H. Complying with 501(r).... A Ticking Time Bomb

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COMPLYING WITH 501(R)…..A TICKING TIME BOMB

October 21-22, 2013

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OBJECTIVES

- Discuss how the 501(r) requirements impact hospital operations and how to best position the healthcare institution in the community health needs assessment process and financial assistance (and related) policy drafting.
- Demonstrate how hospitals can assess their overall compliance readiness with the proposed 501(r) regulations.
- Provide a guided approach to assist hospitals management in updating policies, procedures and systems, training personnel, and achieving management and board education and approval.
- Share industry best practices in community health needs assessments and financial assistance (and related) policy matters so that hospitals can efficiently and effectively bring themselves into compliance.
The Patient Protection and Affordable Care Act of 2010 enacted section 501(r), which adds requirements for charitable hospital organizations. Hospital organizations must meet the requirements of section 501(r) in order to be described in section 501(c)(3).

1. Conduct a community health needs assessment (CHNA) every 3 years
2. Establish financial assistance and emergency medical care policies
3. Limit the amount they charge for certain care provided to individuals eligible for financial assistance
4. Avoid engaging in extraordinary collection actions before making reasonable efforts to determine whether an individual is eligible for financial assistance

WHAT IS SECTION 501(R)?

501(R) TIMELINE

- March 2010: Patient Protection and Affordable Care Act signed into law
- February 2011: Proposed Regulations outline FAP, billing and collection and charge limitations
- June 2012: Proposed Regulations outline excise tax, consequences for failure to meet 501(r) requirements, and outline CHNA requirements
- TBD: FINAL REGULATIONS

June 2010: Notice 2010-39 issued describing new requirements / solicited comments
July 2011: Notice 2011-52 issued describing CHNA requirements / solicited comments
April 2013: Proposed Regulations outline excise tax, consequences for failure to meet 501(r) requirements, and outline CHNA requirements
FINANCIAL ASSISTANCE, BILLING AND COLLECTION, AND LIMITATION ON CHARGES

RECAP OF PROPOSED REGULATIONS

Proposed regulations were issued on June 22, 2012.

- Require hospitals to establish financial assistance and emergency medical care policies.
  - Includes a lengthy list of points that must be addressed in each Hospital Facility’s FAP.
- Limit the amount hospitals can charge for certain care provided to individuals eligible for financial assistance.
  - Mandates hospitals follow one of two specific and detailed methods for calculating AGB.
- Prohibit a hospital from engaging in extraordinary collection actions before making reasonable efforts to determine whether an individual is eligible for assistance.
  - Defines a rigid timetable when a hospital may (or must) take various actions.

PAY ATTENTION TO THE “FINE LINES”!!
1. A hospital facility must establish a written policy that requires the hospital facility to provide, without discrimination, care for emergency medical conditions (within the meaning of EMTALA) to individuals regardless of whether they are FAP-eligible.

2. Interference with provision of emergency medical care. Emergency medical care policy must prohibit the hospital facility from engaging in actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities in the emergency department or in other areas of the hospital facility where such activities could interfere with the provision, without discrimination, of emergency medical care.


FINANCIAL ASSISTANCE POLICY (FAP) – FUNDAMENTAL ELEMENTS

1. State the Mission / Describe the Program
2. Include Definitions of Terms
3. Provide Eligibility Criteria
4. Basis for Calculating Amounts Charged to Patients
5. Application Process
6. Reference to Billing and Collection Policy
7. Measures to Widely Publicize FAP
Amounts Generally Billed – AGB

“The Method Controversy” (i.e. Look-back and Prospective Medicare)

- As required by section 501(r)(5)…hospitals should not charge any FAP-eligible individual more than AGB.
  - This should be referenced in the FAP!!

<table>
<thead>
<tr>
<th>Charges to Individuals Eligible for Assistance under the FAP (FAP-Eligible Individuals)</th>
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<tbody>
<tr>
<td>20</td>
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<tr>
<td>a</td>
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<td>b</td>
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<td>c</td>
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</table>

Commentators provide….

- Financial assistance should include the insured, however AGB should only apply to uninsured individuals.
- If AGB applied to the insured, that would potentially limit the amount of financial assistance that the hospital could provide.
- Hospitals have flexibility in setting eligibility requirements, including providing assistance to the insured.
# FAPS – COMMON ISSUES (CONTINUED)

- **Widely Publicizing – commonly missing from FAPs**
  - Included measures to publicize the policy within the community served by the hospital facility? . . .
  - If “Yes,” indicate how the hospital facility publicized the policy (check all that apply):
    - a. The policy was posted on the hospital facility’s website
    - b. The policy was attached to billing invoices
    - c. The policy was posted in the hospital facility’s emergency rooms or waiting rooms
    - d. The policy was posted in the hospital facility’s admissions offices
    - e. The policy was provided, in writing, to patients on admission to the hospital facility
    - f. The policy was available on request
    - g. Other (describe in Part VI)

- **Be mindful that the FAP is a public document . . .
  - Instructions / guidelines for employees (i.e. General Ledger coding) should be in a document separate from the FAP.

