IRS Issues Final Regulations Under Section 501(r)

Connecticut Tax Update

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On December 29, 2014, the IRS issued final regulations [2] under 28 U.S.C. §501(r)[3] both amending and ratifying the 2012 [4] and 2013 [5] temporary regulations and setting the time for compliance for a hospital organization's first taxable year beginning after December 29, 2015.

The final regulations provide over one hundred changes to the temporary regulations. Many of these changes will require substantial process and recordkeeping changes for hospitals.[6] It is important to observe that the regulations indicate that following an established process is a consideration in mitigating the sanction of loss of tax exempt status for failure to comply with §501(r).[7]

This memo briefly identifies several of the changes from the temporary regulations imposed by the final regulations. It categorizes the changes generally consistently with the Explanation of Revisions released by the IRS together with the final regulations.[8]

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[2] 79 FR 78953 (December 31, 2014); Reg. § 1.501(r)-1, Reg. § 1.501(r)-2, Reg. § 1.501(r)-3, Reg. § 1.501(r)-4, Reg. § 1.501(r)-5, Reg. § 1.501(r)-6, Reg. § 1.501(r)-7 , Reg. § 1.6012-2, Reg. § 1.6012-3, Reg. § 1.6033-2, Reg. § 53.4959-1, Reg. § 53.6011-1 , Reg. § 53.6071-1

[3] P.L. 111-148

[4] 77 FR 38148 (June 26, 2012)

[5] 78 FR 20523 (April 5, 2013)

[6] The IRS estimates the regulations will impose an additional recordkeeping burden of 136 hours per record keeper per year

[7] Reg.§1.501(r)-2(a)(6)

[8] *See*, note 2, *supra.*

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Multiple Hospital Buildings Under a Single Hospital License

The final regulations provide that, in the case of a hospital facility consisting of multiple buildings that operate under a single state license and serve different geographic areas or populations, the community served by the hospital facility is the aggregate of such areas or populations.[9] However, in such a case, the hospital facility consisting of multiple buildings could, if desired, assess the health needs of the different geographic areas or populations served by the different buildings separately and document the assessments in separate chapters or sections of the hospital facility's CHNA report and implementation strategy.

One Building Under Multiple Hospital Licenses

Separate hospital facilities within the same building that define their communities to be the same may conduct a joint CHNA and adopt a joint implementation strategy addressing the significant health needs identified in the joint CHNA. Thus, the final regulations allow for hospital facilities within the same building to jointly comply with many of the section 501(r) requirements.[10]

Accountable Care Organizations

Separate hospital facilities that define their community to be the same may conduct a joint CHNA and adopt a joint implementation strategy addressing the significant health needs identified in the joint CHNA. Thus, the final regulations provide opportunities for separate hospital facilities participating in an ACO to jointly comply with many of the section 501(r) requirements.[11]

"Operating" a Hospital Facility

The 2013 proposed regulations generally provided that an organization operates a hospital facility if it owns a capital or profits interest in an entity treated as a partnership for federal tax purposes that operates the hospital facility.[12] The final regulations maintain this general rule with two additions. First, the final regulations clarify 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.

[9] Reg. §1.501(r)-3(b)(3)
[10] *See*, Reg. §§1.501(r)-3(b)(6)(iv) and (v)
[11] *Id.*
[12] Reg. §1.501(r)-1(b)(28)

Second, the final regulations clarify how the question of whether an organization "operates" a hospital facility relates to the question of whether the organization needs to meet the requirements of section 501(r) (and, therefore, would be subject to any consequences for failing to meet such requirements). Specifically, § 1.501(r)-2(e) of the final regulations 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. In addition, as stated in the preamble to the 2013 proposed regulations, the final regulations provide that a hospital organization is not required to meet the requirements of section 501(r) with respect to the operation of a facility that is not a "hospital facility" because it is not required by a state to be licensed, registered, or similarly recognized as a hospital. The final regulations also provide that a hospital organization is not required to meet the requirements of section 501(r) with respect to any activities that constitute an unrelated trade or business described in section 513 with respect to the hospital organization.

