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HFMA Summary of IRS 501(r) Final Rule

In the December 31, 2014, *Federal Register*, the IRS published a final rule providing guidance regarding the requirements for charitable hospital organizations added by the Affordable Care Act. The regulations, effective December 29, 2014, will affect charitable hospital organizations. Following is a summary of the provisions of the final rule.

Multiple Buildings Under a Single License (p. 15): The final regulations clarify 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. 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 Community Health Needs Assessment (CHNA) report and implementation strategy.

One Building Under Multiple State Licenses (p. 17): While the IRS did not amend the final rule to allow one hospital building operating under multiple state licenses as a single hospital facility for purposes of 501r, the final rule notes that separate hospital facilities within the same building may have identical Financial Assistance Policies (FAP) and other policies established for them or share one policy document as long as 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. Furthermore, 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.

Government Hospital (p. 17): The final rule restates that governmental hospitals are required to comply with all 501(r) requirements. While government hospitals do not have to file form 990 or include any CHNA related information with form 990 they are still expected to make their CHNA reports and FAPs widely available on a website.

Accountable Care Organizations (p. 20): The final rule confirms that ACOs or other integrated health care models will not be treated as a single hospital organization for purposes of 501(r). However, multiple hospital facilities may have identical FAPs and other policies established for them or share one joint policy document as long as 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. Furthermore, 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.

"Operating" a Hospital Facility (p. 22): 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.

The final regulations also 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.

Also, 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.

Providing Care in a Hospital Facility through Hospital Owned Entities (e.g. hospital owned physician practices providing care in the hospital) - (p. 22): Whether or not the 501(r) requirements apply to hospital-owned physician practices depends on how the entities are classified for federal tax purposes. If the entity is a separate taxable corporation, 501(r) will not apply. For example, a hospital facility would not be required to meet the 501(r) requirements with respect to a taxable corporation providing care in the hospital facility, even if the corporation is wholly or partially owned by the hospital organization that operates the hospital facility.

By contrast, if a hospital organization is the sole member or owner of an entity providing care in one of its hospital facilities and that entity is disregarded as separate from the hospital organization for federal tax purposes, the care provided by the entity would be considered to be care provided by the hospital organization through its hospital facility. Accordingly, the hospital organization would be required to meet the section 501(r) requirements with respect to care provided by the disregarded entity in any hospital facility that the hospital organization operates.

If a hospital organization owns a capital or profits interest in an entity providing care in a hospital facility that is treated as a partnership for federal tax purposes, the activities of the partnership are treated as the activities of the hospital organization for purposes of determining whether the hospital organization is operated exclusively for exempt purposes or engaged in an unrelated trade or business under generally applicable tax principles. Accordingly, emergency or other medically necessary care provided in a hospital facility by a partnership in which the hospital organization operating the facility has a capital or profits interest is treated as care provided by the hospital organization in its hospital facility for purposes of section 501(r).

Authorized Body (p. 24): “Authorized body of a hospital facility” is defined to include:

- 1) The governing body (that is, the board of directors, board of trustees, or equivalent controlling body) of the hospital organization;
- 2) A committee of, or other party authorized by, the governing body of the hospital organization, to the extent permitted under state law; or
- 3) In the case of a hospital facility that has its own governing body and is recognized as an entity under state law but is a disregarded entity for federal tax purposes, the governing body of that hospital facility, or a committee of, or other party authorized by, that governing body to the extent permitted under state law.

Further, 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. If allowed by state law, a single individual may be considered the “authorized body.”

Failure to Satisfy the Requirement of 501r (p. 26):

Minor Omissions and Errors (p. 27): The final rule requires an omission or error to be minor in order to be corrected and not considered a failure under 501(r). Errors are only considered minor if they are minor in the aggregate. If an error has occurred and previously corrected but continues to occur, it will be a factor considered in determining whether or not it is truly inadvertent. It also provides the option for correction without disclosure if the omission or error is minor and either inadvertent or due to reasonable cause.

Corrections of omissions or errors must include establishment (or review and/or revision) of practices and procedures that are reasonably designed to achieve overall compliance with 501(r). Hospitals will not have to disclose minor omissions and errors publicly.

Excusing Certain Failures if a Hospital Facility Corrects and Makes Disclosure (p. 30): Failure to meet one or more of the requirements described in 501(r) that is not considered “willful” or egregious will be excused if a hospital corrects and provides disclosure as set forth by the IRS. Willful is defined in the final rule as a failure due to gross negligence, reckless disregard, and willful neglect. The term “egregious failures” will be reserved for very serious failures, taking into account the severity of impact and the number of affected persons. The IRS will provide more specific guidance in the future as it gains experience with various types of failures.

The final rule does not adopt a presumption that disclosures and correction of a failure is not determinative of the hospital’s “willfulness” or the egregiousness of that failure. However, the final rule states that a hospital facility that corrects and discloses a failure to meet a section 501(r) requirement is less likely to have acted willfully in failing to meet that requirement, and thus the final regulations provide that correction and disclosure of a failure is a factor tending to show that an error or omission was not willful.

