LONG-AWAITED FINAL 501(R) REGULATIONS ISSUED: ARE YOU PREPARED?

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OBJECTIVES

• What are the general requirements of a Community Health Needs Assessment (CHNA)?
• What are the essential elements of a compliant financial assistance policy (FAP)?
• What are my options for computing amounts generally billed?
• What types of reasonable efforts are required before initiating an extraordinary collections action?
• What are the consequences of non-compliance?
• What encompasses the term “executive compensation”?
  ▪ Are your officers protected?
RECENT BACKGROUND – HOW DID WE GET HERE?

• Senator Charles Grassley
• IRS Exempt Organizations Hospital Study
• Affordable Care Act
• Notice 2010-39
• Notice 2011-52
• 2012 Proposed Regulations
• 2013 Proposed Regulations
• Notice 2014-2 & 2014-3
• Final Regulations
501(r)

- CHNA 501(r)(3)
- Written FAP Policy 501(r)(4)
- Limits on Charges 501(r)(5)
- Reasonable Efforts before ECAs 501(r)(6)

= Tax-Exempt Hospital
DEFINITIONS - HOSPITAL FACILITIES & ORGANIZATIONS

- Hospital organizations must comply with 501(r)
- Hospital facility – required by a state to be licensed, registered or similarly recognized as a hospital
- Multiple buildings operated under a single state license are considered a single facility
WHEN MUST HOSPITALS BE IN FULL COMPLIANCE WITH FINAL REGULATIONS?

• By beginning of first tax year beginning after December 29, 2015

• First impacted hospitals are calendar year entities that must be in compliance on January 1, 2016

• “Reasonable interpretation” required until then
HOSPITAL FACILITIES & ORGANIZATIONS

• Dual status hospitals must comply with 501(r)
  ▪ However, may voluntarily terminate 501(c)(3) status
    • 7.04 (14) of Rev Proc 2014-4

• Applicability to hospital-owned entities depends on federal tax classification
  ▪ Wholly or partially owned corporation does not have to comply
  ▪ Disregarded entity must comply
  ▪ Partnership depends
Section 501(r)(3) – Community Health Needs Assessment (CHNA)
GENERAL CHNA REQUIREMENTS

- Must be completed at least once every three years
- Define community served by the hospital
- Solicit and take into account input from the persons who represent broad interests for the community
- Document your CHNA in a **WRITTEN** report
- CHNA **AND** implementation strategy must be adopted by an authorized body of the hospital facility
- Make CHNA widely available to the public
PENALTY FOR NONCOMPLIANCE

• $50,000 Penalty for noncompliance
  ▪ Excise Tax

• Penalty is applied to each noncompliant hospital facility operated by the organization

• Penalty is disclosed on Schedule H on the Form 990
  ▪ Why is this important – any thoughts?
CHNA – UPDATES FROM FINAL REGULATIONS

• An evaluation of impact of any actions taken since hospital facility finished conducting its immediately preceding CHNA to address significant health needs identified in the hospital facility’s prior CHNA(s)

• Collaborating organizations may participate in joint CHNA
IMPLEMENTATION STRATEGY

• Final regulations maintain extension of time for implementation strategies to be adopted by an authorized body of the hospital facility.
  ▪ Extended due date is on or before the 15th day of the 5th month after the end of such taxable year.

• Like the CHNA, the adopted implementation strategy must be made widely available to the public.

• Implementation strategy should include significant needs identified in the CHNA.
Section 501(r)(4) – Financial Assistance Policy
FINANCIAL ASSISTANCE POLICY

- Eligibility criteria
- Adoption of FAP by authorized body of hospital
- Basis for calculating amounts charged
- Other sources hospital uses to make FAP determination
- Policy relating to Emergency Medical Care
- Method for applying
- List all providers delivering emergency or medically necessary care
- Actions that may be taken for nonpayment
In addition to being written, the FAP and Emergency Care Policy must be adopted by an authorized body of the hospital facility.

Must apply to all emergency & other medically necessary care, including all such care provided by a substantially related entity.

