Complying with the IRS 501r Requirements: Will Your Hospital Be Ready When the Tax Collectors Contact Your Organization?

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Presented by Preston Quesenberry, Loeb & Loeb LLP
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Preston Quesenberry advises clients throughout the nonprofit sector on a wide variety of legal and strategic issues, including qualification for tax-exempt status, unrelated business income tax (UBIT), charitable contributions, domestic and international grant-making, joint ventures, lobbying and political activities and executive compensation. He has a particular depth of experience advising charitable hospitals and other tax-exempt organizations on regulatory issues related to the Patient Protection and Affordable Care Act.

A former senior attorney in the Tax Exempt and Government Entities Division of the IRS Office of Chief Counsel, Mr. Quesenberry drafted many of the Treasury regulations and other published guidance that play a critical role in his clients’ business structures and operations. For example, during his tenure at the IRS, he was extensively involved in several guidance projects relating to the Affordable Care Act, such as regulations under § 501(r) and guidance on affordable care organizations. He also helped draft regulations regarding supporting organizations and program-related investments.

The checklists included in this presentation have been prepared by Mr. Quesenberry to help hospitals with their section 501(r) compliance work. Any questions concerning these compliance requirements, please contact Mr. Quesenberry directly.

In addition, Mr. Quesenberry supported the Department of Justice and field attorneys with litigation and supervised attorneys in issuing private letter rulings and determination letters on exempt organization issues, including matters related to UBIT, private foundation excise taxes, political activities, and qualification for tax-exemption under a wide-variety of Code sections.

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Overview

- When the IRS Comes Knocking
- Section 501(r)(4) Compliance
- Section 501(r)(5) Compliance
- Section 501(r)(6) Compliance
- Section 501(r)(3) Compliance
When the IRS Comes Knocking.

- Audits for § 501(r) compliance are underway
- EO (exempt organizations) work plan: As of 6/30/16, 692 reviews, 166 exam referrals
- By 10/25/16, EO was reporting 300 exam referrals
- Reviews will continue in 2017
Compliance with Statute or Regulations?

- § 501(r) is effective tax years beginning after 3/23/10
  - 3/23/12 for § 501(r)(3)
- Final § 501(r) regulations are effective tax years beginning in 2016
- IRS reviews reportedly covering the 2012-2014 period
- Do questions on IDR s (Information Document Requests) implicate regulations?
- **Recommendation**: Check compliance with regulations going back to 2012
Compliance Checks: What if Errors Are Discovered?

- Error occurring or continuing into 2016: Begin correcting error asap
  - Hospital must be in process of correcting upon IRS contact if it wants error to be excused pursuant to Rev. Proc. 2015-21
  - If Form 990 for year in which error is discovered comes due and error is more than minor, disclose failure and correction in Part VI of Sch H

- If error occurred in tax years beginning before 2016 and did not recur or continue in 2016 tax year, you have two options:
  - Correct (and, if more than minor, disclose) as described above; or
  - Argue that hospital complied with the statute
Section 501(r)(4) Compliance

➢ Do policies contain everything they’re supposed to?
  o FAP (financial assistance policy)(and associated documents)
  o Billing and collection policy
  o Emergency medical care policy

➢ Were policies widely publicized?

➢ Were policies properly adopted and implemented?
Were Policies Widely Publicized?

- IDR (information document request)
- Website Posting and Translations
- Translation Methodology
- Notifying Patients of the Hospital
- Remaining Widely Publicizing Requirements
Were Policies Widely Publicized?

- Most of the § 501(r)(4) IDRs appear to be related to widely publicizing

Sample IDRs:

- IDR #1: Were all of the FAP documents available on a website during the year?

- IDR #2: Provide a copy of any translated FAP documents

- IDR #3: Describe the methodology used to ensure that LEP (limited English proficient) populations served by the hospital have access to the translated documents
Website Posting and Translation

- The following documents need to be available on a website and translated:
  - FAP
  - Plain language summary (PLS)
  - FAP application
  - AGB (amounts generally billed-to individuals with insurance) percentages (if separate)
  - Billing and collection policy (if separate)
  - List of providers (if separate)? (See Notice 2015-46)

- The above also need to be available upon request as paper copies by mail and in public locations in hospital
Translation Methodology

Prior to 2016, are translations required at all?

Prior to 2016, hospitals clearly may use threshold of 10% of community served

For 2016: the lesser of 1,000 individuals or 5% of the community served by the hospital or of the population “likely to be affected or encountered” by the hospital

- Quoted language from HHS’s Guidance on Title VI Prohibition on Discrimination Against LEP Populations.

