FOLLOWING THE ACA

ASSOCIATED TOPICS: EQUITY AND DISPARITIES, HOSPITALS, POPULATION HEALTH, PUBLIC HEALTH

Additional Requirements For Charitable Hospitals: Final Rules On Community Health Needs Assessments And Financial Assistance

Sara Rosenbaum

January 23, 2015

On December 29, the Department of the Treasury and the Internal Revenue Service released long-awaited final regulations implementing Affordable Care Act provisions that impose additional obligations on charitable hospital organizations covered by §501(c)(3) of the Internal Revenue Code. Published in the Federal Register on December 31 2014, the regulations are massive, consolidating a series of prior proposals into a single final body of regulatory law. The regulations affect more than 80 percent of U.S. hospitals, both the 60 percent that operate as private nonprofit entities and the 23 percent that operate as governmental units.

Because state and local governments typically condition their own sales, property, and corporate income tax exemptions for nonprofit entities to a hospital's §501(c)(3) status, the final regulations carry broad and deep implications from both a policy and financial perspective. According to the Congressional Budget Office the 2002 the national value of the federal tax exemption exceeded $12 billion, a figure that undoubtedly has risen considerably.

Background

The ACA Amendments. The ACA added §501(r) to the Internal Revenue Code[1]; this provision provides that hospital organizations will not be treated as tax-exempt under 501(c)(3) unless they meet certain requirements. First, organizations must conduct a community health

needs assessment (CHNA) at least once every 3 years and must adopt an implementation strategy (updated annually) to address community health needs identified in the CHNA. Second, organizations must establish a written financial assistance policy (FAP) and a written policy governing emergency medical care.

Third, in the case of emergency medical care and other medically necessary care, organizations are barred from charging persons eligible for financial assistance more than amounts generally billed to insured patients. Finally, hospital organizations must make reasonable efforts to determine whether patients are eligible for financial assistance before engaging in extraordinary collection efforts.

Each of these requirements is applicable to each facility operated by a hospital organization, and organizations must satisfy each requirement before claiming tax-exempt status for each hospital facility they operate.

With the exception of the CHNA provisions, the ACA requirements apply to taxable years beginning after March 23, 2010. The CHNA assessment and implementation strategy requirements became effective for taxable years beginning after March 23, 2012. Hospitals that fail to meet the CHNA requirement must pay a $50,000 excise tax (§4959 of the Internal Revenue Code). Hospitals must also comply with additional reporting requirements (§6033 of the Internal Revenue Code) and must file a copy of their audited financial statements with their annual information returns (Form 990).

The IRS has amended Schedule H, which accompanies Form 990, to include extensive facility-specific information regarding §501(r) compliance. (Schedule H also requires a hospital organizations to provide organization-specific information about its community benefit expenditures as a charitable organization under 501(c)(3)).

Evolution of Implementation. The final regulations come nearly 5 years after enactment of the ACA, the culmination of an implementation process that began in the summer of 2010 and rolled out over the intervening years through a series of proposed regulations and sub-regulatory guidance.[2] Proposed rules implementing provisions related to financial assistance, limitations on charges, and billing and collection practices were published on June 26 2012. Proposed rules implementing the CHNA provisions were published on April 5 2013.

The proposed rule was preceded by IRS Notice 2011-52, which offered early guidance on the CHNA process. Regulations implementing the excise tax and reporting requirements were published as a final and temporary rule on August 15, 2013. In January 2014, the agencies released Notice 2014-3, which set forth the procedures the agencies would require hospitals to use in correcting and disclosing failures to satisfy 501(r) requirements.

This long, unwinding regulatory process is not dissimilar to the ACA amendments themselves, which were the product of years of policy deliberations triggered by ongoing news stories detailing serious abuses by nonprofit hospitals. A series of Congressional hearings conducted by Republican and Democratic Members of Congress alike focused on excessive charges, the absence of financial assistance, and the use of exceptionally harsh billing and collections practices; these practices included stationing debt collectors in emergency departments, withholding treatment from people with outstanding bills for prior care, and imposing wage garnishment and liens.

