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Complying with Section 501(r) in a Post-ACA World—Focus on the Financial Assistance Requirements

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I. Introduction

In 2010, the Affordable Care Act (ACA) added significant new statutory requirements that must be met by all hospitals seeking or maintaining exemption from federal income tax as Section 501(c)(3) organizations (charitable hospitals). These new requirements were codified in Section 501(r) of the Internal Revenue Code. Four years later, after issuing various forms of interim guidance, the IRS released detailed, final regulations on these new requirements, effective for tax years beginning in 2016. Thus, while the statute was effective much earlier, now that final Section 501(r) regulations have been issued and made fully effective, many hospitals are now undertaking more rigorous compliance efforts.

Given recent election results, and in light of subsequent executive branch and legislative actions, some charitable hospitals also are wondering to what extent these financially burdensome compliance efforts will continue to be necessary in a post-ACA world. Based on our assessment of the political and regulatory climate, Section 501(r) will continue to be a major enforcement focus of the IRS, and its requirements are not likely to be modified or alleviated by legislative or regulatory action. Further, in light of the expected rise in uninsured and under-insured individuals under the current direction of health-care reform, charitable hospitals should start preparing now for new post-ACA economic burdens by reviewing and revising the Section 501(r) policies and procedures they were required to adopt and implement over the past several years.

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One of the first acts of President Donald J. Trump was to sign an executive order aimed at minimizing the economic burden of the ACA. Among other things, it allows the IRS to ''exercise all authority and discretion available . . . to waive, defer, grant exemptions from, or delay the implementation of any provision [of the ACA] that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on . . . health-care providers. . . .'' Although this order could be read to justify a decrease in the intensity of IRS enforcement of Section 501(r) or some regulatory modifications, nothing indicates that the IRS is likely to take this approach unless pressured to do so. Rather, with final regulations already effective and an ongoing and bipartisan mandate to report to Congress each year on tax-exempt hospitals' level of charity care and costs incurred for community benefit activities, the IRS is more likely to ramp up Section 501(r) enforcement actions.

In March, the 115th Congress turned its full attention to fulfilling the Republican promise to ''repeal and replace'' the ACA. On March 6, 2017, Republicans in the U.S. House of Representatives released their ACA ''repeal and replace'' budget reconciliation legislation. The American Health Care Act (AHCA) consisted of two titles — one drafted by the Energy and Commerce Committee and one by the Ways and Means Committee. But although almost every other tax provision in the ACA was modified, deleted or delayed, the proposed legislation did not amend Section 501(r). To the surprise of many, and after much political wrangling, the House did not vote on AHCA after coming to the conclusion that there was not enough support for its passage. At press time, the debate over ACA ''repeal and replace''

continues with the Trump Administration still working to secure the needed commit to pass AHCA in some form. And while a revised bill could include additional modifications to existing law, we do not believe that Section 501(r) will be significantly modified in the coming weeks and months. So long as hospitals benefit from their tax-exempt status, Congress is likely to continue requirements aimed at making such hospitals accountable for the provision of community benefits.

As projected by the Congressional Budget Office (CBO), the ACA ''repeal and replace'' legislation (at least in the form contemplated by the U.S. House of Representatives in March) will significantly increase the number of uninsured and under-insured Americans. Further, even if such legislation is not resuscitated, health care industry experts anticipate that a number of factors (including executive actions) will cause steady increases in the number of uninsured and under-insured Americans. This combination — serving more uninsured patients and under-insured patients (including those who could afford insurance, but decline to arrange for coverage), while still being subject to the requirements of Section 501(r) — could prove to be a recipe for financial disaster for many charitable hospitals. Thus, it is more important than ever that every charitable hospital understand what is required (and what is not required) under Section 501(r) and the final IRS regulations, and be prepared to revise its policies and procedures, particularly its Financial Assistance Policy (FAP), to survive in a post-ACA world.

II. Navigating the Requirements of Section 501(r)

In brief, Section 501(r) requires charitable hospitals to:

1. Prepare a Community Health Needs Assessment (CHNA) every three years,

2. Adopt a written FAP and a policy specifically relating to emergency medical care,

3. Abide by certain limitations on the amounts it can charge to those individuals who qualify for financial assistance under the FAP,

4. Limit the way outstanding charges are collected prior to making a reasonable effort to determine whether an individual is eligible for financial assistance under the hospital's FAP.

Charitable hospitals are required to file information regarding how they complied with the above requirements with the IRS on Form 990, Schedule H. The IRS requires this information to be made available to the general public and also can follow up with charitable hospitals. A recent IRS report identified compliance with Section 501(r) as an ''emerging issue'' and indicated both that IRS revenue agents have been actively reviewing charitable hospitals to ensure compliance and that they will continue to do so in 2017.

Developing, implementing and periodically updating a CHNA (item 1 above) is no small task, and most hospitals have dedicated significant resources to accomplish it. However, the aspect of Section 501(r) compliance that is potentially most costly directly flows from the FAP and its related requirements regarding billing and collection (items 2 to 4 above). The FAP obligates the hospital to provide free and/or discounted care if certain criteria are met.

