IRS Rule 501(r) that takes effect as early as January 1, 2016 not only adds specific requirements for hospitals to qualify for tax-exempt status, it adds restrictions for how they can pursue payment for care provided. For most 501(c)(3) hospitals the rule changes will necessitate far-reaching changes to financial assistance policies, patient communication, billing, collections, vendor management and other processes. The scope of what the 501(r) rule changes require is frequently misunderstood, and the effort need to comply can easily be underestimated. This article provides an overview of the key changes and requirements.

501(r) at a Glance

The 501(r) rules primarily govern how hospitals can bill patients for medically necessitated emergency care and has four main components:

- **501(r)(3)** – Establishes the requirement to conduct a Community Health Needs Assessment (CHNA)
- **501(r)(4)** – Governs financial assistance policies (FAP)
- **501(r)(5)** – Sets limits on charges and defines average general billing (AGB) and methodologies for calculating the limitations
- **501(r)(6)** – Sets communication requirements, timetables and restrictions for billing and collections

The rules take effect for hospitals on the first day of their 2016 fiscal year. For example, if the fiscal year is the calendar year the compliance deadline is January 1, 2016; if the fiscal year runs July to June then the compliance deadline is July 1, 2016.

Hospital organizations must comply with all four components to qualify for tax-exempt status. There is flexibility in how the requirements can be met, and the rules allow hospital organizations to use different processes and methodologies at different facilities.
501(r)(3) Community Health Needs Assessments

Section 501(r)(3) builds on and updates previous community health needs assessments rules established in IRS Notice 2011-52. It now requires hospitals to develop or update a CHNA at least every three years. More specific information is available on the IRS website and hospitals should review the requirements with their auditors.

501(r)(4) Financial Assistance Policy

New requirements for a hospital’s financial assistance policy (FAP) represent the most significant change in the 501(r) rule. The 501(r)(4) requirements are so extensive and specific that nearly every hospital will need to make changes to comply. Figure 1 shows the seven essential elements of a financial assistance policy.

Some of the general 501(r) requirements include:

- The financial assistance policy must be “widely communicated” to patients. One requirement is for all billing statements to include a reference to the FAP and how the patient may learn more about it.
- The FAP must include a list of all physicians and other providers that deliver emergency/medically necessitated care at the facility and whether the AGB discount applies to their professional fees.
- Patients must be provided a copy of the FAP in a plain language summary format.
- The plain language summary must be translated into all languages used by at least 5 percent of the patient population.
- Multi-facility systems may have a single FAP or different policies for different facilities.

The IRS is very clear on what needs to be communicated, but not how. That creates flexibility for hospitals to craft and communicate the FAPs, and also risk that they will not comply.
501(r)(5) Limitations on Charges & AGP Methodology

501(r) limits what facilities can charge for medically necessary care. It also establishes complex methodologies for calculating the limits and requires hospitals to set discounts for patients that qualify for financial assistance. Once again, different facilities within a system can use different methodologies. The charge limits are based on the average generally billed (AGB) amount for specific services. The IRS allows two methodologies for calculating AGB – LookBack and Prospective – which are too complex to detail here. One important detail to note is sliding fee scales will no longer meet AGB requirements.

501(r)(6) Billing & Collections

The new rules include significant restrictions on how hospitals can bill patients, plus when and how accounts may be moved into bad debt. Most of the focus and requirements of 501(r)(6) are for determining if patients are eligible for financial assistance under the FAP and for making reasonable efforts prior to initiating “extraordinary collection actions” (ECA). ECA includes actions such as reporting debts to credit bureaus, selling debt to a third party, and pursuing liens, garnishments and other legal actions. Rule 501(r)(6) establishes a window for when these activities can occur. Hospitals will be held responsible for ECA rules violations made by their business associates, such as billing services or collection agencies. The 501(r)(6) rule does not restrict what can be designated as bad debt, but restricts action that can be taken to resolve it.

Before initiating extraordinary collection activity hospitals must make a “reasonable effort” to inform patients about the financial assistance plan and determine if the patient is eligible. Required reasonable efforts include making multiple attempts to communicate the FAP through multiple channels (e.g. website, posters, brochures, plain language summary, phone calls, mail, email). Obtaining a signed waiver from patients does not qualify as a reasonable effort.

<table>
<thead>
<tr>
<th>Collection Action</th>
<th>Days from First Post Discharge Billing Statement</th>
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<tr>
<td></td>
<td>0-30</td>
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<tr>
<td>First Post Discharge Billing Statement</td>
<td>√</td>
</tr>
<tr>
<td>Patient may apply for FAP</td>
<td>√</td>
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<tr>
<td>30 day notice re: pending ECAs</td>
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</tr>
<tr>
<td>First date ECA may be initiated</td>
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<tr>
<td>Last Day for patient to apply for FAP</td>
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ECA and reasonable efforts rules will have a significant impact on billing cycles and processes because they establish strict timetables and deadlines for when billing, notification and collection actions can take place, and require collections to be suspended if a patient applies for and/or is determined to be FAP eligible.

Hospitals must wait a minimum of 120 days from the date of the patient’s first post-discharge statement before they can pursue extraordinary collection actions, and must notify patients 30 days before any ECA actually commences. There are specific requirements for the information to be contained in the advanced notification. Once the patient applies for financial assistance all ECA activity must be suspended until the determination is made. A key distinction is that although ECAs may be commenced starting at day 121 after the first post-discharge billing statement, the patient may still apply for financial assistance through day 240. Any ECAs taken against patients during the day 121 – 240 time period after the first post-discharge billing statement must be ceased, and any adverse impact on the patient must be reversed, if it is determined the patient is FAP eligible.

Any mistakes made in credit reporting or initiation of legal action could not only represent a 501(r) violation but could also expose the hospital to liability under the Fair Credit Reporting Act (FCRA). For those reasons alone, ECA will need to be used carefully and sparingly until there is more clarity on how courts will treat hospitals’ interpretation and application of the rules.

Conclusion

This two-page summary provides just a hint of the 501(r) rule requirements, changes and risks. The IRS itself provides a guide to the rationale behind the rule and its interpretation in Bulletin 2015-5, which is a 47-page document. Adreima has developed a checklist of more than 50 action items that charitable hospitals need to address to ensure they continue to receive tax-exempt status. The activity is beyond the scope of the compliance department and requires education, communication and process changes that cut across financial and clinical operations. Contact Adreima to learn more about how to comply with 501(r) requirements and the resources that are available to help.