**Substantially related entity**
- Entity treated as a partnership for federal tax purposes in which hospital owns a capital or profits interest
- Disregarded entity
- Provides emergency or other medically necessary care in hospital facility, unless provision of care is an unrelated trade or business

Medically necessary care may be defined under state laws, Medicaid definition, generally accepted standards of medicine or an examining physician’s determination.
FINANCIAL ASSISTANCE POLICY

- Required to list providers delivering emergency or other medically necessary care
  - Specify whether covered by FAP
  - If emergency room is outsourced to third party & not covered under FAP, may not be considered to operate an emergency room for community benefit standards
FINANCIAL ASSISTANCE POLICY

• Explain basis for amounts charged to patients
  ▪ IRS recognizes discounts might be offered outside of FAP, such as uninsured or prompt pay
  ▪ Those discounts do not have to comply with 501(r)
  ▪ They also do not count as “community benefit” for Schedule H reporting purposes or evaluating hospital’s exempt status
METHODS FOR APPLYING FOR FINANCIAL ASSISTANCE

• FAP must describe how an individual applies for financial assistance under the FAP.
• FAP or FAP application must describe the information and documentation the hospital facility may require an individual to provide as part of his or her FAP application.
• May grant assistance based on evidence other than that described in FAP.
• May (but not required to) obtain information orally from applicant.
WIDELY PUBLICIZING THE FAP

• FAP, FAP application form & a plain language summary of FAP must be available on a website
• Paper copies available upon request
• Conspicuous public displays reasonably calculated to attract visitors’ attention
• Notify residents of community in a manner reasonably calculated to reach those who are most likely to require assistance
WIDELY PUBLICIZING THE FAP

- Final regulations eliminate requirement to list measures taken to widely publicize the FAP
- Provide FAP information to patients before discharge & with billing statements
  - This requirement was moved from 501(r)(6) proposed regulations
  - Billing statement must include a conspicuous written notice that notifies recipient of the FAP & includes contact information
  - Plain language summary *offered* as part of either “intake or discharge process”
PLAIN LANGUAGE SUMMARY

Plain language summary

Brief description of eligibility requirements & assistance offered
Direct website address & physical location for copies
How to apply for financial assistance

Brief summary of how to apply for assistance under FAP
How to obtain free copy by mail
Contact info (office or dept that can provide assistance)

Statement of available translations (if applicable)
Statement that no FAP-eligible patient will be charge more than AGB
Provide when sending individual written notice about potential ECAs
TRANSLATING FAP DOCUMENTS

• Translation threshold changed to include LEP language groups that constitute 5% or 1,000, whichever is less, of population of persons likely to be affected

• May use any reasonable method to determine LEP populations
ESTABLISHING FAP & RELATED POLICIES

• Multiple hospital facilities may have identical policies or share a joint policy
• However, each facility may have different AGB percentages &/or calculation methods, & these need to be clearly reflected
• Gather pertinent policies
• Perform “gap” analysis
• At a minimum, you will likely need to
  ▪ Draft plain language summary
  ▪ If your hospital outsources to outside providers, list those providers &
    determine whether FAP applies
  ▪ If your hospital uses presumptive measures, evaluate whether these
    are adequately described in your FAP
• If your hospital offers discounts outside the FAP, evaluate how those discounts interact
  ▪ Converting what could be “charity care” to a contractual allowance
    may have a negative impact
• Impact of states that have expanded Medicaid, increase in high-deductible plans & shift in where charity care is
  generated
Section 501(r)(5) – Limitation on Charges
LIMITATION ON CHARGES

• Must limit amounts charged for care provided to a FAP eligible individual to
  ▪ Not more than amounts generally billed (AGB) to individuals who have insurance covering such care in case of emergency or other medically necessary care
  ▪ Less than gross charges for all other medical care

• Billing statement may state gross charges & apply discounts provided actual amount individual is personally responsible for is less than gross charges
May change method used to determine AGB at any time
FAP should be updated to include changes prior to implementing
Different facilities operated by same organization may use different methods
Individual only considered “charged” for amount he or she is personally responsible for paying, after all deductions, discounts & insurance reimbursements have been applied
AMOUNTS GENERALLY BILLED

Look-back method

Prospective method
LOOK-BACK METHOD

• Calculate at least annually
• Divide sum of amounts of claims for emergency & other medically necessary care that have been allowed by health insurers (defined on next slide) during a prior 12-month period by sum of associated gross charges
• Include full amount allowed by health insurer including amount individual is personally responsible for
HEALTH INSURERS USED IN LOOK-BACK COMPUTATION

• Choose between the following
  ▪ Medicare fee-for-service
  ▪ Medicare fee-for-service & all private insurers that pay claims to hospital facility or
  ▪ Medicaid, either alone or in combination with insurers described above
LOOK-BACK METHOD

• May use one overall percentage or multiple AGB percentages for separate categories of care
• Begin using by 120th day after end of 12-month period
• May choose to use claims allowed for all medical care rather than just for emergency & other medically necessary care
• Hospital facilities under same Medicare provider agreement may calculate one AGB percentage
PROSPECTIVE METHOD