Substantially Related Entity

The final regulations use a new defined 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 (or a disregarded entity of which the hospital organization is the sole owner or member) 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.[13]

Authorized Body of a Hospital Facility

The final regulations provide that an authorized body of a hospital facility 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 (or a committee of, or other party authorized by, that governing body to the extent such committee or other party is permitted under state law to act on behalf of the governing body), and thus either the governing body (or committee or other authorized party) of the hospital organization or of the disregarded entity or partnership may be considered the authorized body of the hospital facility.[14]

Under the regulatory definition of "authorized body of a hospital facility" in both the 2013 proposed regulations and these final regulations, a single individual may constitute either a committee of the governing body or a party authorized by the governing body to act on its behalf, provided that state law allows a single individual to act in either of these capacities.[15]

[13] *See,* Reg.§1.501(r)-4(b)(i) (extending FAP obligations to substantially related entities)

[14] Reg. §1.501(r)-1(b)(4)

[15] Hospitals are urged to review their governing documents to determine both that they have the authority to establish such an "authorized body" and that such authorized body can and does have the necessary authority to act

Failure to Satisfy the Requirements of Section 501(r)

Minor Omissions and Errors

The final regulations require an omission or error to be minor in order to be corrected and not considered a failure under § 1.501(r)-2(b). However, the final regulations provide that the option for correction without disclosure provided in § 1.501(r)-2(b) will be available if the omission or error is minor and either inadvertent or due to reasonable cause. The final regulations also clarify the meaning of "reasonable cause" for purposes § 1.501(r)-2(b).[16]

The final regulations provide additional guidance regarding the factors that will be considered in determining whether an omission or error is minor and either inadvertent or due to reasonable cause. With respect to the notion of "minor," the final regulations clarify that, in the case of multiple omissions or errors, the omissions or errors are considered minor only if they are minor in the aggregate. The final regulations further provide that the fact that the same omission or error has occurred and been corrected previously is a factor tending to show that an omission or error is not inadvertent. Finally, with respect to reasonable cause, the final regulations provide that a hospital facility's establishment of practices or procedures (formal or informal) reasonably designed to promote and facilitate overall compliance with the section 501(r) requirements[17] prior to the occurrence of an omission or error is a factor tending to show that the omission or error was due to reasonable cause.

Importance of Established Procedures to Avoid Penalty

The final regulations specify that correction of minor omissions or errors must include establishment (or review and, if necessary, revision) of practices or procedures (formal or informal) that are reasonably designed to achieve overall compliance with the requirements of section 501(r).[18] O*ur office suggests that hospitals ought establish such practices and procedures promptly and in advance of any inquiry by IRS into a claim of a 501(r) violation.*

Excusing Certain Failures if a Hospital Facility Corrects and Makes Disclosure

The final regulations delete the reference to civil penalties, but continue to provide that a "willful" failure includes a failure due to gross negligence, reckless disregard, and willful neglect—all terms with well-established meanings in case law—to assist hospital facilities in distinguishing between a failure that is willful and a failure that may be excused if it is corrected and disclosed. Hence, in our view, the IRS makes it plain here that they intend to use the courts to incorporate this new section of tax law into their enforcement plan.

The Final regulations use the "neither willful nor egregious" standard in providing a "disclose and correct" defense to hospitals which violate §§1.501(r)(3)-(6).[19]

[16] Reg. §1.501(r0-2(b)(4)
[17] Reg. §1.501(r)-2(a)(5) (emphasis mine)
[18] Reg. §§1.501(r)-2(a)(5) and (6)
[19] Reg. §1.501(r)-2(c)

The final regulations under section 4959 also make clear that such a minor omission or error related to the CHNA requirements that is corrected will not give rise to an excise tax under section 4959.[20]

Facts and Circumstances Considered in Determining Whether to Revoke Section 501(c)(3) Status

The final regulations provide that all of the relevant facts and circumstances will be considered in determining whether to revoke a hospital organization's section 501(c)(3) status, including the size, scope, nature, and significance of the organization's failure, as well as the reason for the failure and whether the same type of failure has previously occurred.[21] The IRS will also consider whether the hospital organization had, prior to the failure, established practices or procedures (formal or informal) reasonably designed to promote and facilitate overall compliance with the section 501(r) requirements[22]; whether such practices or procedures were being routinely followed; and whether the failure was corrected promptly.[23]

Taxation of Noncompliant Hospital Facilities

The final regulations clarify that application of the facility-level tax will not, by itself, result in the operation of the noncompliant hospital facility being considered an unrelated trade or business described in section 513.[24]

Community Health Needs Assessments

The final regulations provide that a hospital organization meets the requirements of section 501(r)(3) in any taxable year with respect to a hospital facility it operates only if the hospital facility has conducted a CHNA in such taxable year or in either of the two immediately preceding taxable years and an authorized body of the hospital facility has adopted an implementation strategy to meet the community health needs identified through the CHNA.[25]

Conducting a Community Health Needs Assessment

Consistent with the 2013 proposed regulations, the final regulations provide that, in conducting a CHNA, a hospital facility must define the community it serves and assess the health needs of that community. In assessing the community's health needs, the hospital facility must solicit and take into account input received from persons who represent the broad interests of its community. The hospital facility must also document the CHNA in a written report (CHNA report) that is adopted