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# BILLING AND COLLECTIONS POLICY – FUNDAMENTAL ELEMENTS

1. **Definitions**
2. **Billing and Collection Guidelines**
   - a) ECAs – Extraordinary Collection Actions
     - i. No ECA’s until FAP-eligibility is determined.
     - ii. Define ECAs
3. **Determine FAP-Eligibility**
   - a) Notification Periods
4. **Application Process . . .** describe what to do if:
   - a) Complete FAP
   - b) Incomplete FAP; or
   - c) No FAP
5. **Miscellaneous (i.e. Anti-Abuse Rule)**
BILLING AND COLLECTION POLICIES.....COMMON ISSUES

1. Many policies lacking listing of Extraordinary Collection Actions (ECAs) that may be taken....including, but not limited to, the following:
   - Reporting adverse information about the individual to consumer credit bureaus;
   - Commencing a civil action (i.e. file law suit);
   - Garnishing wages;
   - Placing lien on property.

2. Notification period
   - Proposed regulations provide long time periods, most hospitals have much shorter periods in place....tedious to monitor and adjust.

3. Lacking provisions to govern FAP application processing.
   - How hospital monitors and handles incomplete, complete, or failure to file FAP applications.

COMPLIANCE AND TIMING - WHAT TO DO NOW

1. Take this opportunity to reaffirm that the hospital organization currently satisfies all of the express requirements of Section 501(r) of the Tax Code (which are currently in effect).
2. Begin compliance efforts now by reviewing existing financial assistance policies, charge methodologies, and billing and collection policies and procedures.
   - The tax community anticipates that the final regulations will generally track the overall framework of the proposed regulations.
   - The tax community does not anticipate lengthy transition relief once final regulations are announced.
   - Hospitals should be mindful of their responses to the questions on Form 990, Schedule H, that address their financial assistance policy, billing and collection policy, and emergency medical care policy, and regarding how a hospital charges individuals eligible for financial assistance.
3. Educate and plan implementation process.
   - Boards and leadership should be aware of new requirements.
4. Involve professional advisors to help ensure that all regulatory issues are addressed.
COMMUNITY HEALTH NEEDS ASSESSMENTS

Proposed regulations were issued on April 3, 2013.
Section 501(r)(3):
- Requires hospitals to conduct a CHNA at least once every three years and adopt an implementation strategy to meet the community health needs identified through the CHNA
- Provides that the CHNA must take into account input from persons who represent the broad interests of the community served, including those with special knowledge of or expertise in public health
- Provides that the CHNA must be made widely available to the public

Possible penalties for noncompliance:
- $50,000 excise tax
- Correction/disclosure
- Facility-level tax
- Loss of tax-exemption (willful or egregious failure to comply)

IS CHNA REVIEW AN ISSUE NOW?
WHAT MUST A CHNA ACCOMPLISH?

- Technical compliance with IRS rules
  - Conduct a CHNA to identify community-wide health needs
  - Adopt an implementation strategy to meet the community health needs identified

WHAT CAN A CHNA ACCOMPLISH?

- Hospital becomes focal point for organizing and mobilizing residents, community organizations, human service providers, and local governments around healthcare
- Opportunity to effectuate broader awareness / change
CHNA – FUNDAMENTAL ELEMENTS

1. Describe community served (i.e. geography, target populations – children, women, aged, etc).
2. Describe process and methods used to conduct the CHNA.
   a) Sources / dates of data;
   b) Organizations with which hospital collaborated;
   c) Third-party contracts – experience and qualifications.
3. Describe demographics and health of community served.
4. Describe how the hospital gathered input from the broad interests in the community (i.e. public health departments, minority populations, medically underserved, etc.)
5. Identify and prioritize significant health needs.
6. Describe resources available to address health needs identified.

