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DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Parts 1, 53, and 602

[TD 9708]

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Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations and removal of temporary regulations.

SUMMARY: This document contains final regulations that provide guidance regarding the requirements for charitable hospital organizations added by the Patient Protection and Affordable Care Act of 2010. The regulations will affect charitable hospital organizations.

DATES: Effective date: The final regulations are effective on **[INSERT DATE OF FILING (PUBLIC INSPECTION) IN THE FEDERAL REGISTER]**.

Applicability date: For dates of applicability, see §§1.501(r)-7(a); 1.6033-2(k)(4); 53.4959-1(b); and 53.6071-1(i)(2).

FOR FURTHER INFORMATION CONTACT: Amy F. Giuliano, Amber L. MacKenzie, or Stephanie N. Robbins at (202) 317-5800 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collection of information contained in these final regulations has been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)) under control number 1545-0047. The collection of information in the final regulations is in §§1.501(r)-3, 1.501(r)-4, and 1.501(r)-6(c). The collection of information is required for hospital organizations to receive the benefits of being described in section 501(c)(3) of the Internal Revenue Code (Code) and flows from section 501(r)(3), which requires a hospital organization to conduct a community health needs assessment (CHNA) and adopt an implementation strategy to meet the community health needs identified through the CHNA at least once every three years; section 501(r)(4), which requires a hospital organization to establish a written financial assistance policy (FAP) and a written policy related to care for emergency medical conditions; and section 501(r)(6), which requires a hospital organization to make reasonable efforts to determine whether an individual is eligible for assistance under a FAP before engaging in extraordinary collection actions. The expected recordkeepers are hospital organizations described in sections 501(c)(3) and 501(r)(2).

1. 2012 Proposed Regulations

On June 26, 2012, the Department of the Treasury (Treasury Department) and the IRS published a notice of proposed rulemaking (NPRM) (REG-130266-11; 77 FR 38148) that contained proposed regulations regarding the requirements of sections 501(r)(4) through 501(r)(6) relating to FAPs, limitations on charges, and billing and

collections (the 2012 proposed regulations). The 2012 proposed regulations estimated that the collection of information in the proposed regulations relating to sections 501(r)(4) and 501(r)(6) would result in an average annual paperwork burden per recordkeeper of 11.5 hours. (The requirements of section 501(r)(3) were addressed in different proposed regulations, released in 2013, and the collection of information associated with those proposed regulations is addressed in section 2 of this portion of the preamble relating to the Paperwork Reduction Act.)

In response to this burden estimate, the Treasury Department and the IRS received 15 comments generally stating that the estimates set forth in the 2012 proposed regulations were too low and that the burden was significantly higher, with some commenters offering estimates ranging between 15 and 38,500 hours annually. However, these commenters provided insufficient information regarding the hours necessary to comply with the information collection requirements of §§1.501(r)-4 and 1.501(r)-6(c) of the 2012 proposed regulations for the IRS to determine why, or by how much, the proposed burden estimate should be increased. A few commenters noted that they would have to devote significant resources up-front to amending policies and procedures and altering information systems.

The Treasury Department and the IRS anticipated an up-front commitment of resources when they derived the 11.5-hour annual burden estimate proposed in the 2012 proposed regulations by dividing an estimated 34.5-hour burden over three years (the maximum OMB approval period for a collection of information burden estimate) by three. It was anticipated that a large share of those 34.5 hours would be devoted to

updating policies, procedures, and information systems in the first year. The Treasury Department and the IRS also expected that hospitals would be building upon existing policies and processes rather than establishing entirely new policies. For example, §1.501(r)-6(c)(2) of the 2012 proposed regulations was intended to enable hospitals to notify patients about the FAP primarily by adding information to billing statements, necessitating some time to change the template of the billing statement but presumably relatively little time thereafter. However, in light of the comments received, the Treasury Department and the IRS have increased their estimate of the average amount of time a hospital organization will devote to amending policies and procedures and altering information systems in the first year to come into compliance with §§1.501(r)-4 and 1.501(r)-6(c) to 60 hours (with additional time needed each year to implement the requirements).

One commenter stated that hospitals' experience in administering charity care programs under existing state law required more than 100 annual staff hours per hospital, and that the 2012 proposed regulations would increase that burden. However, the total amount of time spent administering charity care programs in general under the commenter's state law is not equivalent to the amount of time necessary to comply with the collection of information requirements, in particular, in the 2012 proposed regulations.

Most of the 38,500 burden hours that one commenter estimated for the paperwork burden resulting from the 2012 proposed regulations was based on the time the commenter estimated would be spent by 16 financial counseling staff members to

provide direct patient counseling. While providing direct patient financial counseling is a commendable activity that would help ensure that patients obtain the financial assistance for which they are eligible, the burden estimates under the Paperwork Reduction Act are limited to collections of information authorized or imposed by the statute and regulations, and, therefore, such counseling activity would not be captured in the estimates.

The Treasury Department and the IRS also note that, in response to comments, these final regulations contain several changes intended to reduce the paperwork burden of the 2012 proposed regulations. Most significantly, numerous commenters noted that the requirement in §1.501(r)-6(c)(2) to include a plain language summary of the FAP with all (and at least three) billing statements during a 120-day notification period would add significantly to the cost of mailing the billing statements and be a waste of paper. In response to these comments, rather than requiring a plain language summary with every bill issued during the notification period, the final regulations instead require a hospital facility to include on each billing statement a conspicuous written notice that notifies and informs patients about the availability of financial assistance, including both a telephone number of the office or department that can provide information about the FAP and FAP application process and the direct Web site address (or URL) where copies of the FAP, FAP application form, and plain language summary of the FAP may be obtained. Additionally, the final regulations require a plain language summary to be included with only one post-discharge communication and give a hospital facility the flexibility to send this one plain language summary only to the

subset of patients against whom the hospital facility actually intends to engage in extraordinary collection actions. These changes are intended to maintain the frequent reminders to patients of the availability of financial aid while reducing the burden and cost of mailing multiple copies of a plain language summary of the FAP.

The one change in the final regulations that may materially increase the paperwork burden relates to translations of the FAP and related documents. The 2012 proposed regulations required a hospital facility to translate its FAP (as well as the FAP application form and plain language summary of the FAP) into the primary language of any populations with limited English proficiency (LEP) that constitute more than 10 percent of the residents of the community served by the hospital facility. In response to comments discussed in section 4.a.iv.F of this preamble, the final regulations change that threshold to 5 percent or 1,000, whichever is less, of the population of individuals likely to be affected or encountered by the hospital facility. This may increase the overall number of translations that hospital organizations affected by the final regulations will be required to make.

Taking into account all of the comments received, as well as the changes made in these final regulations that will affect the paperwork burden, the Treasury Department and the IRS have adjusted their burden estimate for §§1.501(r)-4 and 1.501(r)-6(c) to 60 hours per recordkeeper of up-front time to update information systems and draft and amend policies, procedures, and template billing statements and notifications, plus 15 hours per recordkeeper per year for each of three years to implement the collection of information requirements. This results in a total of 105 hours over a three-year period,

or an average of 35 hours per year per recordkeeper, up from the estimate of 11.5 hours per year per recordkeeper proposed in the 2012 proposed regulations. The Treasury Department and the IRS note that the burden estimates must be updated every three years and that future estimates can be amended to reflect hospitals' actual experience in implementing the collection of information requirements in §§1.501(r)-4 and 1.501(r)-6(c).

2. 2013 Proposed Regulations

On April 5, 2013, the Treasury Department and the IRS published a NPRM (REG-106499-12; 78 FR 20523) that contained proposed regulations regarding the CHNA requirements under section 501(r)(3) (the 2013 proposed regulations). The 2013 proposed regulations estimated that the collection of information in the proposed regulations would result in an average annual paperwork burden per recordkeeper of 80 hours. In response to this burden estimate, the Treasury Department and the IRS received 10 comments stating generally that the estimates set forth in the 2013 proposed regulations were too low and that the burden was significantly higher, with most commenters stating that satisfying the requirements described in the 2013 proposed regulations would necessitate "thousands of hours." However, because commenters provided little specific information regarding the hourly burden of activities that are required to comply with the collection of information required by section 501(r)(3), it is difficult for the Treasury Department and the IRS to determine how to appropriately revise the burden estimate.

The Treasury Department and the IRS note that a hospital organization only has

to satisfy the CHNA requirements once every three years, and the burden estimate reflected in the 2013 proposed regulations was 240 hours per CHNA, averaged over three years. In addition, the Treasury Department and the IRS recognize that the amount of time hospitals devote to their CHNAs will vary greatly depending on their size and resources and whether they choose to collaborate with other organizations and facilities in conducting their CHNAs.

One commenter asked that the IRS clarify its definition of “recordkeeper” to indicate that the estimate is for a hospital organization with a single hospital facility and that a hospital organization with multiple hospital facilities would have an estimated burden that would be multiplied by the number of hospital facilities. However, both the 2013 proposed regulations and these final regulations allow hospital organizations with multiple hospital facilities to collaborate and produce one joint CHNA report and implementation strategy for all of its hospital facilities, provided the hospital facilities define their communities to be the same. As a result, the Treasury Department and the IRS do not believe the burden estimate will necessarily increase in direct relation to the number of hospital facilities operated. On the other hand, the Treasury Department and the IRS do recognize that some hospital facilities operated by the same organization will define their communities to be different and will therefore conduct separate CHNAs and produce separate CHNA reports. For purposes of estimating the total paperwork burden, and in the absence of data on which hospital facilities will conduct joint CHNAs and which will not, the Treasury Department and the IRS have assumed that hospital facilities operated by hospital organizations with three or fewer hospital facilities will

produce joint CHNA reports and hospital facilities operated by hospital organizations with more than three hospital facilities will conduct separate CHNA reports. Based on the latest available IRS data on the number of hospital organizations and facilities, the assumption that hospital organizations operating more than three hospital facilities will conduct separate CHNAs for each hospital facility increases the average annual burden associated with the CHNA requirements per hospital organization from 80 to 101 hours. The Treasury Department and the IRS note that the burden estimates must be updated every three years and that future estimates can be amended to reflect hospitals' actual experience in implementing the collection of information requirements in §1.501(r)-3.

3. Adjusted Burden Estimates for Final Regulations

After taking into account all the comments and information available and based on the latest IRS data on the number of hospital organizations and facilities, the Treasury Department and the IRS have reached the following reporting burden estimates:

Estimated total annual reporting burden: 401,905

Estimated average annual burden hours per recordkeeper: 136 hours

Estimated number of recordkeepers: 2,955

Estimated frequency of collections of such information: Annual

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number assigned by the Office of Management and Budget.

Books or records relating to a collection of information must be retained as long

as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by section 6103.

Background

Section 501(r) was added to the Code by the Patient Protection and Affordable Care Act, Public Law 111-148 (124 Stat. 119 (2010)) (the Affordable Care Act), enacted March 23, 2010, and imposes additional requirements on charitable hospital organizations. Section 501(r)(1) provides that a hospital organization described in section 501(r)(2) will not be treated as a tax-exempt organization described in section 501(c)(3) unless the organization meets the requirements of sections 501(r)(3) through 501(r)(6). Section 501(r)(3) requires a hospital organization to conduct a community health needs assessment (CHNA) at least once every three years and to adopt an implementation strategy to meet the community health needs identified through the CHNA. Section 501(r)(4) requires a hospital organization to establish a written financial assistance policy (FAP) and a written policy relating to emergency medical care. Section 501(r)(5) requires a hospital organization to not use gross charges and to limit amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the organization's FAP (FAP-eligible individuals) to not more than the amounts generally billed to individuals who have insurance covering such care (AGB). Section 501(r)(6) requires a hospital organization to make reasonable efforts to determine whether an individual is FAP-eligible before engaging in extraordinary collection actions. Section 501(r)(2)(B) requires a hospital organization to

meet each of these requirements separately with respect to each hospital facility it operates.

The statutory requirements of section 501(r) (except for section 501(r)(3)) apply to taxable years beginning after March 23, 2010. Section 501(r)(3) applies to taxable years beginning after March 23, 2012. A hospital organization has had to comply with the statutory requirements of section 501(r) since these applicability dates.

The Affordable Care Act also added section 4959, which imposes a \$50,000 excise tax on a hospital organization that fails to meet the CHNA requirements for any taxable year, and amended section 6033 to add certain reporting requirements related to section 4959 and the CHNA requirements and to require hospital organizations to file a copy of their audited financial statements with their annual information returns.

In May 2010, the Department of the Treasury (Treasury Department) and the IRS issued Notice 2010-39 (2010-24 IRB 756 (June 14, 2010)), which solicited comments regarding the additional requirements imposed by section 501(r). Approximately 125 comments were received in response to Notice 2010-39.

In July 2011, the Treasury Department and the IRS issued Notice 2011-52 (2011-30 IRB 60 (July 25, 2011)), which described (and solicited comments regarding) provisions related to the CHNA requirements that the Treasury Department and the IRS anticipated would be included in proposed regulations. More than 80 comments were received in response to Notice 2011-52.

On June 26, 2012, the Treasury Department and the IRS published a notice of proposed rulemaking in the **Federal Register** (REG-130266-11, 77 FR 38148) (2012

proposed regulations) that contained proposed regulations regarding the requirements of sections 501(r)(4) through 501(r)(6) relating to FAPs, limitations on charges, and billing and collections. The 2012 proposed regulations also defined key terms used throughout the regulations, such as “hospital organization” and “hospital facility.” More than 200 written comments were received in response to the 2012 proposed regulations, and a public hearing was held on December 5, 2012.

On April 5, 2013, the Treasury Department and the IRS published a notice of proposed rulemaking in the **Federal Register** (REG-106499-12, 78 FR 20523) (2013 proposed regulations) that contained proposed regulations regarding the CHNA requirements of section 501(r)(3), the related reporting obligations under section 6033, the excise tax under section 4959, and the consequences for failing to meet any of the section 501(r) requirements. The 2013 proposed regulations also added a few additional defined terms and made minor amendments to the definitions of “hospital organization” and “hospital facility” contained in the 2012 proposed regulations. More than 90 written comments were received in response to the 2013 proposed regulations. No public hearing was requested or held.

On August 15, 2013, the Treasury Department and the IRS published final and temporary regulations and a cross-reference notice of proposed rulemaking in the **Federal Register** (TD 9629, 78 FR 49681; REG-115300-13, 78 FR 49700) under sections 6011 and 6071, which provided guidance regarding the requirement that a return accompany payment of the section 4959 excise tax for failure to meet the CHNA requirements for any taxable year. Specifically, the temporary regulations direct

hospital organizations liable for the tax imposed by section 4959 to file Form 4720, "Return of Certain Excise Taxes Under Chapters 41 and 42 of the Internal Revenue Code," by the 15th day of the fifth month after the end of the organization's taxable year in which the liability was incurred. The cross-reference notice of proposed rulemaking solicited public comments. No public comments were received, and no public hearing was requested or held.

In January 2014, the Treasury Department and the IRS published Notice 2014-2 (2014-3 IRB 407 (January 13, 2014)) to confirm that hospital organizations could rely on both the 2012 proposed regulations and the 2013 proposed regulations, pending the publication of final regulations or other applicable guidance. This Treasury decision obsoletes Notice 2014-2, but the final regulations contained in this Treasury decision continue to allow reliance on both the 2012 proposed regulations and the 2013 proposed regulations until a hospital organization's first taxable year beginning after December 29, 2015.

Also in January 2014, the Treasury Department and the IRS published Notice 2014-3 (2014-3 IRB 408 (January 13, 2014)), which contained, and solicited public comments on, a proposed revenue procedure that provides correction and reporting procedures under which certain failures to meet the requirements of section 501(r) will be excused for purposes of sections 501(r)(1) and 501(r)(2)(B). The Treasury Department and the IRS received six comments in response to Notice 2014-3.

After consideration of the comments received on the 2012 and 2013 proposed regulations, both sets of proposed regulations under section 501(r) are adopted as

amended by this Treasury decision. In addition, this Treasury decision removes the temporary regulations under sections 6011 and 6071 and adopts as amended the proposed regulations that cross-referenced the text of those temporary regulations. The major areas of comment and the revisions are discussed in this preamble. The comments are available for public inspection at www.regulations.gov or on request.

Summary of Comments and Explanation of Revisions

These final regulations provide guidance on the requirements described in section 501(r), the entities that must meet these requirements, and the reporting obligations relating to these requirements under section 6033. In addition, the final regulations provide guidance on the consequences described in sections 501(r)(1), 501(r)(2)(B), and 4959 for failing to satisfy the section 501(r) requirements.

1. Hospital Facilities and Organizations

a. In general

In accordance with section 501(r)(2)(A)(i) and consistent with the proposed regulations, the final regulations define “hospital organization” as an organization recognized (or seeking to be recognized) as described in section 501(c)(3) that operates one or more hospital facilities and define “hospital facility” as a facility that is required by a state to be licensed, registered, or similarly recognized as a hospital. The final regulations refer to hospital facilities taking certain actions, and such references are intended to include instances in which the hospital organization operating the hospital facility takes action through or on behalf of the hospital facility.

Section 501(r)(2)(A)(ii) provides that a hospital organization also includes “any

other organization that the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption” under section 501(c)(3). One commenter requested that this language be incorporated into the definition of “hospital organization” contained in the final regulations.

At this time, the Treasury Department and the IRS have not identified any additional categories of organizations or facilities (other than hospital facilities and organizations operating them) with the principal function or purpose of providing hospital care. If any such categories of organizations or facilities are later identified, the Treasury Department and the IRS will issue proposed regulations identifying them, with the expanded definition applying prospectively only if, and when, the proposed regulations are finalized, after an opportunity for notice and comment.

b. Multiple buildings under a single hospital license

The definition of “hospital facility” in the 2012 proposed regulations provided that a hospital organization “may treat” multiple buildings operated under a single state license as a single hospital facility. To increase the certainty and consistency in the designation of hospital facilities, the 2013 proposed regulations revised this definition to indicate that multiple buildings operated by a hospital organization under a single state license “are” considered a single hospital facility for purposes of section 501(r).

In response to the 2013 proposed regulations, several commenters stated that buildings in different geographic locations that share a license (for example, a hospital facility with satellite sites in various locations) may serve distinct communities and stakeholders, whose needs could be missed or unaddressed if they are aggregated into

one large community served for purposes of the CHNA requirements. Multiple commenters asked that such a hospital facility be given the flexibility to conduct separate CHNAs for its separate buildings, noting that state law may require the facility to file separate implementation strategies for each building describing how each building plans to meet the health needs in its community.

The Treasury Department and the IRS believe that a fixed rule regarding the treatment of multiple buildings under a single state license will provide for consistency and certainty in tax administration and increase the ability of both the IRS and the public to understand and to evaluate information reported on hospital organizations' Forms 990 from year to year. Accordingly, the final regulations continue to provide that multiple buildings operated by a hospital organization under a single state license are considered to be a single hospital facility. The final regulations also clarify that, in the case of a hospital facility consisting of multiple buildings that operate under a single state license and serve different geographic areas or populations, the community served by the hospital facility is the aggregate of such areas or populations. However, in such a case, the hospital facility consisting of multiple buildings could, if desired, assess the health needs of the different geographic areas or populations served by the different buildings separately and document the assessments in separate chapters or sections of the hospital facility's CHNA report and implementation strategy.

c. One building under multiple state licenses

A few commenters asked that the final regulations allow a hospital organization to treat operations in a single building under more than one state license as a single

“hospital facility,” a situation the proposed regulations did not address. These commenters stated that entities operating within the same building have a high degree of integration and similar patient populations and that requiring each licensed facility to comply separately with section 501(r) would impose burdens without benefitting the community served.

The final regulations do not adopt this suggestion because the Treasury Department and the IRS believe that having one definition of “hospital facility” based on state licensure alone is simpler and more administrable. However, the Treasury Department and the IRS note that, as discussed in section 4.c of this preamble, separate hospital facilities within the same building may have identical FAPs and other policies established for them or share one policy document as long as the information in the policy or policies is accurate for all such facilities and any joint policy clearly states that it is applicable to each facility. Furthermore, as discussed in sections 3.a.v and 3.b.iii of this preamble, separate hospital facilities within the same building that define their communities to be the same may conduct a joint CHNA and adopt a joint implementation strategy addressing the significant health needs identified in the joint CHNA. Thus, the final regulations allow for hospital facilities within the same building to jointly comply with many of the section 501(r) requirements.

d. Government hospital organizations

The statutory language of section 501(r) applies to all hospital organizations that are (or seek to be) recognized as described in section 501(c)(3) and does not provide an exception for government hospital organizations. Accordingly, the preamble to the

2012 proposed regulations stated that the Treasury Department and the IRS intend to apply section 501(r) to every hospital organization that has been recognized (or seeks recognition) as an organization described in section 501(c)(3), regardless of whether a hospital organization is a government hospital organization. However, in recognition of the unique position of government hospital organizations, the Treasury Department and the IRS also requested comments regarding alternative methods a government hospital organization could use to satisfy the requirements of section 501(r).

A number of commenters noted that government hospital organizations have long-standing relationships with their communities, are already known as “safety net” health care providers, and are already obligated to provide care regardless of ability to pay (although care is sometimes limited to or prioritized for citizens of the locality that is supporting the hospital). Commenters also stated that government hospital organizations disproportionately serve patients who are uninsured, Medicaid beneficiaries, or hard to reach (such as homeless individuals, migrant workers, and undocumented individuals), and have governance structures that reflect a level of public accountability. Commenters added that, as stewards of public funds, government hospital organizations have an obligation to local taxpayers to ensure that scarce financial resources go toward patient care and not toward unnecessary administrative costs. However, rather than offering alternative methods a government hospital organization could use to satisfy the requirements of section 501(r), these commenters instead effectively requested that the Treasury Department and the IRS provide exemptions from the requirements imposed by section 501(r) for government hospital

organizations. For example, commenters recommended that government hospital organizations be exempted from all of the documentation requirements related to CHNAs, be deemed to have met the FAP requirements by virtue of their public status, or be permitted to charge some FAP-eligible individuals more than AGB as long as the average annual discounted charge provided to FAP-eligible individuals did not exceed AGB.

Other commenters expressed support for applying the requirements of section 501(r) to government hospital organizations, stating that no exceptions for particular categories of section 501(c)(3) organizations are permitted by the statute. Commenters also stated that, from the point of view of individuals seeking or receiving care, most government hospital organizations are indistinguishable from any other section 501(c)(3) hospital organization and that their practices with regard to charges, billing, and collections are substantially the same.

Because section 501(r) has no express or implicit exceptions for government hospital organizations, the final regulations require the section 501(r) requirements to be met by all hospital organizations that are (or seek to be) recognized as described in section 501(c)(3), including those that are government hospital organizations. The Treasury Department and the IRS note, however, that government hospital organizations that have previously been recognized as described in section 501(c)(3) but do not wish to comply with the requirements of section 501(r) may submit a request to voluntarily terminate their section 501(c)(3) recognition as described in section 7.04(14) of Rev. Proc. 2014-4 (2014-1 IRB 125) (or a successor revenue procedure).

A number of commenters asked whether and how government hospital organizations can satisfy the reporting requirements related to CHNAs, given that they are excused from filing a Form 990, "Return of Organization Exempt From Income Tax," under Rev. Proc. 95-48 (1995-2 CB 418). The Affordable Care Act did not change the requirements regarding which organizations are required to file a Form 990. Rev. Proc. 95-48 provides that certain government entities are relieved from any requirement to file a Form 990 (and therefore are relieved from having to disclose information or documents on or with a Form 990). Accordingly, a government hospital organization (other than one that is described in section 509(a)(3)) described in Rev. Proc. 95-48 or a successor revenue procedure is not required to file a Form 990 or include any CHNA-related information with a Form 990. However, to be treated as described in section 501(c)(3), government hospital organizations still must meet all section 501(r) requirements that do not involve disclosure on or with the Form 990, including making their CHNA reports and FAPs widely available on a Web site.

e. Accountable care organizations

Several commenters asked that separate entities cooperating in accountable care organizations (ACOs) or similar integrated care models be treated as a single "hospital organization" for purposes of section 501(r), arguing that this would create administrative efficiencies as the participating organizations develop one standard set of policies and procedures and result in less confusion for patients as they move through a "continuum of care." The final regulations do not adopt this suggestion, but the Treasury Department and the IRS note that, as discussed in section 4.c of this

preamble, multiple hospital facilities may have identical FAPs and other policies established for them or share one joint policy document as long as the information in the policy or policies is accurate for all such facilities and any joint policy clearly states that it is applicable to each facility. Furthermore, as discussed in sections 3.a.v and 3.b.iii of this preamble, separate hospital facilities that define their community to be the same may conduct a joint CHNA and adopt a joint implementation strategy addressing the significant health needs identified in the joint CHNA. Thus, the final regulations provide opportunities for separate hospital facilities participating in an ACO to jointly comply with many of the section 501(r) requirements.

f. “Operating” a hospital facility

The 2013 proposed regulations generally provided that an organization operates a hospital facility if it owns a capital or profits interest in an entity treated as a partnership for federal tax purposes that operates the hospital facility. The final regulations maintain this general rule with two additions.¹ First, the final regulations clarify that an organization is considered to own a capital or profits interest in an entity treated as a partnership for federal tax purposes if it owns such an interest directly or indirectly through one or more lower-tier entities that are treated as partnerships for federal tax purposes.²

¹ The final regulations delete the specific reference to joint ventures and limited liability companies contained in the 2013 proposed regulations because those entities are sufficiently covered by the general phrase “entity treated as a partnership for federal tax purposes.” The final regulations also delete the reference to “members of” an entity treated as a partnership for federal tax purposes because the intended organizations should be captured by the references to owners of a capital or profits interest in the partnership. These changes are not intended to be substantive changes.

² The final regulations also provide that an organization operates a hospital facility if it is the sole member

Second, the final regulations clarify how the question of whether an organization “operates” a hospital facility relates to the question of whether the organization needs to meet the requirements of section 501(r) (and, therefore, would be subject to any consequences for failing to meet such requirements). Specifically, §1.501(r)-2(e) of the final regulations clarifies that a hospital organization is not required to meet the requirements of section 501(r) with respect to any hospital facility it is not “operating” within the meaning of that defined term. In addition, as stated in the preamble to the 2013 proposed regulations, the final regulations provide that a hospital organization is not required to meet the requirements of section 501(r) with respect to the operation of a facility that is not a “hospital facility” because it is not required by a state to be licensed, registered, or similarly recognized as a hospital. The final regulations also provide that a hospital organization is not required to meet the requirements of section 501(r) with respect to any activities that constitute an unrelated trade or business described in section 513 with respect to the hospital organization.

g. Providing care in a hospital facility through hospital-owned entities

A number of commenters asked that the final regulations clarify the extent to which certain section 501(r) requirements apply to hospital-owned physician practices providing care in the hospital, with a few commenters requesting that the section 501(r)

or owner of a disregarded entity that operates the hospital facility. Section 301.7701-2(a) provides that a disregarded entity’s activities are treated in the same manner as a branch or division of the owner. Accordingly, if a hospital organization is the sole owner of one disregarded entity that is, in turn, the sole owner of another disregarded entity that operates a hospital facility, the hospital organization would be considered to operate the hospital facility.

requirements apply to all care provided in a hospital facility by such practices.³

Whether or not the section 501(r) requirements apply to hospital-owned physician practices or other entities providing care in a hospital facility depends upon how the entities are classified for federal tax purposes. For example, a hospital facility would not be required to meet the section 501(r) requirements with respect to a taxable corporation providing care in the hospital facility, even if the corporation is wholly or partially owned by the hospital organization that operates the hospital facility, because the corporation is a separate taxable entity to which section 501(r) does not apply.

By contrast, if a hospital organization is the sole member or owner of an entity providing care in one of its hospital facilities and that entity is disregarded as separate from the hospital organization for federal tax purposes, the care provided by the entity would be considered to be care provided by the hospital organization through its hospital facility. Accordingly, the hospital organization would be required to meet the section 501(r) requirements with respect to care provided by the disregarded entity in any hospital facility that the hospital organization operates.

If a hospital organization owns a capital or profits interest in an entity providing care in a hospital facility that is treated as a partnership for federal tax purposes, the activities of the partnership are treated as the activities of the hospital organization for purposes of determining whether the hospital organization is operated exclusively for exempt purposes or engaged in an unrelated trade or business under generally

³ As discussed in section 4.a of this preamble, in response to comments, the final regulations require a hospital facility's FAP to identify the providers, other than the hospital facility itself, that may deliver emergency or other medically necessary care in the hospital facility and specify which providers are covered by the hospital facility's FAP and which are not.

applicable tax principles. See Rev. Rul. 2004-51 (2004-1 CB 974); Rev. Rul. 98-15 (1998-1 CB 718). Accordingly, emergency or other medically necessary care provided in a hospital facility by a partnership in which the hospital organization operating the facility has a capital or profits interest is treated as care provided by the hospital organization in its hospital facility for purposes of section 501(r). If the provision of such care by the partnership is an unrelated trade or business with respect to the hospital organization, the hospital organization does not have to meet the section 501(r) requirements with respect to the care because, as noted in section 1.f of this preamble, the final regulations provide that a hospital organization is not required to meet the requirements of section 501(r) with respect to any activity that constitutes an unrelated trade or business with respect to the hospital organization. On the other hand, if the provision of emergency or other medically necessary care by the partnership is not an unrelated trade or business with respect to the hospital organization, the final regulations clarify that the hospital organization must meet the requirements of sections 501(r)(4) through 501(r)(6) with respect to such care. The final regulations use a new defined term, “substantially-related entity,” to refer to an entity that is treated as a partnership for federal tax purposes in which a hospital organization owns a capital or profits interest (or a disregarded entity of which the hospital organization is the sole owner or member) and that provides, in a hospital facility operated by the hospital organization, emergency or other medically necessary care that is not an unrelated trade or business with respect to the hospital organization.⁴

⁴ The final regulations also clarify that the term “substantially-related entity” does not include any

h. Authorized body

The 2013 proposed regulations defined the term “authorized body of a hospital facility” to include: (1) the governing body (that is, the board of directors, board of trustees, or equivalent controlling body) of the hospital organization; (2) a committee of, or other party authorized by, the governing body of the hospital organization, to the extent permitted under state law; or (3) in the case of a hospital facility that has its own governing body and is recognized as an entity under state law but is a disregarded entity for federal tax purposes, the governing body of that hospital facility, or a committee of, or other party authorized by, that governing body to the extent permitted under state law.

In cases in which a hospital organization owns a capital or profits interest in a partnership that operates a hospital facility, the Treasury Department and the IRS believe the governing body of the partnership should also be considered an authorized body of the hospital facility, and the final regulations are amended to reflect this change. In particular, the final regulations provide that an authorized body of a hospital facility may include the governing body of an entity that operates the hospital facility and is disregarded or treated as a partnership for federal tax purposes (or a committee of, or other party authorized by, that governing body to the extent such committee or other party is permitted under state law to act on behalf of the governing body), and thus either the governing body (or committee or other authorized party) of the hospital

partnership that qualifies for a grandfather rule included in the 2013 proposed regulations and adopted in the final regulations. Under that rule, an organization will not be considered to “operate” a hospital facility despite owning a capital or profits interest in an entity treated as a partnership for federal tax purposes that operates the hospital facility if it has met certain conditions since March 23, 2010.

organization or of the disregarded entity or partnership may be considered the authorized body of the hospital facility.

Some questions have arisen regarding whether adoption of a CHNA report, implementation strategy, FAP, or other policy by one authorized official of a hospital facility would constitute adoption by an authorized body of the hospital facility for purposes of the regulatory requirements. Under the regulatory definition of “authorized body of a hospital facility” in both the 2013 proposed regulations and these final regulations, a single individual may constitute either a committee of the governing body or a party authorized by the governing body to act on its behalf, provided that state law allows a single individual to act in either of these capacities.⁵

2. Failures to Satisfy the Requirements of Section 501(r)

The Treasury Department and the IRS recognize that errors may occur even in circumstances in which a hospital facility has practices and procedures in place that are reasonably designed to facilitate overall compliance with section 501(r) and has implemented safeguards reasonably calculated to prevent errors. Thus, the 2013 proposed regulations provided that a hospital facility’s omission of required information from a policy or report described in §1.501(r)-3 or §1.501(r)-4, or an error with respect to the implementation or operational requirements described in §§1.501(r)-3 through 1.501(r)-6, would not be considered a failure to meet a requirement of section 501(r) if: (1) the omission or error was minor, inadvertent, and due to reasonable cause, and (2)

⁵ This interpretation of “authorized body of a hospital facility” is consistent with the interpretation of the term “authorized body” under Treas. Reg. §53.4958-6(c)(1)(i). See TD 8978 (67 FR 3076, 3082).

the hospital facility corrected such omission or error as promptly after discovery as is reasonable given the nature of the omission or error.

In addition, to provide an incentive for hospital facilities to take steps not only to avoid errors but also to correct and provide disclosure when they occur, the 2013 proposed regulations provided that a hospital facility's failure to meet one or more of the requirements described in §§1.501(r)-3 through 1.501(r)-6 that is neither willful nor egregious would be excused if the hospital facility corrects and makes disclosure in accordance with guidance set forth by revenue procedure, notice, or other guidance published in the Internal Revenue Bulletin. On January 13, 2014, the Treasury Department and the IRS published Notice 2014-3, which contained a proposed revenue procedure setting forth procedures for correction and disclosure of such failures and solicited public comments regarding the proposed revenue procedure. The Treasury Department and the IRS intend to release a revenue procedure finalizing the guidance proposed in Notice 2014-3 in the near future.

a. Minor omissions and errors

Several commenters supported the proposed approach to minor and inadvertent omissions and errors that are due to reasonable cause, agreeing that if they are promptly corrected upon discovery they should not result in sanctions. Accordingly, the final regulations retain this general approach, with some modifications.

One commenter suggested modifying the proposed rule so that it will apply to omissions or errors that are minor, inadvertent, "or" due to reasonable cause (rather than "and"), stating that an omission or error was unlikely to satisfy all three conditions.

The same commenter noted that “reasonable cause” may be interpreted differently in a variety of circumstances, potentially making this safe harbor too narrow. The Treasury Department and the IRS believe that the insignificance of an omission or error should always be a necessary condition for receiving the benefit of correcting under §1.501(r)-2(b) without any obligation to disclose to the IRS or the public. Thus, the final regulations require an omission or error to be minor in order to be corrected and not considered a failure under §1.501(r)-2(b). However, in response to this comment, the final regulations provide that the option for correction without disclosure provided in §1.501(r)-2(b) will be available if the omission or error is minor and either inadvertent or due to reasonable cause. As noted later in this section of the preamble, the final regulations also clarify the meaning of “reasonable cause” for purposes §1.501(r)-2(b).

Numerous commenters asked for further guidance and specific examples with respect to the types of omissions and errors that would be considered minor, inadvertent, and/or due to reasonable cause, as opposed to those that are excused only if they are corrected and disclosed, as discussed in section 2.b of this preamble. As more experience is gained regarding the types of omissions or errors that typically occur in implementing the section 501(r) requirements, the Treasury Department and the IRS will consider issuing further guidance in this area. In the meantime, the final regulations provide additional guidance regarding the factors that will be considered in determining whether an omission or error is minor and either inadvertent or due to reasonable cause. With respect to minor, the final regulations clarify that, in the case of multiple omissions or errors, the omissions or errors are considered minor only if they are minor

in the aggregate. The final regulations further provide that the fact that the same omission or error has occurred and been corrected previously is a factor tending to show that an omission or error is not inadvertent. Finally, with respect to reasonable cause, the final regulations provide that a hospital facility's establishment of practices or procedures (formal or informal) reasonably designed to promote and facilitate overall compliance with the section 501(r) requirements prior to the occurrence of an omission or error is a factor tending to show that the omission or error was due to reasonable cause.

Commenters also asked for guidance and examples demonstrating how minor omissions or errors should be remedied to avoid sanctions. The final regulations specify that correction of minor omissions or errors must include establishment (or review and, if necessary, revision) of practices or procedures (formal or informal) that are reasonably designed to achieve overall compliance with the requirements of section 501(r). As more experience is gained regarding the types of omissions or errors that typically occur in implementing the section 501(r) requirements, the Treasury Department and the IRS will consider issuing further guidance on the correction of minor omissions or errors.

A few commenters asked that hospital facilities be required to disclose the minor omissions or errors that they correct, either on a Web site or on the Form 990, to increase transparency and encourage continuous improvement. The Treasury Department and the IRS expect that minor omissions or errors will not have a significant impact on individuals in a hospital facility's community and, therefore, will be sufficiently

inconsequential that they do not justify the additional burden of disclosure. Instead, as discussed in section 2.b of this preamble, disclosure is a requirement reserved for those omissions and errors that rise above the level of “minor” and have a broader scope and greater impact on individuals within the hospital facility’s community, as well as those that are neither inadvertent nor due to reasonable cause and thus involve a degree of culpability on the part of the hospital facility.

b. Excusing certain failures if a hospital facility corrects and makes disclosure

The 2013 proposed regulations provided that a hospital facility’s failure to meet one or more of the requirements described in §§1.501(r)-3 through 1.501(r)-6 that is neither willful nor egregious would be excused if the hospital facility corrects and provides disclosure in accordance with guidance set forth by revenue procedure, notice, or other guidance published in the Internal Revenue Bulletin. The 2013 proposed regulations indicated that, for purposes of this provision, a “willful” failure would be interpreted consistent with the meaning of that term in the context of civil penalties, which would include a failure due to gross negligence, reckless disregard, or willful neglect. Several commenters indicated that the reference to “civil penalties” was unclear. In response, the final regulations delete the reference to civil penalties, but continue to provide that a “willful” failure includes a failure due to gross negligence, reckless disregard, and willful neglect -- all terms with well-established meanings in case law -- to assist hospital facilities in distinguishing between a failure that is willful and a failure that may be excused if it is corrected and disclosed.

Similarly, several commenters asked for guidance on what would qualify as

“egregious” noncompliance, recommending that the term should be reserved for actions that are of the utmost seriousness and that would undermine the intent of section 501(r) as a whole. The Treasury Department and the IRS agree with commenters that the term “egregious” should encompass only very serious failures, taking into account the severity of the impact and the number of affected persons, and the final regulations are amended to reflect this. As the Treasury Department and the IRS gain additional experience with the types of failures to meet section 501(r) that occur, examples of failures that are or are not willful or egregious may be provided in future guidance.