[20] Reg. §53.4959-1(b)
[21] Reg. §1.501(r)-2(a)
[22] Reg.§1.501(r)-2(a)(5)
[23] *See,* Reg.§1.501(r)-2(a)(6)-9)
[24] Reg. §1.501(r)-2(d)
[25] Reg. §§1.501(r)-3(a)(1) and (2)

for the hospital facility by an authorized body of the hospital facility. Finally, the hospital facility must make the CHNA report widely available to the public. A hospital facility is considered to have conducted a CHNA on the date it has completed all of these steps, including making the CHNA report widely available to the public.[26]

The final regulations also provide that hospital facilities may not exclude low-income or minority populations living "in the geographic areas from which the hospital facility draws its patients," and not only those already receiving care from the facility. [27]

Assessing Community Health Needs

The final regulations expand the examples of health needs that a hospital facility may consider in its CHNA 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.[28] The preamble to the regulations notes that the list of possible health needs in the final regulations is only a list of examples, and a hospital facility is not required to identify all such types of health needs in its CHNA report if all such types are not determined by the hospital facility to be significant health needs in its community.

Hospitals Must Identify Resources

The final regulations require a hospital facility to identify resources potentially available to address the significant health needs, with the term "resources" including programs, organizations, or facilities. In addition, the final regulations clarify that resources of the hospital facility itself may be identified.[29]

Input from Persons Representing the Broad Interest of the Community

The final regulations clarify that the requirement to take into account input in assessing the health needs of the community includes taking into account input in identifying and prioritizing significant health needs, as well as identifying resources potentially available to address those health needs.[30]

Posting of Draft CHNA Does Not Trigger Three-Year Cycle

The final regulations provide that the posting of a draft CHNA report will not trigger the start of a hospital facility's next three-year CHNA cycle.[31]

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[26] Reg. §1.501(r)-3(b)
[27] Reg. §1.501(r)-3(b)(3)
[28] Reg. §1.501(r)-3(b)(4)
[29] Reg. §1.501(5)-3(b)(4)
[30] Reg. §1.501(r)-3(b)(5)
[31] Reg. §1.501(r)-3(b)(7)(ii)

Copy of Implementation Strategy

A hospital organization must either attach to its Form 990 a copy of the most recently adopted implementation strategy for each hospital facility it operates or provide on the Form 990 the URL(s) of the Web page(s) on which it has made each implementation strategy widely available on a Web site.[32] Section 6104 requires Form 990 to be made available to the public by both the filing organization and the IRS, and members of the public may obtain a copy of a hospital organization's Forms 990 from one of the privately-funded organizations that gathers and disseminates Forms 990 online or by completing IRS Form 4506-A, "Request for Public Inspection or Copy of Exempt or Political Organization IRS Form."

Written Public Comments

The final regulations do not require a specific method for collection of written comments from the public, providing hospital facilities with the flexibility to set up a collection and tracking system that works with their internal systems and makes the most sense for their particular community.

The final regulations require hospital facilities to describe generally any input received in the form of written comments (or from any other source) in their CHNA reports.[33]

Input on Financial and Other Barriers

The final regulations focus on ensuring transparency regarding the health needs identified through a CHNA rather than requiring hospital facilities to identify any particular categories of health needs. As with all significant health needs identified through a CHNA, a hospital facility's decision as to whether and how to address a significant health need involving financial barriers to care (including through an amendment to a hospital facility's FAP) will be disclosed publicly in the hospital facility's implementation strategy and subject to public comments in preparing the next CHNA.[34] Thus, the final regulations do not require any additional link between a hospital facility's CHNA and its FAP.

Documentation of a CHNA

The final regulations clarify that a hospital facility may rely on (and the CHNA report may describe) data collected or created by others in conducting its CHNA and, in such cases, may simply cite the data sources rather than describe the "methods of collecting" the data.[35]

[32] IRC § 6033(b)(15), Reg. § 1.6033-2(a)(2)(ii)(l)
[33] Observe that 26 U.S.C. §501(r)(3) requires this as well. *See*, Reg. §§1.501(r)-3(b)(1)(iii) and (b)(5)
[34] Reg.§1.501(r)-3(b)(4)
[35] Reg. §1.501(r)-3(c)(6)(ii)

Collaboration on CHNA Reports

The final regulations amend the proposed regulations to clarify that joint CHNA reports must contain all of the same basic information that separate CHNA reports must contain (discussed in section 3.a.iv of the preamble).[36]

Defining a Common Community

The final regulations permit hospital facilities with different but overlapping communities to collaborate in conducting a CHNA and to include substantively identical portions in their separate CHNA reports if appropriate under the facts and circumstances.[37] The final regulations elaborate upon this point with an example of two hospital facilities with overlapping, but not identical, communities that are collaborating in conducting a CHNA and state that, in such a case, the portions of each hospital facility's CHNA report relevant to the shared areas of their communities may be identical. Thus, the final regulations not only expressly permit hospital facilities with different communities (including general and specialized hospitals) to collaborate but also allow such hospital facilities to adopt substantively identical CHNA reports to the extent appropriate.