The final regulations clarify that a hospital facility that fails to meet the CHNA requirements will be subject to an excise tax, notwithstanding its correction and disclosure of the failure. However, this only applies if the failure is not “minor,” “inadvertent,” or due to reasonable cause and if the error is corrected.

Facts and Circumstances Considered in Determining Whether to Revoke Section 501(c)(3) Status (p. 33): 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. 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; whether such practices or procedures were being routinely followed; and whether the failure was corrected promptly.

Taxation of Noncompliant Facilities (p. 34): The final rule provides for a facility level tax for hospital organizations operating more than one facility that fails to meet one or more of the 501(r) requirements

with respect to one or more hospital facilities during a taxable year. This facility level tax would apply to an organization that continues to be recognized as 501(c)(3), but would not continue to be recognized as such if the noncompliant facility were the only facility operated by the organization. The facility-level tax is applied to income derived from the noncompliant hospital facility during the taxable year of noncompliance. The application of a facility level tax to income will not by itself affect the tax-exempt status of bonds issued to finance the noncompliant facility. The final rule clarifies that application of the facility level tax will not by itself result in the noncompliant facility being considered an unrelated trade or business for purposes of tax-exempt bonds.

Community Health Needs Assessment (p. 35)

Conducting a Community Health Needs Assessment (p. 35): The final rule clarifies that hospitals may build on previous CHNAs (and the IRS expects that they would). However the final rule requires the solicitation and consideration of new input from persons representing the broad interests of the community with each CHNA.

Community Served by the Hospital Facility (p. 36): The final regulations continue to give hospital facilities broad flexibility to define the communities they serve or intend to serve (both in addressing needs identified through their CHNAs and otherwise) taking into account all relevant facts and circumstances, provided that they do not exclude medically underserved, low-income, or minority populations.

The rule also provides 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.

Assessing Community Health Needs (p. 38): 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. The rule 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.

The list of prioritization criteria in the final regulations remains a non-exhaustive list of examples, and hospital facilities have flexibility to choose how best to prioritize the significant health needs of their particular communities. However, to ensure transparency with respect to a hospital facility’s prioritization, the final regulations, like the 2013 proposed regulations, require a hospital facility’s CHNA report to describe the process and criteria used in prioritizing the significant health needs identified. In addition, the final regulations require a hospital facility to take into account community input not only in identifying significant health needs but also in prioritizing them.

Input from Persons Representing the Broad Interests of the Community (p. 42): The final rule retains the requirement that hospitals seek comments from the following three sources as part of its CHNA development process:

- 1) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community;

- 2) Members of medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations; and
- 3) Written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy.

However the final rule clarifies that hospitals must "solicit" (not obtain) feedback from the three categories listed above. Any comments received must be considered in the development of the CHNA. Further, if a hospital claims that it solicited but was not able to obtain feedback from one or more of the categories listed above it should be able to provide documentation of reasonable efforts made. The CHNA report will need to describe these efforts.

Governmental Health Departments (p. 43): The final rule clarifies that the parenthetical in the following phrase from the proposed rule, "a governmental public health department (or equivalent department or agency)," does not provide hospitals an exemption from collaborating with public health departments. It is merely meant to recognize that in various communities/states, agencies with this function operate under different names. The rule also finalizes the proposal that hospitals have the discretion to choose the appropriate jurisdictional level at which to engage public health departments.

The final rule also defines a state office of rural health as a public health department (even if it is located in a state university or other non-profit) and would satisfy the relevant requirement. The rule also clarifies that while hospitals are free to employ or contract with public health experts to assist with their CHNAs, the final regulations require a hospital facility to solicit and take into account input received from a governmental public health department.

Medically Underserved, Low-Income, and Minority Populations (p. 46): "Medically underserved" populations are defined in the proposed regulations as populations "at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers." The final rule does not make any changes to the definition.

Written Comments (p. 48): The final regulations retain the requirement that a hospital take into account written comments on the hospital's most recently conducted CHNA report and most recently adopted implementation strategy. The rule does not adopt an additional requirement to post a draft CHNA report for public comment before it is finalized. In addition, the rule notes that hospitals may choose to post a draft CHNA report for public comment. The rule specifies that the posting of a draft CHNA report will not trigger the start of a hospital facility's next three-year CHNA cycle.

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. The Treasury Department and the IRS expect that this description in the CHNA report will provide sufficient confirmation that comments have been received and considered and intend that hospital facilities will otherwise have flexibility in determining whether further responses are necessary. Thus, the final regulations do not adopt any specific requirements regarding how hospital facilities must respond to written comments received from the public.

Additional Sources of Input (p. 52): The final regulations do not require hospitals to solicit input from additional persons, although a hospital facility is free to solicit input from the suggested sources (health care consumers and consumer advocates, nonprofit and community-based organizations, academic experts, local government officials, local school districts, health care providers and community health

centers, health insurance and managed care organizations, private businesses, and labor and workforce representatives, as well as other sources) and must take into account input received from any person (including these sources) in the form of written comments on the most recently conducted CHNA or most recently adopted implementation strategy.

Input on Financial Barriers (p. 53): The final regulations do not require any additional link between a hospital's CHNA and its FAP.