A number of commenters suggested that the final regulations should create a rebuttable presumption that a failure that is corrected and disclosed is neither willful nor egregious. Commenters reasoned that such a presumption would ensure that hospital facilities that correct and disclose failures would get some benefit in return for their efforts and reduce uncertainty regarding their section 501(c)(3) status. The final regulations do not provide for such a presumption because correction and disclosure of a failure are not determinative of a hospital facility’s willfulness or the egregiousness of the failure. However, the Treasury Department and the IRS do believe that a hospital facility that corrects and discloses a failure to meet a section 501(r) requirement is less likely to have acted willfully in failing to meet that requirement, and thus the final regulations provide that correction and disclosure of a failure is a factor tending to show that an error or omission was not willful.

A few commenters questioned whether a system of correction and disclosure should be sufficient to prevent revocation of section 501(c)(3) status, with one

commenter asking that proposed §1.501(r)-2(c) be struck in its entirety. The Treasury Department and the IRS believe that the statute's objectives of promoting transparency of hospital facilities' CHNAs and FAPs and of providing protections to FAP-eligible patients with respect to charges and collections are well served by a system that encourages hospitals to adopt practices that prevent failures and promptly discover and correct any failures that happen to occur. In addition, disclosure of failures and what has been done to correct them provides significant transparency. Accordingly, the final regulations retain §1.501(r)-2(c).

The 2013 proposed regulations stated that a hospital facility may, in the discretion of the IRS, be subject to an excise tax under section 4959 for a failure to meet the CHNA requirements, notwithstanding the hospital facility's correction and disclosure of the failure in accordance with the relevant procedures. Several commenters expressed confusion as to whether and how the tax under section 4959 would apply in the event of a failure that was corrected and disclosed. Although some commenters did not think the excise tax should apply upon correction and disclosure, at least one commenter suggested that the statute does not permit the excise tax to be excused.

To eliminate the uncertainty, the final regulations under section 4959 provide that a hospital facility failing to meet the CHNA requirements "will" (rather than "may, in the discretion of the IRS") be subject to an excise tax under section 4959, notwithstanding its correction and disclosure of the failure. However, as discussed in section 2.a of this preamble, a hospital facility's omission or error with respect to the CHNA requirements

will not be considered a failure to meet the CHNA requirements if the omission or error is minor and either inadvertent or due to reasonable cause and if the hospital facility corrects the omission or error in accordance with §1.501(r)-2(b)(1)(ii) of the final regulations. Accordingly, the final regulations under section 4959 also make clear that such a minor omission or error related to the CHNA requirements that is corrected will not give rise to an excise tax under section 4959.

c. Facts and circumstances considered in determining whether to revoke section 501(c)(3) status

Consistent with the 2013 proposed regulations, the final regulations provide that the IRS will consider all relevant facts and circumstances when determining whether revocation of section 501(c)(3) status is warranted as a result of a failure to meet one or more requirements of section 501(r).

Several commenters asked that the regulatory text of the final regulations include the statement found in the preamble to the 2013 proposed regulations that application of these facts and circumstances will ordinarily result in revocation of section 501(c)(3) status only if the organization's failures to meet the requirements of section 501(r) are willful or egregious. On the other hand, one commenter expressed concern that this statement signals that revocation could result due to failures that are willful, but not serious or material.

The final regulations provide that all of the relevant facts and circumstances will be considered in determining whether to revoke a hospital organization's section 501(c)(3) status, including the size, scope, nature, and significance of the organization's failure, as well as the reason for the failure and whether the same type of failure has

previously occurred. The IRS will also consider whether the hospital organization had, prior to the failure, established practices or procedures (formal or informal) reasonably designed to promote and facilitate overall compliance with the section 501(r) requirements; whether such practices or procedures were being routinely followed; and whether the failure was corrected promptly.

d. Taxation of noncompliant hospital facilities

Like the 2013 proposed regulations, the final regulations provide for a facility-level tax for a hospital organization operating more than one hospital facility that fails to meet one or more of the requirements of section 501(r) separately with respect to a hospital facility during a taxable year. Specifically, this facility-level tax applies to a hospital organization that continues to be recognized as described in section 501(c)(3) but would not continue to be so recognized based on the facts and circumstances described in section 2.c of this preamble if the noncompliant facility were the only hospital facility operated by the organization. The facility-level tax is applied to income derived from the noncompliant hospital facility during the taxable year of non-compliance and is computed as provided in section 11 (or as provided in section 1(e) if the hospital organization is a trust described in section 511(b)(2)).

The 2013 proposed regulations also stated that the application of the facility-level tax to income derived from a noncompliant hospital facility would not, by itself, affect the tax-exempt status of bonds issued to finance the noncompliant hospital facility.

Numerous commenters requested that the final regulations further specify that a noncompliant hospital facility subject to the facility-level tax will not be treated as an

unrelated trade or business for purposes of tax-exempt bonds issued to finance the noncompliant facility. In response to these comments, the final regulations clarify that application of the facility-level tax will not, by itself, result in the operation of the noncompliant hospital facility being considered an unrelated trade or business described in section 513.

3. Community Health Needs Assessments

Consistent with section 501(r)(3)(A), the final regulations provide that a hospital organization meets the requirements of section 501(r)(3) in any taxable year with respect to a hospital facility it operates only if the hospital facility has conducted a CHNA in such taxable year or in either of the two immediately preceding taxable years and an authorized body of the hospital facility has adopted an implementation strategy to meet the community health needs identified through the CHNA.

a. Conducting a community health needs assessment

Consistent with the 2013 proposed regulations, the final regulations provide that, in conducting a CHNA, a hospital facility must define the community it serves and assess the health needs of that community. In assessing the community's health needs, the hospital facility must solicit and take into account input received from persons who represent the broad interests of its community. The hospital facility must also document the CHNA in a written report (CHNA report) that is adopted for the hospital facility by an authorized body of the hospital facility. Finally, the hospital facility must make the CHNA report widely available to the public. A hospital facility is considered to have conducted a CHNA on the date it has completed all of these steps,

including making the CHNA report widely available to the public.

Several commenters suggested that a hospital facility should be considered to have conducted a CHNA if it updates a previously conducted CHNA, as opposed to being required to create an entirely new CHNA every three years. The Treasury Department and the IRS expect that, in conducting CHNAs, hospital facilities will build upon previously-conducted CHNAs, and nothing in either the 2013 proposed regulations or the final regulations is intended to prevent this practice. Hospital facilities should note, however, that both the 2013 proposed regulations and these final regulations require the solicitation and consideration of input from persons representing the broad interests of the community anew with each CHNA, even if the CHNA builds upon a previously conducted CHNA.

i. Community Served by the Hospital Facility

The 2013 proposed regulations provided that a hospital facility may take into account all of the relevant facts and circumstances in defining the community it serves, including the geographic area served by the hospital facility, target populations served (for example, children, women, or the aged), and principal functions (for example, focus on a particular specialty area or targeted disease). The 2013 proposed regulations further provided that a hospital facility may define its community to include populations in addition to its patient populations and geographic areas outside of those in which its patient populations reside. However, the 2013 proposed regulations did not permit a hospital facility to define its community in a way that excluded medically underserved, low-income, or minority populations who are served by the hospital facility, live in the

geographic areas in which its patient populations reside (unless such populations are not part of the hospital facility's target population or affected by its principal functions), or otherwise should be included based on the method used by the hospital facility to define its community.

A few commenters expressed concern that the sentence suggesting that a hospital facility could define its community to include populations in addition to its patient populations and geographic areas outside of those in which its patient populations reside could create confusion among both hospital organizations and the public, as it implies that the community that is defined for CHNA purposes may not actually be the community served by the hospital facility. To avoid potential confusion, the final regulations delete this language. However, the final regulations continue to give hospital facilities broad flexibility to define the communities they serve or intend to serve (both in addressing needs identified through their CHNAs and otherwise) taking into account all relevant facts and circumstances, provided that they do not exclude medically underserved, low-income, or minority populations.

With respect to the provision in the 2013 proposed regulations that a hospital facility may not define its community in a way that excludes medically underserved, low-income, or minority populations, several commenters asked that the final regulations prohibit exclusion of additional populations, such as populations with limited English proficiency (LEP) or potential patients within the community who are not currently receiving care. With respect to potential patients not currently receiving care, commenters noted that individuals may live within a hospital facility's service community

but not use the facility for reasons that include cost, lack of transportation, lack of adequate language access services, stigma, or other barriers.

The 2013 proposed regulations and these final regulations define “medically underserved” populations as including populations “at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers.” The reference to language barriers in the definition of medically underserved already encompasses LEP populations. In addition, the definition of “medically underserved” already prevents the exclusion of those living within a hospital facility’s service area but not receiving adequate medical care from the facility because of cost, transportation difficulties, stigma, or other barriers. The final regulations also provide that hospital facilities may not exclude low-income or minority populations living “in the geographic areas from which the hospital facility draws its patients,” and not only those already receiving care from the facility. Accordingly, the Treasury Department and the IRS believe the concerns addressed by these commenters are addressed by the final regulations.

ii. Assessing Community Health Needs

The 2013 proposed regulations provided that, to assess the health needs of its community, a hospital facility must identify the significant health needs of its community, prioritize those health needs, and identify potential measures and resources (such as programs, organizations, and facilities in the community) available to address the health needs. For these purposes, the 2013 proposed regulations stated that health needs include requisites for the improvement or maintenance of health status both in the

community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities). The preamble added that requisites for the improvement or maintenance of health status in a community may include improving access to care by removing financial and other barriers to care, such as a lack of information regarding sources of insurance designed to benefit vulnerable populations. Numerous commenters asked for clarification that the term “health needs” also encompasses needs in addition to access to care, such as access to proper nutrition and housing, the mitigation of social, environmental, and behavioral factors that influence health, or emergency preparedness. In response to these comments, the final regulations expand the examples of health needs that a hospital facility may consider in its CHNA to include 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. The Treasury Department and the IRS note that the list of possible health needs in the final regulations is only a list of examples, and a hospital facility is not required to identify all such types of health needs in its CHNA report if all such types are not determined by the hospital facility to be significant health needs in its community.

The 2013 proposed regulations provided that a hospital facility may use any criteria to prioritize the significant health needs it identifies, including, but not limited to, the burden, scope, severity, or urgency of the health need; the estimated feasibility and effectiveness of possible interventions; the health disparities associated with the need; or the importance the community places on addressing the need. One commenter

supported the flexibility provided to hospital facilities in determining how to prioritize significant health needs, while several other commenters expressed concern that the language in the proposed rule that a hospital facility may use “any” criteria when prioritizing significant health needs could be read to include criteria that disregard community preferences. Two commenters recommended requiring hospital facilities to use the listed criteria, with one such commenter noting that these are commonly-used criteria in health planning and program evaluation.

Section 501(r)(3) does not mandate the use of particular prioritization criteria. Accordingly, the list of prioritization criteria in the final regulations remains a non-exhaustive list of examples, and hospital facilities have flexibility to choose how best to prioritize the significant health needs of their particular communities. However, to ensure transparency with respect to a hospital facility’s prioritization, the final regulations, like the 2013 proposed regulations, require a hospital facility’s CHNA report to describe the process and criteria used in prioritizing the significant health needs identified. In addition, the final regulations require a hospital facility to take into account community input not only in identifying significant health needs but also in prioritizing them.

A few commenters asked for clarification regarding the requirement in the 2013 proposed regulations that hospital facilities identify potential measures and resources (such as programs, organizations, and facilities in the community) available to address significant health needs. For example, one commenter asked whether the term “measures” referred to how the hospital facility would measure the scope of the health

need, rather than actions the hospital facility might take to address the health need. Another commenter interpreted the proposed requirement as referring to the potential measures and resources only of parties in the community other than the hospital facility itself. To eliminate any confusion associated with the use of the term “measures,” the final regulations eliminate the term and require a hospital facility to identify resources potentially available to address the significant health needs, with the term “resources” including programs, organizations, or facilities. In addition, the final regulations clarify that resources of the hospital facility itself may be identified.

Numerous commenters recommended removing the requirement that a CHNA include potential measures and resources to address the significant health needs identified, stating that the implementation strategy was a better place to discuss the means to address health needs. Other commenters supported this requirement, with one such commenter stating that it is important to consider potential measures and resources early in the CHNA process to provide a framework for determining which health needs to address in the implementation strategy. The Treasury Department and the IRS agree that a vital part of assessing and prioritizing health needs is to begin considering what resources in the community could potentially be harnessed to help address those health needs and thus believe that hospital facilities should get community input on this important aspect of assessing health needs while the CHNA is being conducted. The opportunity for contemporaneous community input on potentially available resources would not exist if such resources were identified as part of the implementation strategy because a hospital facility is not required to take into account

input on an implementation strategy until it is conducting the subsequent CHNA.

Accordingly, the final regulations retain the requirement that a CHNA identify resources potentially available to address significant health needs.

iii. Input From Persons Representing the Broad Interests of the Community

The 2013 proposed regulations provided that, in assessing the health needs of its community, a hospital facility must take into account input received from, at a minimum, the following three sources: (1) at least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community; (2) members of medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations; and (3) written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy.

Several commenters asked that the final regulations address the situation in which a hospital facility, despite its best efforts, is unable to secure input on its CHNA from a required category of persons. In response, the final regulations retain the three categories of persons representing the broad interests of the community specified in the 2013 proposed regulations but clarify that a hospital facility must "solicit" input from these categories and take into account the input "received." The Treasury Department and the IRS expect, however, that a hospital facility claiming that it solicited, but could not obtain, input from one of the required categories of persons will be able to document that it made reasonable efforts to obtain such input, and the final regulations require the

CHNA report to describe any such efforts.

Numerous commenters requested that the final regulations provide for public input on the identification and prioritization of significant health needs, with a few of these commenters expressing a particular interest in ensuring ample opportunity for community input and feedback on which community health needs should be deemed “significant.” By requiring hospital facilities to take into account public input “in assessing the health needs of the community” and defining “assessing the health needs of the community” to include identifying and prioritizing significant health needs, the 2013 proposed regulations already required public input on the identification and prioritization of significant health needs. The final regulations clarify that the requirement to take into account input in assessing the health needs of the community includes taking into account input in identifying and prioritizing significant health needs, as well as identifying resources potentially available to address those health needs.

Finally, the final regulations do not adopt a suggestion from several commenters that a hospital facility be required to take into account public input in defining its community because such a requirement would be circular, as a hospital facility must define its community before it can take into account input from persons who represent the broad interests of that community.

A. Governmental public health departments

Numerous commenters supported requiring hospital facilities to take into account input from a governmental public health department (or equivalent department or agency), noting that governmental health departments typically have access to

statistical and other data that may be helpful in assessing and prioritizing community health needs and, in many cases, conduct community health assessments of their own.

One commenter asked what is meant by “or equivalent department or agency” and whether the term was intended to be an exception to the requirement that hospital facilities collaborate with governmental public health departments. The parenthetical reference to an “equivalent department or agency” in the 2013 proposed regulations and the final regulations is not intended to be an exception. Rather, it is included in recognition of the fact that governments may have different names for the particular unit with jurisdiction over and expertise in public health. For example, the particular unit of a government with jurisdiction over and expertise in public health might be called an “agency,” “division,” “authority,” “bureau,” “office,” or “center” rather than a department and may or may not have the term “public health” in its name. As long as a hospital facility is soliciting and taking into account input received from the unit of a local, state, tribal, or regional government with jurisdiction over and expertise in public health, it will satisfy the requirement to solicit and take into account input received from a governmental public health department.

The 2013 proposed regulations provided flexibility in allowing a hospital facility to choose the level of government that it concluded was most appropriate for its CHNA, and did not require a hospital facility to solicit input from a local public health department, in particular, because not all jurisdictions will have local public health departments available to participate in the CHNA process. Several commenters asked that the final regulations require a hospital facility to solicit input from a local public

health department if one exists in its community. Other commenters, however, expressly supported allowing flexibility to choose the particular governmental health department from which to seek input.

The Treasury Department and the IRS believe that public health departments represent the broad interests of the jurisdictions they serve and have special knowledge of and expertise in public health, regardless of whether they are local, state, tribal, or regional departments. Several commenters noted that local public health departments may vary greatly in their capacity to participate in a CHNA process. In addition, the community served by a hospital facility may span the jurisdictions of multiple local public health departments. Thus, even when a hospital facility's locality has a local public health department, the hospital facility still might reasonably decide that a public health department at a different jurisdictional level may be a more appropriate source of input for its CHNA. Accordingly, the final regulations preserve the flexible approach of the 2013 proposed regulations and allow a hospital facility to select the jurisdictional level (local, state, tribal or regional) of the public health department that is most appropriate for its CHNA.

One commenter asked that the final regulations identify State Offices of Rural Health (SORHs) as governmental public health entities from which hospital facilities may seek input. This commenter stated that SORHs operate on a statewide basis and routinely conduct rural health planning efforts, including both health service access assessments and population health status assessments. The Treasury Department and the IRS note that the substantial majority of SORHs are located in state health

departments, such that rural hospital facilities soliciting input from these state SORHs would presumably be soliciting input from a state public health department. However, because some SORHs are located in state universities or other nonprofits or government departments other than public health departments, the final regulations separately identify SORHs as a source of input from which hospital facilities may solicit and take into account input to satisfy the relevant requirement.

One commenter stated that hospital facilities are increasingly employing or contracting with public health experts. This commenter further stated that it would seem illogical for a hospital facility to be considered to have failed to meet the CHNA requirements because it relied on more specific, in-depth advice and input from a public health expert without necessarily working with a public health agency with strained available resources that is attempting to serve a larger geographic area with a broader set of public health needs than those the hospital facility might address. The Treasury Department and the IRS note that public health expertise alone does not result in a person's representing the broad interests of the community, while a governmental public health department both offers public health expertise and is responsible for ensuring that the broad interests of the community are represented. Thus, while hospital facilities are free to contract with public health experts to assist with their CHNAs, the final regulations require a hospital facility to solicit and take into account input received from a governmental public health department.

B. Medically underserved, low-income, and minority populations

Several commenters asked that hospital facilities be required to seek input from

certain specified groups, such as the disabled, individuals with chronic diseases, women and children, and LEP populations, in addition to the requirement in the 2013 proposed regulations to seek input from medically underserved, low-income, and minority populations. As noted in section 3.a.i of this preamble, “medically underserved” populations are defined in the 2013 proposed regulations and these final regulations as populations “at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers.” The Treasury Department and the IRS believe this definition (along with the inclusion of low-income and minority populations) should be sufficiently broad to encompass many of the populations cited by commenters to the extent such populations are at risk of not receiving adequate medical care. Moreover, even if a hospital facility does not solicit input from a particular population while conducting its CHNA, any person can participate in the CHNA process by submitting written comments on the hospital facility’s most recently conducted CHNA and most recently adopted implementation strategy, as described in section 3.a.iii.C of this preamble. Accordingly, the final regulations do not expand the populations from whom a hospital facility is required to solicit input beyond medically underserved, minority, and low-income populations.

One commenter asked that the final regulations define the broader category of “minority populations” to include certain sub-categories of persons, such as persons with disabilities and LEP individuals, and require hospital facilities to consult a member or representative of each such sub-category identified in their community served. Because the sub-categories within the broad categories of minority and medically

underserved populations will likely vary greatly from community to community, the final regulations continue to provide hospital facilities with the flexibility to identify the significant minority and medically underserved populations in their communities with whom they should consult and do not mandate any specific approach.

C. Written comments

While some comments in response to Notice 2011-52 recommended a requirement that a hospital facility take into account public input on a draft version of its CHNA report before finalizing the report, this recommendation was not adopted in the 2013 proposed regulations due to the complexity of the additional timeframes and procedures such a process would require. Instead, the 2013 proposed regulations required hospital facilities to consider written comments received from the public on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy. Because a new CHNA must be conducted and an implementation strategy adopted at least once every three years, the Treasury Department and the IRS intended for this requirement to establish the same sort of continual feedback on CHNA reports suggested by commenters, albeit over a different timeframe.

In response to the 2013 proposed regulations, some commenters continued to advocate for requiring comments on a draft CHNA report before it is finalized, stating that the burdens of such a rule would be reasonable and commensurate with the benefits of giving interested individuals additional opportunities to participate in the CHNA. These commenters added that without a mandatory opportunity to comment on

the draft CHNA report, interested individuals and organizations may not be aware that a hospital facility is conducting its CHNA until the CHNA is complete, and that opening up the CHNA report for comment in “real time” would yield findings more indicative of community priorities and provide a better framework for collaboration. Other commenters, however, supported the proposed requirement that hospital facilities take into account input in the form of written comments received on the hospital facility’s most recently conducted CHNA and most recently adopted implementation strategy, stating that such comments may provide extremely valuable information to guide future assessments and implementation strategies and that this is a practical way of taking various perspectives into account.

The Treasury Department and the IRS continue to believe that the opportunity for the public to submit written comments on previously adopted CHNA reports and implementation strategies will result in a meaningful exchange over time and that the longer timeframe will both give the public sufficient time to provide comments (including comments reflecting changing circumstances) and give hospital facilities sufficient time to take the comments into account when conducting their next CHNA. The Treasury Department and the IRS also note that hospital facilities’ CHNA processes will be taking into account input in “real time” from various community stakeholders, including, at a minimum, governmental public health departments and medically underserved, low-income, and minority populations (or persons serving or representing them). Accordingly, the final regulations retain the requirement that a hospital facility take into account written comments on the hospital facility’s most recently conducted CHNA

report and most recently adopted implementation strategy and do not adopt an additional requirement to post a draft CHNA report for public comment before it is finalized. In addition, the Treasury Department and the IRS note that hospital facilities may choose to post a draft CHNA report for public comment, and both the 2013 proposed regulations and these final regulations facilitate this option by specifying that the posting of a draft CHNA report will not trigger the start of a hospital facility's next three-year CHNA cycle.

A few commenters asked how the public is expected to comment on the implementation strategy if the information is not made available outside of the Form 990 reporting process. As discussed in section 8.a of this preamble, a hospital organization must either attach to its Form 990 a copy of the most recently adopted implementation strategy for each hospital facility it operates or provide on the Form 990 the URL(s) of the Web page(s) on which it has made each implementation strategy widely available on a Web site. Section 6104 requires Forms 990 to be made available to the public by both the filing organization and the IRS, and members of the public may obtain a copy of a hospital organization's Forms 990 from one of the privately-funded organizations that gathers and disseminates Forms 990 online or by completing IRS Form 4506-A, "Request for Public Inspection or Copy of Exempt or Political Organization IRS Form."

One commenter requested clarification on how hospital facilities should be collecting written comments from the public, asking, for example, if written comments must be collected via a form on a Web site or by email or mailed letter. The final regulations do not require a specific method for collection of these written comments,

providing hospital facilities with the flexibility to set up a collection and tracking system that works with their internal systems and makes the most sense for their particular community.

A few commenters asked that the final regulations clarify how hospital facilities should respond to written comments received from the public. One commenter proposed that a hospital facility designate a representative or division responsible for providing substantive responses to written comments to demonstrate that the hospital facility has received the comment and to ensure that the public will be able to provide continual feedback during the interim period between formal CHNAs. In contrast, another commenter stated that requiring hospitals to individually address each community concern through feedback could become burdensome. As discussed in section 3.a.iv of this preamble, the final regulations require hospital facilities to describe generally any input received in the form of written comments (or from any other source) in their CHNA reports. The Treasury Department and the IRS expect that this description in the CHNA report will provide sufficient confirmation that comments have been received and considered and intend that hospital facilities will otherwise have flexibility in determining whether further responses are necessary. Thus, the final regulations do not adopt any specific requirements regarding how hospital facilities must respond to written comments received from the public.

Finally, one commenter sought confirmation that the requirement to take into account written comments on the hospital facility's "most recently conducted CHNA" means that hospital facilities must take into account public comments submitted after

the CHNA or implementation strategy is finalized to inform and influence future CHNAs and implementation strategies. This is an accurate description of this provision in both the 2013 proposed regulations and these final regulations. The Treasury Department and the IRS intend that the phrase “most recently conducted CHNA” refers not to a CHNA that is in process but rather to the last CHNA that was “conducted,” typically determined as of the date the hospital facility makes an adopted and complete CHNA report widely available to the public.

D. Additional sources of input

The 2013 proposed regulations provided that, in addition to soliciting input from the three required sources, a hospital facility may take into account input from a broad range of persons located in or serving its community, including, but not limited to, health care consumers and consumer advocates, nonprofit and community-based organizations, academic experts, local government officials, local school districts, health care providers and community health centers, health insurance and managed care organizations, private businesses, and labor and workforce representatives.

Numerous commenters requested that the final regulations require, rather than simply permit, hospital facilities to solicit input from additional sources, including from patient and health care consumer organizations located in or serving the hospital facility’s community, county governing boards, experts in nutrition or the local food system, and housing service providers. While these sources may have valuable input to contribute to a hospital facility’s CHNA, mandating input from some or all of these sources could result in a final rule that is unsuited for particular communities and further

complicate the CHNA process and the ability to collaborate. Accordingly, the final regulations do not require hospitals to solicit input from additional persons, although a hospital facility is free to solicit input from the suggested sources (as well as other sources) and must take into account input received from any person (including these sources) in the form of written comments on the most recently conducted CHNA or most recently adopted implementation strategy.

E. Input on financial and other barriers

The 2012 proposed regulations requested comments on the potential link between the needs of a hospital facility's community, as determined through the hospital facility's most recently conducted CHNA, and a hospital facility's FAP. The preamble to the 2013 proposed regulations recognized that the need to improve access to care by removing financial barriers can be among the significant health needs assessed in a CHNA, and the 2013 proposed regulations themselves provided that input from persons representing the broad interests of the community includes, but is not limited to, input on any financial and other barriers to access to care in the community.

Several commenters stated that the CHNA process offers an opportunity to inquire about financial and other barriers to care, which could provide useful information to a hospital facility in updating and evaluating its FAP. However, other commenters noted that section 501(r) does not require a link between a hospital facility's CHNA and its FAP. These commenters further stated that because CHNAs are already required to take into account input from persons who represent the broad interests of the community and the decision of how to meet those needs is the responsibility of the

hospital's governing board, a linkage should be allowed at the discretion of the hospital facility but not required.

In acknowledgement of the importance of assessing financial barriers to care in the CHNA process, the final regulations expressly provide that the health needs of a community may include the need to address financial and other barriers to access to care in the community. However, consistent with the approach taken in Notice 2011-52 and the 2013 proposed regulations, the final regulations focus on ensuring transparency regarding the health needs identified through a CHNA rather than requiring hospital facilities to identify any particular categories of health needs. As with all significant health needs identified through a CHNA, a hospital facility's decision as to whether and how to address a significant health need involving financial barriers to care (including through an amendment to a hospital facility's FAP) will be disclosed publicly in the hospital facility's implementation strategy and subject to public comments in preparing the next CHNA. Thus, the final regulations do not require any additional link between a hospital facility's CHNA and its FAP.

iv. Documentation of a CHNA

Similar to the 2013 proposed regulations, the final regulations provide that a hospital facility must document its CHNA in a CHNA report that is adopted by an authorized body of the hospital facility and includes: (1) a definition of the community served by the hospital facility and a description of how the community was determined; (2) a description of the process and methods used to conduct the CHNA; (3) a description of how the hospital facility solicited and took into account input received from

persons who represent the broad interests of the community it serves; (4) a prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; and (5) a description of resources potentially available to address the significant health needs identified through the CHNA.

Both the 2013 proposed regulations and these final regulations provide that a CHNA report will be considered to describe the process and methods used to conduct the CHNA if the CHNA report describes the data and other information used in the assessment, as well as the methods of collecting and analyzing this data and information, and identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in conducting the CHNA. Some commenters requested that this provision be modified to permit the referencing of publicly available source materials (for example, public health agency data) on which the hospital facility relied in conducting its CHNA. The final regulations clarify that a hospital facility may rely on (and the CHNA report may describe) data collected or created by others in conducting its CHNA and, in such cases, may simply cite the data sources rather than describe the “methods of collecting” the data.

A few commenters requested clarification on how a hospital facility’s CHNA report should describe input received in the form of written comments, with one such commenter asking if a general summary of the input provided, the number of comments received, and the time period during which the comments were received will be

sufficient. The final regulations retain the provisions of the 2013 proposed regulations, which stated that a CHNA report will be considered to describe how the hospital facility took into account community input if it summarizes, in general terms, the input provided and how and over what time period it was provided. This language applies to written comments, as well as to any other type of input provided. In addition, like the 2013 proposed regulations, the final regulations provide that a CHNA report does not need to name or otherwise identify any specific individual providing input on the CHNA, which would include input provided by individuals in the form of written comments.

v. Collaboration on CHNA Reports

The 2013 proposed regulations provided that a hospital organization may choose to conduct its CHNA in collaboration with other organizations and facilities, including related and unrelated hospital organizations and facilities, for-profit and government hospitals, governmental departments, and nonprofit organizations. In general, every hospital facility must document its CHNA in a separate CHNA report. However, the 2013 proposed regulations made clear that portions of a hospital facility's CHNA report may be substantively identical to portions of the CHNA reports of other facilities or organizations, if appropriate under the facts and circumstances. The 2013 proposed regulations further provided that collaborating hospital facilities that define their community to be the same and that conduct a joint CHNA process may produce a joint CHNA report. The final regulations amend the proposed regulations to clarify that joint CHNA reports must contain all of the same basic information that separate CHNA reports must contain (discussed in section 3.a.iv of this preamble).

Numerous commenters expressed support for allowing joint CHNA reports, noting that the purpose of collaboration is to make the most efficient use of resources in assessing community needs and devising strategies to address those needs and that communities would benefit from strengthened collaborative partnerships that help build broad-based support for community-wide solutions to the underlying causes of health problems. In addition, several of these commenters stated that joint CHNA reports would more effectively leverage the health data expertise of governmental public health departments without placing an unreasonable burden on departments that serve jurisdictions with more than one tax-exempt hospital facility. Another commenter stated that joint CHNA reports both enhance overall community health and lessen confusion in the community by providing a more comprehensive view of the identified needs and associated strategies for addressing those needs. For these reasons, the final regulations continue to permit collaborating hospital facilities to produce joint CHNA reports.

Several commenters recommended that the final regulations go beyond simply permitting collaboration to expressly encouraging, or even requiring, hospital facilities located in the same jurisdiction to collaborate in conducting a CHNA and developing an implementation strategy. One of these commenters stated that this would help ensure that the community is not overburdened by multiple CHNA efforts, noting that a “go it alone” approach in a jurisdiction with multiple hospitals is likely to be neither the most efficient nor the most effective way to improve the overall health of the community. Another commenter, however, stated that the discretion to work collaboratively with

others should be left to each particular hospital facility, given the many health care providers operating in a typical community.

Like the 2013 proposed regulations, the final regulations encourage and facilitate collaboration among hospital facilities by allowing for joint CHNA reports. However, section 501(r) applies separately to each hospital organization (and, in the case of hospital organizations operating more than one hospital facility, each hospital facility) and, therefore, it is not appropriate to require hospital organizations to meet the section 501(r)(3) requirements collaboratively with other organizations. Accordingly, the final regulations facilitate, but do not require, collaboration.

Two commenters asked whether the requirement that collaborating hospital facilities must “conduct a joint CHNA process” to adopt a joint CHNA report means that the collaborating hospital facilities must make the joint CHNA report widely available to the public (including posting the CHNA report on a Web site) on the same day. The Treasury Department and the IRS do not intend for collaborating hospital facilities to have to make a joint CHNA report widely available to the public on the same day. Thus, in response to these comments and to avoid potential confusion, the final regulations remove the reference to a joint CHNA process.

A. Defining a common community

Several commenters expressed concern regarding the requirement that hospital facilities that collaborate on a CHNA and intend to produce a joint CHNA report must define their communities to be the same. Two of these commenters requested that a hospital facility collaborating on a CHNA being conducted for a larger shared community

also be able to identify and address needs that are highly localized in nature or occurring within only a small portion of that community. The 2013 proposed regulations and these final regulations define “health needs” to include requisites for the improvement or maintenance of health status in particular parts of the community, such as particular neighborhoods or populations experiencing health disparities. Accordingly, a joint CHNA conducted for a larger area could identify as a significant health need a need that is highly localized in nature or occurs within only a small portion of that larger area. In addition, nothing in the final regulations prevents a hospital facility collaborating on a CHNA from supplementing a joint CHNA report with its own assessment of more highly localized needs. Because the 2013 proposed regulations already allowed collaborating hospital facilities to address highly localized needs experienced in a particular part of their shared community, the final regulations do not amend the proposed regulations in response to these comments.

One commenter requested that collaborating hospital facilities that serve different communities be allowed to adopt a joint CHNA report, stating that requiring all hospital facilities participating in a joint CHNA report to define their community to be the same would appear to prohibit collaboration between general and specialized hospital facilities in the same geographic area if the specialized hospital facilities define their communities in terms of service area or principal function and the general hospital facilities define their communities geographically.

The 2013 proposed regulations and these final regulations permit hospital facilities with different but overlapping communities to collaborate in conducting a CHNA

and to include substantively identical portions in their separate CHNA reports if appropriate under the facts and circumstances. The final regulations elaborate upon this point with an example of two hospital facilities with overlapping, but not identical, communities that are collaborating in conducting a CHNA and state that, in such a case, the portions of each hospital facility's CHNA report relevant to the shared areas of their communities may be identical. Thus, the final regulations not only expressly permit hospital facilities with different communities (including general and specialized hospitals) to collaborate but also allow such hospital facilities to adopt substantively identical CHNA reports to the extent appropriate.

A few commenters recommended that the final regulations make clear that, to the extent that the communities served by collaborating hospital facilities differ, a CHNA report must reflect the unique needs of the community of the particular hospital facility adopting the report. By stating that collaborating hospital facilities with different but overlapping communities may include substantively identical portions in their separate CHNA reports only "if appropriate under the facts and circumstances," the 2013 proposed regulations and these final regulations convey that the CHNA reports of collaborating hospital facilities should differ to reflect any material differences in the communities served by those hospital facilities.

B. Collaborating with public health departments

Two commenters requested that hospital facilities be permitted to adopt the CHNA of a local public health department in the event that: (1) the hospital facility has the same community as the local public health department (as defined by the hospital

facility), and (2) the CHNA adopted by the local public health department meets the requirements set forth in these regulations. The final regulations clarify that if a governmental public health department has conducted a CHNA for all or part of a hospital facility's community, portions of the hospital facility's CHNA report may be substantively identical to those portions of the health department's CHNA report that address the hospital facility's community. The final regulations also clarify that a hospital facility that collaborates with a governmental public health department in conducting its CHNA may adopt a joint CHNA report produced by the hospital facility and public health department, as long as the other requirements applicable to joint CHNA reports are met.

vi. Making the CHNA Report Widely Available to the Public

The 2013 proposed regulations provided that a hospital facility must make its CHNA report widely available to the public both by making the CHNA report widely available on a Web site and by making a paper copy of the CHNA report available for public inspection without charge at the hospital facility. The 2013 proposed regulations further provided that the CHNA report must be made widely available to the public in this manner until the date the hospital facility has made widely available to the public its two subsequent CHNA reports.

A few commenters recommended that the final regulations require the CHNA report to be translated into multiple languages. Commenters also recommended that the hospital facility be required to make paper copies of the CHNA report available in locations other than the hospital facility that may be more accessible to the community

at large and proactively inform the community when the report is available.

The Treasury Department and the IRS note that section 501(r)(3) requires the CHNA to be made “widely available” to the public, in contrast to the requirement in section 501(r)(4) regarding measures to “widely publicize” the FAP. The Treasury Department and the IRS have interpreted the term “widely publicize” to require proactive efforts to inform, and make a document available in, the community at large, but have not so interpreted the term “widely available.” The Treasury Department and the IRS interpret “widely available” in a manner consistent with how that term is defined for purposes of section 6104 (relating to disclosure of annual information returns). See §301.6104(d)-2(b) (interpreting the term “widely available” in section 6104(d)(4) to include the posting of information returns and exemption applications on a Web page). Accordingly, the final regulations retain the definition of “widely available” set forth in the proposed regulations and decline to adopt a definition that would include the suggested measures to translate and proactively publicize the CHNA report within the community served by the hospital facility.

Additional commenters requested that hospital facilities be required to post their CHNA reports (and implementation strategies) on a national, searchable Web site. Given that hospital facilities are already required to conspicuously post their CHNA reports on a Web site, any individual interested in a particular hospital facility’s CHNA report should be able to locate it. The Treasury Department and the IRS do not have, and cannot require a third party to host, a comprehensive Web site containing all hospital facilities’ CHNA reports. Accordingly, the final regulations do not adopt this

additional suggested requirement.

One commenter asked that the final regulations clarify how a hospital facility is required to make a paper copy of its CHNA report available for public inspection and, specifically, whether a paper copy of the CHNA report must be publicly displayed or, rather, may be made available only upon request. The final regulations clarify that a hospital facility need only make a paper copy of the CHNA report available for public inspection upon request.

vii. Frequency of the CHNA Cycle

The 2013 proposed regulations provided that, to satisfy the CHNA requirements for a particular taxable year, a hospital facility must conduct a CHNA in that taxable year or in either of the two taxable years immediately preceding such taxable year. A few commenters requested that the final regulations provide flexibility in the timeline to limit impediments to collaboration amongst hospital facilities with different taxable years. Commenters also requested that the CHNA cycle match the five-year cycle that local public health departments follow in conducting their community health assessments for national accreditation by the Public Health Accreditation Board. One such commenter stated that adopting this five-year timeline would avoid duplication of effort and incentivize hospital facilities to collaborate more fully with local public health departments. Because section 501(r)(3)(A)(i) requires a hospital organization to conduct a CHNA in the current or one of the two prior taxable years, the final regulations do not adopt these suggestions.

b. Implementation strategies

The final regulations provide, consistent with the 2013 proposed regulations, that a hospital facility's implementation strategy is a written plan that, with respect to each significant health need identified through the CHNA, either: (1) describes how the hospital facility plans to address the health need, or (2) identifies the health need as one the hospital facility does not intend to address and explains why the hospital facility does not intend to address the health need.