Collaborating with Public Health Departments

The final regulations clarify that if a governmental public health department has conducted a CHNA for all or part of a hospital facility's community, portions of the hospital facility's CHNA report may be substantively identical to those portions of the health department's CHNA report that address the hospital facility's community. The final regulations also clarify that a hospital facility that collaborates with a governmental public health department in conducting its CHNA may adopt a joint CHNA report produced by the hospital facility and public health department, as long as the other requirements applicable to joint CHNA reports are met.[38]

Paper Copy of CHNA

The final regulations clarify that a hospital facility need only make a paper copy of the CHNA report available for public inspection upon request.[39]

Describing How a Hospital Facility Plans to Address a Significant Health Need

The final regulations replace the proposed requirement that the implementation strategy describe a plan to evaluate its impact with a requirement that the CHNA report include an evaluation of the impact of any actions that were taken since the hospital facility finished conducting its

[36] Reg. §1.501(r)-3(b)(6)(v)
[37] Reg. §1.501(r)-3(b)(6)(iv)
[38] Reg. §1.501(r)-3(b)(6)(v)
[39] Reg. §1.501(r)-3(b)(7)(i)(B)

immediately preceding CHNA to address the significant health needs identified in the hospital facility's prior CHNA(s).[40]

The final regulations specify that the health needs identified through a CHNA may, for example, include the need to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community.[41] Thus, the final regulations make clear that an implementation strategy may describe interventions designed to prevent illness or to address social, behavioral, and environmental factors that influence community health.

When the Implementation Strategy Must be Adopted

The final regulations provide hospital facilities with an additional four and a half months to adopt the implementation strategy, specifically requiring an authorized body of the hospital facility to adopt an implementation strategy to meet the health needs identified through a CHNA on or before the 15th day of the fifth month after the end of the taxable year in which the hospital facility finishes conducting the CHNA.[42] By matching the date by which an authorized body of the hospital facility must adopt the implementation strategy to the due date (without extensions) of the Form 990 filed for the taxable year in which the CHNA is conducted, this approach is expected to not materially reduce transparency, because an implementation strategy (or the URL of the Web site on which it is posted) is made available to the public through the Form 990. The final regulations do not go further and permit a hospital facility to delay adoption of an implementation strategy until the due date for the Form 990, including extensions. This is because hospital facilities need to report on Form 4720 any excise tax they owe under section 4959 as a result of failing to meet the CHNA requirements in a taxable year by the 15th day of the fifth month following the end of that taxable year and thus need to know whether they have met the requirement to adopt an implementation strategy by that date.

Acquired Hospital Facilities

The final regulations provide that, in the case of a merger that results in the liquidation of one organization and survival of another, the hospital facilities formerly operated by the liquidated organization will be considered "acquired," meaning they will have until the last day of the second taxable year beginning after the date of the merger to meet the CHNA requirements.[43]Thus, the final regulations treat mergers equivalently to acquisitions.

New Hospital Organizations

A facility is not considered a "hospital facility" until it is licensed, registered, or similarly recognized as a hospital by a state, and an organization operating a hospital facility is not subject to section 501(r) until it is recognized as described in section 501(c)(3). Thus, the Treasury Department and the IRS intend that a new hospital organization must meet the CHNA

[40] Reg. §1.501(r)-3(b)(6)(i)(F)
[41] Reg. §1.501(r)-3(b)(4)
[42] Reg. §1.501(r)-3(b)(1)(iii)
[43]Reg. §1.501(r)-3(d)(1)

requirements by the last day of the second taxable year beginning after the later of the effective date of the determination letter or ruling recognizing the organization as described in section 501(c)(3) or the first date a facility operated by the organization was licensed, registered, or similarly recognized by its state as a hospital. The final regulations are amended to make this clarification.[44]

Transferred or Terminated Hospital Facilities

The final regulations provide that a hospital organization is not required to meet the requirements of section 501(r)(3) with respect to a hospital facility in a taxable year if the hospital organization transfers all ownership of the hospital facility to another organization or otherwise ceases its operation of the hospital facility before the end of the taxable year. The same rule applies if the facility ceases to be licensed, registered, or similarly recognized as a hospital by a state during the taxable year.[45]

