on website and made available on paper, upon request
  - Provider list also must be regularly updated in LEP languages
- Other documents that must be translated into LEP languages and made widely available include:
  - Document describing method used to determine AGB and how AGB percentage was calculated, if that information is not included in FAP
  - Billing and collections policy or other document that describes collections actions that can be taken for nonpayment, if this information is not included in FAP

Widely publicizing the FAP

- A hospital facility must:
  - Make its FAP, FAP application and plain language summary widely available and conspicuously placed on a website at all times and in all LEP languages requiring translation
  - Inform and notify visitors of the FAP through “conspicuous” public displays, including in emergency rooms and admissions areas
- Make its FAP, FAP application and plain language summary available upon request (by mail and in public locations in facility)
  - Inform and notify residents of the community served likely to require financial assistance about the FAP
    - Not just through facility’s website
    - May contact community groups representing low-income persons
    - Thoroughly document specific efforts made to do so
  - Offer (though not necessarily provide) a plain language summary of the FAP to patients as part of the intake or discharge process
  - Include conspicuous notice on all bills regarding FAP application

Emergency medical care policy

- A hospital facility must provide care, without discrimination, for emergency medical conditions to individuals whether or not they are FAP-eligible.
- An emergency medical care policy must prohibit the hospital facility from engaging in actions that discourage individuals from seeking emergency medical care, including:
  - Demanding payment before providing treatment
  - Permitting debt collection activities that interfere with provision of emergency medical care
- An emergency medical care policy may be included in the same document as the FAP or Emergency Medical Treatment and Labor Act policy.

Establishing policies

- A FAP, a separate billing and collections policy (if applicable) and an emergency medical care policy must be adopted by an "authorized body" of the hospital facility.
  - Governing body of the hospital organization
  - Committee of the governing body
  - Other parties authorized by governing body to act on its behalf if permitted by state law to do so
- Timing issues: The board of directors must have sufficient time to review and approve policies by the first day of the 2016 tax year.
  - Ensure staff has appropriate time to begin implementing policies
- Multiple hospital facilities may share identical policies.
  - If accurate for each hospital facility and if any joint policy states that it is applicable to each hospital facility
  - May require multiple governing bodies to approve

FAP implications

- Like the CHNA, the FAP documents are public and likely to be closely scrutinized, so hospitals should ensure that these documents comply with each FAP requirement.
- A hospital may consider providing fewer types of financial assistance under its FAP to minimize the types of patients to which AGB requirements apply.
- The revenue cycle, patient services and financial assistance should coordinate closely to ensure compliance with FAP provisions.
  - Consider communicating with CHNA team regarding definition of community, notifying community groups of FAP availability and seeking board approval for FAP

Limitations on charges

EY

Limitations on charges regulations

Section 1.501(r)(5) – general rules

- A hospital facility must limit the amounts charged to any FAP-eligible individual for emergency or other medically necessary care covered under the FAP to not more than the *amounts generally billed* to individuals who have insurance covering such care.
- The amount "charged" includes the amount an FAP-eligible individual is personally responsible for paying, after all deductions and discounts (including those under the FAP) and less any amounts reimbursed by insurers.
  - Regardless of whether or when full amount allowed is actually paid
- Two methods for determining AGB – look-back and prospective.
  - Look-back **numerator** should include both amounts insurer will pay or reimburse and amount (if any) individual is personally responsible for paying (e.g., co-payments, co-insurance, deductibles)
  - **Denominator:** the sum of the associated gross charges for those claims

EY

Limitations on charges
Look-back method

- Under the look-back method, the AGB percentage may be:
  - One average percentage of gross charges for *all* care, or for all emergency and other medically necessary care, provided by the hospital facility
    Or
  - Multiple AGB percentages for separate categories of care or for separate items or services
- Hospital facilities covered under the same Medicare provider agreement may calculate their AGB percentage(s) based on all claims and gross charges for all such facilities and apply such percentage(s) across all such facilities.
- Start date: Facility must begin using its AGB percentage by the 120th day after the end of the 12-month period for which it is calculated.
  - Must calculate AGB percentage at least annually
  - May recalculate AGB percentage at any time, but also must update FAP

Limitations on charges

Example 1

- Underinsured patient qualifies for 20% discount under FAP from gross charges for service ($10,000)
- AGB limitation under look-back method: 65% of gross charges, or $6,500
- Insurance allows claim, agrees to pay $2,000
- Patient responsibility: $10,000 - $2,000 (FAP discount) - $2,000 (insurance company payment) = $6,000
- $6,000 is less than AGB ($6,500), which is consistent with Section 501(r)
  - Even though total amount paid by insurer and patient ($8,000) is greater than AGB