Documentation of a CHNA (p. 54): The final regulations provide that a hospital must document its CHNA in a CHNA report that is adopted by an authorized body of the hospital facility and includes:

- 1) A definition of the community served by the hospital facility and a description of how the community was determined;
- 2) A description of the process and methods used to conduct the CHNA;
- 3) A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;
- 4) A prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; and
- 5) A description of resources potentially available to address the significant health needs identified through the 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.

The final rule retains the provisions which stated a CHNA report will be considered to describe how the hospital facility took into account community input if it summarizes, in general terms, the input provided and how and over what time period it was provided. This language applies to written comments, as well as to any other type of input provided. In addition, the final regulations provides that a CHNA report does not need to name or otherwise identify any specific individual providing input on the CHNA.

Collaboration on CHNA Reports (p. 56): The final regulations continue to allow collaborating hospitals to produce joint CHNA reports. However, they amend the proposed regulations to clarify that joint CHNA reports must contain all of the same basic information that separate CHNA reports must contain.

Defining a Common Community (p. 58): The proposed and final rules define "health needs" to include requisites for the improvement or maintenance of health status in particular parts of the community, such as particular neighborhoods or populations experiencing health disparities. Accordingly, a joint CHNA conducted for a larger area could identify as a significant health need a need that is highly localized in nature or occurs within only a small portion of that larger area. In addition, nothing in the final regulations prevents a hospital facility collaborating on a CHNA from supplementing a joint CHNA report with its own assessment of more highly localized needs.

The proposed and final rules 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.

Collaborating with Public Health Departments (p. 60): 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. Also 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.

Making the CHNA Report Widely Available to the Public (p. 61): The final regulations retain the definition of "widely available" set forth in the proposed regulations and decline to adopt a definition that would include the suggested measures to translate the report into different languages and proactively publicize the CHNA report within the community served by the hospital facility. Also, the rule clarifies that a hospital only need make a paper copy of the CHNA available upon request.

Implementation Strategies (p. 64): The final rule states that a hospital facility's implementation strategy is a written plan that, with respect to each significant health need identified through the CHNA, either:

- 1) Describes how the hospital facility plans to address the health need, or
- 2) Identifies the health need as one the hospital facility does not intend to address and explains why the hospital facility does not intend to address the health need.

The final regulations do not prohibit implementation strategies from discussing health needs identified through means other than a CHNA, provided that all of the significant health needs identified in the CHNA are also discussed.

Describing How a Hospital Facility Plans to Address a Significant Health Need (p. 66): The final rule requires that an implementation strategy must:

- 1) Describe the actions the hospital facility intends to take to address the health need, the anticipated impact of these actions, and include an evaluation of the impact of any actions that were taken since the hospital facility finished conducting its immediately preceding CHNA to address the significant health needs identified in the hospital facility's prior CHNA(s);
- 2) Identify the programs and resources the hospital facility plans to commit to address the health need; and
- 3) Describe any planned collaboration between the hospital facility and other facilities or organizations in addressing the health need.

Describing Why a Hospital Is Not Addressing a Significant Health Need (p. 68): The final regulations preserve the ability for a hospital facility to explain its reasons for not addressing a significant health need (including resource constraints or a lack of expertise), even if those reasons could be mitigated through collaboration.

Joint Implementation Strategies (p. 69): The final rule adopts the provision allowing for joint implementation strategies.

When the Implementation Strategy Must Be Adopted (p. 69): The final regulations provide hospitals 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.

Exception for Hospital Facilities that Are New, Newly Acquired, or Newly Subject to 501(r) (p. 71): The final regulations continue to require hospital facilities that are newly acquired or placed into service (or become newly subject to section 501(r) to meet the CHNA requirements by the last day of the second taxable year beginning after the later of the date of acquisition, licensure, or recognition of section 501(c)(3) status.

Terminated or Transferred Hospitals (p. 74): 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.

Financial Assistance Policies and Emergency Medical Care Policies (p. 75):

Financial Assistance Policies (p. 76): The final regulations require a hospital facility's FAP to list the providers, other than the hospital facility itself, delivering emergency or other medically necessary care in the hospital facility and to specify which providers are covered by the hospital facility's FAP (and which are not).

The final regulations clarify that a hospital facility's FAP must apply to all emergency and other medically necessary care provided in a hospital facility by a partnership owned in part by, or a disregarded entity wholly owned by, the hospital organization operating the hospital facility, to the extent such care is not an unrelated trade or business with respect to the hospital organization.

If a hospital facility outsources the operation of its emergency room to a third party and the care provided by that third party is not covered under the hospital facility's FAP, the hospital facility may not be considered to operate an emergency room for purposes of the factors considered in Rev. Rul. 69-545 (1969-2 CB 117).

Eligibility Criteria and Basis for Calculating Amounts Charged to Patients (p. 77): The final regulations only require the FAP to describe discounts "available under the FAP" rather than all discounts offered by the hospital facility. However only discounts specified in a hospital facility's FAP (and, therefore, subject to the AGB limitation) may be reported as "financial assistance" on Schedule H of the Form 990. 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 nor for purposes of the totality of circumstances that are considered in determining whether a hospital organization is described in section 501(c)(3).