Eligibility Criteria and Basis for Calculating Amounts Charged to Patients

The IRS intends that hospital facilities may offer payment discounts or other discounts outside of their FAPs and may charge discounted amounts in excess of AGB to individuals that are not FAP-eligible. Accordingly, the final regulations only require the FAP to describe discounts "available under the FAP" rather than all discounts offered by the hospital facility.[46] Note, however, that only the discounts specified in a hospital facility's FAP (and, therefore, subject to the AGB limitation) may be reported as "financial assistance" on Schedule H, "Hospitals," of the Form 990. Moreover, discounts provided by a hospital facility that are not specified in a hospital facility's FAP will not be considered community benefit activities for purposes of section 9007(e)(1)(B) of the Affordable Care Act (relating to reports on costs incurred for community benefit activities) nor for purposes of the totality of circumstances that are considered in determining whether a hospital organization is described in section 501(c)(3).

Method for Applying for Financial Assistance

The final regulations are not intended to restrict hospital facilities' ability to grant financial assistance to an applicant who has failed to provide such information or documentation. Accordingly, the regulations expressly state that a hospital facility may grant financial assistance under its FAP notwithstanding an applicant's failure to provide such information.[47] Thus, a hospital facility may grant financial assistance based on evidence other than that described in a

[44] Reg. §1.501(r)-3(d)(2)
[45] Reg. §1.501(r)-3(d)(4)
[46] Reg. §1.501(r)-4(b)(2)(i)(A)
[47] Reg.§ 1.501(r)-4(b)(3)

FAP or FAP application form or based on an attestation by the applicant, even if the FAP or FAP application form does not describe such evidence or attestations.

FAP Application Form

The example of the FAP application form in the final regulations is modified so that the instructions identify specific documentation (including federal tax returns, paystubs, or documentation establishing qualification for certain specified state means-tested programs) but also state that if an applicant does not have any of the listed documents to prove household income, he or she may call the hospital facility's financial assistance office and discuss other evidence that may be provided to demonstrate eligibility.[48]

FAP Application May be Oral or In Writing

The final regulations amend the definition of "FAP application" to clarify that the term is not intended to refer only to written submissions and that a hospital facility may obtain information from an individual in writing or orally (or a combination of both).[49]

FAP Eligibility Determination May Include Information from Other Sources

The final regulations permit a hospital facility to determine that an individual is eligible for assistance under its FAP based on information other than that provided by the individual or based on a prior FAP-eligibility determination, provided that certain conditions are met. The final regulations require a hospital facility to describe in its FAP any information obtained from sources other than individuals seeking assistance that the hospital facility uses, and whether and under what circumstances it uses prior FAP-eligibility determinations, to presumptively determine that individuals are FAP-eligible.[50]

Widely Publicizing the FAP

The final regulations eliminate the requirement that the FAP list the measures taken to widely publicize the FAP and instead require only that a hospital facility implement the measures to widely publicize the FAP in the community it serves.[51] This approach is consistent with the definition of "establishing" a FAP discussed in section 4.c of the preamble to the final regulations, which includes not only adopting the FAP but also implementing it, and with the Joint Committee on Taxation's (JCT) Technical Explanation of the Affordable Care Act. *See*, Staff of the Joint Committee on Taxation, Technical Explanation of the Revenue Provisions of

[48] *Id.*, Example
[49] Reg. §1.501(r)-1(b)(13)
[50] Reg. §§1-501(r)-1(b)(25), 6(c)(2)
[51] Reg. §1.501(r)-4(b)(i)(2)

the "Reconciliation Act of 2010," as Amended, in Combination with the "Patient Protection and Affordable Care Act" (March 21, 2010), at 82 (Technical Explanation) (stating that section 501(r)(4) requires each hospital facility to "adopt, implement, and widely publicize" a written FAP).