- Different and narrower concept than “community served by the hospital facility”
Notifying Patients of the Hospital

- IDR #4: Make arrangements for an onsite tour of all signage and publications on FAP in hospital
  - Public display or other means of attracting patient’s attention
  - Has to be in emergency room and admission areas
  - Has to say how and where to obtain more information about the FAP and FAP application process and to obtain FAP documents

- IDR #5: Provide a copy of a representative billing statement
  - Telephone # of relevant hospital office or department
  - Website address where copies of FAP documents may be obtained.
Remaining “Widely Publicizing” Requirements

- Must offer a paper copy of the PLS to patients as part of the intake or discharge process
- Notifying broader community
  - Can target efforts on those community members who are most likely to require financial assistance from the hospital facility
  - Evidence?
Were Policies Properly Adopted and Implemented?

- “Establishing” a FAP (or other policy) requires both adoption by an “authorized body” and consistently carrying out the policy

- IDR #6. Provide a list of all of the committees of the Board of Directors/Trustees and copy of the minutes of the meetings held by the Board of Directors
  - Authorized body can be full board, authorized committee, or authorized individual
  - Evidence of approval and (w/ committee or individual) evidence of authority

- IDR #7. Provide copies of any complaints, including legal complaints, in which a patient alleged that a hospital failed to comply with its FAP or § 501(r)(4).
  - If you have received complaints, document how they were resolved
Section 501(r)(5) Compliance

- Not listed in EO work plan as area being reviewed
- **Question 1**: Do the § 501(r)(5) requirements only apply to FAP-eligible individuals?
- **Answer**: Yes, but…
  - “FAP-eligible” is defined without regard to whether an individual has applied
  - If individual hasn’t applied, hospital won’t always know that s/he is not FAP-eligible
  - If hospital doesn’t know, should follow “safe harbor” in § 501(r)-5(d):
    - If later determined to be FAP-eligible → refund
    - Don’t request or charge more than AGB as a pre-condition for providing medically necessary care
Section 501(r)(5) Compliance (cont)

**Question 2**: Can AGB calculation be based on when care was provided as opposed to when it was allowed by health insurer?

- For years prior to 2016, yes
- For future years: Request IRB guidance?
- What dollar amount would be used for care provided at the very end of the 12-month measurement period?
- Does 120-day phase-in period permit actual amount allowed to be used for care provided during 12-months?
Section 501(r)(6) Compliance

- Listed in EO Work Plan as area of review
- Only aware of one related IDR
- If no ECAs (extraordinary collection actions) → reasonable efforts requirements do not apply
- Presumptive FAP-eligibility determinations
- Notification and processing applications
- Special notice when ECA = deferring or denying care
Presumptive FAP-eligibility Determinations

- Must describe in FAP
- If presumptively granted free care (or most generous discount), reasonable efforts have been made
- If less than most generous discount and want ability to engage in ECAs to collect discounted amount, then must—
  - Notify how to apply for more generous assistance
  - Give a reasonable period of time to apply for more generous assistance
Notification and Processing Applications

- Wait 120 days after first post-discharge bill before engaging in ECAs

- At least 30 days before ECAs are initiated--
  - Provide a written notice about ECAs (30-day ECA notice), plus PLS
  - Attempt to call or orally notify

- Process any applications received 240 days after the first post-discharge bill.
  - Will be >240 days if--
    - No 30-day ECA notice sent as of day 210 (and/or deadline stated in notice is later)
    - Incomplete application was submitted toward the end of the application period
Details on Processing Complete Applications

- Suspend ECAs
- Notify in writing of eligibility determination and basis
- If eligible, then—
  - Reverse ECAs
  - If other than free care, corrected billing statements that shows how amount was determined and AGB for care
  - Refund overpayment
Processing when ECA is denying care

- Instead of 30-day ECA notice, provide FAP application and notice stating deadline for submitting FAP application

- Process applications received before deadline on an expedited basis
Section 501(r)(3) Compliance: IDR}s

1. Provide a copy of hospital facility's CHNA (community health needs assessment) conducted during the tax year or in either of the two immediately preceding tax years

2. Provide the dates that each CHNA was adopted by an authorized body of the hospital facility and evidence of each CHNA's adoption (i.e., copies of board meeting minutes or resolutions, etc.)

3. Provide a copy of the written implementation strategy (IS) that your facility adopted with respect to CHNA

4. Provide the dates that each IS was adopted by an authorized body of the hospital facility and evidence of each IS's adoption (i.e., copies of board meeting minutes or resolutions, etc.)