The final regulations do not mandate any particular eligibility criteria and require only that an FAP specify the eligibility criteria for receiving financial assistance under the FAP.

While the final rule does not mandate that FAPs include a statement explaining the patient's obligation to cooperate with a hospital's requests for information to determine FAP eligibility, it notes that hospital have the flexibility to include any additional information in the FAP that the hospital chooses to convey or that may be helpful to the community, including such a statement.

Method of Applying for Financial Assistance (p. 79): The final regulations state that a hospital may grant financial assistance under its FAP notwithstanding an applicant's failure to provide such information. Thus, a hospital facility may grant financial assistance based on evidence other than that described in an 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.

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).

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. Hospitals are required to describe in their FAP any information obtained from sources other than individuals seeking assistance that the hospital uses, and whether and under what circumstances they use prior FAP-eligibility determinations, to presumptively determine that individuals are FAP-eligible. Further, while the final rule does not prescribe or restrict information/documentation a hospital may request, it requires the information be described in the FAP or application form.

Actions that May be Taken in the Event of Non-Payment (p. 84): The final regulations provide that an authorized body of the hospital facility must adopt the hospital's FAP and, if applicable, billing and collections policy. Additionally, the final rule clarifies that translations were intended to be part of making a billing and collections policy readily obtainable.

Widely Publicizing the FAP (p. 86): 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.

Measures to "Widely Publicize" the FAP

Widely Available on a Website (p. 88): The final rule retains the requirement that the full/complete FAP be widely available on a public website.

Making Paper Copies Available upon Request (p. 89): 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 department (if any) and the admissions areas.

The final regulations clarify that hospital facilities may inform individuals requesting copies that the various FAP documents are available on a website or otherwise offer to provide the documents electronically (for example, by email or on an electronic screen). However, the final rule also makes 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.

Notifying and Informing Patients (p. 90): The final rule states that a "conspicuous" public display is one that is both of noticeable size and placed in a location where visitors/patients are likely to see it. See above discussion of the ED and Admissions areas under "making paper copies available upon request."

The final regulations consolidate all of the requirements that involve notifying patients generally about the FAP under the section 501(r)(4) widely publicizing requirements. As a result, the notification component of reasonable efforts to determine FAP-eligibility under the section 501(r)(6) final regulations is focused primarily on those patients against whom a hospital actually intends to engage in extraordinary collection actions.

Further, the final rule amends the requirements related to notifying individuals before discharge and on billing statements in several ways:

- 1) Rather than require a full plain-language summary with billing statements, the final regulations require only that a hospital's billing statement include a conspicuous written notice that informs the recipient 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 where the copies of the FAP documents may be obtained.
- 2) The final regulations refer to offering the plain language summary as part of either the "intake or discharge process." Those terms are intended to be interpreted broadly to include whatever processes are used to initiate or conclude the provision of hospital care to individuals who are patients of the hospital facility.
- 3) In addition, the final regulations require only that a hospital facility "offer" (rather than "provide") a plain-language summary as part of the intake or discharge process. A hospital will not have failed to widely publicize its FAP because an individual declines a plain language summary that was offered on intake or before discharge or indicates that he or she would prefer to receive a plain language summary electronically.

Notifying and Informing the Broader Community (p. 93): The final regulations retain the requirement to notify and inform members of the hospital's community in a manner reasonably calculated to reach those members who are most likely to require financial assistance from the hospital facility. The rule states that the phrase "widely publicize...within the community" requires going beyond merely making the FAP available on a website or upon request. The final rule clarifies that hospitals should affirmatively reach out to members of the communities they serve and notify them about the financial assistance offered.

Plain-Language Summary of FAP (p. 93): The final rule defines the plain language summary as a written statement that notifies an individual that the hospital facility offers financial assistance under an FAP and provides certain specified information, including but not limited to:

- 1) The direct website address and physical location(s) (may include a room number/telephone number, if applicable) where the individual can obtain copies of the FAP and FAP application form; and
- 2) The contact information of either the hospital office or department that can provide assistance with (rather than just "information about") the FAP application process or, if the hospital 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.

Additionally, the final rule requires that the plain-language summary of the FAP include how to apply for financial assistance. A hospital is permitted, but not required, to include in its plain-language summary any additional items of information it deems relevant to the FAP and FAP application process. This includes but is not limited to a statement of patient responsibilities.

Translating the FAP Documents (p. 97): The final rule lowers the translation threshold applicable to FAP documents to the lesser of 5 percent of the patient population or 1,000 individuals. This was done to create consistency with the Civil Rights Act. If there are fewer than 50 persons in a language group that reaches the 5-percent trigger, the recipient of federal financial assistance does not have to translate vital written materials to satisfy the safe harbor but rather may provide written notice in the primary language of the limited English proficiency (LEP) language group of the right to receive competent oral interpretation of those written materials, free of cost.

The final regulations provide that a hospital facility may use any reasonable method to determine whether a population reaches the translation threshold for FAP documents. Examples of some sources cited include: the latest Census Bureau decennial census or the latest American Community Survey data to determine if a population reaches the trigger threshold. Additionally, it may be appropriate for hospitals to examine not only census data but also their prior experiences with LEP patients, data from school systems and community organizations, and data from state and local governments. Additionally, the final rule requires hospitals to translate the full FAP into the necessary languages to serve the populations that meet the above defined threshold.