The preamble to the 2013 proposed regulations further provided that although an implementation strategy must consider the significant health needs identified through a hospital facility's CHNA, the implementation strategy is not limited to considering only those health needs and may describe activities to address health needs that the hospital facility identifies in other ways. Several commenters supported this proposed flexibility to discuss health needs identified in ways other than through conducting a CHNA, with two such commenters requesting that this language appear in the regulatory text of the final regulations. Another commenter, however, stated that CHNA reports and implementation strategies should be tightly integrated and expressed concern that allowing or encouraging hospital facilities to introduce in the implementation strategy additional needs beyond those identified in the CHNA may undermine the role of community input.

In general, the final regulations under section 501(r) provide detail only with respect to the minimum elements that must be included in the various documents and policies required under sections 501(r)(3) and 501(r)(4), preserving flexibility for hospital

facilities to otherwise determine the contents of such documents and policies.

Consistent with this approach, the final regulations do not prohibit implementation strategies from discussing health needs identified through means other than a CHNA, provided that all of the significant health needs identified in the CHNA are also discussed.

Many commenters recommended that the statutory requirements that a CHNA “take into account input from persons who represent the broad interests of the community” and “be made widely available to the public” should also apply to implementation strategies to allow communities to monitor, assist, and provide input on hospital facilities’ efforts to address health needs. With respect to making the implementation strategy more accessible to the public, commenters also asked that the final regulations clarify how the public may access an implementation strategy that is attached to the Form 990.

Section 501(r)(3)(B) applies the requirements regarding community input and wide availability to the public only to CHNAs. In addition, only section 501(r)(3)(A)(i), which refers to CHNAs, and not section 501(r)(3)(A)(ii), which refers to implementation strategies, cross-references the requirements regarding community input and wide availability to the public contained in section 501(r)(3)(B). Accordingly, the final regulations do not adopt the suggested changes. However, the 2013 proposed regulations and these final regulations respond to commenters’ requests to require public input on the implementation strategy by requiring a hospital facility to take into account comments received on the previously adopted implementation strategy when

the hospital facility is conducting the subsequent CHNA. Furthermore, as discussed in section 8.a of this preamble, the 2013 proposed regulations and these final regulations respond to commenters' requests to require the implementation strategy to be made widely available to the public by requiring a hospital organization to attach to its Form 990 a copy of the most recently adopted implementation strategy for each hospital facility it operates (or provide on the Form 990 the URL(s) of the Web page(s) on which it has made each implementation strategy widely available on a Web site). As noted in section 3.a.iii.C of this preamble, section 6104 requires Forms 990 to be made available to the public by both the filing organization and the IRS, and members of the public may easily obtain a copy of a hospital organization's Forms 990 from one of the privately-funded organizations that gathers and disseminates Forms 990 online or by completing IRS Form 4506-A.

i. Describing How a Hospital Facility Plans to Address a Significant Health Need

In describing how a hospital facility plans to address a significant health need identified through the CHNA, the 2013 proposed regulations provided that the implementation strategy must: (1) describe the actions the hospital facility intends to take to address the health need, the anticipated impact of these actions, and the plan to evaluate such impact; (2) identify the programs and resources the hospital facility plans to commit to address the health need; and (3) describe any planned collaboration between the hospital facility and other facilities or organizations in addressing the health need.

Many commenters supported the proposed requirement that a hospital facility

include a plan to evaluate the impact of its efforts in its implementation strategy and further recommended that the final regulations require hospital facilities to actually perform the planned evaluation and publish the results of the evaluation. Some of these commenters recommended publication of the results in the subsequent CHNA report. Other commenters requested permission for hospital facilities to accomplish the “plan to evaluate the impact” of the implementation strategy through the process of conducting the next CHNA. In response to these comments, the final regulations replace the proposed requirement that the implementation strategy describe a plan to evaluate its impact with a requirement that the CHNA report include an evaluation of the impact of any actions that were taken since the hospital facility finished conducting its immediately preceding CHNA to address the significant health needs identified in the hospital facility’s prior CHNA(s).

The preamble to the 2013 proposed regulations provided the example that if a hospital facility's CHNA identified high rates of financial need or large numbers of uninsured individuals and families in the community as a significant health need in its community, its implementation strategy could describe a program to address that need by expanding its financial assistance program and helping to enroll uninsured individuals in sources of insurance such as Medicare, Medicaid, Children's Health Insurance Program (CHIP), and the new Health Insurance Marketplaces (also known as Exchanges), as appropriate. A few commenters stated that, in addition to examples involving access to health care, it would be helpful to have examples of other interventions designed to prevent illness or to address social, behavioral, and

environmental factors that influence community health. An implementation strategy may describe the actions the hospital facility intends to take to address any significant health needs identified through the CHNA process, and, as noted in section 3.a.ii of this preamble, the final regulations specify that the health needs identified through a CHNA may, for example, include the need to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community. Thus, the final regulations make clear that an implementation strategy may describe interventions designed to prevent illness or to address social, behavioral, and environmental factors that influence community health.

ii. Describing Why a Hospital Facility Is Not Addressing a Significant Health Need

The 2013 proposed regulations provided that a hospital facility may provide a brief explanation of its reason for not addressing a significant health need, including, but not limited to, resource constraints, relative lack of expertise or competencies to effectively address the need, a relatively low priority assigned to the need, a lack of identified effective interventions to address the need, and/or the fact that the need is being addressed by other facilities or organizations in the community. Several commenters thought hospital facilities should not be able to cite “resource constraints” or “lack of expertise” as reasons for not addressing a significant health need. These commenters state that a hospital facility that is unable, for reasons of lack of resources or expertise or other factors, to address a community health need should instead collaborate with community partners to address that need. Other commenters supported allowing hospital facilities to provide any explanation as to why some health

needs will not be addressed, consistent with the proposed rule.

As discussed in section 3.a.v of this preamble, the final regulations permit but do not require collaboration. Thus, the final regulations preserve the ability for a hospital facility to explain its reasons for not addressing a significant health need (including resource constraints or a lack of expertise), even if those reasons could be mitigated through collaboration.

iii. Joint Implementation Strategies

The 2013 proposed regulations provided that a hospital facility adopting a joint CHNA report along with other hospital facilities and organizations (as described in section 3.a.v of this preamble) may also adopt a joint implementation strategy as long as it meets certain specified requirements.

Numerous commenters generally supported joint implementation strategies, with some of these commenters stating that such collaboration is an important way to conserve resources, promote cross-system strategies, and yield better outcomes. Commenters also noted that the proposed approach avoids the need to create duplicative separate documents while still ensuring that information for each hospital facility is clearly presented. Accordingly, the final regulations adopt the proposed provision allowing for joint implementation strategies.

iv. When the Implementation Strategy Must Be Adopted

To satisfy the CHNA requirements with respect to any taxable year, section 501(r)(3)(A)(ii) requires a hospital facility to adopt an implementation strategy to meet the health needs identified through the CHNA described in section 501(r)(3)(A)(i). The

2013 proposed regulations provided that, to satisfy this requirement, an authorized body of the hospital facility must adopt an implementation strategy to meet the health needs identified through a hospital facility's CHNA by the end of the same taxable year in which the hospital facility finishes conducting the CHNA. In addition, the Treasury Department and the IRS sought comments on whether this rule would materially inhibit the ability of hospital facilities with different taxable years to collaborate with each other or otherwise burden hospital facilities unnecessarily.

Some commenters requested additional time in which to adopt the implementation strategy to accommodate collaboration between hospital facilities, public health departments, and community organizations with different fiscal years and on different CHNA schedules. Suggestions from these commenters ranged from an additional four and a half months to 12 months after the end of the taxable year in which the CHNA was conducted.

In response to these comments, the final regulations provide hospital facilities with an additional four and a half months to adopt the implementation strategy, specifically requiring an authorized body of the hospital facility to adopt an implementation strategy to meet the health needs identified through a CHNA on or before the 15th day of the fifth month after the end of the taxable year in which the hospital facility finishes conducting the CHNA. By matching the date by which an authorized body of the hospital facility must adopt the implementation strategy to the due date (without extensions) of the Form 990 filed for the taxable year in which the CHNA is conducted, this approach does not materially reduce transparency, because

an implementation strategy (or the URL of the Web site on which it is posted) is made available to the public through the Form 990. The final regulations do not go further and permit a hospital facility to delay adoption of an implementation strategy until the due date for the Form 990 including extensions. This is because hospital facilities need to report on Form 4720 any excise tax they owe under section 4959 as a result of failing to meet the CHNA requirements in a taxable year by the 15th day of the fifth month following the end of that taxable year and thus need to know whether they have met the requirement to adopt an implementation strategy by that date.

Because all hospital organizations now have until the 15th day of the fifth month following the close of the taxable year in which they conduct a CHNA to adopt the associated implementation strategy, the final regulations remove the transition rule that allowed for this result for CHNAs conducted in a hospital facility's first taxable year beginning after March 23, 2012.

c. Exception for hospital facilities that are new, newly acquired, or newly subject to section 501(r)

The 2013 proposed regulations provided that a hospital facility that was newly acquired or placed into service by a hospital organization, or that became newly subject to section 501(r) because the hospital organization that operated it was newly recognized as described in section 501(c)(3), must meet the CHNA requirements by the last day of the second taxable year beginning after the date, respectively, the hospital facility was acquired, placed into service, or newly subject to section 501(r).

Several commenters interpreted the 2013 proposed regulations as providing new and newly acquired hospital facilities with only two taxable years to meet the CHNA

requirements. Two such commenters requested that these hospital facilities be given three taxable years, to correspond to the length of the CHNA cycle provided in the statute.

The 2013 proposed regulations gave hospital facilities two complete taxable years plus the portion of the taxable year of acquisition, licensure, or section 501(c)(3) recognition (as applicable) to meet the CHNA requirements. As noted in the preamble to the 2013 proposed regulations, a short taxable year of less than twelve months is considered a taxable year for purposes of section 501(r). Thus, the portion of the taxable year in which a hospital facility is acquired or placed into service, or becomes newly subject to section 501(r), is a taxable year for purposes of the CHNA requirements, regardless of whether that taxable year is less than twelve months. As a result, a deadline of the last day of the second taxable year beginning after the date of acquisition, licensure, or section 501(c)(3) recognition provides these new hospital facilities with three taxable years (even if less than three full calendar years) to meet the section 501(r)(3) requirements. By contrast, a deadline of the last day of the third taxable year beginning after the date of acquisition, licensure, or section 501(c)(3) recognition would provide these new hospital facilities with more than three taxable years, and possibly close to four taxable years, to meet the CHNA requirements. Accordingly, the final regulations continue to require hospital facilities that are newly acquired or placed into service (or become newly subject to section 501(r)) to meet the CHNA requirements by the last day of the second taxable year beginning after the later of the date of acquisition, licensure, or recognition of section 501(c)(3) status.

i. Acquired Hospital Facilities

The 2013 proposed regulations provided that a hospital facility that was newly acquired must meet the CHNA requirements by the last day of the second taxable year beginning after the date the hospital facility was acquired. Several commenters asked for guidance on whether and how this rule for acquisitions applies in the case of a merger of two hospital organizations.

The final regulations provide that, in the case of a merger that results in the liquidation of one organization and survival of another, the hospital facilities formerly operated by the liquidated organization will be considered “acquired,” meaning they will have until the last day of the second taxable year beginning after the date of the merger to meet the CHNA requirements. Thus, the final regulations treat mergers equivalently to acquisitions.

ii. New Hospital Organizations

One commenter asked whether a new hospital organization must meet the CHNA requirements by the last day of the second taxable year beginning after the date of licensure or section 501(c)(3) recognition if the organization seeks and obtains recognition of section 501(c)(3) status based on its planned activities before the hospital facility it plans to operate is licensed and placed into service. A facility is not considered a “hospital facility” until it is licensed, registered, or similarly recognized as a hospital by a state, and an organization operating a hospital facility is not subject to section 501(r) until it is recognized as described in section 501(c)(3). Thus, the Treasury Department and the IRS intend that a new hospital organization must meet the CHNA requirements

by the last day of the second taxable year beginning after the later of the effective date of the determination letter or ruling recognizing the organization as described in section 501(c)(3) or the first date a facility operated by the organization was licensed, registered, or similarly recognized by its state as a hospital. The final regulations are amended to make this clarification.

iii. Transferred or Terminated Hospital Facilities

One commenter recommended that a hospital organization should not be required to meet the CHNA requirements in a particular taxable year with respect to a hospital facility if, before the end of that taxable year, the hospital organization transfers the hospital facility to an unaffiliated organization or otherwise terminates its operation of that hospital facility. This commenter reasoned that requiring a hospital organization to invest time and energy in conducting a CHNA and developing an implementation strategy for a hospital facility will create inefficiencies if the organization is transferring or terminating its operation of the hospital facility, as the new hospital organization may have different perceptions of the community's needs and the optimal channels for addressing those needs. In response to this comment, the final regulations provide that a hospital organization is not required to meet the requirements of section 501(r)(3) with respect to a hospital facility in a taxable year if the hospital organization transfers all ownership of the hospital facility to another organization or otherwise ceases its operation of the hospital facility before the end of the taxable year. The same rule applies if the facility ceases to be licensed, registered, or similarly recognized as a hospital by a state during the taxable year.

Another commenter asked whether a government hospital organization that voluntarily terminates its section 501(c)(3) status must meet the CHNA requirements in the taxable year of termination to avoid an excise tax under section 4959. As noted in section 1.d of this preamble, government hospital organizations that have previously been recognized as described in section 501(c)(3) but do not wish to comply with the requirements of section 501(r) may submit a request to voluntarily terminate their section 501(c)(3) recognition as described in section 7.04(14) of Rev. Proc. 2014-4 (or a successor revenue procedure). A government hospital organization that terminates its section 501(c)(3) recognition in this manner is no longer considered a “hospital organization” within the meaning of these regulations and therefore will not be subject to excise tax under section 4959 for failing to meet the CHNA requirements during the taxable year of its termination.

4. Financial Assistance Policies and Emergency Medical Care Policies

In accordance with the statute and the 2012 proposed regulations, the final regulations require hospital organizations to establish written FAPs as well as written emergency medical care policies.

a. Financial assistance policies

Consistent with the 2012 proposed regulations, the final regulations provide that a hospital organization meets the requirements of section 501(r)(4)(A) with respect to a hospital facility it operates only if the hospital organization establishes for that hospital facility a written FAP that applies to all emergency and other medically necessary care provided by the hospital facility.

A number of commenters noted that patients, including emergency room patients, are commonly seen (and separately billed) by private physician groups or other third-party providers while in the hospital setting. Commenters asked for clarification on the extent to which a hospital facility's FAP must apply to other providers a patient might encounter in the course of treatment in a hospital facility, including non-employee providers in private physician groups or hospital-owned practices. Some of these commenters noted that patients are often unaware of the financial arrangements between various providers in the hospital facility and may unknowingly be transferred to a provider that separately bills the patients for care. A few commenters noted that emergency room physicians in some hospital facilities separately bill for emergency medical care provided to patients and recommended that the section 501(r) requirements apply to such emergency room physicians.

In response to comments and to provide transparency to patients, the final regulations require a hospital facility's FAP to list the providers, other than the hospital facility itself, delivering emergency or other medically necessary care in the hospital facility and to specify which providers are covered by the hospital facility's FAP (and

which are not). As discussed in section 1.g of this preamble, the final regulations also clarify that a hospital facility's FAP must apply to all emergency and other medically necessary care provided in a hospital facility by a partnership owned in part by, or a disregarded entity wholly owned by, the hospital organization operating the hospital facility, to the extent such care is not an unrelated trade or business with respect to the hospital organization. In addition, the Treasury Department and the IRS note that if a hospital facility outsources the operation of its emergency room to a third party and the care provided by that third party is not covered under the hospital facility's FAP, the hospital facility may not be considered to operate an emergency room for purposes of the factors considered in Rev. Rul. 69-545 (1969-2 CB 117) (providing examples illustrating whether a nonprofit hospital claiming exemption under section 501(c)(3) is operated to serve a public rather than a private interest, with one activity of the section 501(c)(3) hospital being the operation of a full time emergency room).

i. Eligibility Criteria and Basis for Calculating Amounts Charged to Patients

Section 501(r)(4)(A)(i) and (ii) require a hospital facility's FAP to specify the eligibility criteria for financial assistance, whether such assistance includes free or discounted care, and the basis for calculating amounts charged to patients.

Accordingly, the 2012 proposed regulations provided that a hospital facility's FAP must specify all financial assistance available under the FAP, including all discounts and free care and, if applicable, the amount(s) (for example, gross charges) to which any discount percentages will be applied. The 2012 proposed regulations also provided that

a hospital facility's FAP must specify all of the eligibility criteria that an individual must satisfy to receive each discount, free care, or other level of assistance.

A number of commenters asked that hospital facilities be allowed to offer patients certain discounts -- including self-pay discounts, certain discounts mandated under state law, and discounts for out-of-state patients -- outside of their FAPs and that this assistance not be subject to the requirements of sections 501(r)(4) through 501(r)(6), including the AGB limitation of section 501(r)(5)(A). Several commenters noted that subjecting all assistance provided by hospital facilities to the AGB limitation could result in hospitals offering fewer discounts or less assistance than they might otherwise provide to certain categories of patients.

The Treasury Department and the IRS recognize that not all discounts a hospital facility might offer its patients are properly viewed as "financial assistance" and intend that hospital facilities may offer payment discounts or other discounts outside of their FAPs and may charge discounted amounts in excess of AGB to individuals that are not FAP-eligible. Accordingly, the final regulations only require the FAP to describe discounts "available under the FAP" rather than all discounts offered by the hospital facility.⁶ The Treasury Department and the IRS note, however, that only the discounts specified in a hospital facility's FAP (and, therefore, subject to the AGB limitation) may be reported as "financial assistance" on Schedule H, "Hospitals," of the Form 990.

Moreover, discounts provided by a hospital facility that are not specified in a hospital

⁶ The 2012 proposed regulations stated that a hospital facility's FAP must specify "all financial assistance available under the FAP, including all discount(s)." Although the term "all discount(s)" was not qualified with the phrase "available under the FAP," this interpretation was intended. The final regulations add "available under the FAP" after "all discounts" to clarify that discounts may be offered outside of the FAP.

facility's FAP will not be considered community benefit activities for purposes of section 9007(e)(1)(B) of the Affordable Care Act (relating to reports on costs incurred for community benefit activities) nor for purposes of the totality of circumstances that are considered in determining whether a hospital organization is described in section 501(c)(3).

Some commenters asked for the final regulations to confirm that hospital facilities will be given the flexibility to develop FAP-eligibility criteria that respond to local needs. Like the 2012 proposed regulations, the final regulations do not mandate any particular eligibility criteria and require only that a FAP specify the eligibility criteria for receiving financial assistance under the FAP.

A number of commenters recommended that the final regulations require the FAP to contain a statement that explains the patient's obligation to cooperate with the hospital facility's requests for information needed to make an eligibility determination. The Treasury Department and the IRS decline to impose this specific requirement but note that hospital facilities have the flexibility to include any additional information in the FAP that the hospital facility chooses to convey or that may be helpful to the community, including such a statement.

ii. Method for Applying for Financial Assistance

Section 501(r)(4)(A)(iii) requires a hospital facility's FAP to include the method for applying for financial assistance under the FAP. Accordingly, the 2012 proposed regulations provided that a hospital facility's FAP must describe how an individual applies for financial assistance under the FAP and that either the hospital facility's FAP

or FAP application form (including accompanying instructions) must describe the information or documentation the hospital facility may require an individual to submit as part of his or her FAP application. The 2012 proposed regulations also made clear that financial assistance may not be denied based on the omission of information or documentation if such information or documentation was not specifically required by the FAP or FAP application form.

Numerous commenters asked that the final regulations add language to ensure that hospital facilities are not prohibited from granting financial assistance despite an applicant's failure to provide any or all information or documentation described in the FAP or FAP application form and requested that hospital facilities have the flexibility to grant financial assistance based on other evidence or an attestation by the applicant. While the Treasury Department and the IRS intend to require hospital facilities to establish a transparent application process under which individuals may not be denied financial assistance based on a failure to provide information or documentation unless that information or documentation is described in the FAP or FAP application form, they do not intend to restrict hospital facilities' ability to grant financial assistance to an applicant who has failed to provide such information or documentation. Accordingly, the final regulations expressly state that a hospital facility may grant financial assistance under its FAP notwithstanding an applicant's failure to provide such information. Thus, a hospital facility may grant financial assistance based on evidence other than that described in a FAP or FAP application form or based on an attestation by the applicant, even if the FAP or FAP application form does not describe such evidence or

attestations.

One commenter stated that the example in the 2012 proposed regulations of a hospital facility with a FAP that requires certain specified documentation demonstrating household income (including federal tax returns or paystubs) or “other reliable evidence of the applicant’s earned and unearned household income” was contrary to the idea that a FAP must “describe the information and documentation” required. The Treasury Department and the IRS intended for the reference to “other reliable evidence” in the example to signal that a hospital facility may be flexible in allowing applicants to provide alternative documentation to demonstrate eligibility. The example was not intended to suggest that a reference in a FAP or FAP application form to “reliable evidence” alone (without also identifying specific documentation applicants could provide) would be sufficient. To clarify this intent, the example of the FAP application form in the final regulations is modified so that the instructions identify specific documentation (including federal tax returns, paystubs, or documentation establishing qualification for certain specified state means-tested programs) but also state that if an applicant does not have any of the listed documents to prove household income, he or she may call the hospital facility’s financial assistance office and discuss other evidence that may be provided to demonstrate eligibility.

A number of commenters noted that total reliance on paper applications does not reflect current practices in which much information is gathered from patients orally, with a few commenters recommending that the final regulations expressly permit eligibility determinations on the basis of information obtained through face-to-face meetings or

over the phone rather than through a paper application process. The Treasury Department and the IRS did not intend to mandate paper applications or to imply that information needed to determine FAP-eligibility could not be obtained from an individual in other ways. Accordingly, and in response to comments, the final regulations amend the definition of “FAP application” to clarify that the term is not intended to refer only to written submissions and that a hospital facility may obtain information from an individual in writing or orally (or a combination of both).

Numerous commenters stated that hospitals can, and commonly do, rely on trustworthy methods and sources of information other than FAP applications to determine FAP-eligibility and recommended that hospital facilities be allowed to rely on these information sources and methods to determine FAP-eligibility, provided that the sources and methods are disclosed in the FAP or on the hospital facility’s Form 990. Commenters also recommended that a hospital should be able to rely on prior FAP-eligibility determinations, provided that such reliance is disclosed in its FAP.

As discussed in section 6.b.vi of this preamble, the final regulations permit a hospital facility to determine that an individual is eligible for assistance under its FAP based on information other than that provided by the individual or based on a prior FAP-eligibility determination, provided that certain conditions are met. Given this change, and consistent with commenters’ recommendations, the final regulations require a hospital facility to describe in its FAP any information obtained from sources other than individuals seeking assistance that the hospital facility uses, and whether and under what circumstances it uses prior FAP-eligibility determinations, to presumptively

determine that individuals are FAP-eligible.

Some commenters requested that the final regulations specifically prohibit hospital facilities from using social security numbers or credit card information or from running credit checks that damage consumer credit, while another commenter would impose a requirement that all requested information or documentation be reasonable and adequate to establish eligibility for the hospital facility's FAP. The final regulations do not prescribe or restrict the information or documentation a hospital facility may request but do require that a hospital facility describe such information or documentation in its FAP or FAP application form. The Treasury Department and the IRS expect that the transparency achieved by requiring the information or documentation to be described in the FAP or FAP application form will discourage hospital facilities from requesting information or documentation that is unreasonable or unnecessary to establish eligibility.

A number of commenters noted that a patient's financial status may change over time and requested clarification on the point in time used to determine financial eligibility. A few of these commenters requested clarification that a hospital facility has the discretion to determine that point in time in its FAP, a few recommended that a specific point in time be used (for example, the date of service or the date of application), and a few suggested that the final regulations should require the point in time to be specified in a FAP.

The Treasury Department and the IRS intend for hospital facilities to have the flexibility to choose the time period used to determine FAP eligibility and expect that that

the relevant point(s) in time will be made clear based on the information and/or documentation requested from applicants in the FAP or FAP application form. For example, if a hospital facility's FAP application form asks for "last month's" income, the hospital facility presumably will look at the applicant's income from the month preceding the submission of the FAP application to determine whether the applicant satisfies the income-based eligibility criteria. Similarly, the example regarding application methods in these final regulations describes a hospital facility that requests proof of household income in the form of payroll check stubs "from the last month" (which would reflect wages in the time period shortly before the application) or, if last month's wages are not representative of the applicant's annual income, a copy of the applicant's "most recent federal tax return" (which would reflect annual income in a year preceding the application). Because the Treasury Department and the IRS expect that the time period(s) used to assess eligibility should be evident from the information and/or documentation requested to demonstrate eligibility, the final regulations do not provide further elaboration on this point.

iii. Actions That May Be Taken in the Event of Nonpayment

In the case of a hospital facility that does not have a separate billing and collections policy, section 501(r)(4)(A)(iv) requires a hospital facility's FAP to include actions that may be taken in the event of nonpayment. Accordingly, the 2012 proposed regulations provided that either a hospital facility's FAP or a separate written billing and collections policy established for the hospital facility must describe the actions that the hospital facility (or other authorized party) may take related to obtaining payment of a

bill for medical care, including, but not limited to, any extraordinary collection actions described in section 501(r)(6).

A few commenters recommended that the final regulations require governing board approval of the billing and collections policy of a hospital facility. The Treasury Department and the IRS note that these final regulations, like the 2012 proposed regulations, provide that a FAP “established” by a hospital facility must describe the hospital facility’s actions in the event of nonpayment unless the hospital facility has “established” a billing and collections policy that describes these actions. As described in section 4.c of this preamble, a billing and collections policy or a FAP is “established” only if it is adopted by an authorized body of the hospital facility, which includes the governing body of the hospital facility or a committee of, or other party authorized by, such governing body. Thus, the final regulations provide that an authorized body of the hospital facility must adopt the hospital facility’s FAP and, if applicable, billing and collections policy.

Two commenters asked that hospital facilities with separate billing and collections policies be required both to include some basic information about those policies in their FAPs and to translate the separate billing and collections policies into foreign languages. The 2012 proposed regulations provided that a hospital facility that described its actions in the event of nonpayment in a separate billing and collections policy must state in its FAP that the actions in the event of nonpayment are described in a separate billing and collections policy and explain how members of the public may readily obtain a free copy of this separate policy. In addition, the definition of “readily

obtainable information” in the 2012 proposed regulations provided that a separate billing and collections policy would be readily obtainable if it were made available free of charge both on a Web site and in writing upon request in the same manner that a FAP is made available on a Web site and upon request, which included making translated copies available on a Web site and upon request. To clarify that translations were intended to be part of making a billing and collections policy readily obtainable, §1.501(r)-4(b)(6) of the final regulations relating to “readily obtainable information” has been amended to expressly refer to the provision of translations.

iv. Widely Publicizing the FAP

Section 501(r)(4)(A)(v) requires a hospital facility’s FAP to include measures to widely publicize the FAP within the community served by a hospital facility. To satisfy this requirement, the 2012 proposed regulations provided that a FAP must include, or explain how members of the public may readily obtain a free written description of, the measures taken by the hospital facility to--

- Make the FAP, FAP application form, and a plain language summary of the FAP (together, “FAP documents”) widely available on a Web site;
- Make paper copies of the FAP documents available upon request and without charge, both in public locations in the hospital facility and by mail;
- Notify and inform visitors to the hospital facility about the FAP through conspicuous public displays or other measures reasonably calculated to attract visitors’ attention; and
- Notify and inform residents of the community served by the hospital facility about

the FAP in a manner reasonably calculated to reach those members of the community who are most likely to require financial assistance.

Several commenters asked that hospitals be given the flexibility to “widely publicize” the FAP in any manner they see fit. The Treasury Department and the IRS view the provisions in the 2012 proposed regulations as already giving hospital facilities broad flexibility to determine the methods they think are best to notify and inform their patients and broader communities about their FAPs. In addition, the Treasury Department and the IRS see the requirements to make the FAP widely available on a Web site and to make paper copies available upon request as minimal steps that are necessary to ensure patients have the information they need to seek financial assistance. Accordingly, the final regulations continue to require a hospital facility to make the FAP documents available upon request and widely available on a Web site and to notify and inform both visitors to the hospital and members of the community served by the hospital about its FAP.

One commenter suggested that a hospital facility’s FAP should only be required to “summarize” the measures to widely publicize the FAP, suggesting that requiring detailed information about such measures would unnecessarily increase mailing, copying, and compliance costs. In response to this comment and to reduce the documentation burden associated with the FAP, these final regulations eliminate the requirement that the FAP list the measures taken to widely publicize the FAP and instead require only that a hospital facility implement the measures to widely publicize the FAP in the community it serves. This approach is consistent with the definition of

“establishing” a FAP discussed in section 4.c of this preamble, which includes not only adopting the FAP but also implementing it, and with the Joint Committee on Taxation’s (JCT) Technical Explanation of the Affordable Care Act. See Staff of the Joint Committee on Taxation, Technical Explanation of the Revenue Provisions of the “Reconciliation Act of 2010,” as Amended, in Combination with the “Patient Protection and Affordable Care Act” (March 21, 2010), at 82 (Technical Explanation) (stating that section 501(r)(4) requires each hospital facility to “adopt, implement, and widely publicize” a written FAP).

A. Widely available on a Web site

A number of commenters stated that FAPs will be updated more frequently than summaries, so that making the full FAP widely available on a Web site would be burdensome. One of these commenters stated that the full FAP is not especially useful for most patients, as it is written for internal compliance and difficult for the general public to understand. On the other hand, numerous other commenters strongly supported the requirement to make these documents widely available on a Web site, with some noting that doing so would allow patients to more easily identify the assistance they might be eligible for and to speak knowledgeably with financial assistance personnel at the hospital facility. The Treasury Department and the IRS believe that making the complete FAP widely available to the public on a Web site is important in achieving transparency and that the benefits of this transparency outweigh the burdens incurred in posting an updated document on a Web site. Thus, the final regulations retain this requirement.

B. Making paper copies available upon request

With respect to the requirement to make paper copies of the FAP documents available upon request and without charge in public locations in the hospital facility, one commenter stated that “public locations” could be interpreted to mean all public locations in the hospital and that essentially every area of the hospital could be classified as a public location. Another commenter asked that “public locations” specifically include the admissions areas and the emergency room, noting that patients and their family members generally pass through one of those two areas during their stay and that having at least one uniform location where these documents are available would help ensure that patients know where to go for paper copies. In response to these comments, the final regulations specify that “public locations” in a hospital facility where paper copies must be provided upon request include, at a minimum, the emergency room (if any) and the admissions areas.

Other commenters asked that making paper copies “available upon request” should be required only with respect to patients who indicate that they lack access to the Internet. The final regulations clarify that hospital facilities may inform individuals requesting copies that the various FAP documents are available on a Web site or otherwise offer to provide the documents electronically (for example, by email or on an electronic screen). However, the Treasury Department and the IRS continue to believe that making paper copies of the FAP documents available to those persons who request them is important to achieve adequate transparency. Accordingly, the final regulations also make clear that a hospital facility must provide a paper copy unless the individual

indicates he or she would prefer to receive or access the document electronically.

C. Notifying and informing hospital facility patients

With respect to the requirement in the 2012 proposed regulations to notify and inform visitors to a hospital facility about the FAP through a conspicuous public display (or other measures reasonably calculated to attract visitors' attention), a number of commenters asked for clarification on what makes a public display "conspicuous," with one such commenter noting that placement of a small placard in a corner of a financial assistance office that is rarely seen by patients should not be sufficient.

The Treasury Department and the IRS believe that what makes a public display "conspicuous" is both for the display to be of a noticeable size and for the display to be placed in a location in the hospital facility where visitors are likely to see it. Thus, similar to the requirement regarding making paper copies of the FAP documents available upon request in "public locations" in the hospital facility, the final regulations clarify that hospital facilities must notify and inform visitors about the FAP in "public locations" in the hospital facility, including, at a minimum, the emergency room (if any) and admissions areas.

In addition to notifying patients about the FAP through a conspicuous public display (or through other measures reasonably calculated to attract visitors' attention), the final regulations also require hospital facilities to widely publicize their FAPs by providing FAP information to patients before discharge and with billing statements. The 2012 proposed regulations included the notification of patients about the FAP before discharge and with billing statements as part of the notification component of

reasonable efforts to determine FAP-eligibility under section 501(r)(6). However, these efforts to notify and inform patients about the FAP before discharge and with billing statements may also be appropriately categorized as measures to widely publicize the FAP under section 501(r)(4). Thus, the final regulations consolidate all of the requirements that involve notifying patients generally about the FAP under the section 501(r)(4) widely publicizing requirements. As a result, the notification component of reasonable efforts to determine FAP-eligibility under the section 501(r)(6) final regulations is simplified and is focused primarily on those patients against whom a hospital facility actually intends to engage in extraordinary collection actions. The Treasury Department and the IRS expect that moving the requirement that hospital facilities notify and inform patients about the FAP with billing statements and as part of their intake or discharge process from the section 501(r)(6) regulations to the section 501(r)(4) regulations will increase understanding of the requirements and compliance, without a loss of notification to patients.

In addition to requiring hospital facilities to notify individuals about their FAPs before discharge and on billing statements as part of widely publicizing their FAPs, the final regulations also amend these requirements in several important respects in response to comments to the 2012 proposed regulations. First, rather than require a full plain language summary with billing statements, the final regulations require only that a hospital facility's billing statement include a conspicuous written notice that notifies and informs the recipient about the availability of financial assistance under the hospital facility's FAP and includes the telephone number of the hospital facility office or

department that can provide information about the FAP and FAP application process and the direct Web site address (or URL) where the copies of the FAP documents may be obtained. This change responds to those comments (discussed in greater length in section 6.b.iii of this preamble) that noted that a reference on the billing statement to the availability of the FAP and a brief description of how to obtain more information should provide sufficient notification to patients while minimizing costs for hospital facilities.

Second, some commenters appeared to interpret the phrase “before discharge” in the 2012 proposed regulations as requiring distribution “at discharge” and suggested that the latter requirement would not work because outpatients do not always revisit with a hospital registration staff member after care is provided or may never be physically present at the hospital facility. In response to these comments, the final regulations refer to offering the plain language summary as part of either the “intake or discharge process,” and the Treasury Department and the IRS intend that those terms be interpreted broadly to include whatever processes are used to initiate or conclude the provision of hospital care to individuals who are patients of the hospital facility. In addition, in response to commenters who noted that many patients will have no interest in receiving a plain language summary of the FAP because they know they are not FAP-eligible, the final regulations require only that a hospital facility “offer” (rather than “provide”) a plain language summary as part of the intake or discharge process. Thus, a hospital facility will not have failed to widely publicize its FAP because an individual declines to take a plain language summary that the hospital facility offered on intake or before discharge or indicates that he or she would prefer to receive or access a plain

language summary electronically rather than receive a paper copy.

D. Notifying and informing the broader community

Several commenters recommended eliminating altogether the requirement to notify and inform members of the hospital facility's community about the FAP, stating that the other three measures to widely publicize the FAP are sufficient and that this additional specification is vague, open to subjective interpretation, and overly burdensome for hospitals. Other commenters, however, strongly supported the requirement, particularly the special emphasis placed on members of the community most likely to need financial help.

The Treasury Department and the IRS interpret the phrase "widely publicize . . . within the community to be served by the organization" in section 501(r)(4)(v) as going beyond merely making a FAP "widely available" on a Web site or upon request and requiring hospital facilities to affirmatively reach out to the members of the communities they serve to notify and inform them about the financial assistance they offer. Accordingly, the final regulations retain the requirement to notify and inform members⁷ of the hospital's community in a manner reasonably calculated to reach those members who are most likely to require financial assistance from the hospital facility.

E. Plain language summary of the FAP

The 2012 proposed regulations defined the plain language summary of the FAP as a written statement that notifies an individual that the hospital facility offers financial

⁷ In recognition of the fact that not all hospital facilities will define the communities they serve along strictly geographic lines, the final regulations are amended to refer to "members" of the hospital facility's community rather than "residents."

assistance under a FAP and provides certain specified information, including but not limited to: (1) the direct Web site address and physical location(s) (including a room number, if applicable) where the individual can obtain copies of the FAP and FAP application form; and (2) the contact information, including telephone numbers and physical location (including a room number, if applicable), of hospital facility staff who can provide the individual with information about the FAP and the FAP application process, as well as of the nonprofit organizations or government agencies, if any, that the hospital facility has identified as available sources of assistance with FAP applications.

A number of commenters noted that many hospitals currently assist patients with the FAP application process and that such assistance can be very important for low-income patients with literacy barriers. A few commenters requested that the final regulations require hospitals to assist and/or provide contact information for hospital staff who can assist with the FAP application process. One commenter suggested that the plain language summary should not have to include the contact information of nonprofit organizations or government agencies that assist with FAP applications, recommending instead that hospital facilities be able to include the contact information for the hospital facility's own community health clinics as sources of FAP application assistance.

Although assisting patients with the FAP application process can be an important step in ensuring that patients obtain the financial assistance for which they are eligible, nonprofit organizations or government agencies can be as effective sources of this

assistance as hospital facilities themselves. To ensure both that patients have notice of how to obtain assistance with the FAP application process and that hospital facilities have the flexibility to refer patients to other organizations rather than provide assistance themselves, the final regulations require the plain language summary to include the contact information of a source of assistance with FAP applications but allow for this source to be either the hospital facility itself or a different organization. More specifically, the final regulations provide that the plain language summary must include the contact information of either the hospital facility office or department that can provide assistance with (rather than just “information about”) the FAP application process or, if the hospital facility does not provide assistance with the FAP application process, at least one nonprofit organization or government agency that the hospital facility has identified as an available source of such assistance.

One commenter recommended that the plain language summary of the FAP only be required to list a department rather than a physical location because hospital facility remodeling and redesign could mean that the precise physical location could be subject to change, therefore requiring re-drafting of the plain language summary. Another commenter asked that the final regulations clarify that the plain language summary may identify the location and phone number of the appropriate office or department to contact for more information about the FAP, without naming a specific staff person.

The Treasury Department and the IRS continue to think that the physical location in the hospital facility where patients can obtain copies of the FAP and FAP application form and information about and/or assistance with the FAP application process is

important, basic information to provide to individuals in the plain language summary. Therefore, the final regulations continue to require this information regarding physical location. However, the final regulations remove a specific reference to a room number to give hospital facilities more flexibility to describe the physical location in the manner that makes the most sense for the hospital facility. The final regulations also clarify that the plain language summary may identify the location and phone number of the appropriate office or department to contact for more information about the FAP and, if applicable, assistance with the FAP application process and does not need to name a specific staff person.