Making Paper Copies of FAP Available Upon Request

The final regulations specify that "public locations" in a hospital facility where paper copies must be provided upon request include, at a minimum, the emergency room (if any) and the admissions areas.[52] The regulations also provide that the hospital must inform visitors about the FAP in such public locations.[53]

The final regulations clarify that hospital facilities may inform individuals requesting copies that the various FAP documents are available on a Web site or otherwise offer to provide the documents electronically (for example, by email or on an electronic screen). The final regulations also make clear that a hospital facility must provide a paper copy unless the individual indicates he or she would prefer to receive or access the document electronically.[54]

Conspicuous Written Notice of FAP

In addition to requiring hospital facilities to notify individuals about their FAPs before discharge and on billing statements as part of widely publicizing their FAPs, the final regulations also amend these requirements in several important respects. In particular, rather than require a full plain language summary with billing statements, the final regulations require only that a hospital facility's billing statement include a conspicuous written notice that notifies and informs the recipient about the availability of financial assistance under the hospital facility's FAP and includes the telephone number of the hospital facility office or department that can provide information about the FAP and FAP application process and the direct Web site address (or URL) where the copies of the FAP documents may be obtained.[55]

Plain Language Summary of the FAP

The final regulations require the plain language summary to include the contact information of a source of assistance with FAP applications but allow for this source to be either the hospital facility itself or a different organization. More specifically, the final regulations provide that the plain language summary must include the contact information of either the hospital facility office or department that can provide assistance with (rather than just "information about") the FAP application process or, if the hospital facility does not provide assistance with the FAP application process, at least one nonprofit organization or government agency that the hospital facility has identified as an available source of such assistance.[56]

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[52] Reg. §1.501(r)-4(b)(5)(i)(B)
[53] Reg. §1.501(r)-4(b)(5)(i)(D)(3)
[54] Reg.§1.501(r)-4(b)(5)(i)(B) and Example 1(iii)
[55] *Id.*
[56] Reg. §1.501(r)-4(b)(5)(i)(D)(2)

No Room Number Needed in FAP Disclosure

The final regulations remove a specific reference to a room number to give hospital facilities more flexibility to describe the physical location in the manner that makes the most sense for the hospital facility. The final regulations also clarify that the plain language summary may identify the location and phone number of the appropriate office or department to contact for more information about the FAP and, if applicable, assistance with the FAP application process and does not need to name a specific staff person.[57]

Translating the FAP Documents

The FAP, FAP application form and plain language summary must be available in the languages of any portion of the population represented by the lesser of 1,000 persons or 5% of the population served by or likely to be encountered by the hospital facility. A hospital facility may use any reasonable method to determine such populations.[58]

Emergency Medical Care Policy

Section 1.501(r)-4(c)(2) of the 2012 proposed regulations was intended to apply only to debt collection activities in the emergency department (or other areas of the hospital facility) that could interfere with the provision of emergency care, not to all payment activities in the emergency department regardless of their potential to interfere with care. To make this intent clear, the final regulations are revised to prohibit "debt collection activities that interfere with the provision, without discrimination, of emergency medical care," regardless of where such activities occur.[59]

Establish and Consistently Carry Out Policies to Access Minor Error Defense

The final regulations provide that omissions or errors that are minor and either inadvertent or due to reasonable cause will not result in a failure to meet the requirements of section 501(r)(4) (or any other requirements under section 501(r)) as long as they are corrected in accordance with §1.501(r)-2(b)(1)(ii) of the final regulations. Therefore, the final regulations make clear that the Treasury Department and the IRS do not intend that every error in implementing a policy described in section 501(r)(4) will result in a failure to meet the requirements of section 501(r)(4). On the other hand, a policy that is simply adopted by an authorized body of a hospital facility but not followed in any regular fashion has not been "established" for purposes of section 501(r)(4). Whether a policy is "consistently carried out" is to be determined based on all of the facts and circumstances. However, if the authorized body of a hospital facility adopts a policy and provides reasonable resources for and exercises due diligence regarding its implementation, then the standard should be met.[60]

Identical FAPs – Different AGB Percentages

The final regulations clarify that multiple hospital facilities may have identical FAPs, billing and collections policies, and/or emergency medical care policies established for them (or even share

[57] *Id.*
[58] Reg. §1.501(r)-4(b)(5)(ii)
[59] Reg. §1.501(r)-4(c)
[60] Reg. §1.501(r)-2(b)

one joint policy document), provided that the information in the policy or policies is accurate for all such facilities and any joint policy clearly states that it is applicable to each facility. The final regulations also note, however, that different hospital facilities may have different AGB percentages or use different methods to determine AGB that would need to be reflected in each hospital facility's FAP (or, in the case of AGB percentages, in a separate document that can be readily obtained).[61]

Amounts Generally Billed

The final regulations allow hospital facilities to base AGB on Medicaid rates, either alone or in combination with Medicare (or, under the look-back method, together with Medicare and all private health insurers), at the hospital facility's option.[62]

Limitation on Charges

The final regulations clarify that, for purposes of the section 501(r)(5) limitation on charges, a FAP-eligible individual is considered to be "charged" only the amount he or she is personally responsible for paying, after all deductions and discounts (including discounts available under the FAP) have been applied and less any amounts reimbursed by insurers.[63] Thus, in the case of a FAP-eligible individual who has health insurance coverage, a hospital facility will not fail to meet the section 501(r)(5) requirements because the total amount required to be paid by the FAP-eligible individual and his or her health insurer together exceeds AGB, as long as the FAP-eligible individual is not personally responsible for paying (for example, in the form of co-payments, co-insurance, or deductibles) more than AGB for the care after all reimbursements by the insurer have been made. The final regulations also add several examples demonstrating how the limitation on charges works when applied to insured FAP-eligible individuals.