Emergency Medical Care Policy (p. 100): The final rule clarifies that the prohibition on “debt collection activities” in the emergency department (or other areas) that could interfere with the provision of patient care is limited strictly to debt collection. The prohibition does not apply to other payment activities regardless of their ability to interfere with care.

The final regulations do not prevent an emergency medical care policy from being included within the same document as the FAP or from being added to an already existing document related to emergency medical care (such as a document setting forth EMTALA compliance).

Establishing the FAP and Other Policies (p. 103): The final regulations make clear that the Treasury Department and the IRS do not intend that every error in implementing an FAP policy will result in a failure to meet the requirements. 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.

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 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, that different hospital facilities may have different amounts generally billed (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).

Limitation on Charges (p. 105):

Amounts Generally Billed (p. 105): The final rule retains both the retrospective method based on actual past claims paid to the hospital facility by either Medicare fee-for-service alone or Medicare fee-for-service together with all private health insurers paying claims to the hospital facility and prospective method based on the amount estimated Medicare (including cost sharing) would pay for medically necessary services. The final rule also recognizes that payment systems will likely evolve and allow Treasury/IRS to provide for additional methods in the future.

The rule also allows hospitals to base AGB on Medicaid rates, either alone or in combination with Medicare (or under the look back method together with Medicare or private health plans) at the hospital's option. The rule considers Medicaid and Medicaid managed care as the same.

The final regulations continue to apply the AGB limitation of section 501(r)(5) to all individuals eligible for assistance under the hospital facility's FAP, without specific reference to the individual's insurance status. However, the final regulations clarify that, for purposes of the section 501(r)(5) limitation on charges, an 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. Thus, in the case of an 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. As such, the final rule confirms that AGB is to be considered a ceiling, not a floor on what FAP-eligible individuals may be charged.

The final regulations provide that a hospital facility may change the method it uses to determine AGB at any time. However, because the final regulations under section 501(r)(4) require a hospital facility's FAP to describe the method used to determine AGB, a hospital facility must update its FAP to describe a new method before implementing it.

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 healthcare providers and health insurers may have reasonable differences in opinion on whether some healthcare services are medically necessary in particular circumstances. Hospital facilities may (but are not required to) use the Medicaid definition used in the hospital'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.

Look-Back Method (p. 111): The final regulations provide that, when calculating its AGB percentage(s) under the look-back method, a hospital should include in the numerator the full amount of all of the hospital'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).

Under the final regulations, the inclusion of a claim in a hospital's calculation of its AGB percentage(s) is not based on whether the care associated with the claim was provided during the prior 12-month period. Rather, it is based on whether the claim is "allowed" (formerly, "paid in full") during the prior 12-month period. The final regulations also state that, if the amount a health insurer will allow for a claim has not been finally determined as of the last day of the 12-month period used to calculate the AGB percentage(s), a hospital facility should exclude the amount of the claim from that calculation and include it in the subsequent 12-month period during which the amount allowed is finally determined.

Additionally, the final regulations provide that a hospital facility may include in the calculation of its AGB percentage(s) claims for all medical care allowed during the prior 12-month period rather than just the claims allowed for emergency and other medically necessary care.

AGB may be calculated using all payers. The final rule removed the reference to "primary payers" to allow for instances where a secondary payer covers a service that was not covered by the primary.

The final regulations do not allow for a system wide AGB. However, if a health system bills Medicare under one provider number (CMS Certification number), it is allowed to calculate one AGB. The rule also clarifies that within a system, individual hospitals may choose either the prospective or look-back method.

The final rule extends the period from the end of the 12-month period hospitals base their AGB percentage on to calculate the AGB percentage from 45 to 120 days.

Prospective Method (p. 120): The final regulations do not permit hospital facilities to determine AGB using the prospective method based on the private health insurers with the lowest rate or the three private health insurers with three lowest rates.

Consistent with changes made to the look-back method, the final regulations allow hospital facilities to determine AGB under the prospective method based on Medicaid, either alone or in combination with Medicare fee-for service.

Gross Charges (p. 121): The final regulations clarify that the prohibition on gross charges applies only to FAP-eligible individuals. Further, the final regulations clarify that this limitation applies only to charges for care covered under a hospital facility's FAP, which may, but need not, cover care that is neither emergency nor medically necessary care.

Billing and Collection (p. 125): The final regulations provide that a hospital meets the requirements of section 501(r)(6) only if the hospital facility does not engage in extraordinary collection actions (ECAs) against an individual to obtain payment for care before making reasonable efforts to determine whether the individual is FAP-eligible for the care. For these purposes a hospital will be considered to have engaged in ECAs against an individual to obtain payment for care if the hospital facility engages in such ECAs against any other individual who has accepted or is required to accept responsibility for the first individual's hospital bill for the care. This provision does not require a hospital facility to make reasonable efforts to determine FAP eligibility before engaging in ECAs against private or public insurers or any other liable third parties that are not individuals.