The failure by nonprofit hospitals to invest in community health was also a focus of concern. (A landmark 2013 *New England Journal of Medicine* study of hospitals' community benefit expenditures during the 2009 tax year would later report that although hospitals on average spent about 7.5 percent of their operating revenues on community benefit activities, less than 0.5 percent of hospital expenditures were allocated to community health improvement activities for which there is no expectation of payment).

The implementation of the ACA amendments also comes at a transformational moment for U.S. hospitals; they are increasingly being held to high efficiency operational standards, but also, through organizational advances such as accountable care organizations, are expected to bring a greater focus to population health in the communities they serve. Implementation thus arrives at an important moment in U.S. health policy, when health care access for historically excluded populations and improvements in population health both are receiving a high level of focus.

Major Provisions of the Final Rule

A consolidation of multiple previous rulemaking efforts, the final rule is lengthy and complex, addressing the full range of issues contained in the amendments themselves. This approach underscores the important relationships between community health planning and service to disadvantaged populations. Because these expanded obligations address the scope and nature of hospitals' community benefit obligations under 501(c)(3), it is likely that over time, these expanded obligations will begin to influence how hospitals invest in their communities, particularly in the areas of financial assistance for medically indigent population and community health improvement.

Scope of the rules: government hospitals, private hospitals, and accountable care organizations. The regulations apply to licensed hospital facilities, meaning that compliance is facility-specific rather than organization-wide. Hospital organizations that operate multiple facilities thus effectively are held to a facility-specific compliance standard.

The rules apply to government hospital organizations, which had sought an exemption from the requirements; they argued that their safety net status and inherent public accountability should be deemed to satisfy 501(r)'s CHNA and financial assistance requirements, as well as its curbs on excessive charges and billing and collection practices. In applying the rule to governmental hospitals, the agencies note that the ACA contains no exemptions for public hospitals and indicate that such hospitals are free to voluntarily terminate their 501(c)(3) recognition should they not wish to comply with 501(r).[3]

However, because IRS policy exempts government hospitals from having to file a Form 990, the information that private hospitals must include in Form 990 and its appendices (e.g., community benefit, community health planning, and financial assistance information included on Schedule H, attached to the 990 form; and the annual implementation strategies flowing from the CHNA process) do not apply. But the agencies clarify that, like private hospitals, government hospitals must make both their CHNA reports and their financial assistance policies widely available on a Web site.[4] (Presumably state or local laws governing access to public information would allow individuals to seek and obtain public hospitals' implementation strategies in cases in which they are not made available).

The final rules also address the question of how hospitals and hospital organizations that are part of Accountable Care Organizations (ACOs) are expected to comply with 501(r). The agencies

indicate that they will permit multiple hospital facilities involved in a single ACO to engage in joint CHNA activities and to develop a joint financial assistance policy, but will require that each facility separately adopt the policy as the policy of the facility so as not to evade the law's facility-specific requirements.[5] (As discussed below, the final rule also permits (and encourages) multi-facility development of CHNA reports and joint implementation strategies).

The agencies also clarify that hospital-owned entities such as physician practices that are considered to be part of the hospital organization and not separate taxable entities are covered by both the CHNA and financial assistance obligations. This means that medical practices operated by the facility or organization itself would be considered part of the services provided by the hospital organization or the facility.

Enforcement of failures to satisfy 501(r) – actionable failures versus minor errors and omissions. The final regulation focuses considerable attention on enforcement, as one might expect given the potential seriousness of compliance failures — namely, revocation of tax-exempt status[6] as well as corporate income tax exposure on the part of individual noncompliant hospital facilities.[7]

In the case of compliance failures determined to be neither "willful" nor "egregious" (i.e., grossly negligent failures evidencing reckless disregard or willfully negligent conduct — a finding that the IRS will base on all facts and circumstances), hospitals will be given the chance to cure the failure through correction and disclosure procedures established in agency policy instructions. In determining whether a failure is sufficiently egregious or willful to merit the toughest penalties, the agencies will use a ten-factor "facts and circumstances" test. Factors to be considered include the nature and scope of the failure; any record of prior failures; whether there were multi-facility failures in the case of hospital organizations operating multiple facilities; the underlying reasons for the failure; whether the hospital had a compliance plan in place at the time of the failure that was being routinely followed; whether the hospital promptly corrected and disclosed its failure, and whether it did so prior to discovery by the IRS.[8]