Medically Necessary Care

The final regulations allow hospital facilities to define the term "medically necessary care" for purposes of their FAPs and the AGB limitation in recognition of the fact that health care providers and health insurers may have reasonable differences in opinion on whether some health care services are medically necessary in particular circumstances. In defining medically necessary care for purposes of their FAPs and the AGB limitation, the final regulations clarify that hospital facilities may (but are not required to) use the Medicaid definition used in the hospital facility's state, other definitions provided by state law, or a definition that refers to the generally accepted standards of medicine in the community or an examining physician's determination.[64]

[61] Reg. §1.501(r)-4(d)(3)
[62] Reg. §1.501(r)-5(b)(3)
[63] Reg. §1.501(r)-5(b)(2)
[64] Reg. §1.501(r)-5(e)

Look-Back Method in Calculating AGB

To eliminate the uncertainty created by the phrase "paid in full," the final regulations provide that, when calculating its AGB percentage(s) under the look-back method, a hospital facility should include in the numerator the full amount of all of the hospital facility's claims for emergency and other medically necessary care that have been "allowed" (rather than "paid") by health insurers during the prior 12-month period. For these purposes, the full amount allowed by a health insurer should include both the amount to be reimbursed by the insurer and the amount (if any) the individual is personally responsible for paying (in the form of co-payments, co-insurance, or deductibles), regardless of whether and when the individual actually pays all or any of his or her portion and disregarding any discounts applied to the individual's portion (under the FAP or otherwise).[65]

Safe Harbor for Certain Charges in Excess of AGB

The final regulations provide that the § 1.501(r)-5(d) safe harbor does not apply to charges made or requested as a pre-condition of providing medically necessary care to a FAP-eligible individual. Thus, if a hospital facility requires an individual to make an upfront payment for medically necessary care that exceeds the AGB for the care and the individual turns out to be FAP-eligible, the hospital facility will have failed to meet the requirements of section 501(r)(5).[66]

Safe Harbor for Certain Liens

The proceeds of settlements, judgments, or compromises arising from a patient's suit against a third party who caused the patient's injuries come from the third party, not from the injured patient, and thus hospital liens to obtain such proceeds should not be treated as collection actions against the patient. In addition, the portion of the proceeds of a judgment, settlement, or compromise attributable under state law to care that a hospital facility has provided may appropriately be viewed as compensation for that care. Accordingly, in response to comments, the final regulations expressly provide that these liens are not ECAs.[67]

[65] Reg. §1.501(r)-5(b)(3)
[66] Reg. §1.501(r)-5(d)
[67] Reg. §1.501(r)-6(b)(3)

Sale of an Individual's Debt to a Third Person

Section 501(r)(6) of the Code does not prohibit any collection actions outright; therefore, the final regulations do not prohibit debt sales altogether. The final regulations do, however, retain the general rule that debt sales are ECAs.[68] Hospitals have less control over a debt once it has been sold and that debt buyers will generally have less information regarding the individual and the debt and more incentive to engage in ECAs before making reasonable efforts to determine whether an individual is FAP-eligible.

The final regulations provide that the sale of an individual's debt is not an ECA if, prior to the sale, the hospital facility enters into a legally binding written agreement with the purchaser of the debt containing four conditions. First, the purchaser must agree not to engage in any ECAs to obtain payment of the debt. Second, the purchaser must agree not to charge interest on the debt in excess of the rate in effect under section 6621(a)(2) at the time the debt is sold (or such other interest rate set by notice or other guidance published in the Internal Revenue Bulletin). Third, the debt must be returnable to or recallable by the hospital facility upon a determination by the hospital facility or the purchaser that the individual is FAP-eligible. And, fourth, if the individual is determined to be FAP-eligible and the debt is not returned to or recalled by the hospital facility, the purchaser must adhere to procedures specified in the agreement that ensure that the individual does not pay, and has no obligation to pay, the purchaser and the hospital facility together more than he or she is personally responsible for paying as a FAP-eligible individual.[69] Because debt sales subject to these four conditions are not considered to be ECAs under the final regulations, a hospital facility may make these debt sales without first having made reasonable efforts to determine FAP-eligibility. Debt sales that do not satisfy these four conditions are ECAs and therefore may not be made until after a hospital facility has made reasonable efforts to determine FAP-eligibility.