The final regulations retain the provision holding a hospital facility accountable for the ECAs of the third parties collecting debt on its behalf or to which it sells debt. However, under this provision, if a hospital facility acts reasonably and in good faith to supervise and enforce the section 501(r)(6) obligations of its contractual agreements with debt collectors or purchasers and corrects any contractual violations it discovers, then an error on the part of the debt collectors or purchasers should not be willful and, provided that it is not egregious, could be excused if the hospital facility corrects and discloses the failure in accordance with the procedures outlined in the revenue procedure described in §1.501(r)-2(c).

Extraordinary Collection Efforts (p. 128):

Reports to Credit Agencies (p. 129): The final regulations continue to include the reporting of adverse information to credit agencies as an ECA.

Certain Liens (p. 130): 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, the final regulations expressly provide that these liens are not ECAs.

Sale of an Individual's Debt to Another Party (p. 131): The final regulations retain the general rule that debt sales are ECAs. However, if the conditions below are satisfied prior to sale, then the sale of a patient debt would not be considered an ECA.

- 1) The purchaser must agree not to engage in any ECAs to obtain payment of the debt.
- 2) 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).
- 3) 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.
- 4) 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 an FAP-eligible individual.

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 (p. 133): The rule states requiring a payment (whether partial or full) before providing care is a not collection action unless it is related to an attempt to collect a prior medical bill. Accordingly, the final regulations do not include these activities as ECAs.

However, if a hospital defers, 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. The rule views these collection actions as extraordinary

and includes them within the definition of ECAs. 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.

Reasonable Efforts (p. 135):

Notification and Application Periods (p. 137): The final regulations provide that the applicable 120- and 240-day periods start on the date that the first "post-discharge" billing statement is provided, rather than just the first billing statement. A billing statement for care is considered "post-discharge" if it is provided to an individual after the care (whether inpatient or outpatient) is provided and the individual has left the hospital facility.

The final reaffirms the 120 day "notification period" and additional 120 day application period (for a possible total of 240 days). The rule states that hospitals may allow for an open ended application period if it so desires. It also reaffirms that ECAs may begin after 120 days assuming proper notifications have been provided. However if a patient subsequently submits an FAP application in the application period, any ECAs will have to be suspended and, if the person is FAP-eligible, reversed.

The final regulations provide that the application period for an individual who has not been presumptively determined to be FAP-eligible will be longer than 240 days if the hospital facility provides the individual with a written notice about available financial assistance and potential ECAs that states a deadline that is after the 240th day from the first post-discharge bill.

For example, if a hospital provides an individual with a written notice about potential ECAs to obtain payment for care on the 250th day after the first post-discharge bill for the care and informs the individual that he or she has 30 days to apply for financial assistance before the identified ECAs may be initiated (the minimum number of days the deadline may be from the date the written notice is provided), the hospital facility would be required to process any FAP application that the individual submits by the 280th day after the first post-discharge bill. Thus, with the exception of individuals who are presumptively determined to be FAP-eligible, an individual's application period will remain open until at least 30 days after the hospital facility provides the individual with a written notice that sets a deadline after which ECAs may be initiated.

Meeting the 501(r)(6) Requirements on an Episode-of-Care Basis (p. 144): The final regulations clarify that a hospital facility may satisfy the notification requirements simultaneously for multiple episodes of care for purposes of notifying the individual about its FAP and potential ECAs. However, the final rule also states that a hospital facility that aggregates an individual's outstanding bills for multiple episodes of care before initiating one or more ECAs to obtain payment for those bills, may not initiate the ECA(s) until 120 days after it provided the first post-discharge bill for the most recent episode of care included in the aggregation.

Notification Requirements (p. 145): To satisfy the notification component of "reasonable efforts" with respect to any care provided to an individual, the final rule requires a hospital to take the following actions:

- 1) Include a plain language summary of the FAP in one post-discharge communication and all subsequent statements include a notice informing patients about the availability of financial assistance, how to get information about the FAP, and an application.

- 2) During the notification period, inform all patients against whom the hospital may engage in ECAs about the FAP in all oral communications regarding the amount due for the care.
- 3) Provide the individual with at least one written notice informing the individual about the ECAs the hospital facility (or other authorized party) may take if the individual did not submit an FAP application or pay the amount due.

Providing Plain Language Summaries with Written Communications (p. 146): The notification component of the reasonable efforts under the final regulations requires a hospital to provide a plain-language summary of the FAP to an individual only if and when it sends that individual the written notice about potential ECAs. The final regulations also only require a conspicuous written notice about the FAP to be included on a hospital facility's billing statement as part of "widely publicizing" the FAP for purposes of meeting the requirements under section 501(r)(4).

Oral Notification (p. 148): The final regulations replace the oral notification requirement with a requirement that a hospital facility make a reasonable effort to orally notify an individual about the hospital facility's FAP and about how the individual may obtain assistance with the FAP application process at least 30 days before the initiation of ECAs against the individual.

Notification about Impending ECAs (p. 149): The final regulations amend the requirement regarding the written notice about ECAs to require that the notice state the ECA(s) that the hospital (or other authorized party) actually "intends to take," rather than requiring a description of every ECA a hospital "may" take in the future. The final regulations do not require a hospital facility (or third party collecting a hospital facility's debt) to provide this notice unless and until it actually intends to initiate one or more ECA(s) against an individual. The notice indicates that financial assistance is available and must state a deadline after which the identified ECAs may be initiated that is no earlier than 30 days from the date the notice is provided.