Limitations on charges
Example 2

- Underinsured patient does not initially apply for financial assistance for service with gross charge of $10,000
- AGB limitation under look-back method: 65% of gross charges, or $6,500
- Insurance allows claim, agrees to pay $3,000
- Patient responsibility: $10,000 - $3,000 (insurance company payment) = $7,000
- Patient pays $7,000, then subsequently applies for financial assistance for care within application period and qualifies for 20% discount ($2,000)
- Because patient is FAP-eligible, hospital needs to refund $2,000 (amount above what patient is responsible for paying as an FAP-eligible individual)

Limitations on charges implications

- Consider making prepayment and deposit amounts below AGB for each service in case the individual paying is later determined to be FAP-eligible
- If an individual is charged more than AGB and is later determined to be FAP-eligible, excess amounts of $5 or more need to be refunded
- Carefully define the time periods for which an individual is FAP-eligible; otherwise, refunds for prior care might be required

Limitations on charges questions

- If a hospital offers only 100% free care to all FAP-eligible individuals, must it establish an AGB method (and, if look-back, an AGB calculation) in its FAP?
- Do these limitations apply only to charges for self-pay patients or also to charges for insured patients?
- How should secondary payors be accounted for, if at all, in AGB calculations?
- How should a hospital account for value-based, shared savings or accountable care capitated payments in its AGB calculation?

Billing and collection requirements

Billing and collection requirements
Regulations Section 1.501(r)(6) – general rules

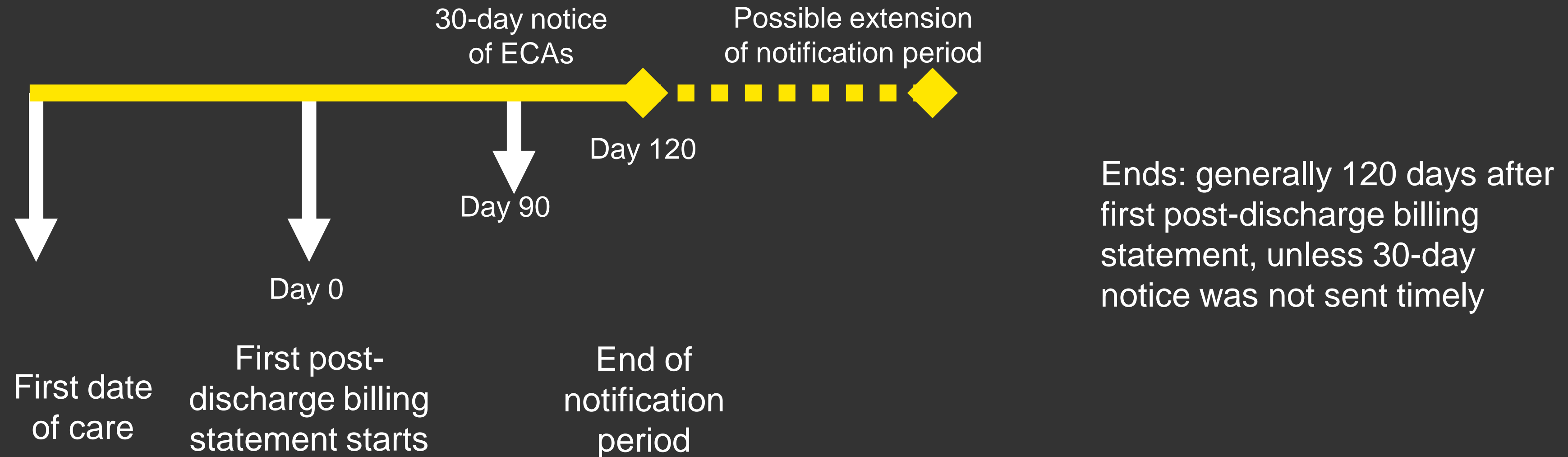
- A hospital facility may not engage in extraordinary collection actions (ECAs) against an individual, or another individual responsible for payment of the individual's bill for hospital care, before making "reasonable efforts" to determine the individual's eligibility under the FAP. ECAs include actions that:
  - Involve selling an individual's debt
  - Involve reporting adverse information about individual to consumer credit reporting agencies or credit bureaus
  - Require a legal or judicial process
  - Require payment on past unpaid bills for FAP-related care before providing medically necessary care – "defer or denial ECA"
- Applies to any ECAs taken by:
  - Any purchaser of the individual's debt
  - Any debt collection agency to which the facility referred the debt