Determine AGB

Use same billing & coding process

Medicare fee-for-service, Medicaid or both
SAFE HARBOR FOR CERTAIN CHARGES IN EXCESS OF AGB

• Hospital will remain in compliance if more than AGB is charged under these conditions
  ▪ Charge was not made or requested as a pre-condition of providing medically necessary care to FAP-eligible individual
  ▪ Complete FAP application has not been submitted or individual has not otherwise been determined as FAP-eligible
  ▪ If a FAP application is subsequently submitted & individual is eligible, any excess collected is refunded unless amount is less than $5
ADDITIONAL THOUGHTS ON 501(R)(5)

• Many hospitals moving away from sliding scale & to one or two discount levels
• Small FAP discounts can be problematic
• Must weigh complexity of AGB computations with financial impact
• Keep in mind IRS has not mandated what criteria is used for financial assistance
Section 501(r)(6) – Billing & Collection
BILLING & COLLECTION

Reasonable Efforts

FAP Determination

Extraordinary Collection Actions (ECAs)
EXTRAORDINARY COLLECTION ACTIONS

• Selling an individual’s debt to another party (some exceptions apply)
• Reporting adverse information to consumer credit reporting agencies or credit bureaus
• Deferring or denying, or requiring payment before providing, medically necessary care because of nonpayment of previously provided care under the FAP
• Actions that require a legal or judicial process
DEBT SALE EXCEPTION

• Debt sale is not an ECA if
  ▪ Purchaser is prohibited from engaging in ECA
  ▪ Purchaser is prohibited from charging interest in excess of IRS rates
  ▪ Debt is returnable or recallable upon subsequent FAP determination
  ▪ If not returnable or recallable, purchaser is required to adhere to appropriate discounts
Presumptive determinations

- No longer required to offer most generous discount
- Notify individual regarding basis for determination & way to apply for more generous care
- Gives individual a reasonable amount of time
- Accepts a completed application within the application period & determines eligibility
REASONABLE EFFORTS

• Refrain from engaging in ECA for at least 120 days from first post-discharge billing statement

• Give individuals submitting an incomplete application instructions & reasonable opportunity to appropriately complete

• If aggregating multiple episodes of care, must wait 120 days from first post-discharge billing for most recent episode of care
REASONABLE EFFORTS

• Obtaining a waiver does not constitute a reasonable effort
• Agreements with third parties must be legally binding written agreement designed to ensure no ECA is initiated until reasonable efforts have been made
• Documents may be provided electronically to any individual who indicates he or she prefers electronic communications
APPLICATION PERIOD

• Period in which hospital must accept & process financial assistance applications

• Begins on date care is provided & ends 240th day after first post-discharge billing statement (subject to certain exceptions for incomplete applications or presumptively determined individuals)
REASONABLE EFFORTS

• Must do following at least 30 days before ECA
  ▪ Provide written notice financial assistance is available, identify ECAs & state a deadline no earlier than 30 days after notice is provided
  ▪ Provide plain language summary with written notice
  ▪ Reasonable effort to orally notify
COMPLETE FAP APPLICATIONS

• If received during application period, hospital will have made reasonable efforts if
  ▪ ECAs are suspended
  ▪ Makes financial assistance determination
  ▪ If eligible, provides a revised billing statement
  ▪ Refunds excess payments unless amount is less than $5
  ▪ Takes all reasonably available measures to reverse any ECA

• May postpone financial assistance determination until after Medicaid eligibility is determined
ADDITIONAL THOUGHTS ON 501(R)(6)

• Seems that many hospitals have separate billing & collection policy; make sure it is appropriately approved
• Review billing statements
• Closely review contracts with third-party collection agencies
• Review policies & procedures for writing off bad debts alongside billing & collection practices
• Review ECAs
OVERALL THOUGHTS & RECOMMENDATIONS

• Form a compliance team
• Develop a timeline for implementation
• Consider “gap” analysis
• Consider developing tools & processes to continually monitor ongoing compliance (potentially an internal audit function)
• Don’t forget to consider potential state law & reimbursement considerations
• Many of changes made from proposed regulations would be considered hospital friendly
• It is likely every hospital will have to make some changes to policies & procedures to fully comply with final regulations
Executive Compensation - Are You and Your Organization Covered?
A disqualified person – is any person who is or was in a position to exercise substantial influence (whether exercised or not) of the affairs of the tax-exempt organization at any time during the look back period
- Many of you in this room!
- The look back period is five years prior to when the excess benefit transaction took place

Disqualified persons include
- Voting board members
- Executives of the organization,
- Family members & controlled entities of disqualified persons
ESTABLISHING EXECUTIVE COMPENSATION (THINK DISQUALIFIED PERSON(S))