Documentation Notification (p. 150): The final regulations eliminate any separate requirement under the section 501(r)(6) regulations to document notification. The rule notes that hospitals must report whether and how they made reasonable efforts to determine FAP eligibility before engaging in ECAs on their Forms 990 and, as a general matter, are responsible for maintaining records to substantiate any information required by the Form 990.

Miscellaneous Issues Involving Written Communications (p. 151): The final regulations clarify that a hospital facility may provide any of the written notices or communications described in §1.501(r)- 6 of the final regulations electronically (for example by email) to any individual who indicates he or she prefers to receive the written notice or communication electronically. It also states that in the case of communications that are mailed, the communication will be considered "provided" for purposes of compliance on the date they are mailed. A communication may also be considered provided on the date it is sent electronically or delivered by hand.

Incomplete FAP Applications (p. 152): The final regulations provide that a hospital must suspend ECAs against the individual until either the individual completes the FAP application and the hospital facility determines whether the individual is FAP eligible or until the individual has failed to respond to requests for additional information and/or documentation within a reasonable period of time.

The reasonableness of the period of time individuals are given to complete an FAP application before ECAs may resume will depend on the particular facts and circumstances, including the amount of

additional information and/or documentation that is being requested. Although the final regulations potentially permit a hospital facility to initiate or resume ECAs before the end of the application period against an individual who has failed to respond to requests for additional information and/or documentation, if the individual subsequently completes the FAP application during the application period, the final regulations would require the hospital facility to again suspend any ECAs taken against the individual until the hospital determines whether the individual is FAP-eligible (and, if the individual is determined to be FAP-eligible, to reverse such ECAs).

Further, the final rule clarifies that a hospital is required to suspend only those ECAs relating to the care at issue upon the submission of an FAP application, not ECAs relating to past care for which the hospital facility has already satisfied the reasonable efforts requirements.

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

Also, the final rule requires a hospital to provide individuals who submit an incomplete FAP application with the contact information of a hospital facility office or department (or, alternatively, a nonprofit organization or government agency) that can provide assistance with the FAP application process.

Complete FAP Applications (p. 155):

General Requirements for Following the Receipt of Complete FAP Applications (p. 155): The final regulations provide that, if a hospital receives a complete FAP application from an individual during the application period, the hospital will have made reasonable efforts to determine whether the individual is FAP-eligible only if it suspends any ECAs taken against the individual to obtain payment for the care, makes and documents an eligibility determination in a timely manner (no specific standard is set in the rule defining “timely”), and notifies the individual in writing of the determination and the basis for the determination.

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 an 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.

Requirements When an Individual Is FAP-Eligible (P. 157): The hospital facility must provide the individual with a billing statement that indicates the amount the individual owes as an FAP-eligible individual and shows (or describes how the individual can get information regarding) the AGB for the care and how the hospital determined the amount the individual owes as an FAP-eligible individual. The hospital would also be required to refund any excess payments made by the FAP-eligible individual and take all reasonably available measures to reverse any ECA (with the exception of a sale of debt) taken against the individual to obtain payment for the care at issue.

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).

The proposed and final regulations refer only to refunds of payments “for the care” at issue and are intended to require refunds only of payments for the episode(s) of care to which an individual’s FAP

application (and therefore his or her FAP-eligibility determination) relates. Thus, if an individual receives and pays for a hospital facility's care in both year 1 and year 3 but only applies for financial assistance in year 3 for the care received in year 3 and is determined to be FAP-eligible for the care provided in year 3, the hospital would only have to refund any excess amounts the individual paid for the year-3 care, not any amount the individual paid for the year-1 care.

The final regulations do not require a hospital facility to refund any amount an FAP-eligible individual has paid for care that exceeds the discounted amount he or she owes for the care as an FAP-eligible individual if such excess amount is less than \$5. In addition, recognizing that inflation and other factors may create the need to increase the \$5 threshold in the future, the final regulations allow the Treasury Department or the IRS to increase the threshold in a notice or other guidance published in the Internal Revenue Bulletin. Further, the final rule clarifies that hospitals will only need to make refunds to individuals for amounts paid in excess of the amount he or she owed as an FAP-eligible individual. As discussed above, the FAP amount does not extend to insurers and health plans.

If a hospital facility does initiate an ECA against an individual before the end of the 240-day application period and the individual is subsequently determined to be FAP-eligible for a partial discount, the Treasury Department and the IRS believe the hospital facility should reverse the ECA altogether and begin the collection process anew based on the adjusted amount.

Presumptive FAP Eligibility Determinations Based on Third Party Information or Prior FAP-Eligibility Determinations (p. 161): The final regulations provide that, in addition to presumptively determining that an individual is eligible for the most generous assistance available under its FAP, a hospital facility may also presumptively determine that an individual is eligible for less than the most generous assistance available under the FAP based on information other than that provided by the individual or based on a prior FAP-eligibility determination (hereinafter referred to as presumptive determinations).