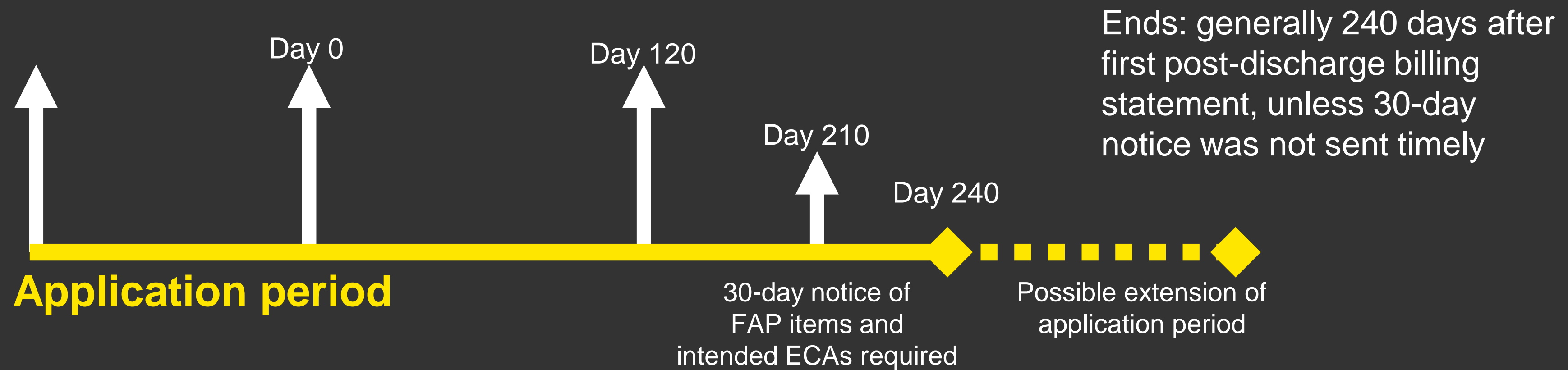
Billing and collection requirements
Reasonable efforts

- "Reasonable efforts" to determine whether an individual is FAP-eligible include notifying the individual about FAP and refraining from initiating ECAs during a "notification period."
  - Notification period begins on the date the facility provided the first post-discharge billing statement and ends 120 days later
  - Must provide *at least* one written notice to the individual disclosing:
    - That financial assistance is available for eligible individuals
    - ECAs the facility *intends to initiate* against the individual
    - Deadline after which such ECAs may be initiated (no earlier than 30 days after the date of the notice or 120 days after the first post-discharge billing statement, whichever is later)
    - Multiple notices may be required
  - Must provide a plain language summary of the FAP with the above notice
  - Must make a reasonable effort to orally notify individual about the FAP and about how he/she may obtain assistance with the application process
    - No need to **actually** notify individual orally
    - Need to document **efforts** to orally notify

Timeline of Section 501(r) notification to satisfy "reasonable efforts" before initiating ECAs

Notification period





Billing and collections implications

- If a hospital facility does not engage in ECAs, this section of the regulations is not applicable.
- If a patient submits a complete FAP application, the hospital is not required to meet the notification requirements or take other Section 501(r) reasonable efforts.
  - However, presumptively determining that an individual is not FAP-eligible does not constitute reasonable efforts.
- If a hospital refers or outsources its debt collection efforts, or sells an individual's debt, it must ensure that its agents and/or debt purchasers are complying with these requirements to avoid unauthorized ECAs.
  - Service agreements with collection agencies should require compliance with Section 501(r) and/or the hospital's Section 501(r)-related policies and procedures.
- Patient services and the revenue cycle should work closely together to coordinate compliance with these requirements.

Billing and collections questions

- If a hospital refers an account to a collections agency which then files a report with a credit agency, and months later the hospital sells the debt to a third party, how many 30-day notices are required?
- As long as a hospital complies with the 120-day notification period and 30-day notification letter requirements, can it always engage in extraordinary collections actions against the patient?
- Is the action considered an ECA if a hospital matches patients with a loan provider?