CHNAS– COMMON ISSUES

1. Lack of organization…. think about how IRS would audit.
   ➢ Prepare checklist and assess.
2. Wide disparity in types of CHNA reports….from 25 page reports to 250 page reports.
   ➢ A 250 page report does not necessarily meet requirements provided in proposed regulations.
3. “Hospital Signature” should be clearly stated on the report.
   ➢ Public Document
   ➢ Ensure CHNA aligns with strategy and direction of the hospital.
   ➢ Board authorization required….so understanding of conclusions provided in report is critical.
CHNA – INDUSTRY BEST PRACTICES

Implementation Strategy – Best Practices from Spectrum

- CHNA leadership team analyzed 5 CHNAs; found commonalities in 5 areas of focus
- Wanted to be strategic as a “System”, chose 2 focus areas that could be embedded in our overall strategic plans
  - Access to healthcare
  - Health Literacy, Awareness & Education
- Organized “teams” at each facility to determine key objectives and goals specific to the community – report to Director, Healthier Communities, with input from CHNA leadership team
- Set timeline to finalize, educate board & get board approval – CHNA leadership team reviewed throughout process of completion
- Quarterly updates with all facility teams and Director, Healthier Communities
  - Bi-annual updates with Executive Leadership to discuss progress

YOUR CHNA IS DONE – NOW WHAT?
YOUR CHNA IS DONE – NOW WHAT?

- Example: Completed Goal
  - Community Medicine Clinic opened Aug 5, 2013
    - Intended to improve access to primary care
    - Aimed at patients struggling to find a doctor or oversee medical care, often due to insurance concerns

- Lessons Learned
  - For those with “System” approach – use same organization to complete all CHNAs
    - Easier to analyze results
    - Add more ways to gather information
    - Play a larger role in actual drafting of document to ensure IRS compliance

IRS ACTIVITY
GUIDANCE ON IRS REVIEWS / AUDITS FOR 501(R) COMPLIANCE

- 2012 EO Workplan – “Review of Operations group” formed
  - Dedicated to completing the statutorily required community benefit reviews which began in March 2011.
  - By no later than March 23, 2015, IRS shall submit a report to Congress on trends relating to charity care.

Requirements for Tax-Exempt Hospitals
The Affordable Care Act of 2010 (ACA) added new requirements that tax-exempt hospitals must meet to maintain their tax-exempt status. The IRS is required to review the community benefit activities of hospital organizations at least once every three years. Accordingly, EO Exam formed and trained a Review of Operations group dedicated to completing the statutorily required community benefit reviews which began in March 2011. These reviews are not examinations and the group does not expect to contact hospitals while conducting the reviews. As we move forward, EO will use the information gathered from the reviews for research, reporting and compliance purposes, as well as to identify areas where additional guidance, education or Form 990 changes are needed. The IRS issued Notice 2011-52 in July 2011, to address the Community Health Needs Assessment requirements and related excise tax and reporting obligations applicable to tax-exempt hospitals. We continue to work with Treasury and Counsel to develop guidance on the new Section 501(r) requirements.

ANALOGOUS STATE INITIATIVES
Some states have laws in place that may overlap with section 501(r)

- Fair billing and collection
- Charity care

Be aware of state law overlaps when making revisions to your policies

The intent would seemingly be for the state and federal laws to work in a complementary, rather than preemptive, manner
FAP, BILLING AND COLLECTIONS, AND AGB

<table>
<thead>
<tr>
<th>ITEM</th>
<th>REFERENCE</th>
<th>SCHEDULE H REFERENCE</th>
<th>YES/NO/UNDETERMINED</th>
<th>TARGET SCORE</th>
<th>HOSPITAL SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAP sets forth eligibility criteria; specifies whether care is free or discounted</td>
<td>IRC 501(r)(4)(A)(i); Prop. Reg. 1.501(r)-4(b)(2)(i)(A)</td>
<td>Part V, Line 9 and 12 (Lines 10 and 11, if applicable)</td>
<td>YES</td>
<td>5</td>
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<tr>
<td>FAP includes basis for calculating amounts charged to patients; specifies amounts to which discounts apply</td>
<td>IRC 501(r)(4)(A)(ii); Prop. Reg. 1.501(r)-4(b)(2)(i)(B)</td>
<td>Part V, Line 12</td>
<td>YES</td>
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<tr>
<td>FAP includes method for applying for financial assistance; describes how patients apply</td>
<td>IRC 501(r)(4)(A)(iii); Prop. Reg. 1.501(r)-4(b)(3)</td>
<td>Part V, Line 16 (and 17)</td>
<td>YES</td>
<td>15</td>
<td></td>
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<tr>
<td>FAP sets forth any actions that may be taken in event of nonpayment; process/ time frames in taking collection actions; responsible party</td>
<td>IRC 501(r)(5)(A) and (B); Prop. Reg. 1.501(r)-4(b)(2)(i)(C) and (D); Prop. Reg. 1.501(r)-5(a) and (b)</td>
<td>Part V, Lines 20, 21, and 22</td>
<td>YES</td>
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<tr>
<td>FAP-eligible individuals not charged more than “amounts generally billed” (AGB); hospital must choose look-back method or prospective Medicare method to determine AGB</td>
<td>IRC 501(r)(5)(A) and (B); Prop. Reg. 1.501(r)-4(b)(2)(i)(C) and (D); Prop. Reg. 1.501(r)-5(a) and (b)</td>
<td>Part V, Lines 20, 21, and 22</td>
<td>YES</td>
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<td>No extraordinary collection actions before making reasonable efforts to determine if patient is FAP-eligible</td>
<td>IRC 501(r)(6)</td>
<td>Part V, Line 16 (and 17)</td>
<td>NO</td>
<td>15</td>
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<tr>
<td>Hospital follows procedure for handling complete and incomplete FAPs</td>
<td>IRC 501(r)(6)(b)</td>
<td>Part V, Line 16 (and 17)</td>
<td>YES</td>
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<td>FAP must describe measures taken by hospital to widely publicize the FAP</td>
<td>IRC 501(r)(4)(A)(v); Prop. Reg. 1.501(r)-4(b)(4)</td>
<td>Part V, Line 19</td>
<td>YES</td>
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SCORE 100