5. Identify a person from your facility who has knowledge of actions taken to solicit public input from persons who represent the broad interest of your community and who was responsible for the content the CHNA and the IS
Questions
CHECK LIST APPENDIX
**Checklist #1**

**The IRS Is Checking Hospitals for Compliance with Section 501(r)**

The IRS is hard at work reviewing hospitals for compliance with new requirements imposed by section 501(r) of the Internal Revenue Code. A recently released [work plan](#) of the IRS Tax Exempt and Government Entities Division reveals that as of June 30, 2016, the IRS had completed 692 reviews and referred 166 hospitals for field examination and that the agency will continue its section 501(r) compliance checks throughout the 2017 fiscal year. The issues for which exam referral have been made include failure to meet the requirements related to:

- Community health needs assessment under section 501(r)(3).
- Financial assistance or emergency medical care policies under section 501(r)(4).
- Billing and collection under section 501(r)(6).
Checklist #1

The final regulations implementing the section 501(r) requirements apply to a charitable hospital’s first taxable year beginning in 2016, meaning that hospitals have yet to complete a taxable year in which they are required to comply with these regulations. Nonetheless, the questions in the Information Document Requests (IDRs) that tax-exempt hospitals have been receiving from the IRS have been fairly granular in nature and appear to implicate the regulatory requirements. For example, with respect to financial assistance policies (FAPs), the IDRs have requested, among other items of information:

- An on-site tour of all signage and publications that are present in all hospital facilities regarding the FAP.

- A representative billing statement provided to a patient after discharge (which is presumably being checked for notifications about the FAP).

- A copy of any translated FAP documents and a description of the methodology used to ensure that any limited English proficiency populations served by the hospital organization have access to these translated documents.
Checklist #1

The regulations under section 501(r) are very detailed, which means compliance “foot faults” can easily occur. Fortunately, the regulations allow hospitals to self-correct minor errors and omissions, and a hospital that promptly self-corrects is treated as never having failed to comply with section 501(r) at all. Hospitals that have identified and self-corrected compliance issues before receiving an IDR from the IRS are in a much better position to avoid an exam referral.

Compliance Checklist

1. Financial Assistance Policies (FAPs)

☐ Does your hospital have a written financial assistance policy (FAP)?

☐ Has your hospital’s FAP been adopted by the hospital’s board, a committee of that board or a hospital official (or other party) authorized by the board?

☐ Does your hospital’s FAP cover all emergency and other medically necessary care provided by the hospital?

☐ Does your hospital’s FAP specify all discounts and free care available under the FAP and the eligibility criteria associated with each of these discounts and free care?
Checklist #1

1. Financial Assistance Policies (FAPs)

☐ If your hospital’s FAP expresses discounts in terms of percentages, does it specify the amounts (for example, gross charges) to which these percentages will be applied?

☐ Does your hospital’s FAP specify the method the hospital uses to determine the amounts generally billed to individuals who have insurance covering emergency or other medically necessary care (AGB)?

☐ If the hospital uses the “look-back” method to determine AGB, does your hospital’s FAP state the percentage(s) that the hospital uses to determine AGB and describe how the hospital calculated such percentage(s)?

☐ If not, does the FAP explain how members of the public may readily obtain such percentage(s) (and accompanying description) in writing and free of charge on the hospital’s website, by mail and in public locations in the hospital, including, at a minimum, the emergency room (if any) and admissions areas?

☐ Does your hospital’s FAP contain a list of providers, other than the hospital itself, delivering emergency or other medically necessary care in the hospital and does that list specify which providers are covered by the FAP and which are not?
Checklist #1

1. Financial Assistance Policies (FAPs)
   - If applicable, does your hospital’s FAP describe any information obtained from outside sources (that is, sources other than the patient applying for assistance) that the hospital uses to determine that a patient is eligible for financial assistance (FAP-eligible)?
   - If applicable, does your hospital’s FAP describe whether and under what circumstances it uses prior FAP-eligibility determinations to determine that a patient is FAP-eligible?
   - Does your hospital’s FAP describe how an individual may apply for financial assistance under the FAP and does it (or your hospital’s FAP application form) describe all information and documentation the hospital may require an individual to provide as part of his or her FAP application?
   - Does your hospital’s FAP or FAP application form contain the contact information, including telephone number and physical location, of the hospital office or department that will provide information about the FAP and of either
     - The hospital office or department that can provide assistance with the FAP application process, or
     - If the hospital doesn’t provide assistance with the FAP application process, at least one nonprofit organization or government agency that the hospital has identified as an available source of assistance with FAP applications?
Checklist #1

1. Financial Assistance Policies (FAPs)

☐ Has your hospital prepared a plain language summary of your hospital’s FAP that contains the contact information described in the preceding question, as well as the following information in language that is clear, concise and easy to understand?

