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Alerts

IRS Issues Final 501(r) Regulations for Federal Tax Exemption for Hospitals

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Hinshaw Alert

The IRS adopted final regulations on December 29, 2014, implementing the new Internal Revenue Code Section 501(r) requirements for hospitals to maintain 501(c)(3) federal tax-exempt status. The final regulations apply to taxable years beginning on or after December 29, 2015. In the interim period, compliance with 501(r) requires a hospital to operate with a reasonable, good faith interpretation of the law, which is defined to mean compliance with the proposed or final regulations. Now is the time for hospitals to review their financial assistance policy and application form, to develop a plain language summary of the policy, and to update billing and collection policies. The final regulations affirm hospitals must proactively determine whether patients qualify for financial assistance including directing patients to resources for assistance in completing the application process.

The final regulations do not preempt state laws that impose additional or stricter requirements on hospitals. Hospitals must fully satisfy all of the §501(r) requirements and to the extent state law is more stringent, comply with the stricter state law requirements as well. Navigation between federal and state law may be challenging. For example, federal law requires hospitals to accept and process a financial assistance application for at least 240 days from the date the hospital provides the first post-discharge billing statement, while the Illinois Fair Patient Billing Act requires the financial assistance application to inform patients the application should be completed and returned within 60 days following the date of discharge.

Some key highlights of the final regulations are:

1. A Hospital must make its financial assistance policy, application, and plain language summary of the policy available on its website and in public locations of the hospital including, at a minimum, in the Emergency Room and admission areas.
2. A Hospital must affirmatively reach out to members of its community to inform them about the financial assistance available in a manner reasonably calculated to reach persons most likely to need assistance.
3. The financial assistance policy, application and plain language summary of the policy must be translated into the primary languages spoken by all low-English proficiency populations constituting the lessor of 1,000 persons or 5% of the population.
4. No application may be denied on the basis of the applicant's failure to provide information or documents, unless such information or documents are identified in the policy or application as required to apply for assistance.
5. Either the financial assistance policy or the application must provide contact information, including the telephone number and physical location, of the hospital office or department that can provide information about the policy, as well as contact information for the hospital office / department that can provide assistance with the application process, or, if no such office / department exists, at least one nonprofit organization or government agency the hospital has identified as an available source of assistance with applications.
6. The financial assistance policy must include a list of any providers in addition to the hospital that deliver emergency or other medically necessary care in the hospital facility and identify which providers are covered by the policy and which are not.
7. If an individual who submitted an incomplete application during the 240-day application period subsequently completes the application during the application period (or, if later, within the reasonable time period the hospital

provided to respond to requests for additional information and/or documents), the hospital must take the following actions to be considered to have made reasonable efforts to determine eligibility for assistance:

a. Suspend any extraordinary collection actions including credit bureau reporting;

b. Make an eligibility determination and notify the individual in writing of the determination including, if applicable, the amount of the assistance available and the basis for this determination;

c. If the individual qualified for less than 100% assistance, provide the individual with a billing statement that shows the balance due from the individual, how the amount was determined, and states the AGB percentage or describes how the individual can get the AGB percentage;

d. Refund any amount the individual paid that exceeds the amount determined to be personally owed under the financial assistance eligibility guidelines, unless the refund is less than $5.00; and

e. Take all reasonable measures to reverse any extraordinary collection action including measures to vacate judgments and to remove adverse credit reports.

8. A signed waiver does not satisfy the 501(r)(6) billing and collection requirements. A signed statement that an individual does not wish to apply for financial assistance does not satisfy the reasonable efforts required to determine eligibility for assistance.

9. Hospitals do not satisfy the 501(r) requirements if they presume a patient is ineligible for financial assistance. Presumptive eligibility determinations require a determination of eligibility based on information other than that provided by the individual or based on a prior eligibility determination.

Gone are the days of filing suit against an unresponsive patient to obtain judgment and garnish wages. To be treated as a tax-exempt organization, hospitals must comply with increasingly demanding regulations that require them to proactively seek out and resource financially eligible patients with assistance. Hinshaw is committed to providing clients with the services needed to understand the regulations, how they impact business office and revenue cycle operations, and how to implement full compliance.

Click here to see related Health Law Alert: Report of Hospital's Collection Practices Angers Senator Charles Grassley.