Following the proposed rule, the final rule also adopts a strategy that effectively encourages hospital organizations to be proactive with respect to facility-specific compliance with each 501(r) requirement, since violation of any of the requirements constitutes grounds for revocation of 501(c)(3) status. To encourage compliant behavior, the final rule also maintains a "minor omissions and errors" standard that places value on "practices and procedures in place that are reasonably designed to facilitate overall compliance."[9] Under this standard, failures that are considered by the agencies to be "minor omissions and errors" will not be considered the type of failure that can lead to a loss of 501(c)(3) status if the hospital (i) can demonstrate that the omission or error was "minor and either inadvertent or due to reasonable cause," and (ii) corrects the omission or error "as promptly after discovery as is reasonable given the nature of the omission or error."[10]

Multiple minor omissions are tolerable if minor "in the aggregate;" evidence of repeated failures on the same requirement will cut against the notion that the failure was inadvertent.[11] An error that is "due to reasonable cause" is one that effectively happens despite the fact that "the hospital facility has established practices or procedures (formal or informal) reasonably designed to promote and facilitate overall compliance with §501(r) prior to" an omission or failure going to 501(r) compliance.[12] The correction and disclosure requirements that apply to failures generally under the final rules[13] do not apply to minor omissions and errors. At the same time, however,

the agencies decline to give guidance on which failures are considered "minor and either "inadvertent" or "due to reasonable cause"; this discourages hospitals from classifying all but the most minor infractions as minor omissions and errors, since under the rules, prompt disclosure, correction and reporting are key to a revocation determination.

Community Health Needs Assessments (CHNAs). In general, the final rules follow the proposed approach to the development of a CHNA, the issuance of a CHNA report, and the adoption of the implementation strategy explaining how a hospital facility proposes to meet significant health needs disclosed through the CHNA process. Several aspects of the final rule are noteworthy, however.

Health – not just health care – needs. The final rule makes clear that a CHNA can assess not only significant unmet need for health care, but also significant *health needs* arising from social conditions such as inadequate access to proper nutrition and housing and "the mitigation of social, environmental, and behavioral factors that influence health, or emergency preparedness." In response to extensive public health comments, the final rules thus embrace an approach to the CHNA process that prioritizes "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."[14] This strong signal that the CHNA process is about community health — not simply access to health care — is reinforced by IRS efforts in recent years to clarify that community benefit spending can encompass not only subsidized access to health care but also investments in community health improvement and community building that is linked to community health.[15]

Joint CHNA reports and implementation strategies. The final rules clarify that joint planning activities are not only permissible but encouraged, as long as a joint CHNA report complies with all applicable CHNA development and reporting requirements on a facility-specific basis.[16] The rule also permits joint implementation strategies,[17] to be updated annually, that spell out which prioritized health needs will and will not be addressed during the triennial CHNA cycle.

Two types of joint activities are envisioned: multi-facility collaborations; and collaborations between hospital facilities and public health agencies. In both cases, the key is the commonality of the community and adoption of the planning report by the hospital.[18] In other words, hospitals (or a hospital and a health agency) that share a common community can collaborate on a "joint CHNA report." Hospitals engaged in multi-facility joint planning can include supplementary information that enables individual hospital collaborators to also focus on "localized needs" specific to their community.[19]

In using a "joint CHNA report" approach, hospitals continue to be required to have their "authorized body" (i.e., the hospital board) adopt the report as that of the hospital facility. Furthermore, a joint report must comply with all CHNA procedures: a description of the community served; a description of the process and methods used to conduct the CHNA; a description of how the hospital(s) solicited and took into account input from persons who represent the broad interests of the community served; a prioritized description of "significant" health needs, along with a description of the criteria used to identify and prioritize significant needs, a description of resources available to meet these needs; and an evaluation of the impact of actions taken since the "immediately preceding CHNA" to address significant needs identified in the prior CHNA.[20]

Governmental public health involvement. Input from governmental public health departments is a requirement of the CHNA process.[21] But in consulting with governmental health agencies, the agencies continue, as they did in the proposed rule, to give hospitals flexibility to "select the jurisdictional level (local, state, tribal or regional) of the public health department that is most appropriate for its CHNA."[22] The agencies also clarify that hospitals cannot bypass governmental public health by hiring their own public health consultants.[23]

Defining the community. Perhaps the most vital element of the CHNA requirement is how hospitals define the community they serve. The final rules, like the proposed rules, underscore that the key issue is the community that *needs the care of the hospital,* not simply current patients. The agencies permit hospitals to take "facts and circumstances' into account in defining the communities they serve. (In some states of course, state and local laws might define certain hospital communities served).