☐ A brief description of the eligibility requirements and assistance offered under the FAP.

☐ A brief summary of how to apply for assistance under the FAP.

☐ The direct website address (or URL) and physical locations where the individual can obtain copies of the FAP and FAP application form.

☐ Instructions on how the individual can obtain a free copy of the FAP and FAP application form by mail.

☐ A statement of the availability of translations of the FAP, the FAP application form and a plain language summary of the FAP in other languages, if applicable.

☐ A statement that a FAP-eligible individual may not be charged more than AGB for emergency or other medically necessary care.
Checklist #1

1. Financial Assistance Policies (FAPs)

☐ Does either your hospital’s FAP or a separate billing and collection policy of your hospital describe the following?

☐ Any actions that the hospital (or other authorized party) may take related to obtaining payment of a bill for medical care, including, but not limited to, any extraordinary collection actions (ECAs).

☐ The process and time frames the hospital (or other authorized party) uses in taking the actions to obtain payment, including, but not limited to, the reasonable efforts it will make to determine whether an individual is FAP-eligible before engaging in any ECAs.

☐ The office, department, committee or other body with the final authority or responsibility for determining that the hospital has made reasonable efforts to determine whether an individual is FAP-eligible and may therefore engage in ECAs against the individual.

☐ If your hospital has a separate billing and collection policy (as opposed to including this information in its FAP), does the hospital’s FAP state that the actions the hospital may take in the event of nonpayment are described in a separate billing and collections policy and explain how members of the public may obtain this policy in writing and free of charge on the hospital’s website, by mail and in public locations in the hospital, including, at a minimum, the emergency room (if any) and admissions areas?
Checklist #1

1. Financial Assistance Policies (FAPs)

☐ Does your hospital conspicuously post a complete and current copy of its FAP, FAP application form and plain language summary of the FAP on its website? Is it available on the website free of charge and without requiring the reader to create an account or provide personally identifiable information?

☐ Does your hospital make paper copies of the FAP, FAP application form and plain language summary of the FAP available upon request and without charge, both by mail and in public locations in the hospital, including, at a minimum, in the emergency room (if any) and admissions areas?

☐ Does your hospital notify and inform members of the community it serves about its FAP in a manner reasonably calculated to reach those members who are most likely to require financial assistance from the hospital?

☐ Does your hospital offer a paper copy of the plain language summary of the FAP to its patients as part of its intake or discharge process?

☐ Does your hospital include a conspicuous written notice on its billing statements that notifies and informs recipients about the availability of financial assistance under the hospital’s FAP and includes the telephone number of the hospital office or department that can provide information about the FAP and FAP application process and the direct website address (or URL) where copies of the FAP, FAP application form and plain language summary of the FAP may be obtained?
Checklist #1

1. Financial Assistance Policies (FAPs)
   - Have you set up conspicuous public displays that notify and inform patients about the FAP in public locations in the hospital, including, at a minimum, the emergency room (if any) and admissions areas?
   - Has your hospital translated its FAP, FAP application form and plain language summary of the FAP (and, if applicable, separate billing and collection policy and separate statement regarding AGB percentages) into the primary language(s) spoken by each language group with limited English proficiency that constitutes the lesser of 1,000 individuals or 5 percent of the community served by the hospital or of the population the hospital is likely to encounter?
   - Is your hospital consistently carrying out the provisions provided for in its FAP?

2. Emergency Medical Care Policies
   - Does your hospital have a written policy that requires it to provide, without discrimination, care for emergency medical conditions to individuals regardless of whether they are FAP-eligible (for example, requiring the hospital to comply with the Emergency Medical Treatment and Labor Act)?
2. Emergency Medical Care Policies

☐ Does your hospital’s emergency medical care policy prohibit the hospital 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 that interfere with the provision of emergency medical care?

☐ Has your hospital’s emergency medical care policy been adopted by the hospital’s board, a committee of that board or a hospital official (or other party) authorized by the board?

☐ Is your hospital consistently carrying out the provisions of its emergency medical care policy?
Checklist #1

3. Substantially-related Entities

☐ Does your hospital own a capital or profits interest in an entity treated as a partnership for federal tax purposes that provides emergency or medically necessary care in the hospital? Or is your hospital the sole member or owner of an entity that is disregarded for federal tax purposes and provides emergency or medically necessary care in the hospital? If the answer to both questions is no, you may skip the remainder of this section 3.