Failures, corrections and disclosures

EY

Failure to meet Section 501(r) requirements

- An omission or error will not be considered a “failure” if:
  - The omission or error was minor and either inadvertent or due to reasonable cause
  - The hospital facility promptly corrects the omission or error
    - As part of correction, the facility must establish and/or review practices or procedures reasonably designed to facilitate Section 501(r) compliance
- Where the exception for minor errors does not apply, a failure that is neither willful nor egregious will be “excused” if the organization:
  - Corrects the failure
  - Makes proper disclosure

Failure to meet Section 501(r) requirements
Disclosure

- A failure is disclosed if the hospital facility reports the following items on Form 990, Schedule H for the tax year when the failure is discovered:
  - A detailed description of the failure
  - A description of the correction made, including:
    - The method of correction
    - The date of correction
    - How persons affected by the failure were restored to their prior position and the reasoning if some were not restored
  - A description of any practices and procedures that were revised or an explanation of why revisions were not needed

Failure and correction implications

- Some Section 501(r) noncompliance is inevitable, but the consequences of noncompliance can be mitigated.
- To avoid or minimize penalties, hospitals should ensure that they have excellent documentation of practices and procedures that demonstrate:
  - A good-faith attempt to implement and comply with all requirements
  - Processes for monitoring ongoing compliance
  - Processes to identify and correct any failures that do occur
- A hospital facility should promptly correct all errors and omissions that may constitute noncompliance with Section 501(r).
- If an error or omission is not clearly both minor and either inadvertent or due to reasonable cause, a hospital facility should promptly correct **and disclose** it.

Schedule H implications

EY

Schedule H implications

- Regs. Sec. 1.6033-2 requires hospitals include in Schedule H:
  - A copy of or link to facility's most recent implementation strategy
  - Description of actions taken during the year to address significant health needs identified through its most recently conducted CHNA
- The Preamble to final Section 501(r) regulations states that discounts outside the FAP will not be considered community benefit reportable on Schedule H.
  - A facility may not want to include certain discounts (e.g., prompt pay, self-pay, out-of-state) in its FAP because this would trigger AGB limitations under Section 501(r)
  - But if a discount is not included in its FAP, hospital may not be able to report that discount as financial assistance in Schedule H, Part I
- Dual status (government entity and Section 501(c)(3)) hospitals are not required to file Forms 990 and, therefore, are exempted from new Sec. 6033 regulations.

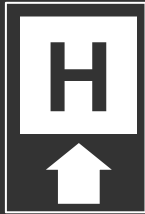
Schedule H implications

- The expenses to meet any need described in the CHNA may be reported as community health improvement service expense in Schedule H.
  - Section 501(r) regulations expand the definition of health needs to include the need to address social, behavioral and environmental factors that influence community health (e.g., community building)
- The Preamble notes that hospitals are responsible for maintaining records to substantiate any Section 501(r)-related information they report on Schedule H.
- Because of the lead time required for changes to IRS Form 990, the 2015 Schedule H does not include any changes based on final regulations.
  - Likely will not reflect final regulations until tax year 2016 version

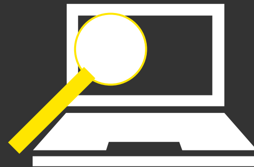
IRS report to Congress on community benefit

- January 28, 2015, IRS report to Congress under Section 9007(e)(1) of the Affordable Care Act – based on 2011 data
- Charity care provided, based on CMS data:
  - Taxable hospitals: 1.31% of total expenses
  - Tax-exempt hospitals: 2.13% of total expenses
  - Government hospitals: 6.56% of total expenses
- Unreimbursed costs for services provided by means-tested programs, based on CMS data:
  - Taxable hospitals: 1.77% of total expenses
  - Tax-exempt hospitals: 1.94% of total expenses
  - Government hospitals: 4.01% of total expenses
- Total community benefit expenses provided by tax-exempt hospitals: 9.67% of total expenses

Ernst & Young LLP's Section 501(r) risk assessment tool
Process



The hospital organization completes Ernst & Young LLP's Section 501(r) online risk assessment questionnaire and provides requested documentation



Ernst & Young LLP analyzes responses and discusses/meets with organization's tax leadership to gain full understanding of its Section 501(r)-related policies and practices

Based on responses and review of related documentation, Ernst & Young LLP will assess compliance with Section 501(r)

Ernst & Young LLP provides written recommendations for strengthening organization's Section 501(r) compliance and meets with tax leadership to discuss recommendations

Questions?

EY