In response to commenters who raised concerns that hospitals would define their patient populations and geographic areas in ways that avoided people in their own service areas, the agencies clarify in the final rule that in defining community, a hospital is to take a number of factors into account: geographic area served; target populations; and principal hospital functions.[24] But the rule also reiterates that a hospital may not define its community to exclude medically underserved low income or minority populations "who live in the geographic areas from which the hospital facility draws its patients (unless such populations are not part of the hospital facility's target patient populations or affected by its principal functions) or otherwise should be included based on the methods the hospital facility uses to define its community."[25] Hospitals are also barred under the final rule from taking uninsured or publicly insured status of into account in their definition of the community served.[26]

Input from persons representing the broad interests of the community. The ACA amendments require a community input process involving persons representing medically underserved, low income, and minority populations. The agencies decline to provide a more expansive definition of the population whose input must be assured. Nor do the agencies agree with commenters that sought to ensure community input at both the draft CHNA report phase and the implementation strategy phase.

At the same time, the agencies clarify in the final rule that the input process is not only intended to assess community input on significant health needs, but also on how significant needs should be prioritized and on identifying resources potentially available to meet those needs. [27] In other words, the community input process addresses both needs and the hospital's role in meeting those needs. The agencies also specify that in obtaining input on subsequent CHNAs, hospitals are expected to consider input on the effectiveness of prior CHNAs and implementation strategies.[28] The agencies decline to prescribe formal procedures for obtaining public input, either oral or written comments, nor do the final rules require facilities to respond to comments.[29]

Widely available. Under the ACA, CHNAs must be made "widely available" to the public, interpreted by the agencies to mean published on a website without proactive efforts (as are required for financial assistance policies) to ensure that the reports actually reach the community. The agencies decline to extend the "widely available" standard to a hospital's implementation strategy, which spells out which of the prioritized significant health needs a hospital facility will respond to and which it will not. Instead, the agencies require that implementation strategies be

attached to the Form 990. This means, as noted, that government hospitals not covered by the Form 990 reporting requirements do not have to make their implementation strategies accessible to the public unless required to do so under separate state or local law.

Excise tax. The agencies clarify that the excise tax tied to CHNA-related failures can be triggered not only by the complete failure on the part of a hospital to prepare a CHNA report and adopt an implementation strategy, but also by the facility's failure to comply with the individual elements of the CHNA process (i.e., input from public health experts, input from representatives of the community served, formal adoption of the report, or a CHNA that contains the requisite elements).[30] At the same time the agencies reaffirm that correction and disclosure can cure a failure and that minor errors and omissions (as yet undefined) can be managed through an effective hospital compliance process.

Financial assistance policies. The final rules make certain modifications to the proposed rules that, in the main, serve to strengthen the original proposals in key respects. The thrust of the final rule is to require charitable hospitals not only to have financial assistance policies but to take affirmative, repeated, and proactive steps to actually make their financial assistance available and accessible to the population in need, not only when care is rendered but prior to initiating any type of extraordinary collection process.

Scope of the policy. The final rules clarify that a hospital's financial assistance policy applies not only to the hospital itself but to all emergency and medically necessary care furnished by "substantially related entities"[31] (i.e., entities treated as a partnership for federal tax purposes, as well as disregarded entities owned by the hospital).[32] Thus, where emergency care or other medically necessary care is furnished by health care personnel treated as part of the hospital itself, the financial assistance policy must extend to these personnel as well.

In situations in which the care is furnished by an independent provider group not owned by the hospital (e.g., contracted emergency personnel employed by an organization considered separate for tax purposes), the financial assistance policy must specify this, as well as specifying which personnel are, in fact, covered by the hospital's policy.[33] The agencies also note that if a hospital "outsources" its emergency room operations to a third party and such care is not covered by its financial assistance policy, then for purposes of its 501(c)(3) status the hospital may not be considered to operate its emergency department as a community benefit under Revenue Ruling 89-545, since under such circumstances the emergency department serves a private rather than public interest.[34] In other words, not extending financial assistance to emergency room personnel carries separate 501(c)(3) implications.