Including Additional Actions as ECAs

If a hospital facility defers or denies, or requires a payment before providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care, such actions constitute actions to collect the unpaid bills. Moreover, these collection actions can properly be viewed as extraordinary, given that such actions can potentially jeopardize the health of the debtor.[70] The final regulations include such collection actions within the definition of ECAs.[71] The final regulations also elaborate on when a requirement for payment will be considered to be "because of" an individual's nonpayment of one or more bills for previously provided care. In particular, the final regulations provide that, if a hospital facility requires payment before providing care to an individual with one or more outstanding bills, such a payment requirement will be presumed to be because of the individual's nonpayment of the outstanding bill(s) unless the hospital facility can demonstrate that it required the payment from the individual based on factors other than, and without regard to, his or her nonpayment of past bills.

[68] Reg. §1.501(r)-6(b)(1)(i)
[69] Reg. §1.501(r)-6(b)(2)
[70] *See*, Reg.§1.501(r)-6(b)(1)(iii)
[71] *See generally*, Reg. §1.501(r)-6(b) for the Service's initial catalogue of what is, and is not, an ECA.

Bankruptcy Claim Not an ECA

The final regulations add a provision stating that filing a claim in a bankruptcy proceeding is not an ECA,[72] so the requirement to suspend ECAs will not jeopardize the ability to file such claims.

Incomplete FAP Applications

Under the final regulations, ECAs taken against an individual who has submitted an incomplete FAP application only have to be suspended for a "reasonable period of time," not a period of at least 240 days from the first post-discharge bill.[73] The final regulations require hospital facilities to provide a notice about potential ECAs (and an accompanying plain language summary of the FAP) to an individual who has submitted an incomplete FAP application under the provisions relating to notification about the FAP rather than separately requiring this notice under the provisions relating to incomplete FAP applications[74] (as had been done in the 2012 proposed regulations). This change is made to simplify the regulations and is not intended to have any substantive effect for individuals who submit an incomplete FAP application before ECAs have been initiated.

Complete FAP Applications

The final regulations do not adopt a specific period of time in which a hospital facility must make a FAP-eligibility determination, opting instead to continue to require the determination to be made "in a timely manner" to provide hospital facilities with the appropriate flexibility to address varied situations.[75] In addition, in cases in which a hospital facility believes an individual who has submitted a complete FAP application may qualify for Medicaid, the final regulations clarify that a hospital facility may postpone making a FAP-eligibility determination until after the individual's Medicaid application has been completed and submitted and a determination as to Medicaid eligibility has been made.[76] However, as is generally the case when an individual has submitted a complete FAP application, a hospital facility may not initiate or resume any ECAs to obtain payment for the care at issue until a FAP-eligibility determination has been made.[77]

Requirements When an Individual is Determined to be FAP-Eligible

The final regulations require written notification that an individual is determined to be eligible for free care but do not require a billing statement indicating that nothing is owed for the care (or stating or describing how the individual can get information regarding AGB for the care).[78]

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[72] Reg. §1.501(r)-6(b)(4)
[73] Reg. §§1.501(r)-6-(c)(3)(ii) and (c)(5)
[74] Reg. §1.501(r)-6(c)(4) and Examples
[75] Reg. §1.501(r)-6(c)(2)(6)
[76] Reg. §1.501(r)-6(c)(6)(iv)
[77] Reg. §§1.501(r)-6(c)(2) and (6) and Example 1 under (c)(2)
[78] Reg. §§1.501(r)-6(c)(6)(i)(C)(1) and (2)

De Minimis Refunds

The final regulations do not require a hospital facility to refund any amount a FAP-eligible individual has paid for care that exceeds the discounted amount he or she owes for the care as a FAP-eligible individual if such excess amount is less than $5.[79]

Effective Dates

The final regulations under section 501(r) apply to a hospital facility's taxable years beginning after December 29, 2015, which will give all hospital facilities at least a year to come into compliance with the final regulations. For taxable years beginning on or before December 29, 2015, the final regulations provide that a hospital facility may rely on a reasonable, good faith interpretation of section 501(r). A hospital facility will be deemed to have operated in accordance with a reasonable, good faith interpretation of section 501(r) if it has complied with the provisions of the 2012 and/or 2013 proposed regulations or the final regulations.[80]

[79] Reg. §1.501(r)-6(c)(6)(i)(2)
[80] Reg. §§1.501(r)-7(a) and (b)