- In establishing a **disqualified person’s** total compensation, all **CASH & NONCASH** benefits are considered. Noncash taxable benefits can include, but are not limited to:
  - Employee Travel – first class or charter travel
  - Travel for companions
  - Club dues
  - Premiums paid by the organization on life insurance where the organization is not the beneficiary
  - Personal use of automobiles
  - Housing allowance
  - Personal services (maid, chauffer, chef)
EXCESSIVE COMPENSATION

• **Excessive Compensation** is compensation in excess of reasonable compensation
  
  ▪ **Reasonable compensation** is the value that would be paid to a person in a similar position, with similar duties, in a similar geographic region with a similar size organization (whether taxable or tax-exempt)
  
  • The section 162 standard
EXCESS BENEFIT TRANSACTION (EBT)

• The IRS defines an **Excess Benefit Transaction (EBT)** as a transaction which an economic benefit is provided by the tax-exempt organization directly or indirectly, to or for the use of a **disqualified person**, & the value of the economic benefit provided by the organization exceeds the value of the consideration received by the organization
  - What does this really mean?
  - Does anyone in your organization have this?
  - This should be addressed on a continual basis
  - Are there automatic benefit transactions?
EBT CONSEQUENCES – TAXES!!

- 25% excise tax on EACH excess benefit transaction
  - Disqualified person must pay the EBT back to the organization
  - Disqualified person is responsible for this tax
- 10% excise tax on the Manager who knew of the transaction
  - Only imposed if 25% tax was assessed
  - Cannot be > $20,000 – single transaction
  - Could potentially be liable for both excise taxes
- FYI – If EBT is egregious enough – IRS has the right to revoke the organization’s exempt status. Don’t let this happen!
CORRECTING AN EXCESS BENEFIT TRANSACTION

- Disqualified Persons **MUST**
  - Undo the transaction – make the organization whole
  - EBT – must be paid in cash or cash equivalents – **NO** promissory notes!
  - Correction amount is the excess benefit plus interest (no lower than applicable federal rate)
  - Cannot transfer property
- Exceptions to EBT
  - Initial Contract Rule – An "initial contract" is a binding written contract between an applicable tax-exempt organization & a person who was not a disqualified person immediately prior to entering into the contract
  - Nontaxable fringe benefits
  - Expense reimbursements under an accountable plan
REBUTTABLE PRESUMPTION OF REASONABLENESS (PAY ATTENTION TO THIS SLIDE!!)

• Per the IRS, if an organization meets the following three requirements, payments it makes to a disqualified person under a compensation arrangement are presumed to be reasonable, & a transfer of property or the right to use property is presumed to be at fair market value. The three requirements for establishing the rebuttable presumption are

1. The compensation arrangement must be approved in advance by an authorized body of the applicable tax-exempt organization, which is composed of individuals who do not have a conflict of interest concerning the transaction,

2. Prior to making its determination, the authorized body obtained & relied upon appropriate data as to comparability &

3. The authorized body adequately & timely documented the basis for its determination concurrently with making that determination
**EXAMPLE**

- Ryan received cash & noncash compensation in 2013 totaling $225,000
- No rebuttable presumption was established
- IRS audited Ryan’s organization & determined reasonable compensation for his position was $200,000
- The burden of proof that Ryan’s compensation is reasonable now falls on the organization & they must do their due diligence to prove their case to the IRS
- If organization fails to successfully defend Ryan’s compensation – the following equation is what Ryan & the officers of the organization who knowingly approved his compensation are in for
EXAMPLE

Ryan’s compensation received in 2013 $225,000
IRS deemed reasonable compensation (200,000)
Excess compensation $ 25,000

- Ryan owes $25,000 (back to the organization) within 30 days. Again, must be cash & cannot be a promissory note – PLUS
- 25,000 x 25 % Excise Tax = $6,250 (Due to the IRS) – PLUS
- Interest on the $25,000 (Due to the organization) at the applicable federal rates at that time
- Organization’s managers who knew & approved of Ryan’s compensation above reasonable or FMV – would be assessed the following
  - 25,000 x .10 = 2,500 – penalty each!
Determine whom in your organization are disqualified persons

Look at all of the compensation each person is receiving
  - Remember cash & noncash items

Do your research – is this compensation REASONABLE & COMPARABLE

Establish the rebuttable presumption for each disqualified person
  - Document, document, document!!

Remember, this is not a one-time deal. This process must be done annually
  - It’s worth the time & effort – you & your employees will appreciate it!

SO ... WHAT SHOULD YOU DO NOW?
THANK YOU!
FOR MORE INFORMATION

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