Services that are eligible for financial assistance. The rule applies financial assistance to "all emergency and other medically necessary care".[35] In the Preamble, the agencies note that hospitals may exempt from their policies certain services that are not considered either emergency or "medically necessary" care, thereby restricting their financial assistance policy only to certain types of care and services.[36]

In the Preamble, the agencies clarify that hospitals have discretion to define what constitutes medically necessary care for purposes of establishing their financial assistance policies. Specifically, the final rule states that for purposes of meeting the financial assistance obligation, "a hospital facility may but is not required to use a definition of medically necessary care applicable under the laws of the state in which it is licensed, including the Medicaid definition, a definition that

refers to the generally accepted standards of medicine in the community, or to an examining physician's determination."[37] The power of hospitals to define what is medically necessary care for purposes of their financial assistance policy is important, not only because the scope of care covered by the policy equals the scope of financial assistance, but also because the ACA's limits on excessive charges and the obligation to charge no more than amounts generally billed to insured patients cover only the treatments and services included in the hospital's financial assistance policy.[38] The agencies note that in reporting financial assistance as a community benefit, hospitals can include only care and services classified as covered under the policy.[39]

Establishing and widely publicizing a financial assistance policy. Hospital financial assistance policies are designed to ensure a thorough explanation of the availability of financial assistance, how to obtain it, and how the hospital will calculate what a patient actually will owe. The final rules are accompanied by illustrative applications to help guide the development of hospital policies.

Under the rule, a hospital's financial assistance policy must spell out its elements in detail, including the services for which free or discounted care may be available, the discounts used, the methods for applying, the methods for determining eligibility, and — in the case of hospitals that do not maintain separate billing and collections policies — the actions that may be taken in the event of nonpayment. The policy also must explain what information will be used to determine eligibility, which other sources of information a hospital may use in making a determination, and whether it will use prior assistance determinations to presumptively determine eligibility for financial assistance. [40]

In addition, the hospital's policy also must explain how the charge owed by the patient will be calculated in relation to the "amount generally billed" to insured patients. A plain language summary of the policy also must be furnished, and patients must have free and ready access to information and the application forms.

The agencies clarify in the Preamble that hospitals can grant financial assistance even if applications are incomplete, and they can be flexible in how they allow patients to obtain information.[41] Thus, hospitals have the flexibility under the final rule to determine the eligibility criteria and the types of information they will collect, and also to act to grant financial assistance even if less than all information is available.

Financial assistance policies must be "established" — that is, they must be adopted by authorized bodies (i.e., the board of trustees or an individual empowered to act on the board's behalf). In the event that the hospital maintains a separate billing and collections policy, both the financial assistance and billing and collections policies must be adopted before they will be considered to have been established.[42] In the Preamble, the agencies make clear that adoption is not sufficient, however, and that the deeper issue is their consistent use in practice.

Financial assistance policies must be "widely publicized." In other words, it is not enough to make the materials available on a website, as is the case with the CHNA report. Under the final rule, hospitals must essentially push their policies out — not only into their facilities but also into the communities they serve. The policy, the summary, and application forms must be available in public locations of the hospital (at a minimum the emergency room and the admissions area), and hospitals are expected to set "up conspicuous public displays."[43] Hospitals must also "notify and inform members of the community" (i.e., not only people who are already patients of the hospital) about their financial assistance policy, so that people "who are likely to require" financial assistance

from the hospital are aware of its existence.[44]

Under the final rules, translation is a key element of widely publicizing a financial assistance policy. The proposed regulations stipulated that documents must be translated into any language spoken by at least 10 percent of the members of the community served by the hospital. The final rules drop the translation threshold to the lesser of 1,000 individuals or 5 percent of the community, thereby conforming the translation obligation to that used by HHS in Title VI enforcement involving hospitals participating in federal health care programs. (The agencies note that hospitals should have no difficulty adjusting their financial assistance policies to the lower threshold, since virtually all hospitals participate in federal health care programs and thus are already subject to the lower standard).[45] The final rules, however, do not require that hospitals make oral interpreters or bilingual staff available on request, as sought by commenters.[46]