Although the statute and final regulations impose specific requirements on what elements a FAP must contain and how it must be implemented and publicized, the IRS allows each hospital flexibility in the following three key areas:

- Defining who is eligible for financial assistance (based on income and/or other factors)
- Determining what level of assistance the hospital is prepared to provide to individuals who qualify under the hospital's guidelines
- Defining what constitutes ''medically necessary care'' for purposes of the limitation on charges applicable to a FAP-qualifying individual

How a charitable hospital defines eligibility for financial assistance under its FAP will then determine not only the dollar amount that eligible individuals can be charged for health care, but also what collection actions a hospital can undertake on outstanding health-care debt before making a reasonable attempt to determine whether the individual (or responsible person) is eligible under the FAP.

The multitude of procedural requirements associated with FAP adoption and implementation will not be discussed in detail here as there are several good sources for that information, including the final regulations themselves. (A checklist, however, is included below.) Rather, in light of the potential seismic shift in health care in 2017, along with the continued IRS scrutiny of this particular area, we recommend that charitable hospitals review the following practical considerations regarding the FAP requirements as soon as possible:

1. Prepare for change—and start now. The ''community'' that a charitable hospital is presently serving is likely to change swiftly and significantly over the next few years. For example, a sharp rise in the uninsured and under-insured is likely as a result of efforts to repeal and replace the ACA. This will put significant financial pressure on hospitals, particularly those serving a disproportionate share of Medicaid patients as well as those hospitals that have expanded to meet increased health-care demand fueled by coverage expansion in recent years.

As noted above, Section 501(r) does not dictate or set eligibility thresholds regarding which individuals have to be offered financial assistance (including both free or discounted care). And, the statute and related regulations do not prohibit hospitals from changing or amending their FAP. Thus, neither Congress nor the IRS foreclosed the possibility that charitable hospitals would alter their FAP—including by modifying the eligibility criteria associated with any discounts and free care—based on factors straining the hospital's own financial resources.

However, before charitable hospitals leap to impose more stringent eligibility criteria or to reduce the level of financial assistance applicable to medically necessary care, it is important to remember that the ACA's additional statutory requirements for tax-exempt hospitals did not sweep away the pre-ACA requirements in IRS rulings and case law, specifically the ''community benefit standard'' as described in IRS Revenue Ruling 69-545 (modified in part by Rev. Rul. 83-157, 1983-2

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C.B. 94). State charity care and community benefit laws also may be implicated. In addition, Form 990 reporting of both charity care and community benefit will continue to be required on Schedule H.

The IRS community benefit standard is a ''facts and circumstances'' test, with no one factor determinative. Revenue Ruling 69-545 focuses on the ''promotion of health'' for the benefit of the community and includes a non-exhaustive list of factors to consider, including (a) having a governing board consisting of individuals who represent the community; (b) using surplus profits to improve facilities, training and patient care; (c) accepting Medicare and Medicaid patients; (d) operating a full-time emergency room open to all regardless of ability to pay and (e) having an open medical staff policy. Unfortunately, these factors do not provide definitive guidance on how much charity care must be undertaken to meet the community benefit standard, particularly if it is in the position of having no ''surplus profits'' because of a combination of factors that may include shrinking insurance reimbursements, Medicaid and Medicare shortfalls and the costs of maintaining an emergency room open to uninsured patients with no ability to pay for services.

In addition to the consideration of federal common law and state requirements on charitable hospitals, there are many FAP procedural requirements that will constrain the immediate implementation of FAP eligibility changes, even if fully supported by law and approved by the hospital's board. For example, the FAP, the FAP application form and the plain language summary of the FAP must be translated for certain populations with limited English proficiency that the charitable hospital is serving. This relatively minor requirement of translating these documents requires hospitals to undertake a more difficult task of being mindful of what populations they are serving and taking action when the population with limited English proficiency reaches the level at which the requirement to have translated documents is triggered. In addition, although the statute and regulations are silent, modifications to a hospital's FAP likely require that services received by a patient eligible for financial assistance under the old FAP guidelines will be charged and collected in accordance with the old FAP.

However, in terms of timing, charitable hospitals have some flexibility in modifying their FAP. The requirement that charitable hospitals conduct regular CHNAs and adopt an implementation plan will compel some hospitals to make changes to their FAP (particularly those resulting in more stringent eligibility criteria), but only in coordination with their triennial assessment of community health needs. However, the IRS regulations do not require that changes in the FAP flow from CHNA modifications, and many hospitals may be able to project net increases in charity care levels even before they conduct a new CHNA, based on decreases in insurance coverage ratios and increases in Medicaid shortfalls resulting from any ACA repeal and replace efforts.

2. Don't wait for the IRS to point out shortcomings and prepare for their arrival. Given the many prescriptive requirements imposed under Section 501(r), the IRS has stated that minor errors and omissions are not actionable, and that certain other errors, so long as they are disclosed and promptly corrected, may also be excused. Charitable hospitals should remain vigilant about their compliance and disclose and correct errors before the IRS discovers them, and before the opportunity to proactively disclose and correct compliance issues without consequence is lost.

