

Patient Protection Regulations for 501(c)(3) Tax-Exempt Hospitals

Over the last several years charitable hospitals have been keeping an eye on the requirements of Code Section 501(r), which was added by the Patient Protection and Affordable Care Act. In 2012 and 2013, the Internal Revenue Service issued proposed regulations to further define the scope of Section 501(r).

Section 501(r) contains operational restrictions and guidelines for charitable hospitals that, if not followed, could result in significant fines and/or loss of tax-exempt status. The IRS issued final regulations under Section 501(r) in December 2014 incorporating most of the proposed rules but making some modifications. Even with the modifications, many charitable hospitals remain concerned about the compliance burden of the new regulations. This post will outline some of the changes to which charitable hospitals should pay close attention, as changes to their internal policies may be in order. However, the new regulations are much larger than can be covered in one blog post, and we invite you to contact our [health care attorneys](#) to learn how these regulations will impact your charitable hospital. **Community**

Health Needs Assessment Under Section 501(r)(3), charitable hospitals must conduct a community health needs assessment (CHNA) every three years and adopt implementation strategies to meet the needs identified in the assessment. However, as under the proposed regulations, the final regulations allow multiple charitable hospitals to produce joint assessments and to share implementation strategies. The proposed regulations required hospitals to include in the CHNA a plan to evaluate the impact of its strategies. The final regulations removed this requirement and instead require a CHNA to include an evaluation of the impact of the actions taken by the hospital following its *prior* CHNA. The final regulations also provide some relief on the timeframe for adopting its implementation strategies by extending the deadline to the 15th day of the fifth month after the taxable year in which the CHNA was conducted. **Financial Assistance Policy** Section 501(r)(4) requires charitable hospitals to have a written financial assistance policy including eligibility criteria for financial assistance and the scope of available discounts. Charitable hospitals must also provide at least one plain-language summary of the policy in a post-discharge billing (instead of three, as required under the proposed regulations), and must include a conspicuous written notice about the policy's availability on each billing during the 120 days following discharge. The final regulations add a new requirement to list in the policy all providers in the hospital who provide emergency care and to state whether such providers are covered by the policy.

Limitations on Charges Section 501(r)(5) requires charitable hospitals to discount services charged to patients eligible under the hospitals' financial assistance policy. Specifically, under the proposed regulations, hospitals cannot charge more than the amounts generally billed for emergency or necessary care using one of two methods to determine that amount: the Medicare prospective method or the "look-back" method. The final regulations also permit hospitals to use Medicaid rates. The proposed regulations required a hospital to select one method and stick with it forever, but the final regulations allow a hospital to change, provided it only uses one method at any given time. **Billing and Collection**

Policies Section 501(r)(6) requires charitable hospitals to use "reasonable efforts" to determine if a patient is eligible for discounted or free services in accordance with the hospital's financial assistance policy before engaging in "extraordinary collection actions." The proposed regulations permitted a hospital to presume a patient's eligibility for financial assistance only if the hospital determined that the patient was eligible for the most generous assistance available under its policy. The final regulations permit a hospital to presume eligibility for less than the most generous assistance available under its policy, but only if the hospital notifies the patient of its basis for determining presumptive eligibility, explains the procedure to apply for more generous assistance under the policy, and gives the patient a reasonable period to apply for more generous assistance before initiating extraordinary collection actions. **That's Not All** There are many other requirements in the final regulations, and we encourage

you to review the regulations and/or seek advice from a qualified health care attorney with any questions. If you are a charitable hospital and want to ensure you are in compliance with the new regulations, please contact one of our [Kansas City Health Care Attorneys](#) today. Image:

Thinkstock/chromatika *This article is very general in nature and does not constitute legal advice. Readers with legal questions should consult with an attorney prior to making any legal decisions.