Emergency care policy. In adopting an emergency care policy, the final rule provides that a hospital will not be considered to be in compliance with ACA requirements unless its policy "prohibits the hospital facility from engaging in actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities that interfere" with the non-discriminatory provision of emergency care.[47]

Limiting charges to the amount generally billed. Charges for treatments and services covered by a hospital's financial assistance policy are subject to an "amount generally billed" standard. That is, in determining the amount that a patient can be charged once free and discounted care are taken into account, hospitals are limited to the amount that they generally charge insurers. In arriving at a final policy, the agencies have structured a process that allows hospitals to use either a retrospective ("look back") or prospective method for establishing the amount generally billed for each service.[48]

In addition, hospitals can use one of two means for calculating the amount charged a patient: either the amount that the hospital would be paid by the traditional Medicare fee-for-service program, or the amount it would be paid under a combination of Medicare and private insurance payments. Some commenters sought added flexibility, recommending that hospitals be able to base their charges on the best, or an average of the three best, negotiated commercial rates. The agencies rejected this recommendation, noting that such an approach would be inconsistent with the "amount generally billed" to insurers standard of the ACA itself.[49] The agencies did, however, clarify that Medicaid could be the basis for calculating charges for services covered by a financial assistance policy.

The agencies also clarified in the final rule how the method applies to insured patients, that is, to patients who are eligible for financial assistance even though they possess insurance. (Nothing in the financial assistance rule requires that hospitals extend their policies to patients who have insurance but who face high deductibles and cost-sharing). A number of commenters sought to narrow the rule's limitation on charges to completely uninsured patients while allowing higher charges in the case of those who are under-insured. Although the rule does not require hospitals to extend their financial assistance policies to patients with inadequate coverage, at the same time the agencies were clear that the law's provisions related to how financial assistance programs must operate are not limited to patients who are completely uninsured. At the same time, the agencies agreed that charges to insured patients can reflect the amount a patient would owe once

the insurer pays and all other applicable discounts have been calculated into the bill. In other words, to the extent that the patient's insurance recognizes a higher charge, a hospital will not violate the excessive charge prohibition if the final amount owed by an insured patient exceeds what an uninsured patient would owe for the same services under the "amount generally billed" formula.[50]

The final rule also offers a safe harbor for certain charges even if the charges exceed the amount generally billed. This safe harbor applies if (i) the amount billed was not specified as a precondition of care; (ii) at the time of the charge, no financial assistance application had been made; and (iii) the hospital refunds the excess once a patient applies for financial assistance and eligibility is determined.[51]

Billing and collection, extraordinary collection actions, and prior notice. The ACA does not ban extraordinary collection actions, but the final rules condition their use on a process that entails a form of due process notice about what will happen if the patient continues not to seek financial assistance, as well as vigorous efforts by the hospital to determine eligibility for financial assistance prior to initiating an extraordinary action. This due process standard sets forth notice time frames that the hospital must follow prior to instituting extraordinary collection actions.

The final rule defines the concept of an extraordinary collection action at length. Such actions include selling individual debt to a third party; reporting adverse information to a consumer credit bureau or reporting agency (the agencies rejected comments arguing that such credit reports should not be identified as an extraordinary collection practice);[52] deferring or denying care until past bills are paid; or using the legal process to place a lien on property, foreclose on a home, garnish wages, attach personal property, commence a civil action, cause an individual to be arrested, or cause a writ of body attachment. (Exempt from the definition of extraordinary collection practices are liens that a hospital is entitled to assert against personal injury judgments and filing a claim in a bankruptcy proceeding. In addition, debt sales will not be considered extraordinary collection actions if the purchaser is limited in the interest it can charge and the debt is returnable once the hospital (or the purchaser) determines that the patient is eligible for financial assistance. [53])

The rule bars hospitals from engaging in extraordinary collection actions against individuals unless they make "reasonable efforts to determine" whether individuals are eligible for financial assistance. Under the rule, the concept of reasonable effort translates into the following steps that hospitals must take at least 30 days before initiating extraordinary actions to collect payment. First, the hospital must provide the individual with written notice of the specific action it intends to take in order to obtain payment, and its notice must state a deadline that is at least 30 days after the date that written notice is provided. Second, the notice must be accompanied by a plain language summary of the hospital's financial assistance policy. Finally, the hospital must also make a reasonable effort to orally notify the individual about the availability of financial assistance and how such assistance can be obtained.[54]