One commenter recommended that, in addition to the required items of information described in the 2012 proposed regulations, the plain language summary should provide a basic outline of the FAP application process and the appropriate times to apply. This commenter stated that many patients will rely on the plain language summary for information about the FAP, in lieu of reading the FAP itself, and that information about when and how to apply for financial assistance is basic information a patient needs to have. The Treasury Department and the IRS agree that information about how to apply for financial assistance is important information for individuals to have, and the final regulations therefore require this information to be included in the plain language summary. Any additional burden created by requiring this information should be mitigated by the fact that the final regulations do not require the plain language summary to be included with all billing statements and other written communications provided during the notification period. As for “when” to apply, while

patients generally have at least 240 days from the date of the first bill to apply for financial assistance, the deadline for any particular patient's FAP application will depend on whether and when the hospital facility sends that patient the notice about potential extraordinary collection actions described in section 6.b.iii.C of this preamble that states a deadline. Given the resulting variability in deadlines, the final regulations do not require the plain language summary to include a description of the appropriate times to apply.

A few commenters asked that the plain language summary be required to include a statement regarding patient responsibilities. The Treasury Department and the IRS do not intend for the list of elements required to be included in a plain language summary of the FAP to limit a hospital facility's ability to provide additional information. Accordingly, a hospital facility is permitted, but not required, to include in its plain language summary any additional items of information it deems relevant to the FAP and FAP application process.

F. Translating the FAP documents

The 2012 proposed regulations provided that hospital facilities must translate FAP documents into the primary language of any LEP populations that constitute more than 10 percent of the members of the community served by the hospital facility. One commenter asked that this requirement be eliminated altogether, at least with regard to small or rural hospital facilities, while two other commenters supported the 10-percent threshold for translation. Many additional commenters requested that the translation threshold be lowered from 10 percent to the lesser of 5 percent or 500 LEP individuals.

They noted that some federal translation thresholds are set as low as 500 LEP individuals and that a 5-percent threshold would result in greater consistency with translation guidance provided by the Department of Health and Human Services (HHS). See HHS, “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons,” 68 FR 47,311 (August 8, 2003) (“HHS Guidance”). The HHS Guidance includes a “safe harbor” that considers it strong evidence that a hospital receiving federal financial assistance is in compliance with written translation obligations under Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d, et. seq.) if it provides written translations of vital documents for each eligible LEP language group that constitutes 5 percent or 1,000, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered.⁸

Both Medicaid and Medicare Part A constitute “federal financial assistance” for purposes of Title VI of the Civil Rights Act, and the Treasury Department and the IRS expect that virtually every hospital facility operated by an organization described in section 501(c)(3) accepts Medicaid and/or Medicare Part A. The Treasury Department and the IRS also expect that documents that describe the financial assistance offered by a hospital facility and that are necessary to apply for such financial assistance would be considered “vital” for purposes of the Title VI obligations. Therefore, the Treasury Department and the IRS expect that many hospital facilities are already translating

⁸ If there are fewer than 50 persons in a language group that reaches the 5-percent trigger, the recipient of federal financial assistance does not have to translate vital written materials to satisfy the safe harbor but rather may provide written notice in the primary language of the LEP language group of the right to receive competent oral interpretation of those written materials, free of cost.

these documents to meet their Title VI obligations, often in accordance with the safe harbor in the HHS Guidance. As a result, the Treasury Department and the IRS agree with commenters that it is reasonable and appropriate to make the translation threshold applicable to the FAP documents generally consistent with the 5-percent/1000 person threshold under the HHS Guidance safe harbor, and the final regulations adopt this change.

The 2012 proposed regulations provided that a hospital facility could determine whether a LEP group exceeded the relevant threshold based on the latest data available from the U.S. Census Bureau or other similarly reliable data. One commenter requested clarification on whether to use the U.S. Census Bureau's decennial survey or more updated information provided through the American Community Survey. The Treasury Department and the IRS believe that a hospital facility basing its determination of LEP populations in whole or in part on data from the U.S. Census Bureau should be allowed to use either the latest decennial census data or the latest American Community Survey data. In addition, other data sources may also be reasonable to use to determine LEP populations for purposes of these regulations. For example, the HHS Guidance notes that, in determining the LEP persons eligible to be served or likely to be affected or encountered, it may be appropriate for hospitals to examine not only census data but also their prior experiences with LEP patients, data from school systems and community organizations, and data from state and local governments. See HHS Guidance, 68 FR at 47314. The Treasury Department and the IRS intend that a hospital facility be able to use these same data sources in determining the LEP persons

in the community it serves or likely to be affected or encountered for purposes of these final regulations. Therefore, rather than list the various data sources a hospital facility may use to determine its LEP populations, the final regulations provide that a hospital facility may use any reasonable method to determine such populations.

Several commenters recommended that hospital facilities only be required to translate the plain language summary of the FAP and the FAP application form, not the full FAP, stating that the summary and application form are the documents most useful to patients and that few, if any, patients request the full FAP. The Treasury Department and the IRS believe that the benefits of ensuring that LEP populations have access to the details provided in the FAP that are not captured in a summary or application form outweigh the additional costs that hospital facilities may incur in translating the full FAP document. Accordingly, the final regulations do not adopt this comment.

Several commenters recommended that the final regulations require hospitals to provide access to oral interpreters or bilingual staff on request, regardless of whether the thresholds for written translations are met. The Treasury Department and the IRS believe it would be overly burdensome to require hospital facilities to provide access to oral interpreters or bilingual staff for every language possibly spoken in a community. Accordingly, the final regulations do not adopt this comment.

b. Emergency medical care policy

To satisfy the requirements of section 501(r)(4)(B), the 2012 proposed regulations provided that a hospital facility must establish a written policy that requires the hospital facility to provide, without discrimination, care for emergency medical

conditions (within the meaning of the Emergency Medical Treatment and Labor Act (EMTALA), section 1867 of the Social Security Act (42 U.S.C. 1395dd)) to individuals, regardless of whether they are FAP-eligible. The 2012 proposed regulations further provided that an emergency medical care policy will generally satisfy this standard if it requires the hospital facility to provide the care for any emergency medical condition that the hospital facility is required to provide under Subchapter G of Chapter IV of Title 42 of the Code of Federal Regulations, which is the subchapter regarding the Centers for Medicare and Medicaid Services' (CMS) standards and certification that includes the regulations under EMTALA. In addition, §1.501(r)-4(c)(2) of the 2012 proposed regulations provided that a hospital facility's emergency medical care policy would not meet the requirements of section 501(r)(4)(B) unless it prohibited the hospital facility from engaging in actions that discouraged individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment or by permitting debt collection activities in the emergency department or in other areas of the hospital facility where such activities could interfere with the provision, without discrimination, of emergency medical care.

Some commenters stated that the regulations under EMTALA already establish rules for registration processes and discussions regarding a patient's ability to pay in the emergency department and that the final regulations should not go beyond those requirements. A number of commenters noted that the broad language regarding "debt collection in the emergency department" could be read to proscribe ordinary and unobjectionable activities in the emergency room, such as collecting co-payments on

discharge, checking for qualification for financial or public assistance, and asking for insurance information or co-pays after patients are stabilized and waiting (sometimes for long periods of time) for test results or follow-up visits from their physician.

Section 1.501(r)-4(c)(2) of the 2012 proposed regulations was intended to apply only to debt collection activities in the emergency department (or other areas of the hospital facility) that could interfere with the provision of emergency care, not to all payment activities in the emergency department regardless of their potential to interfere with care. To make this intent clear, the final regulations are revised to prohibit “debt collection activities that interfere with the provision, without discrimination, of emergency medical care,” regardless of where such activities occur.

In addition, the Treasury Department and the IRS note that, since the publication of the 2012 proposed regulations, CMS has made clear that the regulations under EMTALA prohibit applicable hospital facilities from engaging in actions that delay the provision of screening and treatment for an emergency medical condition to inquire about method of payment or insurance status, or from using registration processes that unduly discourage individuals from remaining for further evaluation, such as by requesting immediate payment before or while providing screening or stabilizing treatment for emergency medical conditions. See CMS Memorandum S&C-14-06 – Hospitals/CAHs re: EMTALA Requirements & Conflicting Payor Requirements or Collection Practices, at 6-7 (Dec. 13, 2013). As a result, a hospital facility that provides the screening care and stabilizing treatment for emergency medical conditions, as applicable, that the hospital facility is required to provide under the regulations under

EMTALA, should generally not be engaging in the activities that §1.501(r)-4(c)(2) of the final regulations requires emergency medical care policies to prohibit.

Two commenters asked whether the emergency medical care policy may be in the same document as the FAP. The final regulations do not prevent an emergency medical care policy from being included within the same document as the FAP or from being added to an already existing document related to emergency medical care (such as a document setting forth EMTALA compliance).

c. Establishing the FAP and other policies

Consistent with the 2012 proposed regulations, the final regulations provide that a hospital organization will have established a FAP, a separate billing and collections policy, or an emergency medical care policy for a hospital facility only if an authorized body of the hospital facility has adopted the policy and the hospital facility has implemented the policy.

The 2012 proposed regulations provided that a hospital facility has “implemented” a policy if it has “consistently carried out” the policy. A number of commenters asked for more clarity on when a policy will be deemed to be “consistently carried out.” Two of these commenters would deem a hospital facility to have consistently carried out a policy only if the hospital facility attests that a policy that meets the requirements of section 501(r)(4) has been followed in all cases.

As discussed in section 2.a of this preamble, the final regulations provide that omissions or errors that are minor and either inadvertent or due to reasonable cause will not result in a failure to meet the requirements of section 501(r)(4) (or any other

requirements under section 501(r)) as long as they are corrected in accordance with §1.501(r)-2(b)(1)(ii) of the final regulations. Therefore, the final regulations make clear that the Treasury Department and the IRS do not intend that every error in implementing a policy described in section 501(r)(4) will result in a failure to meet the requirements of section 501(r)(4). On the other hand, a policy that is simply adopted by an authorized body of a hospital facility but not followed in any regular fashion has not been “established” for purposes of section 501(r)(4). Whether a policy is “consistently carried out” is to be determined based on all of the facts and circumstances. However, if the authorized body of a hospital facility adopts a policy and provides reasonable resources for and exercises due diligence regarding its implementation, then the standard should be met.

The 2012 proposed regulations provided that, while a hospital organization must separately establish a FAP for each hospital facility it operates, such policies “may contain the same operative terms.” Several commenters asked that hospital organizations operating multiple facilities be permitted to adopt one FAP for all of their facilities. These commenters argued that many hospital systems have centralized patient financial services operations, including FAPs, and that adopting a single FAP would avoid both significant administrative costs as well as patient confusion about differences in financial responsibilities based on location.

The final regulations clarify that multiple hospital facilities may have identical FAPs, billing and collections policies, and/or emergency medical care policies established for them (or even share one joint policy document), provided that the

information in the policy or policies is accurate for all such facilities and any joint policy clearly states that it is applicable to each facility. The final regulations also note, however, that different hospital facilities may have different AGB percentages or use different methods to determine AGB that would need to be reflected in each hospital facility's FAP (or, in the case of AGB percentages, in a separate document that can be readily obtained).

5. Limitation on Charges

The final regulations provide that a hospital organization meets the requirements of section 501(r)(5) with respect to a hospital facility it operates only if the hospital facility limits the amounts charged for any emergency or other medically necessary care it provides to a FAP-eligible individual to not more than AGB. The final regulations also require a hospital facility to limit the amounts charged to FAP-eligible individuals for all other medical care covered under the FAP to less than the gross charges for that care.

a. Amounts generally billed

The 2012 proposed regulations provided two methods for hospital facilities to use to determine AGB. The first was a "look-back" method based on actual past claims paid to the hospital facility by either Medicare fee-for-service alone or Medicare fee-for-service together with all private health insurers paying claims to the hospital facility (including, in each case, any associated portions of these claims paid by Medicare beneficiaries or insured individuals). The second method was "prospective," in that it required the hospital facility to estimate the amount it would be paid by Medicare and a Medicare beneficiary for the emergency or other medically necessary care at issue if the

FAP-eligible individual were a Medicare fee-for-service beneficiary. For purposes of the 2012 proposed regulations, the term “Medicare fee-for-service” included only health insurance available under Medicare Parts A and B and not health insurance plans administered under Medicare Advantage.

Many commenters stated that allowing hospital facilities only two methods for calculating AGB was insufficiently flexible. Some commenters asked that the final regulations only require hospital facilities to fully disclose and describe the method they used to determine AGB on their Forms 990, without requiring hospital facilities to determine AGB in any particular manner. A few commenters noted that Medicare and insurer reimbursement models may shift over time and that flexibility will be needed to ensure that the methods for determining AGB set forth in the final regulations do not become antiquated or hamper evolution in reimbursement models. However, no additional methods to determine AGB were identified.

Providing hospital facilities complete discretion to select methods in determining AGB would make it very difficult for the IRS to enforce the statutory requirement that hospital facilities not charge FAP-eligible individuals more than AGB and difficult for the public to understand and recognize whether hospital facilities are complying with this requirement. However, the Treasury Department and the IRS recognize that Medicare and insurer reimbursement methodologies may evolve over time and that additional ways to determine AGB may be identified in the future. Therefore, the final regulations allow the Treasury Department and the IRS to provide for additional methods to determine AGB in future published guidance as circumstances warrant.

Many commenters suggested that the options for determining AGB should be expanded or amended to permit hospital facilities to base AGB on the payments of private, commercial insurers only, without also taking into account Medicare payments. Some commenters specifically asked for the ability to determine AGB based on “either the best, or an average of the three best, negotiated commercial rates,” as suggested in the JCT’s Technical Explanation. See Technical Explanation at 82. These commenters reasoned that individuals with commercial insurance are more representative of FAP-eligible populations than Medicare beneficiaries (as the latter generally include the elderly). A few commenters also suggested that Medicare rates are an inappropriate proxy for AGB because they are not the result of negotiations between parties and, according to these commenters, do not always cover the costs of providing care to Medicare beneficiaries. On the other hand, other commenters recommended that AGB be based on Medicare alone, arguing that this would increase transparency because amounts reimbursed by Medicare are publicly verifiable.

Because Medicare reimbursements constitute a large proportion of most hospital facilities’ total insurance reimbursements, the Treasury Department and the IRS continue to believe a method of determining AGB that excludes Medicare and is based only on the claims or rates of private health insurers would be inconsistent with the statutory phrase “amounts generally billed to individuals who have insurance.” On the other hand, the Treasury Department and the IRS find no support in either the statutory language of section 501(r)(5) or the Technical Explanation for requiring (rather than just allowing) AGB to be based on Medicare alone. Thus, the final regulations continue to

allow hospital facilities using the look-back method to base AGB on the claims of Medicare fee-for-service plus all private health insurers, as well as on Medicare alone.

A few commenters noted that Medicaid is the largest governmental payer for children's hospitals and recommended that hospital facilities be able to use Medicaid rates in calculating AGB. The final regulations adopt this recommendation and allow hospital facilities to base AGB on Medicaid rates, either alone or in combination with Medicare (or, under the look-back method, together with Medicare and all private health insurers), at the hospital facility's option.

With respect to Medicaid, one commenter noted that, in many states, private managed care organizations operate Medicaid managed care plans and that the final regulations should expressly state whether Medicaid managed care claims and rates are to be included when determining AGB. In response to this comment, the final regulations provide that the term "Medicaid," as used in the final regulations, includes medical assistance provided through a contract between the state and a Medicaid managed care organization or a prepaid inpatient health plan and that such assistance is not considered reimbursements from or claims allowed by a private health insurer. By contrast, the final regulations, like the 2012 proposed regulations, provide that a hospital facility must treat health insurance plans administered by private health insurers under Medicare Advantage as the plans of private health insurers.

Many commenters asked how the limitation on charges to AGB applies to insured individuals who are eligible for financial assistance. Most of these commenters recommended that the AGB limitation apply only to uninsured individuals, asserting that

section 501(r)(5) was enacted to provide uninsured individuals in need of assistance with the benefit of rates negotiated by insurance companies and that requiring the use of AGB for insured patients could inadvertently reduce the availability of financial assistance for insured patients. One commenter suggested that, for insured patients who receive a partial financial assistance discount, AGB should be equal to the amounts generally billed for the care minus payments made by the third-party insurer. Another commenter suggested that the AGB limitation should only apply to the patient liability and not include payments made by third parties, such as health insurers.

The Treasury Department and the IRS note that section 501(r)(5) does not distinguish between insured and uninsured FAP-eligible individuals. Accordingly, the final regulations continue to apply the AGB limitation of section 501(r)(5) to all individuals eligible for assistance under the hospital facility's FAP, without specific reference to the individual's insurance status. In response to the comments, however, the final regulations clarify that, for purposes of the section 501(r)(5) limitation on charges, a FAP-eligible individual is considered to be "charged" only the amount he or she is personally responsible for paying, after all deductions and discounts (including discounts available under the FAP) have been applied and less any amounts reimbursed by insurers. Thus, in the case of a FAP-eligible individual who has health insurance coverage, a hospital facility will not fail to meet the section 501(r)(5) requirements because the total amount required to be paid by the FAP-eligible individual and his or her health insurer together exceeds AGB, as long as the FAP-eligible individual is not personally responsible for paying (for example, in the form of

co-payments, co-insurance, or deductibles) more than AGB for the care after all reimbursements by the insurer have been made. The final regulations also add several examples demonstrating how the limitation on charges works when applied to insured FAP-eligible individuals.

A few commenters asked that the final regulations clarify that AGB represents the maximum amount hospital facilities can charge to FAP-eligible individuals and that hospital facilities may charge FAP-eligible individuals less than AGB (that is, provide a more generous discount under a FAP). The Treasury Department and the IRS have added an example to the final regulations to confirm this point.

The 2012 proposed regulations provided that, after choosing a particular method to determine AGB, a hospital facility must continue using that method indefinitely. The preamble to the 2012 proposed regulations requested comments on whether a hospital facility should be allowed to change its method of determining AGB under certain circumstances or following a certain period of time and, if so, under what circumstances or how frequently. Commenters uniformly noted that there could be many practical reasons that a hospital facility might want to change its method for determining AGB, such as changes in technologies or processes that make a previously-selected method less administrable.

In response to these comments, the final regulations provide that a hospital facility may change the method it uses to determine AGB at any time. However, because the final regulations under section 501(r)(4) require a hospital facility's FAP to describe the method used to determine AGB, a hospital facility must update its FAP to

describe a new method before implementing it.

A number of commenters noted that the 2012 proposed regulations do not define the term “medically necessary care.” Some commenters asked that the final regulations provide that hospital facilities have the discretion to determine how non-emergency and elective services are considered under their FAPs. Other commenters recommended that the final regulations define the term “medically necessary care.” Suggested definitions included the Medicaid definition used in the hospital facility's state or other definitions provided by state law, a definition that refers to the generally accepted medical practice in the community, or a definition based on the determination made by the examining physician or medical team.

The final regulations allow hospital facilities to define the term “medically necessary care” for purposes of their FAPs and the AGB limitation in recognition of the fact that health care providers and health insurers may have reasonable differences in opinion on whether some health care services are medically necessary in particular circumstances. In defining medically necessary care for purposes of their FAPs and the AGB limitation, the final regulations clarify that hospital facilities may (but are not required to) use the Medicaid definition used in the hospital facility's state, other definitions provided by state law, or a definition that refers to the generally accepted standards of medicine in the community or an examining physician’s determination.

i. Look-Back Method

Under the look-back method for determining AGB, a hospital facility determines AGB for any emergency or other medically necessary care provided to a FAP-eligible

individual by multiplying the hospital facility's gross charges for that care by one or more percentages of gross charges, called "AGB percentages." Hospital facilities must calculate their AGB percentages no less frequently than annually by dividing the sum of certain claims for emergency and other medically necessary care by the sum of the associated gross charges for those claims. A hospital facility may use the look-back method to calculate one average AGB percentage for all emergency and other medically necessary care provided by the hospital facility, or multiple AGB percentages for separate categories of care (such as inpatient and outpatient care or care provided by different departments) or for separate items or services. However, a hospital facility calculating multiple AGB percentages must calculate AGB percentages for all emergency and other medically necessary care it provides.

The 2012 proposed regulations provided that the AGB percentages must be based on all claims that have been "paid in full" to the hospital facility for emergency and other medically necessary care by Medicare fee-for-service alone, or by Medicare fee-for-service together with all private health insurers, during a prior 12-month period. A few commenters asked whether the phrase "claims . . . paid in full" as used in the 2012 proposed regulations was intended to include claims that a hospital facility had partially written off as bad debt and/or treated as paid in full after taking into account a discount it had granted. If so, commenters asked whether the hospital facility should only include the reduced amount actually paid when calculating the AGB percentage(s). One commenter also asked whether the amount a hospital facility has accepted for the claim in a sale to a third-party debt collector should be treated as "paid in full." Two

commenters suggested that, instead of being based on claims “paid in full,” the AGB percentages should be based on “contracted rates” or the amounts that are allowed by health insurers.

To eliminate the uncertainty created by the phrase “paid in full,” the final regulations provide that, when calculating its AGB percentage(s) under the look-back method, a hospital facility should include in the numerator the full amount of all of the hospital facility’s claims for emergency and other medically necessary care that have been “allowed” (rather than “paid”) by health insurers during the prior 12-month period. For these purposes, the full amount allowed by a health insurer should include both the amount to be reimbursed by the insurer and the amount (if any) the individual is personally responsible for paying (in the form of co-payments, co-insurance, or deductibles), regardless of whether and when the individual actually pays all or any of his or her portion and disregarding any discounts applied to the individual’s portion (under the FAP or otherwise).

Several commenters interpreted the 2012 proposed regulations to mean that hospital facilities had to include the claims for all emergency and other medically necessary care provided during the prior 12-month period when calculating AGB percentages. These commenters pointed out that many of the claims for care provided toward the end of a 12-month period will not be adjudicated by an insurer until some amount of time after the end of that 12-month period. Under both the 2012 proposed regulations and these final regulations, the inclusion of a claim in a hospital facility’s calculation of its AGB percentage(s) is not based on whether the care associated with

the claim was provided during the prior 12-month period. Rather, it is based on whether the claim is “allowed” (formerly, “paid in full”) during the prior 12-month period. The final regulations clarify this point. The final regulations also state that, if the amount a health insurer will allow for a claim has not been finally determined as of the last day of the 12-month period used to calculate the AGB percentage(s), a hospital facility should exclude the amount of the claim from that calculation and include it in the subsequent 12-month period during which the amount allowed is finally determined.

A few commenters asked that hospital facilities be permitted to calculate AGB percentages under the look-back method based on claims for all medical care allowed in the prior 12-month period, rather than just the claims for emergency and medically necessary care. These commenters stated that it would be administratively burdensome to have to sift out only the claims for emergency and medically necessary care. Accordingly, the final regulations provide that a hospital facility may include in the calculation of its AGB percentage(s) claims for all medical care allowed during the prior 12-month period rather than just the claims allowed for emergency and other medically necessary care. The Treasury Department and the IRS note that the calculation of a hospital facility’s AGB percentage(s) includes only claims allowed by insurers and that insurers generally allow claims only for care that is medically necessary. Thus, the Treasury Department and the IRS do not expect that there will be a significant difference between AGB percentages based on all claims allowed by insurers and AGB percentages based on all claims allowed by insurers for emergency and other medically necessary care.

A few commenters noted that the health care delivery system is migrating from a fee-for-service model to other methods of payment, used by both public and private payers, that include “value-based,” accountable care, and shared savings payments. These commenters stated that the 2012 proposed regulations failed to account for these other methods of payment because the method of calculating AGB percentages appeared to be based on claims for individual episodes of care, while value-based, accountable care, shared savings, and similar payments are not necessarily tied to individual episodes of care.

As a general matter, the Treasury Department and the IRS interpret the statutory phrase “amounts generally billed to individuals who have insurance covering such care” as referring to amounts billed or reimbursed for care received by those insured individuals. It is not clear, and commenters did not address, how lump sum payments from an insurer with no direct connection to any specific individual’s care would appropriately be included in a determination of AGB. As a result, the final regulations do not amend the look-back method or the prospective method to specifically account for any such separate payment streams. However, if a hospital facility can reasonably allocate a capitated (or other lump sum) payment made by an insurer to care received by particular patients during a twelve-month period and has also tracked the gross charges for that care, it may be able to reasonably incorporate such payments into its calculation of one or more AGB percentages under the look-back method described in the final regulations. In addition, the Treasury Department and the IRS will continue to consider whether hospital facilities need alternative methods of determining AGB that

directly accommodate capitated payments or value-based, accountable care, shared savings, and similar payments, and, if so, such alternative methods may be provided in future regulations, revenue rulings, or other published guidance.

The look-back method described in the 2012 proposed regulations only included claims paid by Medicare fee-for-service and/or private health insurers as primary payers. One commenter indicated that payments made by secondary payers should also be included in a hospital facility's calculation of its AGB percentage(s) because considering only primary payers and patient co-insurance, co-payments, and deductibles artificially depresses the AGB percentages. The Treasury Department and the IRS intend for hospital facilities to be able to include in the calculation of their AGB percentages the total amount of claims for care allowed by primary insurers (including both the amounts paid by primary insurers and the amounts insured individuals are personally responsible for paying in the form of co-payments, co-insurance, or deductibles), regardless of whether secondary insurers end up paying some or all of the insured individual's portion. In addition, if an individual's primary insurer does not cover a certain procedure but his or her secondary insurer does, including the amount allowed by the secondary insurer in the calculation of the hospital facility's AGB percentage(s) will not result in any duplication because only one amount was allowed by an insurer. Moreover, if the secondary insurer is of the type that is otherwise being included in the hospital facility's calculation of the AGB percentage (that is, Medicare, Medicaid, and/or a private health insurer), the amounts allowed by the secondary insurer should be included in the calculation to ensure that the resulting AGB percentage(s) is fully

representative of the amounts allowed by the applicable type of insurer(s). Thus, to eliminate any confusion, the final regulations remove the references to “primary payers” contained in the 2012 proposed regulations.

Numerous commenters asked that hospital organizations be permitted to calculate AGB percentages on a system-wide basis, stating that many hospital systems have centralized patient financial services operations and that permitting a system-wide calculation would avoid both significant administrative costs and patient confusion about differences in financial responsibilities based on location. Because different hospital facilities within a system can serve distinct geographic areas, offer significantly different services, and have different negotiated rates with insurers, allowing hospital systems to calculate AGB percentages across the entire system could result in AGB percentages that would not accurately reflect the amounts generally billed to individuals with insurance by the separate hospital facilities within the system. Specifically, a system-wide AGB percentage would be an average across hospital facilities, some of which may have lower negotiated reimbursement rates with insurers or more Medicare patients than others. Use of a system-wide AGB percentage could result in higher charges for the FAP-eligible patients of those hospital facilities in the system with lower negotiated reimbursement rates or more Medicare patients than would be the case if the AGB were calculated on a facility-by-facility basis. Accordingly, the final regulations do not permit such system-wide calculations. However, because hospital facilities that have satisfied CMS criteria to bill and be covered under one Medicare provider number may find it administratively difficult to separate claims by hospital facility, the final

regulations allow hospital facilities that are covered under the same Medicare provider agreement (as identified by the same CMS Certification Number) to calculate one AGB percentage (or multiple AGB percentages for separate categories of care or separate items or services) based on the claims and gross charges for all such hospital facilities and implement the AGB percentage(s) across all such hospital facilities.

One commenter asked that the final regulations clarify that a hospital organization operating more than one hospital facility may select the look-back method for some of its facilities and the prospective method for others. The 2012 proposed regulations were not intended to prevent different hospital facilities operated by the same hospital organization from using different methods to determine AGB at different hospital facilities, and these final regulations expressly state that this is permissible.

The 2012 proposed regulations provided that a hospital facility must begin applying its AGB percentage(s) by the 45th day after the end of the 12-month period the hospital facility used in calculating the AGB percentage(s) and requested comments regarding whether a hospital facility needs more than 45 days. Numerous commenters stated that hospital facilities need a period longer than 45 days both to complete the calculation and to make the updates to their policies, processes, systems, and communications necessary to implement the changes and recommended periods ranging from 60 to 120 days. In response to these comments, the final regulations allow a hospital facility to take up to 120 days after the end of the 12-month period used in calculating the AGB percentage(s) to begin applying its new AGB percentage(s). The Treasury Department and the IRS note that, because the final regulations under section

501(r)(4) require a hospital facility's FAP to state the hospital facility's AGB percentage(s) or explain how members of the public may readily obtain such percentages, a hospital facility must update its FAP (or other readily obtainable material) to reflect new AGB percentage(s).

The 2012 proposed regulations requested comments regarding whether a hospital facility using the look-back method should have the option to base its AGB-percentage calculation on a representative sample of claims (rather than all claims) that were paid in full over a prior 12-month period and, if so, how hospital facilities would ensure that such samples are representative and reliable. A few commenters suggested that the final regulations should permit the use of samples, but they did not provide much additional explanation of why samples were necessary or how samples could be determined in a representative and reliable way. Other commenters argued that samples would be inaccurate and that permitting the use of sampling would give hospital facilities an excessive ability to manipulate their computations and exacerbate problems with transparency or protections for consumers. Because legitimate concerns were raised by commenters with respect to sampling and no comments explained why the use of samples was necessary or how hospital facilities could ensure that such samples would be representative and reliable, the final regulations do not allow hospital facilities using the look-back method to base their calculation of AGB percentage(s) on a sample of claims. The Treasury Department and the IRS note, however, that, to the degree using all claims in calculating AGB percentages takes longer than using a representative sample, hospital facilities have 120, not 45, days after the end of the

applicable 12-month period to calculate and implement AGB percentages under the final regulations.

The 2012 proposed regulations also requested comments regarding whether hospital facilities might significantly increase their gross charges after calculating one or more AGB percentages and whether such an increase could mean that determining AGB by multiplying current gross charges by an AGB percentage would result in charges that exceed the amounts that are in fact generally billed to those with insurance at the time of the charges. A number of commenters stated that such safeguards are unnecessary, since most hospitals do not update their gross charges more than once a year, increases are generally based on an annual market analysis, and AGB calculations would not drive hospitals to change their gross charges. After considering the comments received on this issue, the final regulations do not modify the proposed rule in this regard.

ii. Prospective Method

Under the prospective method described in the 2012 proposed regulations, a hospital facility could determine AGB for any emergency or other medically necessary care that the hospital facility provided to a FAP-eligible individual by using the same billing and coding process the hospital facility would use if the individual were a Medicare fee-for-service beneficiary and setting AGB for that care at the amount that Medicare and the Medicare beneficiary together would be expected to pay for the care. The Treasury Department and the IRS requested comments regarding whether a hospital facility should also have the option of determining AGB based on the private

health insurer with the lowest rate or the three private health insurers with the three lowest rates. Some commenters who responded to this request for comments said hospital facilities should have this option under both the prospective and the look-back methods, while other commenters recommended that AGB be based on Medicare alone. For reasons discussed previously in this section 5.a of the preamble (including the fact that Medicare reimbursements constitute a large proportion of most hospital facilities' total insurance reimbursements), the Treasury Department and the IRS believe that excluding Medicare and basing AGB only on the private health insurer with the lowest rate or the three private health insurers with the three lowest rates would not accurately capture the amounts generally billed by hospital facilities to individuals with insurance in many cases. Thus, the final regulations do not permit hospital facilities to determine AGB using the prospective method based on the private health insurers with the lowest rate or the three private health insurers with three lowest rates.

Consistent with changes made to the look-back method, the final regulations allow hospital facilities to determine AGB under the prospective method based on Medicaid, either alone or in combination with Medicare fee-for service. More specifically, the final regulations provide that a hospital facility using the prospective method may base AGB on either Medicare fee-for-service or Medicaid or both, provided that, if it uses both, its FAP describes the circumstances under which it will use Medicare fee-for-service or Medicaid in determining AGB.

b. Gross charges

The 2012 proposed regulations provided that a hospital facility must charge a

FAP-eligible individual less than the gross charges for any medical care provided to that individual. Several commenters argued that, unlike the AGB requirement in section 501(r)(5)(A), the language regarding the prohibition on the use of gross charges in section 501(r)(5)(B) does not refer to FAP-eligible individuals, in particular. As a result, these commenters recommended that the final regulations prohibit the use of gross charges for all individuals, not just FAP-eligible individuals.

The Treasury Department and the IRS believe it is reasonable to interpret section 501(r)(5)(B)'s prohibition on gross charges in the context of section 501(r)(5) as a whole, which is intended to limit the amounts charged to FAP-eligible individuals. The JCT clarified this intent in the Technical Explanation, remarking that “[a] hospital facility may not use gross charges . . . when billing individuals who qualify for financial assistance.” See Technical Explanation, at 82. Thus, the final regulations continue to apply the prohibition on gross charges only to FAP-eligible individuals.

The 2012 proposed regulations applied the AGB limitation only to charges to FAP-eligible individuals for emergency or other medically necessary care, while the prohibition on charging FAP-eligible individuals gross charges would also apply to “all other medical care.” A few commenters interpreted this language to mean that the prohibition on gross charges applies even to elective procedures not covered under the FAP. In response, the final regulations clarify that this limitation applies only to charges for care covered under a hospital facility's FAP, which may, but need not, cover care that is neither emergency nor medically necessary care.

c. Safe harbor for certain charges in excess of AGB

The 2012 proposed regulations included a safe harbor under which a hospital facility would not violate section 501(r)(5) if it charged more than AGB for emergency or other medically necessary care, or charged gross charges for any medical care, to a FAP-eligible individual who had not submitted a complete FAP application as of the time of the charge, provided that the hospital facility made and continued to make reasonable efforts to determine whether the individual was FAP-eligible (within the meaning of and during the periods required under section 501(r)(6)).

Because the steps to notify individuals about the FAP that remain in the regulations under section 501(r)(6) (as opposed to those that have been moved to the regulations under section 501(r)(4)) are focused on the individuals against whom a hospital facility actually intends to initiate extraordinary collection actions, the §1.501(r)-5(d) safe harbor in the final regulations does not retain the requirement in the 2012 proposed regulations that the hospital facility make reasonable efforts to determine whether the individual is FAP-eligible within the meaning of the section 501(r)(6) regulations. Instead, the safe harbor focuses on remedying the overcharging by requiring that, if an individual submits a complete FAP application and is determined to be FAP-eligible for care, the hospital facility must refund any amounts the individual has paid for the care that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible individual. For reasons discussed in section 6.b.v.B of this preamble, the §1.501(r)-5(d) safe harbor in the final regulations also contains an exception to this general requirement to refund under which a hospital

facility is not required to refund excess payments of less than \$5.

One commenter suggested that the §1.501(r)-5(d) safe harbor should only require a hospital facility to refund amounts paid by a FAP-eligible individual in excess of AGB. As part of properly implementing their FAPs, hospital facilities should charge FAP-eligible individuals only the amounts they are determined to owe as FAP-eligible individuals. Thus, a hospital facility should not be permitted to charge FAP-eligible individuals more than AGB and be able to avail itself of the §1.501(r)-5(d) safe harbor unless it is willing to refund any amounts paid by a FAP-eligible individual that exceed the amount he or she is determined to owe as a FAP-eligible individual.

Two commenters recommended that the safe harbor under the section 501(r)(5) regulations require a hospital facility to charge all individuals AGB or less during the application period unless it has affirmatively determined that the individual is not FAP-eligible. The Treasury Department and the IRS expect that a hospital facility will not be able to affirmatively determine whether most of its patients are FAP-eligible because most of its patients who are not FAP-eligible will not apply for financial assistance. Accordingly, such a rule would undercut the purpose of the safe harbor and is not adopted by these final regulations.

As discussed further in section 6.a.iv of this preamble, two commenters noted that charging individuals an upfront payment as a condition of receiving care may be tantamount to denying that care in the case of medically indigent people, and the final regulations consider demanding payment of a past bill as a condition of receiving future medically necessary care to be an extraordinary collection action. In addition, the

Treasury Department and the IRS believe that the §1.501(r)-5(d) safe harbor should not protect hospital organizations that charge an upfront payment in excess of AGB to FAP-eligible individuals. Accordingly, the final regulations provide that the §1.501(r)-5(d) safe harbor does not apply to charges made or requested as a pre-condition of providing medically necessary care to a FAP-eligible individual. Thus, if a hospital facility requires an individual to make an upfront payment for medically necessary care that exceeds the AGB for the care and the individual turns out to be FAP-eligible, the hospital facility will have failed to meet the requirements of section 501(r)(5).

6. Billing and Collection

Consistent with the statute, the final regulations provide that a hospital organization meets the requirements of section 501(r)(6) with respect to a hospital facility it operates only if the hospital facility does not engage in extraordinary collection actions (ECAs) against an individual to obtain payment for care before making reasonable efforts to determine whether the individual is FAP-eligible for the care. For these purposes, and consistent with the 2012 proposed regulations, a hospital facility will be considered to have engaged in ECAs against an individual to obtain payment for care if the hospital facility engages in such ECAs against any other individual who has accepted or is required to accept responsibility for the first individual's hospital bill for the care.

One commenter interpreted the provision in the 2012 proposed regulations regarding ECAs against individuals with responsibility for a patient's hospital bill as applying to private and public insurers covering all or a portion of the patient's hospital

bill. Under the Code, the term “individual” does not include any trust, estate, partnership, association, company, corporation, or governmental entity and, thus, would not include any private or public insurer. Accordingly, the final regulations retain the provision in the 2012 proposed regulations regarding ECAs against individuals with responsibility for a patient’s hospital bill. This provision does not require a hospital facility to make reasonable efforts to determine FAP-eligibility before engaging in ECAs against private or public insurers or any other liable third parties that are not individuals.

The 2012 proposed regulations also provided that a hospital facility will be considered to have engaged in an ECA against an individual to obtain payment for care if any purchaser of the individual’s debt or any debt collection agency or other party to which the hospital facility has referred the individual’s debt has engaged in an ECA against the individual to obtain payment for the care. Many commenters asked that the regulations relieve hospital facilities from strict liability under section 501(r)(6) for the actions of third parties, provided that the hospital facility acts in good faith to supervise and enforce the section 501(r)(6) obligations of its contractual agreements with collection agents and takes remedial steps with respect to any contractual violations it discovers. These commenters argued that a hospital’s tax-exempt status should not be placed in jeopardy by a debt collection agency’s actions of which it is unaware. Other commenters, however, recommended that the final regulations retain the provision holding hospital facilities accountable for the billing and collection actions of third-party contractors and debt buyers.