Moreover, in addition to reviewing the charitable hospital's Form 990, Schedule H, the IRS will likely review a hospital's website, request a copy of the FAP, the FAP application, the required plain language summary of the FAP, samples of billing statements, and documentation that the FAP has been approved by the hospital's board or other authority. It may even request an on-site tour of the hospital. Charitable hospitals should think about how these documents can be used to tell their Section 501(r) compliance story.

3. Beware of likely areas for FAP noncompliance. There are several areas that hospitals are likely to struggle with, and therefore careful, regular review of the FAP requirements is necessary even if no eligibility modifications are undertaken. For example, the final regulations included a new requirement that the FAP list providers, other than the hospital itself, that deliver emergency or other medically necessary care in the hospital and specify which providers are covered by the FAP and which are not. Although this list could fluctuate regularly, the IRS has said that so long as the charitable hospital updates this list quarterly, it will consider the hospital to have taken reasonable steps to ensure that this list is accurate (according to I.R.S Notice 15-46, 2015-28 I.R.B. 64, which was published after the final regulations under Section 501(r). It contains important information about the provider list requirement.)

As another example, before certain collection actions can occur (called ''extraordinary collection actions'') on outstanding debt, a charitable hospital must make a reasonable effort to determine whether the individual is eligible under the FAP. Importantly, this obligation extends to third parties (not just employees) that the charitable hospital hires or contracts to collect its medical debt. While these prescriptive requirements should generally be able to be met through tight internal controls and diligent oversight of third-party contractors, it will be challenging to ensure compliance if a hospital's FAP eligibility standards are modified for financial reasons.

Finally, the Emergency Medical Treatment and Labor Act (EMTALA) generally requires that individuals with an emergency medical condition must be stabilized and treated, regardless of insurance or ability to pay. Under Section 501(r), charitable hospitals must establish a written policy that requires the hospital to provide, without discrimination, care of emergency medical conditions, within the meaning of EMTALA, regardless of whether they are FAP eligible. Final regulations under Section 501(r) make clear that the written policy must prohibit the hospital from engaging in debt collection activities that interfere or discourage individuals from seeking emergency medical care. As the level of uninsured and under-insured rises, hospitals should anticipate further stresses on their emergency departments and be aware of the Section 501(r) requirements.

III. Conclusion

It is likely that the statutory requirements in Section 501(r) will survive ACA repeal and replace efforts. Ac-

cording to CBO estimates, the legislation under consideration in March by the U.S. House of Representatives will, if enacted significantly increase the number of uninsured and under-insured Americans. Charitable hospitals will no doubt struggle under the resulting increased demand for free and discounted services by those lacking adequate insurance.

In a post-ACA world, charitable hospitals will need to promptly review their FAP to determine whether they can afford to increase the level of charity care that they currently provide, as the pool of FAP-eligible persons expands, premium subsidies are dropped, employers opt out of group coverage and Medicaid funds are cut back. Hospitals are free to revise their FAP eligibility guidelines, but they must do so keeping in mind the variety of rules and regulations applicable to FAP adoption and implementation under Section 501(r). In addition, charitable hospitals also should consider such modifications in the context of the overarching IRS community benefit standard and reporting requirements, as well as any state community benefit and charity care standards to which they may be subject.

Sample of FAP Requirements Under Section 501(r)

Does your hospital have a *written* financial assistance policy (FAP) adopted by the hospital's board or other appropriate authority?

Does your FAP include required content? Your FAP should include:

- eligibility criteria for financial assistance, including detail on the various levels of assistance keyed to income or other factors
- a description of the type(s) of medical care qualifying for discounted or free care
- a statement that eligible individuals who require emergency or other medically necessary care will not be charged more than the amounts generally billed (AGB) to insured patients and the methodology for calculating AGB
- a description of how an individual applies for financial assistance and a description of what other information (other than that provided by individual) the hospital will use to determine eligibility
- a list of providers, other than the hospital itself, delivering care in the hospital that specifics which providers are covered under the FAP and which are not
- in the case of a hospital that does not have a separate billing and collections policy, the actions the organization may take in the event of non-payment, including collections action and reporting to credit agencies

Has your FAP been widely publicized? FAP's must be publicized by measures, such as:

- making the FAP, the FAP application and a plain language summary (see below) available on website
- making hard copies of the FAP available on request
- include a conspicuous written notice on billing statements about the availability of financial assistance
- notifying and informing members of the community about the FAP ''in a manner reasonably calculated to reach those members who are most likely to require financial assistance from the hospital''

Do you have a plain language summary of your FAP? Plain language summaries should include:

- a brief description of the eligibility requirements and assistance offered under FAP
- a brief summary of how to apply under the FAP
- contact information of the hospital office or department that can provide information about the FAP

The above checklist items are not intended to be inclusive of all requirements that charitable hospitals must satisfy under Section 501(r) and its voluminous regulations.

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