CHNA AND IMPLEMENTATION STRATEGY

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<tr>
<th>SELECTED REGULATORY REQUIREMENTS</th>
<th>REFERENCE</th>
<th>YES/NO/UNDETERMINED</th>
<th>TARGET SCORE</th>
<th>HOSPITAL SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHNA must include a definition of the community served; how community was determined</td>
<td>IRC 501(r)(3)(B)(i); Prop. Reg. 1.501(r)-3(b)(1)(i)(B); Prop. Reg. 1.501(r)-3(b)(7)(i)(A)</td>
<td>YES</td>
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<tr>
<td>Hospital must assess health needs of community; CHNA must describe process and methods used</td>
<td>IRC 501(r)(3)(B)(ii); Prop. Reg. 1.501(r)-3(b)(1)(ii); Prop. Reg. 1.501(r)-3(b)(7)(i)(B)</td>
<td>YES</td>
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<tr>
<td>CHNA must include a prioritized description of significant health needs; describe process/ criteria</td>
<td>IRC 501(r)(3)(B)(iii); Prop. Reg. 1.501(r)-3(b)(1)(iii); Prop. Reg. 1.501(r)-3(b)(7)(i)(C)</td>
<td>YES</td>
<td>15</td>
<td></td>
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<tr>
<td>CHNA must include description of potential measures/ resources identified to address needs</td>
<td>IRC 501(r)(3)(B)(iv); Prop. Reg. 1.501(r)-3(b)(1)(iv); Prop. Reg. 1.501(r)-3(b)(7)(i)(D)</td>
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<td>Hospital must make CHNA widely available</td>
<td>IRC 501(r)(3)(B)(v); Prop. Reg. 1.501(r)-3(b)(1)(v)</td>
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<td>10</td>
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<td>Hospital must take into account input from at least one state/local/regional health department</td>
<td>IRC 501(r)(3)(B)(vi); Prop. Reg. 1.501(r)-3(b)(1)(vi); Prop. Reg. 1.501(r)-3(b)(7)(i)(E)</td>
<td>YES</td>
<td>10</td>
<td></td>
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<tr>
<td>Hospital must take into account input from members of medically underserved/low income/ minority populations or representatives</td>
<td>IRC 501(r)(3)(B)(vii); Prop. Reg. 1.501(r)-3(b)(1)(vii)</td>
<td>YES</td>
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<td>CHNA must describe how hospital took into account input from those who represent broad interests of the community</td>
<td>IRC 501(r)(3)(B)(viii); Prop. Reg. 1.501(r)-3(b)(1)(viii); Prop. Reg. 1.501(r)-3(b)(7)(i)(F)</td>
<td>YES</td>
<td>10</td>
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<tr>
<td>Implementation strategy must describe how hospital plans to address health needs; explain why it does not intend to address any needs</td>
<td>IRC 501(r)(3)(B)(ix); Prop. Reg. 1.501(r)-3(b)(1)(ix)</td>
<td>YES</td>
<td>10</td>
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<tr>
<td>Implementation strategy must describe actions hospital intends to take to address needs, anticipated impact of actions, plan to evaluate</td>
<td>IRC 501(r)(3)(B)(x); Prop. Reg. 1.501(r)-3(b)(1)(x)</td>
<td>YES</td>
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COMMUNITY HEALTH NEEDS ASSESSMENT SCORE 75
IMPLEMENTATION STRATEGY SCORE 25