The Treasury Department and the IRS continue to believe that hospital facilities

must be held accountable for the ECAs of the debt collection agencies and debt buyers to which they refer or sell debt. Otherwise, hospital facilities could easily avoid their responsibilities under section 501(r)(6) by referring or selling their debt to third parties. Nonetheless, the Treasury Department and the IRS expect that the concerns of these commenters are largely addressed by the provision, outlined in section 2.b of this preamble, under which a hospital facility's failure to meet the requirements of section 501(r)(6) will be excused if the failure is not willful or egregious and the hospital facility both corrects and discloses the failure in accordance with published guidance. Under this provision, if a hospital facility acts reasonably and in good faith to supervise and enforce the section 501(r)(6) obligations of its contractual agreements with debt collectors or purchasers and corrects any contractual violations it discovers, then an error on the part of the debt collectors or purchasers should not be willful and, provided that it is not egregious, could be excused if the hospital facility corrects and discloses the failure in accordance with the procedures outlined in the revenue procedure described in §1.501(r)-2(c). Accordingly, the final regulations retain the provision holding a hospital facility accountable for the ECAs of the third parties collecting debt on its behalf or to which it sells debt.

One commenter interpreted the 2012 proposed regulations as suggesting that a hospital facility must meet the section 501(r)(6) requirements with respect to all care provided by the hospital facility, even if that care is elective and not medically necessary. Section §1.501(r)-6(b) of these final regulations and the 2012 proposed regulations define ECAs as actions related to obtaining payment of bills "for care

covered under the hospital facility's FAP." Both the proposed and final regulations under section 501(r)(4) only require a FAP to cover emergency and other medically necessary care. Because a hospital facility has discretion over whether its FAP covers elective procedures that are not medically necessary, it has discretion over whether or not it must meet the section 501(r)(6) requirements with respect to such elective care.

a. Extraordinary collection actions

The 2012 proposed regulations defined ECAs as actions taken by a hospital facility against an individual related to obtaining payment of a bill for care covered under the hospital facility's FAP that require a legal or judicial process, involve selling an individual's debt to another party, or involve reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus (collectively, "credit agencies").

Some commenters asked that the final regulations clarify that certain additional actions, such as writing off an account to bad debt, sending a patient a bill, or calling a patient by telephone to make reasonable inquiries, are not ECAs. These actions do not require a legal or judicial process or involve reporting adverse information to a credit agency or the selling of an individual's debt and would not come within the definition of ECAs under either the 2012 proposed regulations or the final regulations. However, because there are many possible actions that would not be ECAs and such actions cannot be exhaustively listed in the regulations, the final regulations do not respond to these comments by enumerating actions that are not ECAs (although they do provide for some exceptions with respect to the ECAs that are enumerated, as described in

sections 6.a.ii and 6.a.iii of the preamble).

i. Reports to Credit Agencies

Many commenters argued that reporting adverse information to a credit agency should not be considered an ECA because such reporting is not a collection action and is a common practice of hospital facilities. One commenter argued that Congress could not have intended credit agency reporting to be an ECA because section 501(r)(4)(A)(iv) provides that a tax-exempt hospital facility's FAP or separate billing and collection policy must include, among other items, "the actions the organization may take in the event of non-payment, including collections action[s] and reporting to credit agencies." Other commenters supported defining ECAs to include reporting an individual's non-payment of a debt to a credit agency, noting that such an action is a tool in collecting debt and can have extraordinarily detrimental consequences for individuals by resulting in bad credit records for many years.

The Treasury Department and the IRS view reporting to credit agencies as a collection action because it is a tool to collect delinquent debts, and bad credit reports can have extraordinarily detrimental consequences for the affected individuals. Moreover, the requirement under section 501(r)(4)(A)(iv) that a hospital facility describe reporting to credit agencies in its FAP or billing and collections policy evidences Congress's concern regarding such reporting. In addition, the JCT's Technical Explanation states that "reasonable efforts' includes notification . . . before collection action or reporting to credit agencies is initiated." Technical Explanation, at 82. Because section 501(r)(6) only requires a hospital facility to make reasonable efforts

before initiating an ECA, this statement supports the conclusion that reporting to credit agencies is an ECA. Accordingly, the final regulations continue to include the reporting of adverse information to credit agencies as an ECA.

ii. Certain Liens

The 2012 proposed regulations provided a non-exclusive list of examples of actions that require a legal or judicial process, which included the placement of a lien on an individual's property. Numerous commenters noted that, when a patient has sued a third party due to an auto accident or other type of accident and, as a part of the settlement, is entitled to receive reimbursement for medical bills, state laws commonly allow hospitals to place a lien on that portion of potential settlement proceeds.

Commenters stated that they often need to move quickly if they will ever be able to take possession of such funds and asked that the final rule confirm that this common practice will not be treated as an ECA against the patient.

The proceeds of settlements, judgments, or compromises arising from a patient's suit against a third party who caused the patient's injuries come from the third party, not from the injured patient, and thus hospital liens to obtain such proceeds should not be treated as collection actions against the patient. In addition, the portion of the proceeds of a judgment, settlement, or compromise attributable under state law to care that a hospital facility has provided may appropriately be viewed as compensation for that care. Accordingly, in response to comments, the final regulations expressly provide that these liens are not ECAs.

iii. Sale of an Individual's Debt to Another Party

A number of commenters argued that debt sales should not be considered ECAs because they are an important way for hospitals to avoid having to collect debt themselves. Some commenters noted that holding hospital facilities accountable for the actions of debt buyers should be sufficient to ensure that debt buyers do not themselves engage in ECAs before reasonable efforts are made. In addition, several commenters argued that certain debt sales are beneficial to the patient as well as to the hospital facility because, for example, the buyer may service the debt more efficiently or be able to offer extended payment plans at no or low interest that the hospital facility cannot. These commenters recommended that debt sales should not be considered ECAs if the purchaser of the debt is contractually obligated not to take any actions that are ECAs and/or the debt is returnable to or recallable by the hospital facility.

Other commenters stated that hospital facilities lose control of the debt once they sell it and that debt buyers typically purchase medical debts for pennies on the dollar, without full information about the individual patients, and are thus more likely to pursue flawed claims and engage in abusive practices. These commenters recommended that debt sales be prohibited altogether, even after reasonable efforts are made to determine an individual's FAP-eligibility.

The Treasury Department and the IRS note that section 501(r)(6) does not prohibit any collection actions outright; therefore, the final regulations do not prohibit debt sales altogether. The final regulations do, however, retain the general rule that debt sales are ECAs because the Treasury Department and the IRS agree with those

commenters who noted that hospitals have less control over a debt once it has been sold and that debt buyers will generally have less information regarding the individual and the debt and more incentive to engage in ECAs before making reasonable efforts to determine whether an individual is FAP-eligible.

Nonetheless, the Treasury Department and the IRS believe these concerns about debt sales are mitigated in certain cases in which contractual arrangements with debt buyers both allow hospital facilities to retain control over the debt and benefit patients. Accordingly, the final regulations provide that the sale of an individual's debt is not an ECA if, prior to the sale, the hospital facility enters into a legally binding written agreement with the purchaser of the debt containing four conditions. First, the purchaser must agree not to engage in any ECAs to obtain payment of the debt. Second, the purchaser must agree not to charge interest on the debt in excess of the rate in effect under section 6621(a)(2) at the time the debt is sold (or such other interest rate set by notice or other guidance published in the Internal Revenue Bulletin).⁹ Third, the debt must be returnable to or recallable by the hospital facility upon a determination by the hospital facility or the purchaser that the individual is FAP-eligible. And, fourth, if the individual is determined to be FAP-eligible and the debt is not returned to or recalled by the hospital facility, the purchaser must adhere to procedures specified in the agreement that ensure that the individual does not pay, and has no obligation to pay, the purchaser and the hospital facility together more than he or she is personally

⁹ The interest rate in effect under section 6621(a)(2) was 3 percent at the time these final regulations were published. See Rev. Rul. 2014-29, 2014-52 IRB 960 (Dec. 22, 2014).

responsible for paying as a FAP-eligible individual. Because debt sales subject to these four conditions are not considered to be ECAs under the final regulations, a hospital facility may make these debt sales without first having made reasonable efforts to determine FAP-eligibility. Debt sales that do not satisfy these four conditions are ECAs and therefore may not be made until after a hospital facility has made reasonable efforts to determine FAP-eligibility, as described in section 6.b of this preamble.

iv. Including Additional Actions as ECAs

The preamble to the 2012 proposed regulations asked whether deferring or denying care based on a pattern of nonpayment, requiring deposits before providing care, or charging interest on medical debts should constitute ECAs. Some commenters opined that these actions should be categorized as ECAs to protect patients, with two commenters adding that requiring deposits is tantamount to denying care for medically indigent people. Other commenters recommended that these activities should not be ECAs, noting that requiring some deposit from patients prior to scheduling non-emergency care is a common practice among health care providers and that interest is charged by many credit providers. One of these commenters also stated that it is not inappropriate or extraordinary for a hospital to defer provision of care to a patient who has a documented pattern of non-payment unless that patient is seeking emergency care covered under EMTALA through the emergency department.

The Treasury Department and the IRS view the charging of interest on medical debt as a charge for the extension of credit rather than a collection action. In addition, the Treasury Department and the IRS interpret the term “collection action” as applying

to actions to collect debts owed for services already rendered, not conditions imposed before any services have been provided or any debts have been incurred. Thus, the Treasury Department and the IRS do not believe that requiring a payment (whether partial or full) before providing care is a collection action unless it is related to an attempt to collect a prior medical bill. Accordingly, the final regulations do not include these activities as ECAs.

However, if a hospital facility defers or denies, or requires a payment before providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care, such actions constitute actions to collect the unpaid bills. Moreover, these collection actions can properly be viewed as extraordinary, given that such actions can potentially jeopardize the health of the debtor. While one commenter asserted that "it is not inappropriate" for a hospital to defer the provision of care on the basis of a documented pattern of non-payment unless it is care sought through the emergency department covered under EMTALA, the relevant question for purposes of section 501(r)(6) is not whether deferring or denying care based on past nonpayment is permitted under EMTALA but rather whether it is a collection action that is extraordinary. In addition, as two commenters pointed out, requiring deposits can be tantamount to denying care for medically indigent people, and thus requiring payment before providing medically necessary care because of nonpayment of past bills is also an ECA with respect to those past bills. Therefore, the final regulations include such collection actions within the definition of ECAs. The final regulations also elaborate on when a requirement for payment will be considered to be

“because of” an individual’s nonpayment of one or more bills for previously provided care. In particular, the final regulations provide that, if a hospital facility requires payment before providing care to an individual with one or more outstanding bills, such a payment requirement will be presumed to be because of the individual’s nonpayment of the outstanding bill(s) unless the hospital facility can demonstrate that it required the payment from the individual based on factors other than, and without regard to, his or her nonpayment of past bills.

Several commenters also recommended that patients who are eligible for hospital financial assistance, means-tested public programs, or subsidies should not be subject to any ECAs or other collection actions. Section 501(r)(6) requires hospital facilities to determine whether an individual is FAP-eligible before engaging in ECAs but does not bar ECAs altogether against individuals that have been determined to be FAP-eligible or eligible for assistance under public programs. Therefore, the final regulations do not adopt this comment.

b. Reasonable efforts

The 2012 proposed regulations provided that, with respect to any care provided by a hospital facility to an individual, the hospital facility would have made reasonable efforts to determine whether the individual is FAP-eligible only if the hospital facility notified the individual about the FAP, provided a reasonably sufficient amount of time for the individual to apply for financial assistance, and processed FAP applications received from the individual during a specified period. For purposes of meeting these requirements, the 2012 proposed regulations described both an initial 120-day

“notification period” during which the hospital facility was required to notify an individual about the FAP and a 240-day “application period” during which a hospital facility was required to process any application submitted by the individual, with both periods starting on the date of the first bill. A hospital facility providing the necessary notification during the 120-day notification period could begin to engage in ECAs against an individual after the end of the 120-day notification period but was required to suspend any such ECAs if the individual submitted a FAP application during the remainder of the application period (and to reverse such ECAs if the individual was determined to be FAP-eligible).

Many commenters stated that the reasonable efforts regime set forth in the 2012 proposed regulations was too detailed and prescriptive and asked that the final regulations adopt this regime as a safe harbor rather than as a requirement. These commenters asked that hospital facilities be allowed to maintain current practices regarding the manner and timeframe of notification about the FAP and processing of FAP applications, provided that these practices are made transparent, such as by requiring that these practices be disclosed in FAPs, billing and collection policies, or the hospital facility’s Form 990.

The Treasury Department and the IRS do not believe that disclosure alone of a hospital facility’s notification and FAP-eligibility determination processes constitutes reasonable efforts to determine whether individuals are FAP-eligible. While the regulations under section 501(r)(4) require such disclosure to be made in the FAP or a separate billing and collections policy, such disclosure will not meaningfully or

adequately accomplish the requirement that Congress intended when it enacted section 501(r)(6) and expressly called for the Secretary to issue guidance defining reasonable efforts to determine FAP-eligibility.¹⁰ Accordingly, the final regulations do not provide hospital facilities with complete discretion over how to make reasonable efforts to determine FAP-eligibility. However, the final regulations do make a number of modifications, as described further in this section of the preamble, that are designed to reduce the compliance burden on hospital facilities while at the same time ensuring that the reasonable efforts taken to determine whether individuals are FAP-eligible adequately protect patients.

The final regulations also contain a number of changes to §1.501(r)-6(c) of the 2012 proposed regulations that are intended to streamline and simplify the presentation of the applicable rules and not to have a substantive effect.

i. Notification and Application Periods

The 2012 proposed regulations requested comments on whether the notification and application periods should start later than the date of the first billing statement, such as the date of discharge, in the case of patients staying at a hospital facility for a prolonged period of time and receiving billing statements in the mail before being discharged. The majority of commenters responding to this request for comments stated that the notification and application periods should start no earlier than the time of discharge so that the “clock” on the periods would not start until the patient was

¹⁰ See section 501(r)(7) (providing that the Secretary “shall issue such regulations and guidance as may be necessary to carry out the provisions of [section 501(r)], including guidance relating to what constitutes reasonable efforts to determine the eligibility of a patient under a” FAP for purposes of section 501(r)(6)).

aware of the billing statements and able to focus on the notifications about the FAP. On the other hand, one commenter noted that inpatients present the best opportunity for in-person financial counseling activity and that there was therefore no need for the periods to begin after discharge rather than the first billing statement. Another commenter opined that the requirements relating to FAP notification and applications would be confusing to both providers and consumers if the FAP notification and application periods did not always start on the date of the first billing statement.

In response to the majority of comments on the issue and to ensure that patients who receive care over a prolonged period of time receive adequate notification about the FAP and impending ECAs and have an adequate opportunity to apply for financial assistance, the final regulations provide that the applicable 120- and 240-day periods start on the date that the first “post-discharge” billing statement is provided, rather than just the first billing statement. For these purposes, the final regulations clarify that a billing statement for care is considered “post-discharge” if it is provided to an individual after the care (whether inpatient or outpatient) is provided and the individual has left the hospital facility.

Many commenters asked that the lengths of the proposed 120-day notification period and/or 240-day application period be modified. Some commenters suggested a shorter application period of 90, 120, or 180 days, with the notification period either being concurrent with, or a shorter period within, the application period. Several of the commenters who requested one concurrent notification and application period noted the complexity associated with tracking two different, overlapping periods. In arguing for a

shorter application period, many commenters stated that a 240-day application period would unduly interfere with hospital facilities' ability to recover from patients with resources available to pay the amounts due.

Other commenters, however, suggested longer notification or application periods. One commenter suggested one concurrent notification and application period of 240 days, stating that it would be more effective and less burdensome for all involved to simply prohibit all ECAs during the entire 240-day application period. Other commenters requested an application period of one or two years, noting that many times ECAs are not commenced until long after 240 days and that many patients may not realize that money is owed until after 240 days, particularly if they believe that outstanding charges might be covered by an insurer. Commenters also noted that FAP-eligible individuals may not promptly respond to notifications regarding a hospital facility's FAP if they are sick or have literacy issues. Several commenters recommended that patients be allowed to raise FAP-eligibility as an affirmative defense against ECAs at any time, not just during the application period. One commenter requested clarification that hospitals may extend the application period beyond 240 days.

The Treasury Department and the IRS continue to believe that 120 days from the first post-discharge billing statement is an appropriate amount of time for hospital facilities to wait before initiating ECAs against patients whose FAP-eligibility is undetermined so that patients have sufficient time to learn about the FAP and apply for financial assistance. As noted in the preamble to the 2012 proposed regulations, such

a 120-day period is consistent with some state requirements or recommendations to wait 120 days before taking certain ECAs and, based on typical billing cycles reported by commenters, should ensure patients receive at least three bills before facing an ECA. Moreover, since the release of the 2012 proposed regulations, a taskforce of healthcare finance professionals, healthcare providers, consumer advocates, collections agencies, and credit agencies has recommended that hospitals wait 120 days from the date of the first billing statement before commencing ECAs “to protect patients from undue haste in use of ECAs.” See Best Practices for Resolution of Medical Accounts: A Report from the Medical Debt Collection Task Force, at 9 (Jan. 2014), available at <http://www.hfma.org/medicaldebt/>. Therefore, the final regulations generally provide that a hospital facility may not initiate ECAs against an individual whose FAP-eligibility has not been determined before 120 days after the first post-discharge billing statement. However, due to changes made in the final regulations regarding the notification requirements described in section 6.b.iii of this preamble, the 120-day period during which a hospital facility may not initiate ECAs is no longer called a “notification period.”

With respect to the application period, the Treasury Department and the IRS agree with some commenters that it is generally a good practice for hospital facilities to allow individuals to raise FAP-eligibility as a defense against ECAs at any time and not just during a limited application period. In fact, the Treasury Department and the IRS understand that many hospital facilities currently will accept and process FAP applications from patients at any time, and the definition of “application period” in the final regulations expressly states that hospital facilities may continue to do this.

Moreover, many hospital facilities may prefer simply to allow FAP applications to be submitted at any time rather than track application periods for each patient on an episode-of-care basis. However, in the interest of sound tax administration and achieving certainty for hospital facilities, the question of whether a hospital facility has met the requirements of section 501(r)(6) should not be left open indefinitely.

Accordingly, although hospital facilities may continue to accept and process FAP applications at any time, the final regulations provide an application period after which a hospital facility is not required to accept and process FAP applications for purposes of meeting section 501(r)(6).

The Treasury Department and the IRS continue to believe that about eight months (240 days) after the first post-discharge bill is a reasonable period of time for a hospital facility to give a patient to apply for financial assistance to be considered to have made reasonable efforts to determine whether the patient is FAP-eligible. As one commenter pointed out, individuals may commonly have to wait several months before they know how much of a charge for health care services an insurer will cover and how much they are personally responsible for paying. In addition, the amount of time allowed for FAP applications to be submitted should take into account the fact that a large proportion of applicants may face obstacles such as continuing illness, literacy issues, or language barriers.

While some commenters asserted that an application period of 240 days from the first bill would unduly interfere with hospitals' ability to collect debts from non-FAP-eligible individuals, they provided little support or further explanation for this general

claim, and other commenters suggested that many ECAs are not commenced until long after 240 days from the first bill. Moreover, under both the 2012 proposed regulations and these final regulations, hospital facilities may initiate ECAs against an individual as early as 120 days after the first post-discharge bill without failing to meet the requirements of section 501(r)(6), provided the required notifications have been given prior to the initiation of the ECAs. Some of these ECAs may have to be suspended or reversed if the patients against whom the ECAs are taken subsequently submit FAP applications, but the Treasury Department and the IRS have no reason to believe that the costs associated with such possible suspensions or reversals only for the subset of patients who submit FAP applications during the application period will be so significant as to render it impractical to initiate any ECAs during the application period.

In addition, as discussed in section 6.b.vi of this preamble, many commenters indicated that hospital facilities use a variety of methods and sources of information other than FAP applications submitted by individuals to predict potential FAP-eligibility with a high degree of accuracy. Presumably, hospital facilities will be able to use such methods and information sources to focus ECAs on those patients unlikely to be FAP-eligible, thereby minimizing the risk that they will have to reverse a significant number of ECAs. If a hospital facility receives a complete FAP application during the application period from an individual after initiating an ECA against the individual, it must process the application, but, if the individual is determined to be ineligible for financial assistance, no reversal of ECAs will be necessary (and suspension will be necessary only for the period of time the application is being processed).

For all of these reasons, the Treasury Department and the IRS believe that an application period that ends no earlier than 240 days from the first post-discharge bill appropriately balances the need to protect FAP-eligible patients from ECAs before FAP-eligibility is determined with the need to avoid undue interference with hospital facilities' ability to collect debts from non-FAP-eligible individuals.

The final regulations further provide that the application period for the care of an individual who has not been presumptively determined to be FAP-eligible (as discussed in section 6.b.vi of the preamble) will be longer than 240 days if the hospital facility provides the individual with a written notice about available financial assistance and potential ECAs (described in section 6.b.iii.C of this preamble) that states a deadline that is after the 240th day from the first post-discharge bill. For example, if a hospital facility provides an individual with a written notice about potential ECAs to obtain payment for care on the 250th day after the first post-discharge bill for the care and informs the individual that he or she has 30 days to apply for financial assistance before the identified ECAs may be initiated (the minimum number of days the deadline may be from the date the written notice is provided), the hospital facility would be required to process any FAP application that the individual submits by the 280th day after the first post-discharge bill. Thus, with the exception of individuals who are presumptively determined to be FAP-eligible (as described further in section 6.b.vi of this preamble), an individual's application period will remain open until at least 30 days after the hospital facility provides the individual with a written notice that sets a deadline after which ECAs

may be initiated.¹¹

ii. Meeting the Section 501(r)(6) Requirements on an “Episode-of-Care” Basis

A number of commenters recommended that the reasonable efforts requirements be applied on an “individual patient” basis rather than on an “episode-of-care” basis to avoid unnecessary duplication of notifications to one individual and complexity in tracking multiple notification and application periods. In addition, one commenter noted that, at such time as a hospital would engage in an ECA, it would seek to identify and aggregate all outstanding and delinquent bills for a patient and then initiate an ECA to obtain payment of all the bills together rather than each bill separately.

In response to these comments, the final regulations clarify that a hospital facility may satisfy the notification requirements simultaneously for multiple episodes of care for purposes of notifying the individual about its FAP and potential ECAs. Notwithstanding this allowance for multiple episodes of care, the Treasury Department and the IRS continue to believe that patients should not have less opportunity or time to apply for financial assistance simply because they received care from a hospital facility in the past, especially since illness and accumulating hospital bills themselves could result in a deterioration of an individual’s financial circumstances. Thus, the final regulations also provide that, if a hospital facility aggregates an individual’s outstanding bills for multiple episodes of care before initiating one or more ECAs to obtain payment for those bills, it may not initiate the ECA(s) until 120 days after it provided the first post-discharge bill for

¹¹ If the hospital facility never intends to initiate an ECA against an individual, and therefore never sends a written notice about potential ECAs (and/or a notice with a deadline for applying) to the individual, the application period is irrelevant because section 501(r)(6) only requires a hospital facility to make reasonable efforts to determine FAP-eligibility before engaging in an ECA.

the most recent episode of care included in the aggregation. Similarly, although, as a formal matter, a separate application period starts with each episode of care, as a practical matter, hospital facilities have the option of measuring the 240-day period from the first post-discharge bill for the most recent episode of care.

iii. Notification Requirements

To satisfy the notification component of “reasonable efforts” with respect to any care provided to an individual, the 2012 proposed regulations required a hospital facility to take the following actions: (1) distribute a plain language summary of the FAP, and offer a FAP application form, to the individual before discharge from the hospital facility; (2) include a plain language summary of the FAP with all (and at least three) billing statements for the care and with all other written communications regarding the bill provided during a 120-day notification period; (3) during the notification period, inform the individual about the FAP in all oral communications regarding the amount due for the care; and (4) provide the individual with at least one written notice informing the individual about the ECAs the hospital facility (or other authorized party) may take if the individual did not submit a FAP application or pay the amount due.

As discussed in section 4.a.iv.C of this preamble, the requirement to provide a plain language summary of the FAP as part of the discharge or intake process is included under §1.501(r)-4 of the final regulations as part of widely publicizing the FAP, rather than under §1.501(r)-6(c) of the final regulations. Rather than require that a plain language summary of the FAP be included with all (and at least three) billing statements and with all other written communications regarding the bill provided during a 120-day

period after the first bill, §1.501(r)-4 of the final regulations requires that all billing statements include a notice informing patients about the availability of financial assistance and how to get information about and a copy of the FAP, and §1.501(r)-6(c) of the final regulations requires that a plain language summary of the FAP be included with one post-discharge written communication. The final regulations continue to require oral notification about the FAP as part of reasonable efforts to determine FAP-eligibility in §1.501(r)-6(c), but amend this requirement to focus the oral notification on those patients against whom the hospital facility intends to engage in ECAs rather than require it for all patients who communicate with the hospital facility about the amount due for the care. Finally, §1.501(r)-6(c) of the final regulations continues to require a notice about potential ECAs but requires notice only of the ECAs the hospital facility intends to initiate rather than all ECAs that may be initiated. The comments received on, and the modifications to the components of, the notification actions that remain in §1.501(r)-6(c) of the final regulations are discussed in greater detail in this section 6.b.iii of the preamble. In general, the Treasury Department and the IRS expect that these modifications will significantly reduce the burden on hospital facilities without significantly reducing the notice given to patients about the availability of financial assistance.

A. Providing plain language summaries with written communications

Many commenters stated that requiring hospital facilities to include plain language summaries with all billing statements (as well as with all other written communications) during the notification period would result in significant programming,

printing, and mailing costs. A number of commenters suggested that a reference to the availability of the FAP and a brief description of how to obtain more information should be sufficient information for patients, with some commenters adding that if plain language summaries had to be included with bills at all, the requirement should be limited to only one or two bills. Other commenters noted that multiple notices over time are important, as patients may be in varying states of readiness for information on financial assistance, and these commenters singled out notices with billing statements as especially effective.

In response to these comments, the notification component of reasonable efforts under the final regulations requires a hospital facility to provide a plain language summary of the FAP to an individual only if and when it sends that individual the written notice about potential ECAs described in section 6.b.iii.C of this preamble. Thus, hospital facilities need only incur the additional costs that may be associated with the provision of a plain language summary one time and only with respect to the smaller pool of patients against whom the hospital facility actually intends to engage in ECAs, not with respect to all patients against whom it might one day want to engage in ECAs. As a result, the final regulations significantly reduce the burden on hospital facilities in notifying individuals about their FAPs.

At the same time, many of the commenters who argued that including a plain language summary with every bill would be unnecessarily costly also noted that a brief description of how to obtain more information about the FAP should provide sufficient notification to patients. Other commenters stressed the importance of repeated notices

about the FAP with bills. In response to these comments, and for reasons discussed in section 4.a.iv.C of this preamble, the final regulations require a conspicuous written notice about the FAP to be included on a hospital facility's billing statement as part of "widely publicizing" the FAP for purposes of meeting the requirements under section 501(r)(4). Because the final regulations require this conspicuous notice about the FAP to be included on billing statements, the Treasury Department and the IRS do not expect that the final regulations significantly reduce the information available to individuals who may be FAP-eligible or their opportunity to learn about or apply for financial assistance.

B. Oral notification

Some commenters stated that the requirement that the hospital facility inform the individual about the FAP in all oral communications regarding the amount due for care was overly burdensome, prohibitively difficult to document, prone to human error, and too dependent on the cooperation of the individual (who may, for example, hang up before receiving information about the FAP). A few commenters asked that the oral communication requirement be limited to those patients who indicate they may have difficulty paying their bill rather than applying to any patient with a question "regarding the amount due for care," as the latter could include many routine billing inquiries. Other commenters stated that orally-conveyed information can be the most effective way to ensure that patients know financial assistance is available, especially in the case of LEP populations or individuals with literacy issues.

In response to commenters, the final regulations replace the oral notification

requirement in the 2012 proposed regulations with a requirement that a hospital facility make a reasonable effort to orally notify an individual about the hospital facility's FAP and about how the individual may obtain assistance with the FAP application process at least 30 days before the initiation of ECAs against the individual. By allowing hospital facilities to target their oral notifications to those individuals against whom they actually intend to engage in ECAs, the final regulations respond to the concern that the oral notification rule in the 2012 proposed regulations was too burdensome by greatly reducing the oral notifications that hospital facilities must make. At the same time, the final regulations ensure that individuals who may need financial assistance receive oral notification about a hospital facility's FAP prior to the hospital facility's initiation of ECAs, which addresses concerns raised by commenters who stressed the importance of orally-conveyed information for potentially FAP-eligible individuals.

C. Notification about impending ECAs

A few commenters would eliminate the requirement in the 2012 proposed regulations of a written notice informing individuals about the ECAs the hospital facility may take if the individual does not submit a FAP application or pay the amount due by the specified deadline, stating that such a written notice could be considered a "threatening" communication that is prohibited by the federal Fair Debt Collection Practices Act (FDCPA) (15 U.S.C. 1601 et seq).

The FDCPA does not prevent a debt collector from informing an individual about an ECA if the ECA is lawful and the debt collector "intends" or has a "present intention" to take the action. See 15 U.S.C. 1692e(4)-(5), 1692f(6). In accordance with this

language in the FDCPA and in response to comments, the final regulations amend the requirement regarding the written notice about ECAs to require that the notice state the ECA(s) that the hospital facility (or other authorized party) actually “intends to take,” rather than requiring a description of every ECA a hospital “may” take in the future. Furthermore, like the 2012 proposed regulations, the final regulations do not require a hospital facility (or third party collecting a hospital facility’s debt) to provide this notice unless and until it actually intends to initiate one or more ECA(s) against an individual. This ability to wait to send the notice not only should eliminate any conflict with the FDCPA but also limits the burden associated with providing the notice because a hospital facility need only send it to the subset of patients against whom it actually intends to initiate ECAs.

Similar to the 2012 proposed regulations, the final regulations also require the written notice to state a deadline after which the identified ECA(s) may be initiated that is no earlier than 30 days after the date that the written notice is provided. In addition, the final regulations require the written notice to generally indicate that financial assistance is available for eligible individuals.

D. Documenting notification

The 2012 proposed regulations provided that, if an individual had not submitted a FAP application and the hospital facility had notified the individual as described in the 2012 proposed regulations and documented that it had so notified the individual, the hospital facility would be deemed to have met the reasonable efforts requirements of section 501(r)(6) and could engage in ECAs against that individual. With respect to

documenting compliance with the notification requirements, one commenter asked whether a hard copy or electronic image of every relevant piece of paper given to every individual would be required.

The final regulations eliminate any separate requirement under the section 501(r)(6) regulations to document notification. The Treasury Department and the IRS note, however, that hospital organizations will have to report whether and how they made reasonable efforts to determine FAP-eligibility before engaging in ECAs on their Forms 990 and, as a general matter, are responsible for maintaining records to substantiate any information required by the Form 990. See section 6033(a)(1); §1.6001-1(c).

E. Miscellaneous issues involving written communications

Numerous commenters noted that hospital facilities' billing systems are transitioning from paper to electronic delivery and stated that the 2012 proposed regulations seemed to envision that most written communications would be provided in paper form. In response to these comments, the final regulations clarify that a hospital facility may provide any of the written notices or communications described in §1.501(r)-6 of the final regulations electronically (for example by email) to any individual who indicates he or she prefers to receive the written notice or communication electronically.

A number of provisions in the 2012 proposed regulations referred to the date a written notice or communication was "provided," and one commenter asked whether "provides" means the date the statement is placed into the U.S. mail or the date the statement is received by the patient. The final regulations clarify that, in the case of any

written notice or communication that is mailed, the communication will be considered “provided” on the date of mailing. A communication may also be considered provided on the date it is sent electronically or delivered by hand.

iv. Incomplete FAP Applications

In the case of an individual who submits an incomplete FAP application during the application period, the 2012 proposed regulations provided that a hospital facility must suspend ECAs (defined as not initiating any ECAs or taking further action on any previously initiated ECAs) taken against the individual until either the individual’s FAP application was completed and processed or the “completion deadline” had passed without the individual’s having completed the FAP application. The 2012 proposed regulations further provided that the completion deadline could be no earlier than the later of 30 days from the date of a written notice about impending ECAs or the last day of the application period. Some commenters expressed concern that these provisions in the 2012 proposed regulations effectively allowed an individual to submit a FAP application form with minimal information on it and thereby automatically defer ECAs for up to 240 days.

In response to this concern, and to provide hospital facilities with additional flexibility to work with individuals submitting incomplete FAP applications in a manner appropriate to the particular circumstances, the final regulations provide that a hospital facility must suspend ECAs against the individual until either the individual completes the FAP application and the hospital facility determines whether the individual is FAP-eligible or until the individual has failed to respond to requests for additional information

and/or documentation within a reasonable period of time. The Treasury Department and the IRS expect the reasonableness of the period of time individuals are given to complete a FAP application before ECAs may resume will depend on the particular facts and circumstances, including the amount of additional information and/or documentation that is being requested. Although the final regulations potentially permit a hospital facility to initiate or resume ECAs before the end of the application period against an individual who has failed to respond to requests for additional information and/or documentation, if the individual subsequently completes the FAP application during the application period, the final regulations would require the hospital facility to again suspend any ECAs taken against the individual until the hospital determines whether the individual is FAP-eligible (and, if the individual is determined to be FAP-eligible, to reverse such ECAs).

A few commenters requested clarification that hospital facilities are required to suspend only those ECAs relating to the care at issue upon the submission of a FAP application, not ECAs relating to past care for which the hospital facility has already satisfied the reasonable efforts requirements. The final regulations include this clarification (in the context of processing both incomplete as well as complete FAP applications) by providing that a hospital facility must only suspend any ECAs taken against the individual “to obtain payment for the care” at issue.

Two commenters suggested that the requirement to suspend ECAs ignores specific time frames that must be followed to prevent a hospital facility’s legal rights from being jeopardized, such as filing a claim in a bankruptcy proceeding and filing a

responsive pleading or responding to a motion by prescribed deadlines in pending legal actions. One of these commenters recommended that the final regulations allow for ECAs to continue even when an incomplete FAP application is submitted if suspending the ECA would result in the hospital facility's legal rights being jeopardized.

In response to these comments, the final regulations add a provision stating that filing a claim in a bankruptcy proceeding is not an ECA, so the requirement to suspend ECAs will not jeopardize the ability to file such claims. The final regulations do not adopt the suggestion that ECAs be permitted to continue “if suspending the ECA would result in the hospital facility's legal rights being jeopardized,” as this is a vague standard that would be difficult to enforce and could substantially diminish the protection afforded by the suspension requirement. The Treasury Department and the IRS also note that, under the final regulations, ECAs taken against an individual who has submitted an incomplete FAP application only have to be suspended for a “reasonable period of time,” not a period of at least 240 days from the first post-discharge bill.

The final regulations require hospital facilities to provide a notice about potential ECAs (and an accompanying plain language summary of the FAP) to an individual who has submitted an incomplete FAP application under the provisions relating to notification about the FAP rather than separately requiring this notice under the provisions relating to incomplete FAP applications (as had been done in the 2012 proposed regulations). This change is made to simplify the regulations and is not intended to have any substantive effect for individuals who submit an incomplete FAP application before ECAs have been initiated.

Finally, to ensure that individuals who submit an incomplete FAP application during the application period know who they can contact for assistance in completing the application, and in response to commenters who stressed the importance of oral communication generally, the final regulations require a hospital facility to provide such individuals with the contact information of a hospital facility office or department (or, alternatively, a nonprofit organization or government agency) that can provide assistance with the FAP application process.

v. Complete FAP Applications

A. General requirements following receipt of complete FAP applications

Like the 2012 proposed regulations, the final regulations provide that, if a hospital facility receives a complete FAP application from an individual during the application period, the hospital facility will have made reasonable efforts to determine whether the individual is FAP-eligible only if it suspends any ECAs taken against the individual to obtain payment for the care, makes and documents an eligibility determination in a timely manner, and notifies the individual in writing of the determination and the basis for the determination.

A few commenters recommended that the final regulations require FAP-eligibility determinations to be made within a specified period of time, with the suggested time ranges being five business days, 30 days, and 45 days. However, another commenter agreed with the proposed rule that hospital facilities evaluate whether an applicant is eligible in “a timely manner” (while also adding that “30 days seems reasonable”). Yet another commenter noted that many FAPs will require individuals to apply for Medicaid

before the individual is eligible for financial assistance from the hospital facility and requested that the regulations suspend the time period in which the hospital facility must make the FAP-eligibility determination to allow time for a Medicaid application to be filed and a Medicaid eligibility determination to be made.

The Treasury Department and the IRS believe that the reasonableness of the time period required to make an eligibility determination will vary depending upon particular facts and circumstances. For example, a hospital facility's receipt of an unusually large number of FAP applications in a particular week might reasonably result in that hospital facility taking longer to process the applications than would ordinarily be the case. In addition, the Treasury Department and the IRS note that the final regulations require hospital facilities to suspend ECAs between the time a complete FAP application is submitted and the time an eligibility determination is made, providing some protection for patients during this time period. Thus, the final regulations do not adopt a specific period of time in which a hospital facility must make a FAP-eligibility determination, opting instead to continue to require the determination to be made "in a timely manner" to provide hospital facilities with the appropriate flexibility to address varied situations. In addition, in cases in which a hospital facility believes an individual who has submitted a complete FAP application may qualify for Medicaid, the final regulations clarify that a hospital facility may postpone making a FAP-eligibility determination until after the individual's Medicaid application has been completed and submitted and a determination as to Medicaid eligibility has been made. However, as is generally the case when an individual has submitted a complete FAP application, a

hospital facility may not initiate or resume any ECAs to obtain payment for the care at issue until a FAP-eligibility determination has been made.

Like the 2012 proposed regulations, the final regulations make clear that if a hospital facility determines whether an individual is FAP-eligible for care based on a complete FAP application before initiating any ECAs against the individual to obtain payment for the care, it has made reasonable efforts to determine whether the individual is FAP-eligible for the care, regardless of what notification about the FAP (or, if applicable, about what the individual needs to provide to complete an incomplete FAP application) had been or continues to be provided to the individual.