☐ If your hospital does own an interest in such a partnership or disregarded entity, does it treat the entity’s provision of medical care as an unrelated trade or business such that the profits the hospital earns from the entity are treated as unrelated business taxable income (UBTI)? If yes, you may skip the remainder of this section 3.

☐ If your hospital does own an interest in such a partnership or disregarded entity that does not generate UBTI for the hospital, does the hospital’s FAP cover all emergency or other medically necessary care provided by the partnership or disregarded entity in the hospital?
Checklist #2

Compliance Checklist

1. Prospective Medicare of Medicaid Method

☐ Does your hospital determine AGB for emergency or other medically necessary care by determining the total amount that would be reimbursed by Medicare or Medicaid for the care, plus the amount the Medicare or Medicaid beneficiary would be personally responsible for paying in the form of co-payments, co-insurance, or deductibles? If no, skip to section 2. If yes, complete this section 1 and then skip to section 3.

☐ After applying all FAP and other discounts and insurance reimbursements (if any), is the amount each FAP-eligible individual is personally responsible for paying for emergency or medically necessary care not more than the total amount the hospital determines would be reimbursed by Medicare or Medicaid for the care, plus the amount the Medicare or Medicaid beneficiary would be personally responsible for paying?
Checklist #2

2. Look-back Method

☐ Does your hospital determine AGB by multiplying the hospital’s gross charges for emergency or other medically necessary care by one or more percentages of gross charges (AGB percentages), calculated by dividing—

☐ The sum of amounts of all of its claims for emergency and other medically necessary care (or, alternatively, all medical care) that have been allowed over a prior 12-month period by (i) Medicare, (ii) Medicare together with all private insurers paying claims to the hospital, or (iii) Medicaid, either alone or in combination with (i) and (ii), by

☐ The sum of the associated gross charges for those claims?

☐ If your hospital calculates multiple AGB percentages for separate categories of care or for separate items or services, does the hospital calculate AGB percentages for all emergency and other medically necessary care provided by the hospital?
Checklist #2

2. Look-back Method

☐ After applying all FAP and other discounts and insurance reimbursements (if any), is the amount each FAP-eligible individual is personally responsible for paying for emergency or other medically necessary care not more than the amount determined by multiplying the hospital facility’s gross charges for the care by the applicable AGB percentage(s)?

☐ Does your hospital began applying the AGB percentage(s) it has calculated by the 120th day after the end of the 12-month period used in calculating the AGB percentage(s)?

☐ Does your hospital calculate its AGB percentage(s) at least annually?
3. Other

☐ Is no patient of your hospital who is determined to be FAP-eligible personally responsible for paying gross charges for any medical care covered under the FAP (including care covered by the FAP other than emergency or other medically necessary care)?

☐ If your hospital requires any individual to pay an amount upfront as a precondition for receiving medically necessary care, will such an amount always be equal to or less than the AGB for the care?

☐ If not, has no individual charged such an upfront fee ever been determined to be FAP-eligible?

☐ If an individual personally pays your hospital more than AGB for emergency or other medically necessary care (or gross charges for any other medical care covered under the FAP) and then subsequently submits an application for financial assistance and if your hospital determines the individual to be FAP-eligible for the care, does the hospital refund any amount the individual has paid for the care that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible individual, if such excess amount is $5 or more?
4. Substantially-related entities

☐ Does your hospital own a capital or profits interest in an entity treated as a partnership for federal tax purposes that provides emergency or medically necessary care in the hospital? Or is your hospital the sole member or owner of an entity that is disregarded for federal tax purposes and that provides emergency or medically necessary care in the hospital? If the answer to both questions is No, you may skip the remainder of this section 4.

☐ If your hospital does own an interest in such a partnership or disregarded entity, does it consider the entity’s provision of medical care to be an unrelated trade or business such that the income the hospital earns from the entity is treated as unrelated business taxable income (UBTI)? If yes, you may skip the remainder of this section 4.

☐ If your hospital does own an interest in such a partnership or disregarded entity that does not generate UBTI for the hospital, does the partnership or disregarded entity charge no FAP-eligible individual more than AGB for emergency or other medically necessary care? (See sections 1 through 3 for a checklist on complying with the AGB requirements).

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To Complete the Program Evaluation

The URL below will take you to HFMA on-line evaluation form. You will need to enter your member I.D. # (can be found in your confirmation email when you registered)

Enter this Meeting Code: 16AT71

URL: http://www.hfma.org/awc/evaluation.htm

Your comments are very important and enables us to bring you the highest quality programs!