In the case of patients with multiple episodes of care, a hospital may aggregate the episodes and notify the individual about its extraordinary collection actions in the aggregate. However, where hospitals aggregate notice, they may not institute an extraordinary collection action until at least 120 days after providing the first post-discharge billing statement.[55]

In cases in which the extraordinary collection practice involves deferring treatment because of

nonpayment of prior bills, the final rule permits hospitals to use shorter notice periods prior to withholding care. But the rules also impose a special process that must be followed where the extraordinary action involves withholding care. In such cases, hospitals must provide individuals with a financial assistance application form along with a written notice indicating that financial assistance is available and stating a deadline for filing the application for previously provided care. The deadline must be at least 30 days from the date of written notice or 240 days after the date on which the first post-discharge bill for the previous care was provided. In other words, it is possible to threaten to withhold care using a shorter time frame, but such a threat must be accompanied by an actual application for assistance with prior bills, followed by a waiting period before the hospital actually can institute the step of withholding care. In this situation, applications also must be processed on an expedited basis.[56]

Under the rules, extraordinary collection actions must be suspended in the face of incomplete applications to give patients time to cure deficiencies or missing information. Similarly, extraordinary collection actions must be suspended once an application is completed and submitted, and the suspension must last for the duration of the time period needed to make the financial eligibility determination.

In developing the final rule, the agencies rejected the position of commenters who sought an exemption from the ban against extraordinary collection practices without reasonable efforts to determine eligibility for financial assistance in situations in which hospitals turn bills over to debt collection agencies. Not surprisingly, the agencies reasoned that were hospitals not held liable for the conduct of their collection agencies, the rule would be eviscerated.

Concluding Thoughts

The final regulations implementing the ACA's charitable hospital amendments are far-reaching and extensive. At the same time, important unanswered questions remain with respect to both the health needs assessment process and financial assistance. How will hospitals define their communities going forward? Will the agencies' emphasis on health needs, rather than simply the need for health care serve, increase over time the amount of community benefit expenditure flowing to community health improvement activities? How will hospitals react to the latitude they have been given to define what constitutes emergency or medically necessary care for purposes of financial assistance?

Will definitions be broad in scope or will hospitals seek to narrow their financial assistance policies? How will hospitals treat under-insured patients going forward in relation to their financial assistance policies? Finally, will the use of extraordinary collection practices slow as the obligation to extend financial assistance prior to instituting such practices takes hold?

[1] PPACA §9007

[2] 79 Fed. Reg. 78956

[3] Id.

[4] Id.

[5] Id.

[6] 26 C.F.R. §1.501(r)-2(a)

[7] 26 C.F.R. §501(r)-2(d)

[8] 26 C.F.R. §1.501(r)-2(a)

[9] 79 Fed. Reg. 78960

[10] 26 C.F. R. §1.501(r)-2(b)

[11] Id.

[12] Id.

[13] 26 C.F.R. §1.501(r)-2

[14] 26 C.F.R. §1.501(r)-3(b)(4); 79 Fed. Reg. 78963

[15] See 2014 Hospital Schedule H instructions, http://www.irs.gov/pub/irs-pdf/i990sh.pdf

[16] 79 Fed. Reg. 78967

[17] 26 C.F.R. §1.501(r)-3(c)

[18] Id.

[19] 79 Fed. Reg. 78967

[20] 26 C.F.R. §1.501(r)-3(b)(6)

[21] 26 C.F.R. §1.501(r)-3(b)(5)

[22] 79 Fed. Reg. 78964

[23] Id.

[24] 26 C.F.R. §1.501(r)-3(b)(3)

[25] Id.

[26] Id.

[27] 26 C.F.R. §1.501(r)-3(b)(5); 79 Fed. Reg. 78964

[28] 79 Fed. Reg. 78965

[29] 79 Fed. Reg. 78965

[30] 79 Fed. Reg. 78995

[31] 26 C.F.R. §1.501(r)-4(a)(2)

[32] 26 C.F.R. §1.501(r)-1 (28)

[33] 79 Fed. Reg. 78971

[34] 79 Fed. Reg. 78972

[35] 26 C.F.R. §1-501(r)-4(b)(1)

[36] 79 Fed. Reg. 78972

[37] 26 C.F.R. §1.503(r)-4(b)(8)

[38] 26 C.F.R. §1.503(r)-4(b)(1) and (2)

[39] Id.