B. Requirements when an individual is determined to be FAP-eligible

The 2012 proposed regulations provided that if a hospital facility determines an individual to be FAP-eligible, the hospital facility must provide the individual with a billing statement that indicates the amount the individual owes as a FAP-eligible individual and shows (or describes how the individual can get information regarding) the AGB for the care and how the hospital facility determined the amount the individual owes as a FAP-eligible individual. The hospital facility would also be required to refund any excess payments made by the FAP-eligible individual and take all reasonably available measures to reverse any ECA (with the exception of a sale of debt) taken against the individual to obtain payment for the care at issue.

One commenter recommended that notification about FAP-eligibility be optional in cases in which 100 percent of a patient's account has been written off under a hospital facility's FAP. The Treasury Department and the IRS believe that providing a

patient who has been determined to be eligible for free care with some written documentation of that eligibility determination is necessary both to notify the patient and to protect him or her in the event of any future erroneous charges for the care. However, the Treasury Department and the IRS do agree that a billing statement indicating a \$0 balance is not necessary in addition to a written notification about eligibility for free care. Accordingly, the final regulations require written notification that an individual is determined to be eligible for free care but do not require a billing statement indicating that nothing is owed for the care (or stating or describing how the individual can get information regarding AGB for the care).

A few commenters asked about the time period to which the requirement to refund FAP-eligible patients applies and requested clarification that hospital facilities are not required to refund amounts previously paid to the hospital for care unless the individual is determined to be FAP-eligible for that care. The 2012 proposed regulations and the final regulations refer only to refunds of payments “for the care” at issue and are intended to require refunds only of payments for the episode(s) of care to which an individual’s FAP application (and therefore his or her FAP-eligibility determination) relates. Thus, if an individual receives and pays for a hospital facility’s care in both year 1 and year 3 but only applies for financial assistance in year 3 for the care received in year 3 and is determined to be FAP-eligible for the care provided in year 3, the hospital facility would only have to refund any excess amounts the individual paid for the year 3 care, not any amount the individual paid for the year 1 care. Because the 2012 proposed regulation required only refunds for “the care” at issue, the Treasury

Department and the IRS do not believe that the final regulations need to be amended to further clarify this point.

Two commenters asked that the final regulations set a reasonable threshold, such as \$5, for required refunds, noting that some states apply such thresholds. The Treasury Department and the IRS agree that the administrative costs associated with requiring hospital facilities to process refunds in amounts of less than \$5 would outweigh the benefits to FAP-eligible patients. Accordingly, the final regulations do not require a hospital facility to refund any amount a FAP-eligible individual has paid for care that exceeds the discounted amount he or she owes for the care as a FAP-eligible individual if such excess amount is less than \$5. In addition, recognizing that inflation and other factors may create the need to increase the \$5 threshold in the future, the final regulations allow the Treasury Department or the IRS to increase the threshold in a notice or other guidance published in the Internal Revenue Bulletin.

One commenter sought clarification about whether hospital facilities are required to make refunds only to individuals determined to be FAP-eligible or also to their insurers. The 2012 proposed regulations required refunds only of the amounts the FAP-eligible individual had paid “in excess of the amount he or she is determined to owe as a FAP-eligible individual.” Thus, only refunds to the individual were intended to be required. However, to clarify this intent, the final regulations require the hospital facility to provide refunds “to the individual” and refer to the amount the individual is “personally responsible for paying” rather than the amount the individual “owes.”

One commenter recommended that reversal of ECAs only be required upon a

determination that an individual is FAP-eligible to the extent of the adjustment to the bill made as a result of FAP-eligibility, so that, for example, if a patient were still liable for 50 percent of a bill after an adjustment for a FAP discount, ECAs could continue to be used to collect the discounted amount owed. Other commenters, however, supported the requirement to reverse ECAs, stating that it, along with the requirement to provide refunds, were reasonable and sufficient measures to protect patients.

As noted previously in this preamble, the Treasury Department and the IRS believe that reasonable efforts to determine FAP-eligibility necessitate giving patients a reasonable period of time of at least eight months (240 days) after the first post-discharge bill to learn about a hospital facility's FAP and apply for assistance. Nonetheless, the final regulations, like the 2012 proposed regulations, allow hospital facilities to initiate ECAs against individuals whose FAP-eligibility has not been determined as early as 120 days after the first post-discharge bill to avoid undue interference with hospital facilities' ability to collect debts from non-FAP-eligible individuals. However, if a hospital facility does initiate an ECA against an individual before the end of the 240-day application period and the individual is subsequently determined to be FAP-eligible, the Treasury Department and the IRS believe the hospital facility should reverse the ECA altogether and begin the collection process anew based on the adjusted amount. The Treasury Department and the IRS expect that such a rule will encourage hospital facilities not to begin ECAs during the application period against individuals they believe are likely to be FAP-eligible.

vi. Presumptive FAP-eligibility determinations based on third-party information or prior FAP-eligibility determinations

The 2012 proposed regulations provided that a hospital facility has made reasonable efforts to determine whether an individual is FAP-eligible if it determines that the individual is eligible for the most generous assistance available under the FAP based on information other than that provided by the individual, such as the individual's eligibility under one or more means-tested public programs. The 2012 proposed regulations also provided that a hospital facility will not have made reasonable efforts to determine whether an individual is FAP-eligible as a result of obtaining a signed waiver from the individual and defined a FAP-eligible individual as an individual eligible for FAP assistance without regard to whether the individual has applied for such assistance.

The Treasury Department and the IRS recognized that these provisions, together, effectively left a hospital facility with two options if it wanted to engage in an ECA against an individual who had not submitted a FAP application: either notify the individual about the FAP during the notification period or provide the individual with the most generous assistance available under the FAP. Accordingly, the preamble to the 2012 proposed regulations requested comments on how to provide additional flexibility under the regulations to hospital facilities seeking to determine whether an individual is FAP-eligible, and, in particular, on how a hospital facility might reasonably determine whether an individual is FAP-eligible in ways other than soliciting and processing FAP applications. The preamble to the 2012 proposed regulations also requested comments regarding whether a hospital facility might be able to rely on prior FAP-eligibility determinations for a period of time to avoid having to re-determine whether an individual

is FAP-eligible every time he or she receives care.

Numerous commenters stated that hospitals can, and commonly do, rely on trustworthy methods and sources of information other than FAP applications to determine FAP-eligibility. Some noted the use of public and private records and data sources that, often in combination with predictive models and algorithms, could presumptively determine FAP-eligibility, including for discounts on a sliding scale that are less than the most generous available under the FAP. A number of these commenters suggested that allowing hospital facilities to use these information sources and methods to presumptively determine eligibility only for the most generous discounts under a FAP could inadvertently result in fewer individuals receiving financial assistance. Other commenters noted that hospital facilities could readily and accurately determine the insurance status or residency of particular individuals and, therefore, determine that such individuals are not FAP-eligible when such eligibility depends on being uninsured or on being a resident of the state in which the hospital facility is licensed. Most of these commenters generally recommended that hospital facilities be allowed to rely on information sources and methods other than FAP applications to determine FAP-eligibility as long as the sources and methods are disclosed (for example, in the FAP or on the hospital facility's Form 990) and/or the individual is given a reasonable opportunity to provide information indicating FAP-eligibility or eligibility for a greater discount than the one provided. A few commenters, however, recommended against the use of predictive models that rely on credit scores, noting that such methods assess creditworthiness rather than financial need. A few commenters also suggested

that predictive models should only be used to approve someone for financial assistance, not to deem them ineligible for it.

In addition, commenters recommended that hospital facilities should be able to rely on prior FAP eligibility determinations, arguing that it would be burdensome and costly to require a hospital facility to re-determine whether an individual is FAP-eligible every time the individual receives care. Suggestions ranged from allowing reliance on prior FAP applications for a certain time period (90 days, four months, six months, or twelve months) to allowing hospital facilities the flexibility to determine how long FAP-eligibility status may last. Most of these commenters recommended that a hospital facility's reliance on prior FAP-eligibility determinations should be disclosed in its FAP and/or that patients should be given a reasonable opportunity to resubmit an application if and when their financial situation changes.

In response to these comments and to encourage hospital facilities to provide discounts to potentially FAP-eligible individuals who have not submitted FAP applications, the final regulations provide that, in addition to presumptively determining that an individual is eligible for the most generous assistance available under its FAP, a hospital facility may also presumptively determine that an individual is eligible for less than the most generous assistance available under the FAP based on information other than that provided by the individual or based on a prior FAP-eligibility determination (hereinafter referred to as presumptive determinations). Most commenters recognized, though, that presumptive determinations that an individual is eligible for less than the most generous assistance available under a FAP should not relieve a hospital facility of

the obligation to give patients a reasonable opportunity to seek more generous assistance by providing additional information related to FAP-eligibility. Accordingly, the final regulations provide that a presumptive determination that an individual is eligible for less than most generous assistance available under a FAP only constitutes reasonable efforts to determine FAP-eligibility if three conditions are met. First, the hospital facility must notify the individual regarding the basis for the presumptive FAP-eligibility determination and the way he or she may apply for more generous assistance available under the FAP. Second, the hospital facility must give the individual a reasonable period of time to apply for more generous assistance before initiating ECAs to obtain the discounted amount owed for the care. And, third, the hospital facility must process any complete FAP application that the individual submits by the end of the application period or, if later, by the end of the reasonable time period given to apply for more generous assistance.

The final regulations do not treat as reasonable efforts a presumptive determination that an individual is not FAP-eligible. The Treasury Department and the IRS believe that before being subjected to ECAs, individuals who have received no financial assistance under a FAP and who have not submitted a complete FAP application should, at a minimum, receive a notice about the FAP (through a plain language summary) and about the deadline for submitting a FAP application before ECAs may be initiated, as described in section 6.b.iii of this preamble. The Treasury Department and the IRS note, however, that even though presumptive determinations of FAP-ineligibility do not constitute reasonable efforts to determine FAP-eligibility for

purposes of section 501(r)(6), a hospital facility is not prohibited from using third-party information sources and prior FAP-eligibility determinations to try to predict which of its patients are unlikely to be FAP-eligible.

A number of commenters asked that the definition of “FAP-eligible individual” be revised such that it applies only to individuals “known to be eligible for financial assistance.” Allowing hospital facilities to assume individuals are not FAP-eligible unless and until they obtain knowledge to the contrary would relieve hospital facilities of any obligation to make reasonable efforts to determine whether individuals are FAP-eligible and thereby undercut the purpose of section 501(r)(6). Accordingly, the definition of FAP-eligible individual is not amended to apply only to individuals known to be FAP-eligible.

Many commenters also asked that hospital facilities be allowed to use targeted and limited waivers in determining FAP-eligibility, such as waivers for individuals who the hospital facility has no reason to believe may be FAP-eligible or individuals with adequate insurance and the ability to meet any co-pays and deductibles. In addition, one commenter asked that the final regulations provide that making reasonable efforts to determine an individual is FAP-eligible includes obtaining an attestation from the individual that his or her income and/or assets exceed certain thresholds in the FAP and that the attestation was not made under coercion.

The Treasury Department and the IRS continue to believe that obtaining signatures from individuals on a waiver form is not a meaningful way to determine that they are not FAP-eligible. The Treasury Department and the IRS note, however, that

the final regulations define a complete FAP application as information and documentation provided by an individual that is sufficient to determine the individual's FAP-eligibility, and an individual's attestation regarding his or her income or other criteria relevant to FAP-eligibility could be sufficient to determine FAP-eligibility and therefore could be considered a complete FAP application. Thus, if a hospital facility makes a determination as to whether an individual is FAP-eligible based on an individual's attestation regarding his or her income or other relevant eligibility criteria -- and the hospital facility has no reason to believe that the information on the statement is incorrect and did not obtain the information from the individual under duress or through the use of coercive practices -- the hospital facility will have made a determination based on a complete FAP application and, thus, have made reasonable efforts to determine whether the individual is FAP-eligible for purposes of section 501(r)(6).

vii. Reasonable Efforts in the Case of Denying or Deferring Care Based on Past Nonpayment

As discussed in section 6.a.iv of this preamble and in response to comments, the final regulations include as an ECA the deferral or denial of (or the requirement of a payment before providing) medically necessary care because of the individual's nonpayment of one or more bills for previously provided care. Unlike other ECAs, the timing of this ECA involving the deferral or denial of care will depend on when an individual seeks medically necessary care from the hospital facility, a contingency over which the hospital facility has no control. In addition, if the provision of medically necessary care is at stake, the individual's application for financial assistance should be completed and his or her FAP-eligibility should be determined as quickly as possible to

avoid jeopardizing the individual's health.

Based on these considerations, the final regulations provide that, in the case of an ECA involving deferral and denial of (or requiring payment before providing) care only, a hospital facility is not required to provide the oral and written notification about the FAP and potential ECAs discussed in section 6.b.iii of this preamble at least 30 days in advance of initiating this ECA to have made reasonable efforts to determine whether the individual is FAP-eligible. However, to avail itself of this exception, a hospital facility (or other authorized party) must satisfy several conditions. First, the hospital facility must provide the individual with a FAP application form (to ensure the individual may apply immediately, if necessary) and notify the individual in writing about the availability of financial assistance for eligible individuals and the deadline, if any, after which the hospital facility will no longer accept and process a FAP application submitted by the individual for the previously provided care at issue. This deadline must be no earlier than the later of 30 days after the date that the written notice is provided or 240 days after the date that the first post-discharge billing statement for the previously provided care was provided. Thus, although the ECA involving deferral or denial of care may occur immediately after the requisite written (and oral) notice is provided, the individual must be afforded at least 30 days after the notice to submit a FAP application for the previously provided care. In addition, the hospital facility must notify the individual about the FAP in the two other ways discussed in section 6.b.iii of the preamble (though without regard to the requirement to do so at least 30 days before the initiation of an ECA): namely, by providing a plain language summary of the FAP and by orally

notifying the individual about the hospital facility's FAP and about how the individual may obtain assistance with the FAP application process. Finally, if an individual submits a FAP application for previously provided care during the application period, the hospital facility must process the application on an expedited basis, to ensure that medically necessary care is not unnecessarily delayed.

In the case of the ECA involving the deferral or denial of care, the final regulations also provide an exception to the general rule that reasonable efforts to determine FAP-eligibility ordinarily will require a hospital to wait at least 120 days after the first post-discharge bill before initiating ECAs. Under the exception, a hospital facility may defer or deny (or require payment before providing) medically necessary care¹² because of an individual's nonpayment of one or more bills for previously provided care even though such deferral or denial (or payment requirement) is within 120 days of the first post-discharge bill for the previously provided care. Without such an exception in the final regulations, hospital facilities would effectively be required to provide medically necessary care to individuals with past due bills when these individuals are seeking care within 120 days of the first post-discharge bill.

The Treasury Department and the IRS note that the modified reasonable efforts to determine FAP-eligibility discussed in this section 6.b.vii of the preamble would not be necessary if a hospital facility had already determined whether the individual was

¹² With respect to deferring or denying (or requiring payment before providing) emergency medical care, in particular, hospital organizations are separately subject to the requirements under Subchapter G of Chapter IV of Title 42 of the Code of Federal Regulations, which includes the regulations under EMTALA, and the emergency medical care policy they adopt to meet the requirements of section 501(r)(4)(B) (as discussed in section 4.b of this preamble).

FAP-eligible for the previously provided care at issue based on a complete FAP application or had presumptively determined the individual was FAP-eligible for the previously provided care as described in section 6.b.vi of this preamble. The modified reasonable efforts would also not be needed in cases in which 120 days had passed since the first post-discharge bill for the previously provided care, and the hospital facility had already notified the individual about intended ECAs as described in section 6.b.iii of this preamble.

viii. Agreements with Other Parties

The 2012 proposed regulations provided that if a hospital facility refers or sells an individual's debt to another party during the application period, the hospital facility will have made reasonable efforts to determine whether the individual is FAP-eligible only if it first obtains a legally binding written agreement from the other party to abide by certain specified requirements. The 2012 proposed regulations requested comments regarding the feasibility of this rule. Commenters who responded to this request for comments generally indicated that imposing such contractual obligations on debt collection agencies or debt buyers was not especially unusual or unworkable, and, thus, the Treasury Department and the IRS adopt the provisions of the 2012 proposed regulations with only minor clarifying revisions that are not intended to be substantive changes. In the event a hospital facility does sell or refer an individual's debt and the debt buyer or collection agent takes one or more of the steps required to have made reasonable efforts to determine whether the individual is FAP-eligible, the final regulations also clarify the hospital facility will be treated as having taken those steps for

purposes of making reasonable efforts under section 501(r)(6).

7. Section 501(r) and State Law Requirements

Numerous commenters noted that their states already had laws in effect covering some or most of the same subject matter as the requirements described in §§1.501(r)-3 through 1.501(r)-6 of the proposed regulations and argued that requiring compliance with the section 501(r) regulations in addition to what hospitals are already required to do under state law would create unnecessary duplication of effort and administrative burden. Others went further and argued that the requirements described in §§1.501(r)-3 through 1.501(r)-6 of the proposed regulations conflicted or were inconsistent with certain state law requirements. Areas of inconsistency noted by commenters included the timing and content of notices that must be provided to patients, rules regarding the limitations on charges, and the periods of time during which the hospital facilities must wait to commence certain collection actions. Most of these commenters recommended that a hospital facility should be deemed to have complied with the section 501(r) requirements if it complies with the relevant state law(s) applicable to it. On the other hand, some commenters asked the Treasury Department and the IRS to clarify that nothing in the proposed regulations will preempt state laws that contain additional or more stringent requirements.

Given the wide variation among state laws covering some of the same subject matter as section 501(r), providing that compliance with section 501(r) requires only compliance with the applicable state law would result in widely divergent rules for charitable hospitals in different states. A rule equating compliance with state law to

compliance with section 501(r) would also mean that IRS revenue agents assessing section 501(r) compliance would need to learn each state's laws or that the state office responsible for enforcing the particular state law would have to confirm a hospital facility's compliance with the relevant state law in each taxable year under audit.

More importantly, the language in many of the state laws cited by commenters as analogous does not match the statutory language in section 501(r) -- for example, by not including concepts such as AGB, ECAs, or "reasonable efforts" to determine FAP-eligibility or by requiring CHNAs every five years as opposed to every three years. In these cases, simply deeming compliance with state law to result in compliance with section 501(r) would be inconsistent with the statutory language under section 501(r).

While many of the requirements in the state laws cited by commenters do not match the provisions in the 2012 or 2013 proposed regulations and while some state laws might require more or less of hospital facilities than the comparable provision in the proposed regulations, commenters failed to cite any state laws that conflict with the proposed regulations in a way that would make it impossible for a hospital facility to comply with both the state and the federal requirement. For example, although some state laws set forth a limitation on charges that is different from the limit that would result from the AGB methods described in the 2012 proposed regulations, none of the state laws identified by commenters prohibit hospital facilities from charging FAP-eligible individuals less than the state law limit. Similarly, AGB under section 501(r)(5) is only a maximum amount that hospital facilities can charge FAP-eligible individuals, and hospital facilities are free to provide more generous discounts in their FAPs

(including free care). As a result, hospital facilities are always free to charge the lesser of AGB or a limitation on charges imposed by state law or to establish a uniform discount that will always fall below both the state and federal maximum charges. Similarly, the periods of time during which hospital facilities must wait to commence certain collection activities in both the 2012 proposed regulations and certain state laws cited by commenters are minimum periods, and a hospital facility is always free to wait for the longer of the two applicable periods without violating either section 501(r)(6) or state law requirements.

Accordingly, the final regulations do not contain any provisions equating compliance with one or more requirements in applicable state law to compliance with one or more of the requirements in the final regulations. In addition, the final regulations are not intended to preempt any state laws or regulations, and the Treasury Department and the IRS expect that any additional or stricter requirements under a state's laws or regulations will continue to apply to hospital facilities licensed in that state.

8. Reporting Requirements Related to CHNAs

The final regulations state, consistent with the statute and the 2013 proposed regulations, that a hospital organization must provide with its Form 990 a description of how it is addressing the community health needs identified for each facility it operates, its audited financial statements, and the amount of the excise tax imposed on the organization under section 4959 during the taxable year.

a. Description of how community health needs are being addressed

In accordance with section 6033(b)(15)(A), the 2013 proposed regulations required a hospital organization to furnish annually on its Form 990 a description of the actions taken during the taxable year to address the significant health needs identified through its most recently conducted CHNA, or, if no actions were taken with respect to one or more of those health needs, the reasons no actions were taken. Numerous commenters expressed support for this requirement to annually furnish a description of how a hospital facility is addressing health needs identified through a CHNA, with some commenters stating that it increases transparency and accountability and would provide written documentation of progress over time. Other commenters stated that the annual updates would be burdensome and duplicative, given that the 2013 proposed regulations also required hospital facilities to attach to their Forms 990 their most recently adopted implementation strategies (or provide the URL where the implementation strategies are made widely available on a Web site).

As discussed in section 3.b of this preamble, it is true that a hospital facility's implementation strategy must describe, with respect to each significant health need identified through the CHNA, how the hospital facility plans to address the health need or why the hospital facility does not intend to address the health need. However, as noted in the preamble to the 2013 proposed regulations, section 6033(b)(15)(A) contemplates an annual furnishing of information regarding how a hospital facility is actually addressing needs identified through a CHNA each year, while an implementation strategy is a plan for addressing these needs that only has to be

updated every three years. Accordingly, the final regulations retain the requirement that hospital facilities annually furnish information on their Form 990s about how they are addressing the significant health needs identified through their CHNAs.

b. Audited financial statements

The 2013 proposed regulations reiterated the requirement of section 6033(b)(15)(B) that a hospital organization attach to its Form 990 a copy of its audited financial statements for the taxable year -- or, in the case of an organization the financial statements of which are included in consolidated financial statements with other organizations, such consolidated financial statements. In the preamble to the 2013 proposed regulations, the Treasury Department and the IRS requested comments regarding whether hospital organizations whose financial statements are included in consolidated financial statements should be able to redact financial information about any taxable organizations that are members of the consolidated group.

Two commenters stated that information about taxable organizations should be redacted from publicly available financial statements without further elaboration while another commenter stated that the information provided on the Form 990 should be as detailed as possible to keep tax-exempt hospitals accountable. Consolidated financial statements are fully integrated, making redaction of one particular organization's financial information difficult. The few comments received did not provide any explanation as to how such redactions could be accomplished without compromising the clarity of the statement. Accordingly, the final regulations adopt the proposed requirement without change.

c. Reporting requirements for government hospital organizations

A number of commenters have asked whether and how government hospital organizations can satisfy the reporting requirements related to CHNAs, since they are excused from filing a Form 990 under Rev. Proc. 95-48. As noted in the preamble to the 2013 proposed regulations, the Affordable Care Act did not change the requirements regarding which organizations are required to file a Form 990. Accordingly, a government hospital organization (other than one that is described in section 509(a)(3)) that has been excused from filing a Form 990 under Rev. Proc. 95-48 or a successor revenue procedure is not required to file a Form 990. Because government hospital organizations described in Rev. Proc. 95-48 are relieved from the annual filing requirements under section 6033, they are also relieved from any new reporting requirements imposed on hospital organizations under section 6033, including under section 6033(b)(10)(D) and (b)(15) and the requirement to attach one or more implementation strategies to a Form 990. However, to be treated as described in section 501(c)(3), government hospital organizations still must meet all section 501(r) requirements that do not involve disclosure on or with the Form 990, including making their CHNA reports and FAPs widely available on a Web site.

9. Excise Tax on Failure to Meet CHNA Requirements

Section 4959 imposes a \$50,000 excise tax on a hospital organization that fails to meet the CHNA requirements with respect to any taxable year. The 2013 proposed regulations provided that the excise tax applies on a facility-by-facility basis and may be imposed on a hospital organization for each taxable year that a hospital facility fails to

meet the section 501(r)(3) requirements.

One commenter suggested that the full \$50,000 excise tax should apply only in instances where a hospital facility fails to conduct a CHNA altogether, with a sliding scale of tax applied to organizations that conduct a CHNA but fail to substantially comply with all of the CHNA requirements. Another commenter suggested applying the \$50,000 excise tax separately for each failure of a hospital facility to meet each component of the section 501(r)(3) requirements.

Section 4959 applies the \$50,000 excise tax to a hospital organization that fails to meet the requirements of section 501(r)(3) for any taxable year. Section 501(r)(3) requires that, in conducting a CHNA, a hospital must take into account input from persons who represent the broad interests of the community, make the CHNA widely available to the public, and adopt an implementation strategy to meet the needs identified through the CHNA. Section 4959 appears to provide for one \$50,000 excise tax if a hospital facility fails one or any combination of those components of satisfying section 501(r)(3). It does not appear to provide for either a separate \$50,000 excise tax for each component or a tax of less than \$50,000 if a hospital facility fails some, but not all, of those components. Thus, the final regulations do not adopt these commenters' suggestions.

However, as discussed in section 2.b of this preamble, a hospital facility's omission or error with respect to the CHNA requirements will not be considered a failure to meet the CHNA requirements if the omission or error was minor and either inadvertent or due to reasonable cause and the hospital facility corrects the omission or

error in accordance with §1.501(r)-2(b)(1)(ii). If, as a result of this rule, an omission or error with respect to the CHNA requirements is not considered a failure to meet the CHNA requirements, the omission or error will not give rise to a \$50,000 excise tax under section 4959.¹³

10. Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return

Final and temporary regulations and a cross-reference notice of proposed rulemaking published on August 15, 2013, amended the existing regulations under sections 6011 and 6071 to require hospital organizations liable for the excise tax imposed by section 4959 in any taxable year to file Form 4720 by the 15th day of the fifth month after the end of the taxable year. No public comments were received on these amendments to sections 6011 and 6071. Therefore, these final regulations adopt the text of the temporary and proposed regulations without substantive change and remove the temporary regulations. The final regulations make one non-substantive change by moving the content of §53.6011-1T(c) into existing paragraph §53.6011-1(b).

Effective/Applicability Dates

Numerous commenters requested a transition period for hospital facilities to come into compliance with the final regulations to provide adequate time for hospital facilities to make needed changes in personnel, policies, procedures, and information systems. Specific transition periods of six months and one year were recommended. Several commenters also requested that the final regulations clarify how hospital

¹³ On the other hand, a hospital facility's failure to meet the CHNA requirements will give rise to the excise tax under section 4959 notwithstanding its correction and disclosure pursuant to the guidance described in section 2.c of this preamble.

facilities' compliance with section 501(r) will be assessed for the period between the date section 501(r) was enacted (March 23, 2010) and the date the final regulations are applicable.

In response to these comments, the final regulations under section 501(r) apply to a hospital facility's taxable years beginning after December 29, 2015, which will give all hospital facilities at least a year to come into compliance with the final regulations. For taxable years beginning on or before December 29, 2015, the final regulations provide that a hospital facility may rely on a reasonable, good faith interpretation of section 501(r). A hospital facility will be deemed to have operated in accordance with a reasonable, good faith interpretation of section 501(r) if it has complied with the provisions of the 2012 and/or 2013 proposed regulations or these final regulations.

The final regulations under sections 4959 and 6033 either clarify or confirm compliance with statutory requirements that are already in effect and therefore do not require a transition period. Thus, the final regulations under section 4959 apply on and after **[INSERT DATE OF FILING (PUBLIC INSPECTION) IN THE FEDERAL REGISTER]**, and the final regulations under section 6033 apply to returns filed on or after **[INSERT DATE OF FILING (PUBLIC INSPECTION) IN THE FEDERAL REGISTER]**.

The temporary regulations under section 6071 have applied since August 15, 2013, and this Treasury decision adopts the proposed regulations that cross-referenced the text of those temporary regulations without substantive change. Thus, the final regulations under section 6071 apply on and after August 15, 2013.

Availability of IRS Documents

IRS notices, revenue rulings, and revenue procedures cited in this preamble are made available by the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

Effect on Other Documents

The following publication is obsolete as of **[INSERT DATE OF FILING (PUBLIC INSPECTION) IN THE FEDERAL REGISTER]**: Notice 2014-2 (2014-3 IRB 1).

Special Analyses

It has been determined that this rule is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to the final regulations. It is hereby certified the collection of information in these regulations will not have a significant economic impact on a substantial number of small entities. The collection of information is in §1.501(r)-3, §1.501(r)-4, §1.501(r)-6(c), §1.6033-2(a)(2)(ii)(I), §53.6011-1, and §53.6071-1 of the regulations. The certification is based on the following:

Consistent with the requirements imposed by section 501(r)(3), §1.501(r)-3 of the regulations requires hospital facilities to conduct a CHNA and adopt an implementation strategy. However, these requirements need only be satisfied once over a period of three taxable years. Moreover, some hospital facilities already conduct similar community needs assessments under state law, and the Treasury Department and the

IRS expect that these facilities will be able to draw upon pre-existing processes and resources to some extent. In addition, section 501(r)(3) itself already requires a hospital facility to conduct and widely publicize a CHNA that takes into account input of persons representing the broad interests of the community and to adopt an implementation strategy, so much of the collection of information burden associated with CHNAs is imposed by statute, not by these regulations.

Consistent with the requirements imposed by section 501(r)(4), §1.501(r)-4 of the regulations requires hospital facilities to establish two written policies -- a financial assistance policy (FAP) and an emergency medical care policy -- but much of the work involved in putting such policies into writing will be performed once, with updates made periodically thereafter. Moreover, while hospital facilities may need to periodically modify these policies to reflect changed circumstances, the proposed regulations attempt to minimize that ongoing burden by giving hospital facilities the option of providing certain information separately from the policy, as long as the policy explains how members of the public can readily obtain this information free of charge. In addition, section 501(r)(4) itself already requires a hospital facility to establish a FAP that includes eligibility criteria and other specified elements and an emergency medical care policy, so much of the collection of information burden associated with these policies is imposed by statute, not by regulations.

In addition, as a general matter, §§1.501(r)-4(b)(5) and 1.501(r)-6(c) of the regulations, which, respectively, describe how a hospital facility widely publicizes its FAP and makes reasonable efforts to determine eligibility for assistance under its FAP,

are designed to ensure that a hospital facility can meet these requirements by providing basic information about its FAP using pre-existing processes (such as the issuance of billing statements) and resources (such as its Web site and physician networks) in providing this information.

The applicability date under the final regulations also gives all hospital facilities at least one year to come into compliance with all of the final regulations under section 501(r).

Consistent with the requirements imposed by section 6033(b)(15), §1.6033-2(a)(2)(ii)(l) of the regulations requires affected organizations to report annually on a Form 990 actions taken during the year to address community health needs and to attach audited financial statements to the Form 990. To assist the IRS and the public, the regulations also require affected organizations to attach to the Form 990 a copy of the most recently adopted implementation strategy or provide the URL of a Web page where it is available to the public. For affected organizations, the burden of providing either a copy of the implementation strategy or the address of a Web site where it can be found will be minimal. Consequently, the regulations under section 6033 do not add significantly to the impact on small entities imposed by the statutory scheme.

Sections 53.6011-1 and 53.6071-1 of the regulations merely provide guidance as to the timing and filing of Form 4720 for charitable hospital organizations liable for the section 4959 excise tax, and completing the applicable portion (Schedule M) of the Form 4720 for this purpose imposes little incremental burden in time or expense. The liability for the section 4959 excise tax is imposed by statute, and not these regulations.

In addition, a charitable hospital organization may already be required to file the Form 4720 under the existing final regulations in §§53.6011-1 and 53.6071-1 if it is liable for another Chapter 41 or 42 excise tax.

For these reasons, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Pursuant to section 7805(f) of the Code, the 2012 and 2013 proposed regulations (as well the cross-reference notice of proposed rulemaking under sections 6011 and 6071) preceding these final regulations were submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small entities and no comments were received.

Drafting Information

The principal authors of these final regulations are Preston J. Quesenberry, Amy F. Giuliano, Amber L. MacKenzie, and Stephanie N. Robbins, Office of the Chief Counsel (Tax-Exempt and Government Entities). However, other personnel from the Treasury Department and the IRS participated in their development.

List of Subjects

26 CFR Part 1

Income taxes, Reporting and recordkeeping requirements.

26 CFR Part 53

Excise taxes, Foundations, Investments, Lobbying, Reporting and recordkeeping requirements.

26 CFR Part 602

Reporting and recordkeeping requirements.

Adoption of Amendment to the Regulations

Accordingly, 26 CFR parts 1, 53, and 602 are amended as follows:

PART 1--INCOME TAXES

Paragraph 1. The authority citation for part 1 continues to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

Par. 2. Section 1.501(r)-0 is added to read as follows:

§1.501(r)-0 Outline of regulations.

This section lists the table of contents for §§1.501(r)-1 through 1.501(r)-7.

§1.501(r)-1 Definitions.

- (a) Application.
- (b) Definitions.
 - (1) Amounts generally billed (AGB).
 - (2) AGB percentage.
 - (3) Application period.
 - (4) Authorized body of a hospital facility.
 - (5) Billing and collections policy.
 - (6) Date provided.
 - (7) Discharge.
 - (8) Disregarded entity.
 - (9) Emergency medical care.
 - (10) Emergency medical conditions.
 - (11) Extraordinary collection action (ECA).
 - (12) Financial assistance policy (FAP).
 - (13) FAP application.
 - (14) FAP application form.
 - (15) FAP-eligible.
 - (16) Gross charges.
 - (17) Hospital facility.
 - (18) Hospital organization.
 - (19) Medicaid.
 - (20) Medicare fee-for-service.
 - (21) Noncompliant facility income.
 - (22) Operating a hospital facility.
 - (23) Partnership agreement.
 - (24) Plain language summary of the FAP.

- (25) Presumptive FAP-eligibility determination.
- (26) Private health insurer.
- (27) Referring.
- (28) Substantially-related entity.
- (29) Widely available on a Web site.

§1.501(r)-2 Failures to satisfy section 501(r).

- (a) Revocation of section 501(c)(3) status.
- (b) Minor omissions and errors.
 - (1) In general.
 - (2) Minor.
 - (3) Inadvertent.
 - (4) Reasonable cause.
- (c) Excusing certain failures if hospital facility corrects and discloses.
- (d) Taxation of noncompliant hospital facilities.
 - (1) In general.
 - (2) Noncompliant facility income.
 - (3) No aggregation.
 - (4) Interaction with other Code provisions.
- (e) Instances in which a hospital organization is not required to meet section 501(r).

§1.501(r)-3 Community health needs assessments.

- (a) In general.
- (b) Conducting a CHNA.
 - (1) In general.
 - (2) Date a CHNA is conducted.
 - (3) Community served by a hospital facility.
 - (4) Assessing community health needs.
 - (5) Persons representing the broad interests of the community.
 - (6) Documentation of a CHNA.
 - (7) Making the CHNA report widely available to the public.
- (c) Implementation strategy.
 - (1) In general.
 - (2) Description of how the hospital facility plans to address a significant health need.
 - (3) Description of why a hospital facility is not addressing a significant health need.
 - (4) Joint implementation strategies.
 - (5) When the implementation strategy must be adopted.
- (d) Exception for acquired, new, and terminated hospital facilities.
 - (1) Acquired hospital facilities.
 - (2) New hospital organizations.
 - (3) New hospital facilities.
 - (4) Transferred or terminated hospital facilities.

(e) Transition rule for CHNAs conducted in taxable years beginning before March 23, 2012.

§1.501(r)-4 Financial assistance policy and emergency medical care policy.

- (a) In general.
- (b) Financial assistance policy.
 - (1) In general.
 - (2) Eligibility criteria and basis for calculating amounts charged to patients.
 - (3) Method for applying for financial assistance.
 - (4) Actions that may be taken in the event of nonpayment.
 - (5) Widely publicizing the FAP.
 - (6) Readily obtainable information.
 - (7) Providing documents electronically.
 - (8) Medically necessary care.
- (c) Emergency medical care policy.
 - (1) In general.
 - (2) Interference with provision of emergency medical care.
 - (3) Relation to federal law governing emergency medical care.
 - (4) Examples.
- (d) Establishing the FAP and other policies.
 - (1) In general.
 - (2) Implementing a policy.
 - (3) Establishing a policy for more than one hospital facility.

§1.501(r)-5 Limitation on charges.

- (a) In general.
- (b) Amounts generally billed.
 - (1) In general.
 - (2) Meaning of charged.
 - (3) Look-back method.
 - (4) Prospective Medicare or Medicaid method.
 - (5) Examples.
- (c) Gross charges.
- (d) Safe harbor for certain charges in excess of AGB.
- (e) Medically necessary care.

§1.501(r)-6 Billing and collection.

- (a) In general.
- (b) Extraordinary collection actions.
 - (1) In general.
 - (2) Certain debt sales that are not ECAs.

- (3) Liens on certain judgments, settlements, or compromises.
- (4) Bankruptcy claims.
- (c) Reasonable efforts.
 - (1) In general.
 - (2) Presumptive FAP-eligibility determinations based on third-party information or prior FAP-eligibility determinations.
 - (3) Reasonable efforts based on notification and processing of applications.
 - (4) Notification.
 - (5) Incomplete FAP applications.
 - (6) Complete FAP applications.
 - (7) When no FAP application is submitted.
 - (8) Suspending ECAs while a FAP application is pending.
 - (9) Waiver does not constitute reasonable efforts.
 - (10) Agreements with other parties.
 - (11) Clear and conspicuous placement.
 - (12) Providing documents electronically.

§1.501(r)-7 Effective/applicability dates.

- (a) Effective/applicability date.
- (b) Reasonable interpretation for taxable years beginning on or before December 29, 2015.

Par. 3. Sections 1.501(r)-1 through 1.501(r)-7 are added to read as follows:

§1.501(r)-1 Definitions.

(a) Application. The definitions set forth in this section apply to §§1.501(r)-2 through 1.501(r)-7.

(b) Definitions--(1) Amounts generally billed (AGB) means the amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care, determined in accordance with §1.501(r)-5(b).

(2) AGB percentage means a percentage of gross charges that a hospital facility uses under §1.501(r)-5(b)(3) to determine the AGB for any emergency or other medically necessary care it provides to an individual who is eligible for assistance under

its financial assistance policy (FAP).