Further, presumptive determination that an individual is eligible for less than the most generous assistance available under an FAP only constitutes reasonable efforts to determine FAP-eligibility if three conditions are met. The hospital facility must:

- 1) Notify the individual regarding the basis for the presumptive FAP eligibility determination and the way he or she may apply for more generous assistance available under the FAP.
- 2) Give the individual a reasonable period of time to apply for more generous assistance before initiating ECAs to obtain the discounted amount owed for the care.
- 3) Process any complete FAP application that the individual submits by the end of the application period or, if later, by the end of the reasonable time period given to apply for more generous assistance.

The final regulations do not treat as reasonable efforts a presumptive determination that an individual is not FAP-eligible. Before being subjected to ECAs, individuals who have received no financial assistance under an FAP and who have not submitted a complete FAP application should, at a minimum, receive a notice about the FAP (through a plain-language summary) and about the deadline for submitting an FAP application before ECAs may be initiated. However, even though presumptive determinations of FAP ineligibility do not constitute reasonable efforts to determine FAP eligibility for purposes of section 501(r)(6), a hospital facility is not prohibited from using third-party information sources and prior FAP-eligibility determinations to try to predict which of its patients are unlikely to be FAP-eligible.

If a hospital determines an individual is FAP-eligible based on an individual's attestation regarding his or her income or other relevant eligibility criteria and the hospital facility has no reason to believe that the information on the statement is incorrect, the hospital facility will have made a determination based on a complete FAP application and, thus, have made reasonable efforts to determine whether the individual is FAP-eligible for purposes of section 501(r)(6).

Reasonable Efforts in the Case of Denying or Deferring Care Based on Past Non Payment (p. 166): The final regulations provide that, in the case of an ECA involving deferral and denial of (or requiring payment before providing) care, a hospital is not required to provide the oral and written notification about the FAP and potential ECAs at least 30 days in advance of initiating this ECA to have made reasonable efforts to determine whether the individual is FAP-eligible.

However, to avail itself of this exception, a hospital (or other authorized party) must satisfy several conditions. The hospital facility must:

- 1) Provide the individual with an FAP application form (to ensure the individual may apply immediately, if necessary) and notify the individual in writing about the availability of financial assistance for eligible individuals and the deadline, if any, after which the hospital facility will no longer accept and process an FAP application submitted by the individual for the previously provided care at issue. This deadline must be no earlier than the later of 30 days after the date that the written notice is provided or 240 days after the date that the first post-discharge billing statement for the previously provided care was provided. Thus, although the ECA involving deferral or denial of care may occur immediately after the requisite written (and oral) notice is provided, the individual must be afforded at least 30 days after the notice to submit an FAP application for the previously provided care.
- 2) Notify the individual about the FAP by providing a plain-language summary of the FAP and by orally notifying the individual about the hospital facility's FAP and about how the individual may obtain assistance with the FAP application process.
- 3) Process the application on an expedited basis, to ensure that medically necessary care is not unnecessarily delayed if an application is submitted.

The modified reasonable efforts discussed above would also not be needed in the following cases:

- 1) If 120 days had passed since the first post-discharge bill for the previously provided care, and the hospital facility had already notified the individual about intended ECAs.
- 2) If a hospital had already determined whether the individual was FAP-eligible for the previously provided care at issue based on a complete FAP application or had presumptively determined the individual was FAP-eligible for the previously provided care.

Agreements with Other Parties (p. 169):

In the event a hospital facility does sell or refer an individual's debt and the debt buyer or collection agent takes one or more of the steps required to have made reasonable efforts to determine whether the individual is FAP-eligible, the final regulations also clarify the hospital facility will be treated as having taken those steps for purposes of making reasonable efforts.

501(r) and State Law Requirements (p. 170): The final regulations do not contain any provisions equating compliance with one or more requirements in applicable state law to compliance with one or more of the requirements in the final regulations. The final regulations are not intended to preempt any

state laws or regulations, and the Treasury Department and the IRS expect that any additional or stricter state requirements will continue to apply to a hospital licensed in that state.

Reporting Requirements Related to CHNAs (p. 172): The final regulations state that a hospital organization must provide with its Form 990 a description of how it is addressing the community health needs identified for each facility it operates, its audited financial statements, and the amount of the excise tax imposed on the organization under section 4959 during the taxable year.

Description of How Community Health Needs Are Being Assessed (p. 173): The final regulations retain the requirement that hospital facilities annually furnish information on their Form 990s about how they are addressing the significant health needs identified through their CHNAs.

Reporting Requirements for Governmental Hospitals (p. 175): A government hospital organization (other than one that is described in section 509(a)(3)) is not required to file a Form 990. Because government hospital organizations described in Rev. Proc. 95-48 are relieved from the annual filing requirements under section 6033, they are also relieved from any new reporting requirements imposed on hospital organizations under section 6033, including the requirement to attach one or more CHNA implementation strategies to a Form 990. However, to be treated as described in section 501(c)(3), government hospital organizations still must meet all section 501(r) requirements that do not involve disclosure on or with the Form 990, including making their CHNA reports and FAPs widely available on a website.

Effective/Applicable Dates (p. 178): 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 these final regulations.