[40] Id.

[41] 79 Fed. Reg. 78972-73

[42] 79 Fed. Reg. 78973

[43] 26 C.F.R. §1.501(r)-4(b)(5)

[44] 26 C.F.R. §1.501(r)-4(b)(5)

[45] 79 Fed. Reg. 78976-77

[46] Id.

[47] 26 C.F.R. §1.501(r)-4(c)

[48] 26 C.F.R. §1.501(r)-5 (b)

[49] 79 Fed. Reg. 78979

[50] 79 Fed. Reg. 78979

[51] 26 C.F.R. §1.501(r)-5(d)

[52] 79 Fed. Reg. 78985

[53] 26 C.F.R. §1.501(r)-6(b)

[54] 26 C.F.R. §1.501(r)-6(b)(4)

[55] Id.

[56] Id.

TAGS: CONSUMERS, DISPARITIES, HEALTH REFORM, HOSPITALS, NONMEDICAL DETERMINANTS, POLICY, PREVENTION, PUBLIC HEALTH

COMMENTS

4 Trackbacks for “Additional Requirements For Charitable Hospitals: Final Rules On Community Health Needs Assessments And Financial Assistance”

Using Community Health Needs Assessments to Promote Health Equity - Harder+Company

June 2nd, 2016 at 11:33 am

Expanding The Meaning Of Community Health Improvement Under Tax-Exempt Hospital Policy

January 8th, 2016 at 12:18 pm

Non Profit Hospital Profits Double–But There are Tools You Can Use | The O'Connor Report

June 17th, 2015 at 10:59 pm

Hospital Community Health Needs Assessment Fines and IRS Status; What One Hospital Did; and Hospital Quality Surveys | The O'Connor Report

February 13th, 2015 at 3:34 pm

2 Responses to "Additional Requirements For Charitable Hospitals: Final Rules On Community Health Needs Assessments And Financial Assistance"

Jean Buchannan says:

> I do love the way you have presented this particular challenge and it really does supply us a lot of fodder for thought. Nonetheless, coming from just what I have observed, I simply wish when other commentary stack on that folks stay on point and don't embark upon a tirade regarding some other news of the day. Anyway, thank you for this fantastic point and even though I can not necessarily go
> Read More

March 21st, 2016 at 9:04 am

Marydale DeBor says:

> Thank you Professor Rosenbaum for this excellent summary of the IRS Final Rule applicable to Charitable Hospitals and in particular the emphasis on the important new language in the community health needs assessment provisions: Health–not just health care—needs. As one of the many individuals and organizations that submitted comments on this very point, I look forward to the next
> Read More

January 27th, 2015 at 12:32 pm

LEAVE A REPLY

Comment moderation is in use. Please do not submit your comment twice -- it will appear shortly.

Name (required)

E-mail (will not be published) (required)

Website

Submit Comment

Receive an email if someone else comments on this post? ☐

MOST RECENT | MOST READ

Improving Outcomes for Justice-Involved Individuals With Lessons From Veterans Programs
Tyler N.A. Winkelman and Matthew M. Davis

Many Eligible For Premium Tax Credits Not Receiving Them; A 2017 Open Enrollment Calendar
Timothy Jost

The Uninsured Drop Slowed But Continued Between 2014 and 2015
Laura Skopec, Genevieve Kenney, and Stephen Zuckerman

In Medicaid Expansion States, Uninsured Adults' Share of Physician and ED Visits Has Declined
Thomas Selden, Salam Abdus, and Patricia Keenan

Health Affairs' October Issue: Insurance, The ACA, Care In India & More
Lucy Larner

TOPICS

Select A Topic

HEALTH AFFAIRS NEWSLETTER

Click here to sign up for our *Health Affairs* Today and *Health Affairs* Sunday Update newsletters.

Health Affairs Today leads you to *Health Affairs* Blog posts published that day as well as recent journal articles, Health Policy Briefs, and other new content and upcoming events.

TWITTER UPDATES