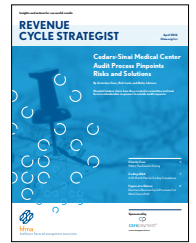


REVENUE CYCLE STRATEGIST

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501(r): The Clock Is Ticking

By Brian Graves

Hospitals cannot afford to be out of compliance with 501(r) because their 501(c)(3) favorable tax statuses would be in jeopardy.

After several years of consideration, the Internal Revenue Service released on Dec. 29, 2014, the final 501(r) rules for hospital financial assistance policies and emergency medical care. Like other healthcare regulations, including the most recent delay of ICD-10 from October 2014 to October 2015, the 501(r) regulations took some time to become finalized. Now that the regulations, which are part of the Affordable Care Act (ACA), have been agreed upon and issued, for those organizations that have not finished their work to comply with 501(r), there is no time to waste.

What Are the Rules?

The rules itemize new requirements that must be satisfied for charitable 501(c)(3) hospitals, and they set operational requirements for these organizations to retain their favorable tax status. The final rules focus on four general requirements for hospitals on a facility-by-facility basis.

- > Establish written financial assistance policies and emergency medical care policies.
- > Limit amounts charged for emergency or other medically necessary care to individuals eligible for assistance under a hospital's financial assistance policy.
- > Make reasonable efforts to determine whether individuals are eligible for assistance under a hospital's financial assistance policy before engaging in extraordinary collections actions (ECA) against individuals.
- > Conduct a community health needs assessment (CHNA) and adopt an implementation strategy at least once every three years.



Which Organizations Must Comply, and When?

Hospitals with 501(c)(3) statuses are covered under the regulations. For organizations with multiple facilities or hospitals, all facilities must report separately on their activities, policies, and practices. Organizations with multiple physical buildings under single licenses are considered single hospital facilities. Government hospitals are covered as well if they are exempt under 501(c)(3). The rules go into effect in the fiscal year following Dec. 29, 2014. For organizations with a Jan. 1 fiscal year, these regulations are already in effect. For those with July 1 and Oct. 1 fiscal years, the time when these rules have an impact is fast approaching.

Why Does 501(r) Matter?

Hospitals cannot afford to be out of compliance with 501(r) because their 501(c)(3) favorable tax statuses would be in jeopardy. The ACA also added section 4959, which imposes a \$50,000 excise tax on hospital organizations that fail to meet the CHNA requirements of 501(r) for any taxable year.

Where Should Hospitals Begin?

The first priority for hospitals, because compliance with 501(r) in part stems from organizations' written financial assistance policies, is to review and document current financial assistance policies and have them reviewed by legal counsel. If a hospital's financial assistance policies haven't been reviewed in the last 12 months, senior leaders should consider taking a closer look at them immediately for issues specifically related to 501(r) and some of the larger changes driven by the ACA that may change how that hospital provides financial assistance today.

For example, now that the ACA has moved at least 9 million patients from uninsured status to a form of government insurance under the bronze, silver, gold, and platinum plans, should hospitals evaluate those patients who have gained coverage under the ACA for financial assistance to pay the balance after insurance owed by those patients when they

were previously uninsured? It is common for previously uninsured patients now covered by ACA plans to still not be able to cover the significant patient responsibility required by these high-deductible health plans. Organizations must now decide on and document their approaches to evaluating this relatively new patient population for financial assistance and whether their balances after insurance, regardless of the sources, should be included in balances evaluated for financial assistance.

Web Extra

Access a 501(r) compliance checklist at hfma.org/rcs/501rComplianceChecklist.

How Has Presumptive Eligibility Been Affected?

The regulations describe that hospitals are permitted to determine if patients are eligible for financial assistance based on information other than that provided directly by patients. This allows the use of presumptive charity categories and models. Hospitals can describe in their policies that patients presumptively qualify for charity assistance if they meet the conditions for means-tested programs, such as the Supplemental Nutrition Assistance Program (SNAP), and the eligibility criteria for those programs are similar to the hospital policy. In addition, hospitals can use predictive models to assess and determine charity presumptively. The bottom line: If hospitals choose to use methods of presumptive charity determination, those methods must be described in presumptive charity policies. An important part of any presumptive charity policy is stating what constitutes substitute documentation on the patient account, such as an approval under another public program or information returned via an electronic screening process.

When Should We Offer Presumptive Charity Care?

Some hospitals and health systems utilize predictive presumptive charity screening technology at day 120 for currently uninsured patients. However, the question arises whether hospitals are required to screen insured patients' balances after insurance as well for charity care eligibility.

The decision to grant presumptive charity to balances after insurance is not an arbitrary decision for presumptive charity screening selection. It is governed by hospital financial assistance policies (FAPs). Keep in mind that presumptive charity screening should be built to emulate hospitals' FAPs. If a hospital provides free or discounted care for balances after insurance, then it should screen for balance after insurance prior to bad debt. It is important to deploy consistent processes that screen all patients using consistent measures. Of course, depending on what ECAs hospitals conduct and how their FAPs describe what accounts are eligible for free care, it is acceptable to exclude deductibles and other accounts based on types of service or balances from consideration under FAPs. It is common practice to screen balance after insurance accounts for presumptive charity, but most hospitals set balance thresholds for small balance and deductibles, and the selection criteria are specifically stated in the hospitals' FAPs.

What Do the Rules Say About Partial Discounting?

Some hospitals have asked whether the "less than most generous financial assistance" provision within 501(r) mean that they should move away from granting presumptive partial charity awards. Most hospitals do not use partial discounting—meaning that charity care is granted at less than the most generous level available—for presumptive charity, although they may deploy partial discounting in their traditional FAP approaches. The IRS does have specific rules that require patient notification of partial discounting decisions for presumptive charity. Patient notifications are not required when patients are granted

free care at the most generous level using electronic presumptive charity tools.

It is likely that traditional FAP procedures will continue to deploy partial discounting because determinations for partial discounts are part of traditional charity application processes. Partial discounting improves affordability and is an important tool for patients and hospitals. If hospitals decide to use tools for any amounts less than the most generous level, they should be sure to abide by the patient notification rules for partial discounting as described in the regulations.

Don't Let Time Run Out

For hospitals with a fiscal year that ends on Dec. 31, 501(r) is a present-day reality. For those with fiscal years that end later in 2016, time is running out to have compliant FAPs in place that address the 501(r) rules. There are concrete steps hospitals can take to mitigate their risks while clarifying and documenting their current processes for administering FAPs. Beware of cut-and-paste approaches. They can be risky. Serious thought should be given to FAPs because authorized body or board approval is now required. Also think about how the rules may provide opportunities to improve your community benefit through presumptive charity. The bottom line is for hospitals

to start now if they haven't already. There is too much at risk to wait any longer. •

Disclaimer: The preceding information is not intended as legal advice and may not be used as legal advice. Legal advice must be tailored to the specific facts and circumstances of each case. Every effort has been made to ensure that the information contained in this article is up-to-date as of the date of publication. It is not intended to be a full and exhaustive explanation of the law in any area, nor should it be used to replace the advice of your own legal counsel.

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