(3) Application period means the period during which a hospital facility must accept and process an application for financial assistance under its FAP submitted by an individual in order to have made reasonable efforts to determine whether the individual is FAP-eligible under §1.501(r)-6(c). A hospital facility may accept and process an individual's FAP application submitted outside of the application period. With respect to any care provided by a hospital facility to an individual, the application period begins on the date the care is provided and ends on the later of the 240th day after the date that the first post-discharge billing statement for the care is provided or either--

(i) In the case of an individual who the hospital facility is notifying as described in §1.501(r)-6(c)(4), the deadline specified by a written notice described in §1.501(r)-6(c)(4); or

(ii) In the case of an individual who the hospital facility has presumptively determined to be eligible for less than the most generous assistance available under the FAP as described in §1.501(r)-6(c)(2), the end of the reasonable period of time described in §1.501(r)-6(c)(2)(i)(B).

(4) Authorized body of a hospital facility means--

(i) The governing body (that is, the board of directors, board of trustees, or equivalent controlling body) of the hospital organization that operates the hospital facility or a committee of, or other party authorized by, that governing body to the extent such committee or other party is permitted under state law to act on behalf of the governing

body; or

(ii) The governing body of an entity that is disregarded or treated as a partnership for federal tax purposes that operates the hospital facility or a committee of, or other party authorized by, that governing body to the extent such committee or other party is permitted under state law to act on behalf of the governing body.

(5) Billing and collections policy means a written policy that includes all of the elements described in §1.501(r)-4(b)(4)(i).

(6) Date provided means, in the case of any billing statement, written notice, or other written communication that is mailed, the date of mailing. The date that a billing statement, written notice, or other written communication is provided can also be the date such communication is sent electronically or delivered by hand.

(7) Discharge means to release from a hospital facility after the care at issue has been provided, regardless of whether that care has been provided on an inpatient or outpatient basis. Thus, a billing statement for care is considered “post-discharge” if it is provided to an individual after the care has been provided and the individual has left the hospital facility.

(8) Disregarded entity means an entity that is generally disregarded as separate from its owner for federal tax purposes under §301.7701-3 of this chapter. One example of a disregarded entity is a domestic single member limited liability company that does not elect to be classified as an association taxable as a corporation for federal tax purposes.

(9) Emergency medical care means care provided by a hospital facility for

emergency medical conditions.

(10) Emergency medical conditions means emergency medical conditions as defined in section 1867 of the Social Security Act (42 U.S.C. 1395dd).

(11) Extraordinary collection action (ECA) means an action described in §1.501(r)-6(b)(1).

(12) Financial assistance policy (FAP) means a written policy that meets the requirements described in §1.501(r)-4(b).

(13) FAP application means the information and accompanying documentation that an individual submits to apply for financial assistance under a hospital facility's FAP. An individual is considered to have submitted a complete FAP application if he or she provides information and documentation sufficient for the hospital facility to determine whether the individual is FAP-eligible and an incomplete FAP application if he or she provides some, but not sufficient, information and documentation to determine FAP-eligibility. The term "FAP application" does not refer only to written submissions, and a hospital facility may obtain information from an individual in writing or orally (or a combination of both).

(14) FAP application form means the application form (and any accompanying instructions) that a hospital facility makes available for individuals to submit as part of a FAP application.

(15) FAP-eligible means eligible for financial assistance under a hospital facility's FAP for care covered by the FAP, without regard to whether an individual has applied for assistance under the FAP.

(16) Gross charges, or the chargemaster rate, means a hospital facility's full, established price for medical care that the hospital facility consistently and uniformly charges patients before applying any contractual allowances, discounts, or deductions.

(17) Hospital facility means a facility that is required by a state to be licensed, registered, or similarly recognized as a hospital. Multiple buildings operated under a single state license are considered to be a single hospital facility. For purposes of this paragraph (b)(17), the term "state" includes only the 50 states and the District of Columbia and not any U.S. territory or foreign country. References to a hospital facility taking actions include instances in which the hospital organization operating the hospital facility takes actions through or on behalf of the hospital facility.

(18) Hospital organization means an organization recognized (or seeking to be recognized) as described in section 501(c)(3) that operates one or more hospital facilities. If the section 501(c)(3) status of such an organization is revoked, the organization will, for purposes of section 4959, continue to be treated as a hospital organization during the taxable year in which such revocation becomes effective.

(19) Medicaid means any medical assistance program administered by the state in which a hospital facility is licensed in accordance with Title XIX of the Social Security Act (42 U.S.C. 1396 through 1396w-5), including programs in which such medical assistance is provided through a contract between the state and a Medicaid managed care organization or a prepaid inpatient health plan.

(20) Medicare fee-for-service means health insurance available under Medicare Part A and Part B of Title XVIII of the Social Security Act (42 U.S.C. 1395c through

1395w-5).

(21) Noncompliant facility income means income that a hospital organization operating more than one hospital facility derives from a hospital facility that fails to meet one or more of the requirements of section 501(r) during a taxable year as determined in accordance with §1.501(r)-2(d).

(22) Operating a hospital facility--(i) In general. Operating a hospital facility includes operating the facility through the organization's own employees or contracting out to another organization to operate the facility. For example, if an organization hires a management company to operate the facility, the hiring organization is considered to operate the facility. An organization also operates a hospital facility if it is the sole member or owner of a disregarded entity that operates the hospital facility. In addition, an organization operates a hospital facility if it owns a capital or profits interest in an entity treated as a partnership for federal tax purposes that operates the hospital facility, unless paragraph (b)(22)(ii) of this section applies. For purposes of this paragraph (b)(22), an organization is considered to own a capital or profits interest in an entity treated as a partnership for federal tax purposes if it owns such an interest directly or indirectly through one or more lower-tier entities treated as partnerships for federal tax purposes.

(ii) Exception for certain partnerships. An organization does not operate a hospital facility despite owning a capital or profits interest in an entity treated as a partnership for federal tax purposes that operates the hospital facility if--

(A) The organization does not have control over the operation of the hospital

facility operated by the partnership sufficient to ensure that the operation of the hospital facility furthers an exempt purpose described in section 501(c)(3) and thus treats the operation of the hospital facility, including the facility's provision of medical care, as an unrelated trade or business described in section 513 with respect to the hospital organization; or

(B) At all times since March 23, 2010, the organization has been organized and operated primarily for educational or scientific purposes and has not engaged primarily in the operation of one or more hospital facilities and, pursuant to a partnership agreement entered into before March 23, 2010--

(1) Does not own more than 35 percent of the capital or profits interest in the partnership (determined in accordance with section 707(b)(3));

(2) Does not own a general partner interest, managing-member interest, or similar interest in the partnership; and

(3) Does not have control over the operation of the hospital facility sufficient to ensure that the hospital facility complies with the requirements of section 501(r).

(23) Partnership agreement means, for purposes of paragraph (b)(22)(ii)(B) of this section, all written agreements among the partners, or between one or more partners and the partnership and concerning affairs of the partnership and responsibilities of the partners, whether or not embodied in a document referred to by the partners as the partnership agreement. A partnership agreement also includes any modifications to the agreement agreed to by all partners, or adopted in any other manner provided by the partnership agreement, except for modifications adopted on or

after March 23, 2010, that affect whether or not the agreement is described in paragraph (b)(22)(ii)(B) of this section. In addition, a partnership agreement includes provisions of federal, state, or local law that were in effect before March 23, 2010, and continue to be in effect that govern the affairs of the partnership or are considered under such law to be part of the partnership agreement.

(24) Plain language summary of the FAP means a written statement that notifies an individual that the hospital facility offers financial assistance under a FAP and provides the following additional information in language that is clear, concise, and easy to understand:

(i) A brief description of the eligibility requirements and assistance offered under the FAP.

(ii) A brief summary of how to apply for assistance under the FAP.

(iii) The direct Web site address (or URL) and physical locations where the individual can obtain copies of the FAP and FAP application form.

(iv) Instructions on how the individual can obtain a free copy of the FAP and FAP application form by mail.

(v) The contact information, including telephone number and physical location, of the hospital facility office or department that can provide information about the FAP and of either--

(A) The hospital facility office or department that can provide assistance with the FAP application process; or

(B) If the hospital facility does not provide assistance with the FAP application

process, at least one nonprofit organization or government agency that the hospital facility has identified as an available source of assistance with FAP applications.

(vi) A statement of the availability of translations of the FAP, FAP application form, and plain language summary of the FAP in other languages, if applicable.

(vii) A statement that a FAP-eligible individual may not be charged more than AGB for emergency or other medically necessary care.

(25) Presumptive FAP-eligibility determination means a determination that an individual is FAP-eligible based on information other than that provided by the individual or based on a prior FAP-eligibility determination, as described in §1.501(r)-6(c)(2).

(26) Private health insurer means any organization that is not a governmental unit that offers health insurance, including nongovernmental organizations administering a health insurance plan under Medicare Advantage (Part C of Title XVIII of the Social Security Act, 42 U.S.C. 1395w-21 through 1395w-29). For purposes of §1.501(r)-5(b), medical assistance provided through a contract between the state and a Medicaid managed care organization or a prepaid inpatient health plan is not considered to be a reimbursement from or a claim allowed by a private health insurer.

(27) Referring an individual's debt to a debt collection agency or other party means contracting with, delegating to, or otherwise using the debt collection agency or other party to collect amounts owed by the individual to the hospital facility while still maintaining ownership of the debt.

(28) Substantially-related entity means, with respect to a hospital facility operated by a hospital organization, an entity treated as a partnership for federal tax purposes in

which the hospital organization owns a capital or profits interest, or a disregarded entity of which the hospital organization is the sole member or owner, that provides emergency or other medically necessary care in the hospital facility, unless the provision of such care is an unrelated trade or business described in section 513 with respect to the hospital organization. Notwithstanding the preceding sentence, a partnership that qualifies for the exception described in paragraph (b)(22)(ii)(B) of this section is not considered a substantially-related entity within the meaning of this paragraph (b)(28).

(29) Widely available on a Web site means--

(i) The hospital facility conspicuously posts a complete and current version of the document on--

(A) The hospital facility's Web site;

(B) If the hospital facility does not have its own Web site separate from the hospital organization that operates it, the hospital organization's Web site; or

(C) A Web site established and maintained by another entity, but only if the Web site of the hospital facility or hospital organization (if the facility or organization has a Web site) provides a conspicuously-displayed link to the Web page where the document is posted, along with clear instructions for accessing the document on that Web site;

(ii) Individuals with access to the Internet can access, download, view, and print a hard copy of the document from the Web site--

(A) Without requiring special computer hardware or software (other than software that is readily available to members of the public without payment of any fee);

(B) Without paying of a fee to the hospital facility, hospital organization, or other entity maintaining the Web site; and

(C) Without creating an account or being otherwise required to provide personally identifiable information; and

(iii) The hospital facility provides individuals who ask how to access a copy of the document online with the direct Web site address, or URL, of the Web page where the document is posted.

§1.501(r)-2 Failures to satisfy section 501(r).

(a) Revocation of section 501(c)(3) status. Except as otherwise provided in paragraphs (b) and (c) of this section, a hospital organization failing to meet one or more of the requirements of section 501(r) separately with respect to one or more hospital facilities it operates may have its section 501(c)(3) status revoked as of the first day of the taxable year in which the failure occurs. In determining whether to continue to recognize the section 501(c)(3) status of a hospital organization that fails to meet one or more of the requirements of section 501(r) with respect to one or more hospital facilities, the Commissioner will consider all relevant facts and circumstances including, but not limited to, the following:

(1) Whether the organization has previously failed to meet the requirements of section 501(r), and, if so, whether the same type of failure previously occurred.

(2) The size, scope, nature, and significance of the organization's failure(s).

(3) In the case of an organization that operates more than one hospital facility,

the number, size, and significance of the facilities that have failed to meet the section 501(r) requirements relative to those that have complied with these requirements.

(4) The reason for the failure(s).

(5) Whether the organization had, prior to the failure(s), established practices or procedures (formal or informal) reasonably designed to promote and facilitate overall compliance with the section 501(r) requirements.

(6) Whether the practices or procedures had been routinely followed and the failure(s) occurred through an oversight or mistake in applying them.

(7) Whether the organization has implemented safeguards that are reasonably calculated to prevent similar failures from occurring in the future.

(8) Whether the organization corrected the failure(s) as promptly after discovery as is reasonable given the nature of the failure(s).

(9) Whether the organization took the measures described in paragraphs (a)(7) and (a)(8) of this section before the Commissioner discovered the failure(s).

(b) Minor omissions and errors--(1) In general. A hospital facility's omission of required information from a policy or report described in §1.501(r)-3 or §1.501(r)-4, or error with respect to the implementation or operational requirements described in §§1.501(r)-3 through 1.501(r)-6, will not be considered a failure to meet a requirement of section 501(r) if the following conditions are satisfied:

(i) Such omission or error was minor and either inadvertent or due to reasonable cause.

(ii) The hospital facility corrects such omission or error as promptly after

discovery as is reasonable given the nature of the omission or error. Such correction must include establishment (or review and, if necessary, revision) of practices or procedures (formal or informal) that are reasonably designed to promote and facilitate overall compliance with the requirements of section 501(r).

(2) Minor. In the case of multiple omissions or errors, the omissions or errors are considered minor for purposes of this paragraph (b) only if they are minor in the aggregate.

(3) Inadvertent. For purposes of this paragraph (b), the fact that the same omission or error has been made and corrected previously is a factor tending to show that an omission or error is not inadvertent.

(4) Reasonable cause. For purposes of this paragraph (b), the fact that a hospital facility has established practices or procedures (formal or informal) reasonably designed to promote and facilitate overall compliance with the section 501(r) requirements prior to the occurrence of an omission or error is a factor tending to show that the omission or error is due to reasonable cause.

(c) Excusing certain failures if hospital facility corrects and discloses. A hospital facility's failure to meet one or more of the requirements described in §§1.501(r)-3 through 1.501(r)-6 that is neither willful nor egregious shall be excused for purposes of this section if the hospital facility corrects and makes disclosure in accordance with rules set forth by revenue procedure, notice, or other guidance published in the Internal Revenue Bulletin. For purposes of this paragraph (c), a "willful" failure includes a failure due to gross negligence, reckless disregard, or willful neglect, and an "egregious" failure

includes only very serious failures, taking into account the severity of the impact and the number of affected persons. Whether a failure is willful or egregious will be determined based on all of the facts and circumstances. A hospital facility's correction and disclosure of a failure in accordance with the relevant guidance is a factor tending to show that the failure was not willful.

(d) Taxation of noncompliant hospital facilities--(1) In general. Except as otherwise provided in paragraphs (b) and (c) of this section, if a hospital organization that operates more than one hospital facility fails to meet one or more of the requirements of section 501(r) separately with respect to a hospital facility during a taxable year, the income derived from the noncompliant hospital facility ("noncompliant facility income") during that taxable year will be subject to tax computed as provided in section 11 (or as provided in section 1(e) if the hospital organization is a trust described in section 511(b)(2)), but substituting the term "noncompliant facility income" for "taxable income," if--

(i) The hospital organization continues to be recognized as described in section 501(c)(3) during the taxable year; but

(ii) The hospital organization would not continue to be recognized as described in section 501(c)(3) during the taxable year based on the facts and circumstances described in paragraph (a) of this section (but disregarding paragraph (a)(3) of this section) if the noncompliant hospital facility were the only hospital facility operated by the organization.

(2) Noncompliant facility income--(i) In general. For purposes of this paragraph

(d), the noncompliant facility income derived from a hospital facility during a taxable year will be the gross income derived from that hospital facility during the taxable year, less the deductions allowed by chapter 1 that are directly connected to the operation of that hospital facility during the taxable year, excluding any gross income and deductions taken into account in computing any unrelated business taxable income described in section 512 that is derived from the facility during the taxable year.

(ii) Directly connected deductions. For purposes of this paragraph (d), to be directly connected with the operation of a hospital facility that has failed to meet the requirements of section 501(r), an item of deduction must have proximate and primary relationship to the operation of the hospital facility. Expenses, depreciation, and similar items attributable solely to the operation of a hospital facility are proximately and primarily related to such operation, and therefore qualify for deduction to the extent that they meet the requirements of section 162, section 167, or other relevant provisions of the Internal Revenue Code (Code). Where expenses, depreciation, and similar items are attributable to a noncompliant hospital facility and other hospital facilities operated by the hospital organization (and/or to other activities of the hospital organization unrelated to the operation of hospital facilities), such items shall be allocated among the hospital facilities (and/or other activities) on a reasonable basis. The portion of any such item so allocated to a noncompliant hospital facility is proximately and primarily related to the operation of that facility and shall be allowable as a deduction in computing the facility's noncompliant facility income in the manner and to the extent it would meet the requirements of section 162, section 167, or other relevant provisions of

the Code.

(3) No aggregation. In computing the noncompliant facility income of a hospital facility, the gross income from (and the deductions allowed with respect to) the hospital facility may not be aggregated with the gross income from (and the deductions allowed with respect to) the hospital organization's other noncompliant hospital facilities subject to tax under this paragraph (d) or its unrelated trade or business activities described in section 513.

(4) Interaction with other Code provisions--(i) Hospital organization operating a noncompliant hospital facility continues to be treated as tax-exempt. A hospital organization operating a noncompliant hospital facility subject to tax under this paragraph (d) shall continue to be treated as an organization that is exempt from tax under section 501(a) because it is described in section 501(c)(3) for all purposes of the Code. In addition, the application of this paragraph (d) shall not, by itself, result in the operation of the noncompliant hospital facility being considered an unrelated trade or business described in section 513 with respect to the hospital organization. Thus, for example, the application of this paragraph (d) shall not, by itself, affect the tax-exempt status of bonds issued to finance the noncompliant hospital facility.

(ii) Noncompliant hospital facility operated by a tax-exempt hospital organization is subject to tax. A noncompliant hospital facility described in paragraph (d)(1) of this section is subject to tax under this paragraph (d), notwithstanding the fact that the hospital organization operating the hospital facility is otherwise exempt from tax under section 501(a) and subject to tax under section 511(a) and that §1.11-1(a) of this

chapter states such organizations are not liable for the tax imposed under section 11.

(iii) Noncompliant hospital facility not a business entity. A noncompliant hospital facility subject to tax under this paragraph (d) is not considered a business entity for purposes of §301.7701-2(b)(7) of this chapter.

(e) Instances in which a hospital organization is not required to meet section 501(r). A hospital organization is not required to meet the requirements of section 501(r) (and, therefore, is not subject to any consequence described in this section for failing to meet the requirements of section 501(r)) with respect to--

(1) Any hospital facility it is not “operating” within the meaning of §1.501(r)-1(b)(22);

(2) The operation of a facility that is not required by a state to be licensed, registered, or similarly recognized as a hospital; or

(3) Any activities that constitute an unrelated trade or business described in section 513 with respect to the hospital organization.

§1.501(r)-3 Community health needs assessments.

(a) In general. With respect to any taxable year, a hospital organization meets the requirements of section 501(r)(3) with respect to a hospital facility it operates only if--

(1) The hospital facility has conducted a community health needs assessment (CHNA) that meets the requirements of paragraph (b) of this section in such taxable year or in either of the two taxable years immediately preceding such taxable year

(except as provided in paragraph (d) of this section); and

(2) An authorized body of the hospital facility (as defined in §1.501(r)-1(b)(4)) has adopted an implementation strategy to meet the community health needs identified through the CHNA, as described in paragraph (c) of this section, on or before the 15th day of the fifth month after the end of such taxable year.

(b) Conducting a CHNA--(1) In general. To conduct a CHNA for purposes of paragraph (a) of this section, a hospital facility must complete all of the following steps:

(i) Define the community it serves.

(ii) Assess the health needs of that community.

(iii) In assessing the health needs of the community, solicit and take into account input received from persons who represent the broad interests of that community, including those with special knowledge of or expertise in public health.

(iv) Document the CHNA in a written report (CHNA report) that is adopted for the hospital facility by an authorized body of the hospital facility.

(v) Make the CHNA report widely available to the public.

(2) Date a CHNA is conducted. For purposes of this section, a hospital facility will be considered to have conducted a CHNA on the date it has completed all of the steps described in paragraph (b)(1) of this section. Solely for purposes of determining the taxable year in which a CHNA has been conducted under this paragraph (b)(2), a hospital facility will be considered to have completed the step of making a CHNA report widely available to the public on the date it first makes the CHNA report widely available to the public as described in paragraph (b)(7)(i) of this section.

(3) Community served by a hospital facility. In defining the community it serves for purposes of paragraph (b)(1)(i) of this section, a hospital facility may take into account all of the relevant facts and circumstances, including the geographic area served by the hospital facility, target population(s) served (for example, children, women, or the aged), and principal functions (for example, focus on a particular specialty area or targeted disease). However, a hospital facility 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 population(s) or affected by its principal functions) or otherwise should be included based on the method the hospital facility uses to define its community. In addition, in determining its patient populations for purposes of defining its community, a hospital facility must take into account all patients without regard to whether (or how much) they or their insurers pay for the care received or whether they are eligible for assistance under the hospital facility's financial assistance policy. In the case of a hospital facility consisting of multiple buildings that operate under a single state license and serve different geographic areas or populations, the community served by the hospital facility is the aggregate of such areas or populations.

(4) Assessing community health needs. To assess the health needs of the community it serves for purposes of paragraph (b)(1)(ii) of this section, a hospital facility must identify significant health needs of the community, prioritize those health needs, and identify resources (such as organizations, facilities, and programs in the

community, including those of the hospital facility) potentially available to address those health needs. For these purposes, the health needs of a community include requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities). These needs may include, for example, the need to address financial and other barriers to accessing care, to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community. A hospital facility may determine whether a health need is significant based on all of the facts and circumstances present in the community it serves. In addition, a hospital facility may use any criteria to prioritize the significant health needs it identifies, including, but not limited to, the burden, scope, severity, or urgency of the health need; the estimated feasibility and effectiveness of possible interventions; the health disparities associated with the need; or the importance the community places on addressing the need.

(5) Persons representing the broad interests of the community--(i) In general.

For purposes of paragraph (b)(1)(iii) of this section, a hospital facility must solicit and take into account input received from all of the following sources in identifying and prioritizing significant health needs and in identifying resources potentially available to address those health needs:

(A) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency), or a State Office of Rural Health described in section 338J of the Public Health Service Act (42 U.S.C. 254r), with

knowledge, information, or expertise relevant to the health needs of that community.

(B) Members of medically underserved, low-income, and minority populations in the community served by the hospital facility, or individuals or organizations serving or representing the interests of such populations. For purposes of this paragraph (b), medically underserved populations include populations experiencing health disparities or at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers.

(C) Written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy.

(ii) Additional sources of input. In addition to the sources described in paragraph (b)(5)(i) of this section, a hospital facility may solicit and take into account input received from a broad range of persons located in or serving its community, including, but not limited to, health care consumers and consumer advocates, nonprofit and community-based organizations, academic experts, local government officials, local school districts, health care providers and community health centers, health insurance and managed care organizations, private businesses, and labor and workforce representatives.

(6) Documentation of a CHNA--(i) In general. For purposes of paragraph (b)(1)(iv) of this section, the CHNA report adopted for the hospital facility by an authorized body of the hospital facility must include--

(A) A definition of the community served by the hospital facility and a description of how the community was determined;

(B) A description of the process and methods used to conduct the CHNA;

(C) A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;

(D) A prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs;

(E) A description of the resources potentially available to address the significant health needs identified through the CHNA; and

(F) An evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s).

(ii) Process and methods used to conduct the CHNA. A hospital facility's CHNA report will be considered to describe the process and methods used to conduct the CHNA for purposes of paragraph (b)(6)(i)(B) of this section if the CHNA report describes the data and other information used in the assessment, as well as the methods of collecting and analyzing this data and information, and identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in conducting the CHNA. In the case of data obtained from external source material, the CHNA report may cite the source material rather than describe the method of collecting the data.

(iii) Input from persons who represent the broad interests of the community served by the hospital facility. A hospital facility's CHNA report will be considered to describe how the hospital facility took into account input received from persons who

represent the broad interests of the community it serves for purposes of paragraph (b)(6)(i)(C) of this section if the CHNA report summarizes, in general terms, any input provided by such persons and how and over what time period such input was provided (for example, whether through meetings, focus groups, interviews, surveys, or written comments and between what approximate dates); provides the names of any organizations providing input and summarizes the nature and extent of the organization's input; and describes the medically underserved, low-income, or minority populations being represented by organizations or individuals that provided input. A CHNA report does not need to name or otherwise identify any specific individual providing input on the CHNA. In the event a hospital facility solicits, but cannot obtain, input from a source described in paragraph (b)(5)(i) of this section, the hospital facility's CHNA report also must describe the hospital facility's efforts to solicit input from such source.

(iv) Separate CHNA reports. While a hospital facility may conduct its CHNA in collaboration with other organizations and facilities (including, but not limited to, related and unrelated hospital organizations and facilities, for-profit and government hospitals, governmental departments, and nonprofit organizations), every hospital facility must document the information described in this paragraph (b)(6) in a separate CHNA report to satisfy paragraph (b)(1)(iv) of this section unless it adopts a joint CHNA report as described in paragraph (b)(6)(v) of this section. However, if a hospital facility is collaborating with other facilities and organizations in conducting its CHNA or if another organization (such as a state or local public health department) has conducted a CHNA

for all or part of the hospital facility's community, portions of the hospital facility's CHNA report may be substantively identical to portions of a CHNA report of a collaborating hospital facility or other organization conducting a CHNA, if appropriate under the facts and circumstances. For example, if two hospital facilities with overlapping, but not identical, communities are collaborating in conducting a CHNA, the portions of each hospital facility's CHNA report relevant to the shared areas of their communities might be identical. Similarly, if the state or local public health department with jurisdiction over the community served by a hospital facility conducts a CHNA for an area that includes the hospital facility's community, the hospital facility's CHNA report might include portions of the state or local public health department's CHNA report that are relevant to its community.

(v) Joint CHNA reports--(A) In general. A hospital facility that collaborates with other hospital facilities or other organizations (such as state or local public health departments) in conducting its CHNA will satisfy paragraph (b)(1)(iv) of this section if an authorized body of the hospital facility adopts for the hospital facility a joint CHNA report produced for the hospital facility and one or more of the collaborating facilities and organizations, provided that the following conditions are met:

(1) The joint CHNA report meets the requirements of paragraph (b)(6)(i) of this section.

(2) The joint CHNA report is clearly identified as applying to the hospital facility.

(3) All of the collaborating hospital facilities and organizations included in the joint CHNA report define their community to be the same.

(B) Example. The following example illustrates this paragraph (b)(6)(v):

Example. P is one of 10 hospital facilities located in and serving the populations of a particular Metropolitan Statistical Area (MSA). P and seven other facilities in the MSA, some of which are unrelated to P, decide to collaborate in conducting a CHNA for the MSA and to each define their community as constituting the entire MSA. The eight hospital facilities work together with the state and local health departments of jurisdictions in the MSA to assess the health needs of the MSA and collaborate in conducting surveys and holding public forums to solicit and receive input from the MSA's residents, including its medically underserved, low-income, and minority populations. The hospital facilities also consider the written comments received on their most recently conducted CHNAs and most recently adopted implementation strategies. The hospital facilities then work together to prepare a joint CHNA report documenting this joint CHNA process that contains all of the elements described in paragraph (b)(6)(i) of this section. The joint CHNA report identifies all of the collaborating hospital facilities included in the report, including P, by name, both within the report itself and on the cover page. The board of directors of the hospital organization operating P adopts the joint CHNA report for P. P has complied with the requirements of this paragraph (b)(6)(v) and, accordingly, has satisfied paragraph (b)(1)(iv) of this section.

(7) Making the CHNA report widely available to the public--(i) In general. For purposes of paragraph (b)(1)(v) of this section, a hospital facility's CHNA report is made widely available to the public only if the hospital facility--

(A) Makes the CHNA report widely available on a Web site, as defined in §1.501(r)-1(b)(29), at least until the date the hospital facility has made widely available on a Web site its two subsequent CHNA reports; and

(B) Makes a paper copy of the CHNA report available for public inspection upon request and without charge at the hospital facility at least until the date the hospital facility has made available for public inspection a paper copy of its two subsequent CHNA reports.

(ii) Making draft CHNA reports widely available. Notwithstanding paragraph (b)(7)(i) of this section, if a hospital facility makes widely available on a Web site (and/or

for public inspection) a version of the CHNA report that is expressly marked as a draft on which the public may comment, the hospital facility will not be considered to have made the CHNA report widely available to the public for purposes of determining the date on which the hospital facility has conducted a CHNA under paragraph (b)(2) of this section.

(c) Implementation strategy--(1) In general. For purposes of paragraph (a)(2) of this section, a hospital facility's implementation strategy to meet the community health needs identified through the hospital facility's CHNA is a written plan that, with respect to each significant health need identified through the CHNA, either--

- (i) Describes how the hospital facility plans to address the health need; or
- (ii) Identifies the health need as one the hospital facility does not intend to address and explains why the hospital facility does not intend to address the health need.

(2) Description of how the hospital facility plans to address a significant health need. A hospital facility will have described a plan to address a significant health need identified through a CHNA for purposes of paragraph (c)(1)(i) of this section if the implementation strategy--

- (i) Describes the actions the hospital facility intends to take to address the health need and the anticipated impact of these actions;
- (ii) Identifies the resources the hospital facility plans to commit to address the health need; and
- (iii) Describes any planned collaboration between the hospital facility and other

facilities or organizations in addressing the health need.

(3) Description of why a hospital facility is not addressing a significant health need. In explaining why it does not intend to address a significant health need for purposes of paragraph (c)(1)(ii) of this section, a brief explanation of the hospital facility's reason for not addressing the health need is sufficient. Such reasons may include, for example, resource constraints, other facilities or organizations in the community addressing the need, a relative lack of expertise or competency to effectively address the need, the need being a relatively low priority, and/or a lack of identified effective interventions to address the need.

(4) Joint implementation strategies. A hospital facility may develop an implementation strategy in collaboration with other hospital facilities or other organizations, including, but not limited to, related and unrelated hospital organizations and facilities, for-profit and government hospitals, governmental departments, and nonprofit organizations. In general, a hospital facility that collaborates with other facilities or organizations in developing its implementation strategy must still document its implementation strategy in a separate written plan that is tailored to the particular hospital facility, taking into account its specific resources. However, a hospital facility that adopts a joint CHNA report described in paragraph (b)(6)(v) of this section may also adopt a joint implementation strategy that, with respect to each significant health need identified through the joint CHNA, either describes how one or more of the collaborating facilities or organizations plan to address the health need or identifies the health need as one the collaborating facilities or organizations do not intend to address and explains

why they do not intend to address the health need. For a collaborating hospital facility to meet the requirements of paragraph (a)(2) of this section, such a joint implementation strategy adopted for the hospital facility must--

(i) Be clearly identified as applying to the hospital facility;

(ii) Clearly identify the hospital facility's particular role and responsibilities in taking the actions described in the implementation strategy and the resources the hospital facility plans to commit to such actions; and

(iii) Include a summary or other tool that helps the reader easily locate those portions of the joint implementation strategy that relate to the hospital facility.

(5) When the implementation strategy must be adopted--(i) In general. For purposes of paragraph (a)(2) of this section, an authorized body of the hospital facility must adopt the implementation strategy on or before the 15th day of the fifth month after the end of the taxable year in which the hospital facility completes the final step for the CHNA described in paragraph (b)(1) of this section, regardless of whether the hospital facility began working on the CHNA in a prior taxable year.

(ii) Example. The following example illustrates this paragraph (c)(5):

Example. M is a hospital facility that last conducted a CHNA and adopted an implementation strategy in Year 1. In Year 3, M defines the community it serves, assesses the significant health needs of that community, and solicits and takes into account input received from persons who represent the broad interests of that community. In Year 4, M documents its CHNA in a CHNA report that is adopted by an authorized body of M, makes the CHNA report widely available on a Web site, and makes paper copies of the CHNA report available for public inspection. To meet the requirements of paragraph (a)(2) of this section, an authorized body of M must adopt an implementation strategy to meet the health needs identified through the CHNA completed in Year 4 by the 15th day of the fifth month of Year 5.

(d) Exception for acquired, new, and terminated hospital facilities--(1) Acquired

hospital facilities. A hospital organization that acquires a hospital facility (whether through merger or acquisition) must meet the requirements of section 501(r)(3) with respect to the acquired hospital facility by the last day of the organization's second taxable year beginning after the date on which the hospital facility was acquired. In the case of a merger between two organizations that results in the liquidation of one organization and the survival of the other organization, the hospital facility or facilities formerly operated by the liquidated organization will be considered "acquired" for purposes of this paragraph (d)(1).

(2) New hospital organizations. An organization that becomes newly subject to the requirements of section 501(r) because it is recognized as described in section 501(c)(3) and is operating a hospital facility must meet the requirements of section 501(r)(3) with respect to any hospital facility by the last day of the second taxable year beginning after the later of the effective date of the determination letter or ruling recognizing the organization as described in section 501(c)(3) or the first date that a facility operated by the organization was licensed, registered, or similarly recognized by a state as a hospital.

(3) New hospital facilities. A hospital organization must meet the requirements of section 501(r)(3) with respect to a new hospital facility it operates by the last day of the second taxable year beginning after the date the facility was licensed, registered, or similarly recognized by its state as a hospital.

(4) Transferred or terminated hospital facilities. A hospital organization is not required to meet the requirements of section 501(r)(3) with respect to a hospital facility

in a taxable year if, before the end of that taxable year, the hospital organization transfers all ownership of the hospital facility to another organization or otherwise ceases its operation of the hospital facility or the facility ceases to be licensed, registered, or similarly recognized as a hospital by a state.

(e) Transition rule for CHNAs conducted in taxable years beginning before March 23, 2012. A hospital facility that conducted a CHNA described in section 501(r)(3) in either its first taxable year beginning after March 23, 2010, or its first taxable year beginning after March 23, 2011, does not need to meet the requirements of section 501(r)(3) again until the third taxable year following the taxable year in which the hospital facility conducted that CHNA, provided that the hospital facility adopted an implementation strategy to meet the community health needs identified through that CHNA on or before the 15th day of the fifth calendar month following the close of its first taxable year beginning after March 23, 2012.

§1.501(r)-4 Financial assistance policy and emergency medical care policy.

(a) In general. A hospital organization meets the requirements of section 501(r)(4) with respect to a hospital facility it operates only if the hospital organization establishes for that hospital facility--

(1) A written financial assistance policy (FAP) that meets the requirements of paragraph (b) of this section; and

(2) A written emergency medical care policy that meets the requirements of paragraph (c) of this section.

(b) Financial assistance policy--(1) In general. To satisfy paragraph (a)(1) of this section, a hospital facility's FAP must--

(i) Apply to all emergency and other medically necessary care provided by the hospital facility, including all such care provided in the hospital facility by a substantially-related entity (as defined in §1.501(r)-1(b)(28));

(ii) Be widely publicized as described in paragraph (b)(5) of this section; and

(iii) Include--

(A) The eligibility criteria for financial assistance and whether such assistance includes free or discounted care;

(B) The basis for calculating amounts charged to patients;

(C) The method for applying for financial assistance;

(D) In the case of a hospital facility that does not have a separate billing and collections policy, the actions that may be taken in the event of nonpayment;

(E) If applicable, any information obtained from sources other than an individual seeking financial assistance that the hospital facility uses, and whether and under what circumstances it uses prior FAP-eligibility determinations, to presumptively determine that the individual is FAP-eligible, as described in §1.501(r)-6(c)(2); and

(F) A list of any providers, other than the hospital facility itself, delivering emergency or other medically necessary care in the hospital facility that specifies which providers are covered by the hospital facility's FAP and which are not.

(2) Eligibility criteria and basis for calculating amounts charged to patients--(i) In general. To satisfy paragraphs (b)(1)(iii)(A) and (b)(1)(iii)(B) of this section, the FAP

must specify the following:

(A) All financial assistance available under the FAP, including all discounts and free care available under the FAP and, if applicable, the amount(s) (for example, gross charges) to which any discount percentages available under the FAP will be applied.

(B) The eligibility criteria that an individual must satisfy to receive each discount, free care, or other level of assistance available under the FAP.

(C) The method under §1.501(r)-5(b) the hospital facility uses to determine the amounts generally billed to individuals who have insurance covering emergency or other medically necessary care (AGB). If the hospital facility uses the look-back method described in §1.501(r)-5(b)(3), the FAP also must state the AGB percentage(s) that the hospital facility uses to determine AGB and describe how the hospital facility calculated such percentage(s) or, alternatively, explain how members of the public may readily obtain such percentage(s) and accompanying description of the calculation in writing and free of charge. In addition, the FAP must indicate that, following a determination of FAP-eligibility, a FAP-eligible individual may not be charged more than AGB for emergency or other medically necessary care.

(ii) Examples. The following examples illustrate this paragraph (b)(2):

Example 1. (i) Q is a hospital facility that establishes a FAP that provides assistance to all uninsured and underinsured individuals whose family income is less than or equal to x% of the Federal Poverty Level (FPL), with the level of discount for which an individual is eligible under Q's FAP determined based upon the individual's family income as a percentage of FPL. Q's FAP defines the meaning of "uninsured," "underinsured," "family income," and "Federal Poverty Level." Q's FAP also states that Q determines AGB by multiplying the gross charges for any emergency or other medically necessary care it provides to a FAP-eligible individual by an AGB percentage of 56%. The FAP states, further, that Q calculated the AGB percentage of 56% based on all claims allowed by Medicare and private health insurers over a specified 12-month

period, divided by the associated gross charges for those claims. Q's FAP contains the following chart, specifying each discount available under the FAP, the amounts (gross charges) to which these discounts will be applied, and the specific eligibility criteria for each such discount:

Family income as % of FPL	Discount off of gross charges
>y% - x%	50%
>z% - y%	75%
≤z%	Free

(ii) Q's FAP also contains a statement that no FAP-eligible individual will be charged more for emergency or other medically necessary care than AGB because Q's AGB percentage is 56% of gross charges and the most a FAP-eligible individual will be charged is 50% of gross charges. Q's FAP satisfies the requirements of this paragraph (b)(2).

Example 2. (i) R is a hospital facility that establishes a FAP that provides assistance based on household income. R's FAP defines the meaning of "household income." R's FAP contains the following chart specifying the assistance available under the FAP and the specific eligibility criteria for each level of assistance offered, which R updates occasionally to account for inflation:

Household income	Maximum amount individual will be responsible for paying
>\$b - \$a	40% of gross charges, up to the lesser of AGB or x% of household income
>\$c - \$b	20% of gross charges, up to the lesser of AGB or y% of household income
≤\$c	\$0 (free)

(ii) R's FAP contains a statement that no FAP-eligible individual will be charged more for emergency or other medically necessary care than AGB. R's FAP also states that R determines AGB by multiplying the gross charges for any emergency or other medically necessary care it provides by AGB percentages, which are based on claims allowed under Medicare. In addition, the FAP provides a Web site address individuals can visit, and a telephone number they can call, if they would like to obtain an information sheet stating R's AGB percentages and explaining how these AGB percentages were calculated. This information sheet, which R makes available on its Web site and provides to any individual who requests it, states that R's AGB percentages are 35% of gross charges for inpatient care and 61% of gross charges for outpatient care. It also states that these percentages were based on all claims allowed

for R's emergency or other medically necessary inpatient and outpatient care by Medicare over a specified 12-month period, divided by the associated gross charges for those claims. R's FAP satisfies the requirements of this paragraph (b)(2).

(3) Method for applying for financial assistance--(i) In general. To satisfy paragraph (b)(1)(iii)(C) of this section, a hospital facility's FAP must describe how an individual applies for financial assistance under the FAP. In addition, either the hospital facility's FAP or FAP application form (including accompanying instructions) must describe the information and documentation the hospital facility may require an individual to provide as part of his or her FAP application and provide the contact information described in §1.501(r)-1(b)(24)(v). A hospital facility may not deny financial assistance under its FAP based on an applicant's failure to provide information or documentation unless that information or documentation is described in the FAP or FAP application form. However, a hospital facility may grant financial assistance under its FAP notwithstanding an applicant's failure to provide information or documentation described in the FAP or FAP application form and may, for example, rely on other evidence of eligibility or an attestation by the applicant to determine that the applicant is FAP-eligible.

(ii) Example. The following example illustrates this paragraph (b)(3):

Example. S is a hospital facility with a FAP that bases eligibility solely on an individual's household income. S's FAP provides that an individual may apply for financial assistance by completing and submitting S's FAP application form. S's FAP also describes how individuals can obtain copies of the FAP application form. S's FAP application form contains lines on which the applicant lists all items of household income received by the applicant's household over the last month and the names of the applicant's household members. The instructions to S's FAP application form tell applicants where to submit the application and provide that an applicant must attach to his or her FAP application form proof of household income in the form of payroll check stubs from the last month or, if last month's wages are not representative of the

applicant's annual income, a copy of the applicant's most recent federal tax return. Alternatively, the instructions state that an applicant may provide documentation of his or her qualification for certain specified state means-tested programs. The instructions also state that if an applicant does not have any of the listed documents proving household income, he or she may call S's financial assistance office and discuss other evidence that may be provided to demonstrate eligibility. S does not deny financial assistance to FAP applicants based on a failure to submit any information or documentation not mentioned in the FAP application form or instructions. S's FAP application form instructions also provide the contact information of the hospital facility office that can provide an applicant with information about the FAP and assistance with the FAP application process. S's FAP satisfies the requirements of this paragraph (b)(3).

(4) Actions that may be taken in the event of nonpayment--(i) In general. To satisfy paragraph (b)(1)(iii)(D) of this section, either a hospital facility's FAP or a separate written billing and collections policy established for the hospital facility must describe--

(A) Any actions that the hospital facility (or other authorized party) may take related to obtaining payment of a bill for medical care, including, but not limited to, any extraordinary collection actions (ECAs) described in §1.501(r)-6(b);

(B) The process and time frames the hospital facility (or other authorized party) uses in taking the actions described in paragraph (b)(4)(i)(A) of this section, including, but not limited to, the reasonable efforts it will make to determine whether an individual is FAP-eligible before engaging in any ECAs, as described in §1.501(r)-6(c); and

(C) The office, department, committee, or other body with the final authority or responsibility for determining that the hospital facility has made reasonable efforts to determine whether an individual is FAP-eligible and may therefore engage in ECAs against the individual.

(ii) Separate billing and collections policy. In the case of a hospital facility that

satisfies paragraph (b)(1)(iii)(D) of this section by establishing a separate written billing and collections policy, the hospital facility's FAP must state that the actions the hospital facility may take in the event of nonpayment are described in a separate billing and collections policy and explain how members of the public may readily obtain a free copy of this separate policy.

(5) Widely publicizing the FAP--(i) In general. To satisfy the requirement in paragraph (b)(1)(ii) of this section to widely publicize its FAP, a hospital facility must--

(A) Make the FAP, FAP application form, and plain language summary of the FAP (as defined in §1.501(r)-1(b)(24)) widely available on a Web site (as defined in §1.501(r)-1(b)(29));

(B) Make paper copies of the FAP, FAP application form, and plain language summary of the FAP available upon request and without charge, both by mail and in public locations in the hospital facility, including, at a minimum, in the emergency room (if any) and admissions areas;

(C) Notify and inform members of the community served by the hospital facility about the FAP in a manner reasonably calculated to reach those members who are most likely to require financial assistance from the hospital facility; and

(D) Notify and inform individuals who receive care from the hospital facility about the FAP by--

(1) Offering a paper copy of the plain language summary of the FAP to patients as part of the intake or discharge process;

(2) Including a conspicuous written notice on billing statements that notifies and

informs recipients about the availability of financial assistance under the hospital facility's FAP and includes the telephone number of the hospital facility office or department that can provide information about the FAP and FAP application process and the direct Web site address (or URL) where copies of the FAP, FAP application form, and plain language summary of the FAP may be obtained; and

(3) Setting up conspicuous public displays (or other measures reasonably calculated to attract patients' attention) that notify and inform patients about the FAP in public locations in the hospital facility, including, at a minimum, the emergency room (if any) and admissions areas.

(ii) Accessibility to limited English proficient individuals. To widely publicize its FAP, a hospital facility must accommodate all significant populations that have limited English proficiency (LEP) by translating its FAP, FAP application form, and plain language summary of the FAP into the primary language(s) spoken by such populations. A hospital facility will satisfy this translation requirement in a taxable year if it makes available translations of its FAP, FAP application form, and plain language summary of the FAP in the language spoken by each LEP language group that constitutes the lesser of 1,000 individuals or 5 percent of the community served by the hospital facility or the population likely to be affected or encountered by the hospital facility. For purposes of this paragraph (b)(5)(ii), a hospital facility may determine the percentage or number of LEP individuals in the hospital facility's community or likely to be affected or encountered by the hospital facility using any reasonable method.

(iii) Meaning of notify and inform. For purposes of paragraphs (b)(5)(i)(C) and

(b)(5)(i)(D)(3) of this section, a measure will notify and inform members of a community or patients about the hospital facility's FAP if the measure, at a minimum, notifies the reader or listener that the hospital facility offers financial assistance under a FAP and informs him or her about how or where to obtain more information about the FAP and FAP application process and to obtain copies of the FAP, FAP application form, and plain language summary of the FAP.

(iv) Meaning of reasonably calculated. Whether one or more measures to widely publicize a hospital facility's FAP are reasonably calculated to notify and inform members of a community or patients about the hospital facility's FAP in the manner described in paragraphs (b)(5)(i)(C) and (b)(5)(i)(D)(3) of this section will depend on all of the facts and circumstances, including the primary language(s) spoken by the members of the community served by the hospital facility and other attributes of the community and the hospital facility.

(v) Examples. The following examples illustrate this paragraph (b)(5):

Example 1. (i) Z is a hospital facility. The home page and main billing page of Z's Web site conspicuously display the following message: "Need help paying your bill? You may be eligible for financial assistance. Click [here](#) for more information." When readers click on the link, they are taken to a Web page that explains the various discounts available under Z's FAP and the specific eligibility criteria for each such discount. This Web page also provides all of the other information required to be included in a plain language summary of the FAP (as defined in §1.501(r)-1(b)(24)), including a telephone number of Z that individuals can call and a room number of Z that individuals can visit for more information about the FAP and assistance with FAP applications. In addition, the Web page contains prominently-displayed links that allow readers to download PDF files of the FAP and the FAP application form, free of charge and without being required to create an account or provide personally identifiable information. Z provides any individual who asks how to access a copy of the FAP, FAP application form, or plain language summary of the FAP online with the URL of this Web page. By implementing these measures, Z has made its FAP widely available on a Web site within the meaning of paragraph (b)(5)(i)(A) of this section.

(ii) Z distributes copies of the plain language summary of its FAP and its FAP application form to all of its referring staff physicians and to the community health centers serving its community. Z also distributes copies of these documents to the local health department and to numerous public agencies and nonprofit organizations in its community that address the health issues and other needs of low-income populations, in quantities sufficient to meet demand. In addition, every issue of the quarterly newsletter that Z mails to the individuals in its customer database contains a prominently-displayed advertisement informing readers that Z offers financial assistance and that people having trouble paying their hospital bills may be eligible for financial assistance. The advertisement provides readers with the URL of the Web page where Z's FAP and FAP application form can be accessed and a telephone number of Z that individuals can call and a room number of Z that individuals can visit with questions about the FAP or assistance with the FAP application process. By implementing these measures, Z notifies and informs members of its community about the FAP within the meaning of paragraph (b)(5)(i)(C) of this section.

(iii) Z makes paper copies of the FAP, FAP application form, and plain language summary of the FAP available upon request and without charge, both by mail and in its admissions areas and emergency room. Z also conspicuously displays a sign in large font regarding the FAP in its admissions areas and emergency room. The sign says: "Uninsured? Having trouble paying your hospital bill? You may be eligible for financial assistance." The sign also provides the URL of the Web page where Z's FAP and FAP application form can be accessed. In addition, the sign provides a telephone number of Z that individuals can call and a room number of Z that individuals can visit with questions about the FAP or assistance with the FAP application process. Underneath each sign, Z conspicuously displays copies of a brochure that contains all of the information required to be included in a plain language summary of the FAP (as defined in §1.501(r)-1(b)(24)). Z makes these brochures available in quantities sufficient to meet visitor demand. Z also offers a plain language summary of the FAP as part of its intake process. Z's billing statements include a conspicuously-placed statement in large font containing the same information that Z includes on its signs. By implementing these measures, Z makes a paper copy of the FAP, FAP application form, and plain language summary of the FAP available upon request within the meaning of paragraph (b)(5)(i)(B) of this section and notifies and informs individuals who receive care from the hospital facility about the FAP within the meaning of paragraph (b)(5)(i)(D) of this section.

(iv) Because Z takes measures to widely publicize the FAP described in paragraphs (b)(5)(i)(A), (b)(5)(i)(B), (b)(5)(i)(C), and (b)(5)(i)(D) of this section, Z meets the requirement to widely publicize its FAP under paragraph (b)(1)(ii) of this section.

Example 2. Assume the same facts as Example 1, except that Z serves a community in which 6% of the members speak Spanish and have limited proficiency in English. Z translates its FAP, FAP application form, and FAP brochure (which

constitutes a plain language summary of the FAP) into Spanish, and displays and distributes both Spanish and English versions of these documents in its hospital facility using all of the measures described in Example 1. Z also distributes Spanish versions of its FAP application form and FAP brochure to organizations serving Spanish-speaking members of its community. Moreover, the home page and main billing page of Z's Web site conspicuously display an "¿Habla Español?" link that takes readers to a Web page that summarizes the FAP in Spanish and contains links that allow readers to download PDF files of the Spanish versions of the FAP and FAP application form, free of charge and without being required to create an account or provide personally identifiable information. Z meets the requirement to widely publicize its FAP under paragraph (b)(1)(ii) of this section.

(6) Readily obtainable information. For purposes of paragraphs (b)(2)(i)(C) and (b)(4)(ii) of this section, information is readily obtainable by members of the public if a hospital facility--

(i) Makes the information available free of charge on a Web site and via a paper copy upon request in a manner similar to that described in paragraphs (b)(5)(i)(A) and (b)(5)(i)(B) of this section; and

(ii) Provides translations of the information as described in paragraph (b)(5)(ii) of this section.

(7) Providing documents electronically. A hospital facility may provide electronically (for example, on an electronic screen, by email, or by providing the direct Web site address, or URL, of the Web page where the document or information is posted) any document or information that is required by this paragraph (b) to be provided in the form of a paper copy to any individual who indicates he or she prefers to receive or access the document or information electronically.

(8) Medically necessary care. For purposes of meeting the requirements of this section, 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, or a definition that refers to the generally accepted standards of medicine in the community or to an examining physician's determination.

(c) Emergency medical care policy--(1) In general. To satisfy paragraph (a)(2) of this section, a hospital organization must establish a written policy for a hospital facility that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of whether they are FAP-eligible.

(2) Interference with provision of emergency medical care. A hospital facility's emergency medical care policy will not be described in paragraph (c)(1) of this section unless it 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 provision, without discrimination, of emergency medical care.

(3) Relation to federal law governing emergency medical care. Subject to paragraph (c)(2) of this section, a hospital facility's emergency medical care policy will be described in paragraph (c)(1) of this section if it requires the hospital facility to provide the care for emergency medical conditions that the hospital facility is required to provide under Subchapter G of Chapter IV of Title 42 of the Code of Federal Regulations (or any successor regulations).

(4) Examples. The following examples illustrate this paragraph (c):

Example 1. F is a hospital facility with a dedicated emergency department that is subject to the Emergency Medical Treatment and Labor Act (EMTALA) and is not a

critical access hospital. F establishes a written emergency medical care policy requiring F to comply with EMTALA by providing medical screening examinations and stabilizing treatment and referring or transferring an individual to another facility, when appropriate, and providing emergency services in accordance with 42 CFR 482.55 (or any successor regulation). F's emergency medical care policy also states that F prohibits any actions that would discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care. F's emergency medical care policy is described in paragraph (c)(1) of this section.

Example 2. G is a rehabilitation hospital facility. G does not have a dedicated emergency department, nor does it have specialized capabilities that would make it appropriate to accept transfers of individuals who need stabilizing treatment for an emergency medical condition. G establishes a written emergency medical care policy that addresses how it appraises emergencies, provides initial treatment, and refers or transfers an individual to another facility, when appropriate, in a manner that complies with 42 CFR 482.12(f)(2) (or any successor regulation). G's emergency medical care policy also prohibits G from engaging in actions that discourage individuals from seeking emergency medical care, such as by demanding that patients pay before receiving initial treatment for emergency medical conditions or permitting debt collection activities that interfere with the facility's appraisal and provision, without discrimination, of such initial treatment. G's emergency medical care policy is described in paragraph (c)(1) of this section.

(d) Establishing the FAP and other policies--(1) In general. A hospital organization has established a FAP, a billing and collections policy, or an emergency medical care policy for a hospital facility only if an authorized body of the hospital facility (as defined in §1.501(r)-1(b)(4)) has adopted the policy for the hospital facility and the hospital facility has implemented the policy.

(2) Implementing a policy. For purposes of this paragraph (d), a hospital facility will be considered to have implemented a policy if the hospital facility has consistently carried out the policy.

(3) Establishing a policy for more than one hospital facility. A hospital organization may establish a FAP, billing and collections policy, and/or emergency

medical care policy for a hospital facility that is identical to that of other hospital facilities or a joint policy that is shared with multiple hospital facilities provided that any joint policy clearly identifies each facility to which it applies. However, hospital facilities that have different AGB percentages or use different methods to determine AGB must include in their FAPs (or, in the case of information related to AGB percentages, otherwise make readily obtainable) different information regarding AGB to meet the requirements of paragraph (b)(2)(i)(C) of this section.

§1.501(r)-5 Limitation on charges.

(a) In general. A hospital organization meets the requirements of section 501(r)(5) with respect to a hospital facility it operates only if the hospital facility (and any substantially-related entity, as defined in §1.501(r)-1(b)(28)) limits the amount charged for care it provides to any individual who is eligible for assistance under its financial assistance policy (FAP) to--

(1) In the case of emergency or other medically necessary care, not more than the amounts generally billed to individuals who have insurance covering such care (AGB), as determined under paragraph (b) of this section; and

(2) In the case of all other medical care covered under the FAP, less than the gross charges for such care, as described in paragraph (c) of this section.

(b) Amounts generally billed--(1) In general. For purposes of meeting the requirements of paragraph (a)(1) of this section, a hospital facility must determine AGB for emergency or other medically necessary care using a method described in

paragraph (b)(3) or (b)(4) of this section or any other method specified in regulations or other guidance published in the Internal Revenue Bulletin. A hospital facility may use only one of these methods to determine AGB at any one time, but different hospital facilities operated by the same hospital organization may use different methods. A hospital facility may change the method it uses to determine AGB at any time.

(2) Meaning of charged. For purposes of paragraph (a)(1) of this section, a FAP-eligible individual is considered to be “charged” only the amount he or she is personally responsible for paying, after all deductions, discounts (including discounts available under the FAP), and insurance reimbursements have been applied. Thus, in the case of a FAP-eligible individual who has health insurance coverage, a hospital facility will meet the requirements of paragraph (a)(1) of this section if the FAP-eligible individual is not personally responsible for paying (for example, in the form of co-payments, co-insurance, and deductibles) more than AGB for the care after all reimbursements by the health insurer have been applied, even if the total amount paid by the FAP-eligible individual and his or her health insurer together exceeds AGB.

(3) Look-back method--(i) In general. A hospital facility may determine AGB for any emergency or other medically necessary care it provides to a FAP-eligible individual by multiplying the hospital facility’s gross charges for the care by one or more percentages of gross charges (AGB percentage(s)). A hospital facility using this method must calculate its AGB percentage(s) at least annually by dividing the sum of the amounts of all of its claims for emergency and other medically necessary care that have been allowed by health insurers described in paragraph (b)(3)(ii) of this section

during a prior 12-month period by the sum of the associated gross charges for those claims. Whether a claim is used in calculating a hospital facility's AGB percentage(s) depends on whether the claim was allowed by a health insurer during the 12-month period used in the calculation, not on whether the care resulting in the claim was provided during that 12-month period. If the amount a health insurer will allow for a claim has not been finally determined as of the last day of the 12-month period used to calculate the AGB percentage(s), a hospital facility should exclude the amount of the claim from that calculation and include it in the subsequent 12-month period during which the amount allowed is finally determined. When including allowed claims in calculating its AGB percentage(s), the hospital facility should include the full amount that has been allowed by the health insurer, including both the amount the insurer will pay or reimburse and the amount (if any) the individual is personally responsible for paying in the form of co-payments, co-insurance, and deductibles, regardless of whether or when the full amount allowed is actually paid and disregarding any discounts applied to the individual's portion.

(ii) Health insurers used in calculating AGB percentage(s). In calculating its AGB percentage(s), a hospital facility must include the claims allowed during a prior 12-month period by--

(A) Medicare fee-for-service;

(B) Medicare fee-for-service and all private health insurers that pay claims to the hospital facility; or

(C) Medicaid, either alone or in combination with the insurer(s) described in

paragraph (b)(3)(ii)(A) or (b)(3)(ii)(B) of this section.

(iii) One or multiple AGB percentages. A hospital facility's AGB percentage that is calculated using the method described in this paragraph (b)(3) may be one average percentage of gross charges for all emergency and other medically necessary care provided by the hospital facility. Alternatively, a hospital facility may calculate multiple AGB percentages for separate categories of care (such as inpatient and outpatient care or care provided by different departments) or for separate items or services, as long as the hospital facility calculates AGB percentages for all emergency and other medically necessary care provided by the hospital facility.

(iv) Start date for applying AGB percentages. For purposes of determining AGB under this paragraph (b)(3), with respect to any AGB percentage that a hospital facility has calculated, the hospital facility must begin applying the AGB percentage by the 120th day after the end of the 12-month period the hospital facility used in calculating the AGB percentage.

(v) Use of all claims for medical care. A hospital facility determining AGB under this paragraph (b)(3) may use claims allowed for all medical care during a prior 12-month period rather than just those allowed for emergency and other medically necessary care.

(vi) Determining AGB percentages for more than one hospital facility. Although generally a hospital organization must calculate AGB percentage(s) separately for each hospital facility it operates, hospital facilities that are covered under the same Medicare provider agreement (as defined in 42 CFR 489.3 or any successor regulations) may

calculate one AGB percentage (or multiple AGB percentages for separate categories of care or for separate items or services) using the method described in this paragraph (b)(3) based on the claims and gross charges for all such hospital facilities and implement the AGB percentage(s) across all such hospital facilities.

(4) Prospective Medicare or Medicaid method. A hospital facility may determine AGB for any emergency or other medically necessary care provided to a FAP-eligible individual by using the billing and coding process the hospital facility would use if the FAP-eligible individual were a Medicare fee-for-service or Medicaid beneficiary and setting AGB for the care at the amount the hospital facility determines would be the total amount Medicare or Medicaid would allow for the care (including both the amount that would be reimbursed by Medicare or Medicaid and the amount the beneficiary would be personally responsible for paying in the form of co-payments, co-insurance, and deductibles). A hospital facility using the method described in this paragraph (b)(4) may base AGB on Medicare fee-for-service or Medicaid or both, provided that, if it uses both, its FAP describes the circumstance under which it will use Medicare fee-for-service or Medicaid in determining AGB.

(5) Examples. The following examples illustrate this paragraph (b):

Example 1. On March 15 of Year 1, Y, a hospital facility, generates data on the amount of all of Y's claims for emergency and other medically necessary care that were allowed by all private health insurers and Medicare fee-for-service over the immediately preceding calendar year. Y determines that the private health insurers allowed a total amount of \$250 million and Medicare fee-for-service allowed a total amount of \$150 million, with the total allowed amounts including both the portion the insurers agreed to reimburse and the portion that the insured patients were personally responsible for paying. Y's gross charges for these claims totaled \$800 million. Y calculates that its AGB percentage is 50% of gross charges (\$400 million/\$800 million). Y updates its FAP to reflect the new AGB percentage of 50% and makes the updated FAP widely

available (both on its Web site and via paper copies upon request) on April 1 of Year 1. Between April 1 of Year 1 (less than 120 days after the end of the preceding calendar year) and March 31 of Year 2, Y determines AGB for any emergency or other medically necessary care it provides to a FAP-eligible individual by multiplying the gross charges for the care provided to the individual by 50%. Y has determined AGB between April 1 of Year 1 and March 31 of Year 2 in accordance with this paragraph (b) by using the look-back method described in paragraph (b)(3) of this section.

Example 2. On August 20 of Year 1, X, a hospital facility, generates data on the amount of all of X's claims for emergency and other medically necessary care that were allowed by Medicare fee-for-service over the 12 months ending on July 31 of Year 1. X determines that, of these claims for inpatient services, Medicare allowed a total amount of \$100 million (including both the portion Medicare agreed to reimburse and the portion Medicare beneficiaries were personally responsible for paying). X's gross charges for these inpatient claims totaled \$250 million. Of the claims for outpatient services, Medicare allowed a total amount of \$125 million. X's gross charges for these outpatient claims totaled \$200 million. X calculates that its AGB percentage for inpatient services is 40% of gross charges ($\$100 \text{ million} / \250 million) and its AGB percentage for outpatient services is 62.5% of gross charges ($\$125 \text{ million} / \200 million). Y discloses its AGB percentages and describes how they were calculated on the Web page where its FAP can be accessed, and it updates this Web page to reflect the new AGB percentages on November 1. Y also starts making an updated information sheet with the new AGB percentages available upon request on and after November 1. Between November 1 of Year 1 (less than 120 days after the end of the 12-month claim period) and October 31 of Year 2, X determines AGB for any emergency or other medically necessary inpatient care it provides to a FAP-eligible individual by multiplying the gross charges for the inpatient care it provides to the individual by 40% and AGB for any emergency or other medically necessary outpatient care it provides to a FAP-eligible individual by multiplying the gross charges for the outpatient care it provides to the individual by 62.5%. X has determined AGB between November 1 of Year 1 and October 31 of Year 2 in accordance with this paragraph (b) by using the look-back method described in paragraph (b)(3) of this section.

Example 3. Whenever Z, a hospital facility, provides emergency or other medically necessary care to a FAP-eligible individual, Z determines the AGB for the care by using the billing and coding process it would use if the individual were a Medicare fee-for-service beneficiary and setting AGB for the care at the amount it determines Medicare and the Medicare beneficiary together would be expected to pay for the care. Z has determined AGB in accordance with this paragraph (b) by using the prospective Medicare method described in paragraph (b)(4) of this section.

Example 4. Using the look-back method described in paragraph (b)(3) of this section, W, a hospital facility, calculates that its AGB percentage for Year 1 is 60% of gross charges. Under W's FAP, which applies to all emergency and other medically

necessary care provided by W and which has been updated to reflect the AGB percentage for Year 1, the most that W charges a FAP-eligible individual is 50% of gross charges. W properly implements its FAP and charges no FAP-eligible individual more for emergency or other medically necessary care than 50% of gross charges in Year 1. W has met the requirements of paragraphs (a)(1) and (b) of this section in Year 1.

Example 5. A, an individual, receives medically necessary care from hospital facility V for which the AGB is \$3y. A is insured by U, a health insurer. Under U's contracts with V and A, the amount allowed for the care V provided to A is \$5y. Of that amount allowed, A is personally responsible for paying \$1y (in co-payments and deductibles) while U is responsible for paying \$4y. Based on the eligibility criteria specified in its FAP, V determines that A is FAP-eligible. Pursuant to paragraph (b)(2) of this section, V may charge U and A collectively \$5y while still meeting the requirements of paragraph (a)(1) of this section because the amount A is personally responsible for paying in co-payments and deductibles (\$1y) is less than the AGB for the care (\$3y).

Example 6. Assume the same facts as Example 5, except that under U's contracts with V and A, A is personally responsible for paying \$4y (in co-payments and deductibles) for the care while U is responsible for paying V \$1y. Because A is FAP-eligible under V's FAP, paragraph (a)(1) of this section requires that A not be personally responsible for paying V more than \$3y (the AGB for the care provided).

(c) Gross charges. A hospital facility must charge a FAP-eligible individual less than the gross charges for any medical care covered under the hospital facility's FAP. A billing statement issued by a hospital facility to a FAP-eligible individual for medical care covered under the FAP may state the gross charges for such care and apply contractual allowances, discounts, or deductions to the gross charges, provided that the actual amount the individual is personally responsible for paying is less than the gross charges for such care.

(d) Safe harbor for certain charges in excess of AGB. A hospital facility will be deemed to meet the requirements of paragraph (a) of this section, even if it charges more than AGB for emergency or other medically necessary care (or gross charges for

any medical care covered under the FAP) provided to a FAP-eligible individual, if--

(1) The charge in excess of AGB was not made or requested as a pre-condition of providing medically necessary care to the FAP-eligible individual (for example, an upfront payment that a hospital facility requires before providing medically necessary care);

(2) As of the time of the charge, the FAP-eligible individual has not submitted a complete FAP application to the hospital facility to obtain financial assistance for the care or has not otherwise been determined by the hospital facility to be FAP-eligible for the care; and

(3) If the individual subsequently submits a complete FAP application and is determined to be FAP-eligible for the care, the hospital facility refunds any amount the individual has paid for the care (whether to the hospital facility or any other party to whom the hospital facility has referred or sold the individual's debt for the care) that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible individual, unless such excess amount is less than \$5 (or such other amount set by notice or other guidance published in the Internal Revenue Bulletin).

(e) Medically necessary care. For purposes of meeting the requirements of this section, 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, or a definition that refers to the generally accepted standards of medicine in the community or to an examining physician's determination.

§1.501(r)-6 Billing and collection.

(a) In general. A hospital organization meets the requirements of section 501(r)(6) with respect to a hospital facility it operates only if the hospital facility does not engage in extraordinary collection actions (ECAs), as defined in paragraph (b) of this section, against an individual to obtain payment for care before the hospital facility has made reasonable efforts to determine whether the individual is eligible for assistance for the care under its financial assistance policy (FAP), as described in paragraph (c) of this section. For purposes of this section, with respect to any debt owed by an individual for care provided by a hospital facility--

(1) ECAs against the individual include ECAs to obtain payment for the care against any other individual who has accepted or is required to accept responsibility for the individual's hospital bill for the care; and

(2) The hospital facility will be deemed to have engaged in an ECA against the individual to obtain payment for the care, or to have taken one or more of the steps necessary to have made reasonable efforts to determine whether the individual is FAP-eligible for the care, if any purchaser of the individual's debt, any debt collection agency or other party to which the hospital facility has referred the individual's debt, or any substantially-related entity (as defined in §1.501(r)-1(b)(28)) has engaged in such an ECA or taken such steps (whichever is applicable).

(b) Extraordinary collection actions--(1) In general. Except as otherwise provided in this paragraph (b), the following actions taken by a hospital facility against an individual related to obtaining payment of a bill for care covered under the hospital

facility's FAP are ECAs:

(i) Selling an individual's debt to another party (other than debt sales described in paragraph (b)(2) of this section).

(ii) Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.

(iii) Deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under the hospital facility's FAP (which is considered an ECA to obtain payment for the previously provided care, not the care being potentially deferred or denied). If a hospital facility requires a payment before providing medically necessary care to an individual with one or more outstanding bills for previously provided care, such a requirement for payment will be presumed to be because of the individual's nonpayment of such bill(s) unless the hospital facility can demonstrate that it required the payment from the individual based on factors other than, and without regard to, the individual's nonpayment of past bills.

(iv) Actions that require a legal or judicial process, including but not limited to--

(A) Placing a lien on an individual's property (other than a lien described in paragraph (b)(3) of this section);

(B) Foreclosing on an individual's real property;

(C) Attaching or seizing an individual's bank account or any other personal property;

(D) Commencing a civil action against an individual;

(E) Causing an individual's arrest;

(F) Causing an individual to be subject to a writ of body attachment; and

(G) Garnishing an individual's wages.

(2) Certain debt sales that are not ECAs. A hospital facility's sale of an individual's debt for care provided by the hospital facility will not be considered an ECA if, prior to the sale, the hospital facility has entered into a legally binding written agreement with the purchaser of the debt pursuant to which--

(i) The purchaser is prohibited from engaging in any ECAs to obtain payment for the care;

(ii) The purchaser is prohibited from charging interest on the debt in excess of the rate in effect under section 6621(a)(2) at the time the debt is sold (or such other interest rate set by notice or other guidance published in the Internal Revenue Bulletin);

(iii) The debt is returnable to or recallable by the hospital facility upon a determination by the hospital facility or the purchaser that the individual is FAP-eligible; and

(iv) If the individual is determined to be FAP-eligible and the debt is not returned to or recalled by the hospital facility, the purchaser is required to adhere to procedures specified in the agreement that ensure that the individual does not pay, and has no obligation to pay, the purchaser and the hospital facility together more than he or she is personally responsible for paying as a FAP-eligible individual.

(3) Liens on certain judgments, settlements, or compromises. Any lien that a hospital facility is entitled to assert under state law on the proceeds of a judgment,

settlement, or compromise owed to an individual (or his or her representative) as a result of personal injuries for which the hospital facility provided care is not an ECA.

(4) Bankruptcy claims. The filing of a claim in any bankruptcy proceeding is not an ECA.

(c) Reasonable efforts--(1) In general. A hospital facility will have made reasonable efforts to determine whether an individual is FAP-eligible for care only if the hospital facility meets the requirements described in paragraph (c)(2) or (c)(3) of this section.

(2) Presumptive FAP-eligibility determinations based on third-party information or prior FAP-eligibility determinations--(i) In general. With respect to any care provided by a hospital facility to an individual, the hospital facility will have made reasonable efforts to determine whether the individual is FAP-eligible for the care if it determines that the individual is FAP-eligible for the care based on information other than that provided by the individual or based on a prior FAP-eligibility determination and, if the individual is presumptively determined to be eligible for less than the most generous assistance available under the FAP, the hospital facility--

(A) Notifies the individual regarding the basis for the presumptive FAP-eligibility determination and the way to apply for more generous assistance available under the FAP;

(B) Gives the individual a reasonable period of time to apply for more generous assistance before initiating ECAs to obtain the discounted amount owed for the care;
and

(C) If the individual submits a complete FAP application seeking more generous assistance during the application period (as defined in §1.501(r)-1(b)(3)), determines whether the individual is eligible for a more generous discount and otherwise meets the requirements described in paragraph (c)(6) of this section with respect to that complete FAP application.

(ii) Examples. The following examples illustrate this paragraph (c)(2):

Example 1. V is a hospital facility with a FAP under which the specific assistance for which an individual is eligible depends exclusively upon that individual's household income. The most generous assistance offered for care under V's FAP is free care. V's FAP states that V uses enrollment in certain specified means-tested public programs to presumptively determine that individuals are FAP-eligible. D, an individual, receives care from V. Although D does not submit a FAP application to V, V learns that D is eligible for certain benefits under a state program that bases eligibility on household income. Based on this knowledge, V presumptively determines that D is eligible to receive free care under its FAP. V notifies D that it has determined he is eligible for free care based on his eligibility for the benefits under the state program and therefore does not owe V anything for the care he received. V has made reasonable efforts to determine whether D is FAP-eligible under this paragraph (c)(2).

Example 2. X is a hospital facility with a FAP that describes the data, including both hospital and publicly-available data, X uses to make presumptive FAP-eligibility determinations. On January 16, F, an individual, receives care from X. Using the hospital and publicly-available data described in its FAP, X presumptively determines that F is eligible for a 50% discount under its FAP, a discount that is not the most generous discount available under the FAP. The first billing statement that X sends to F indicates that F has been given a 50% discount under X's FAP, explains the basis for this presumptive FAP-eligibility determination, and informs F that she may apply for financial assistance if she believes she is eligible for a more generous discount. The billing statement indicates that F may call 1-800-888-xxxx or visit X's Web site at www.hospitalX.org/FAP to learn more about the FAP or the FAP application process. X sends F three more billing statements, each of which contains the standard written notice about the FAP that X includes on all of its billing statements in accordance with §1.501(r)-4(b)(5), but F neither pays the amount she is personally responsible for paying nor applies for more generous financial assistance. The time between the first and fourth billing statement constitutes a reasonable period of time for F to apply for more generous assistance. V has made reasonable efforts to determine whether D is FAP-eligible under this paragraph (c)(2).

(3) Reasonable efforts based on notification and processing of applications. With respect to any care provided by a hospital facility to an individual, the hospital facility will have made reasonable efforts to determine whether the individual is FAP-eligible for the care if it--

(i) Notifies the individual about the FAP as described in paragraph (c)(4) of this section before initiating any ECAs to obtain payment for the care and refrains from initiating such ECAs (with the exception of an ECA described in paragraph (b)(1)(iii) of this section) for at least 120 days from the date the hospital facility provides the first post-discharge billing statement for the care;

(ii) In the case of an individual who submits an incomplete FAP application during the application period, notifies the individual about how to complete the FAP application and gives the individual a reasonable opportunity to do so as described in paragraph (c)(5) of this section; and

(iii) In the case of an individual who submits a complete FAP application during the application period, determines whether the individual is FAP-eligible for the care and otherwise meets the requirements described in paragraph (c)(6) of this section.

(4) Notification--(i) In general. With respect to any care provided by a hospital facility to an individual and except as provided in paragraph (c)(4)(iii) of this section, a hospital facility will have notified an individual about its FAP for purposes of paragraph (c)(3)(i) of this section only if the hospital facility does the following at least 30 days before first initiating one or more ECA(s) to obtain payment for the care:

(A) Provides the individual with a written notice that indicates financial assistance

is available for eligible individuals, identifies the ECA(s) that the hospital facility (or other authorized party) intends to initiate to obtain payment for the care, and states a deadline after which such ECA(s) may be initiated that is no earlier than 30 days after the date that the written notice is provided.

(B) Provides the individual with a plain language summary of the FAP (as defined in §1.501(r)-1(b)(24)) with the written notice described in paragraph (c)(4)(i)(A) of this section (or, if applicable, paragraph (c)(4)(iii) of this section).

(C) Makes a reasonable effort to orally notify the individual about the hospital facility's FAP and about how the individual may obtain assistance with the FAP application process.

(ii) Notification in the event of multiple episodes of care. A hospital facility may satisfy the notification requirements described in paragraph (c)(4)(i) of this section simultaneously for multiple episodes of care and notify the individual about the ECA(s) the hospital facility intends to initiate to obtain payment for multiple outstanding bills for care. However, if a hospital facility aggregates an individual's outstanding bills for multiple episodes of care before initiating one or more ECAs to obtain payment for those bills, it will have not have made reasonable efforts to determine whether the individual is FAP-eligible under paragraph (c)(3) of this section unless it refrains from initiating the ECA(s) until 120 days after it provided the first post-discharge billing statement for the most recent episode of care included in the aggregation.

(iii) Notification before deferring or denying care due to nonpayment for prior care. In the case of an ECA described in paragraph (b)(1)(iii) of this section, a hospital

facility may notify the individual about its FAP less than 30 days before initiating the ECA, provided that the hospital facility does the following:

(A) Otherwise meets the requirements of paragraph (c)(4)(i) of this section but, instead of the notice described in paragraph (c)(4)(i)(A) of this section, provides the individual with a FAP application form and a written notice indicating that financial assistance is available for eligible individuals and stating the deadline, if any, after which the hospital facility will no longer accept and process a FAP application submitted (or, if applicable, completed) by the individual for the previously-provided care at issue. This deadline must be no earlier than the later of 30 days after the date that the written notice is provided or 240 days after the date that the first post-discharge billing statement for the previously provided care was provided.

(B) If the individual submits a FAP application for the previously provided care on or before the deadline described in paragraph (c)(4)(iii)(A) of this section (or at any time, if the hospital facility didn't provide any such deadline to the individual), processes the FAP application on an expedited basis.

(iv) Examples. The following example illustrates this paragraph (c)(4):

Example 1. A, an individual, receives care from T, a hospital facility, in February. T provides A with the first post-discharge billing statement for that care on March 3. This and subsequent billing statements that T sends to A contain the standard written notice about the FAP that X includes on all of its billing statements in accordance with §1.501(r)-4(b)(5). A has not paid her bill or submitted a FAP application when T provides her with the third billing statement for the care, postmarked June 1. With this third billing statement, T includes a plain language summary of the FAP and a letter informing A that if she does not pay the amount owed or submit a FAP application by July 1, T intends to report A's delinquency to credit reporting agencies. T also calls A and informs her about the financial assistance available to eligible patients under T's FAP and about how to obtain assistance with the FAP application process. A does not pay her bill or submit a FAP application by July 1. T has made reasonable efforts to

determine whether A is FAP-eligible, and thus may report A's delinquency to credit reporting agencies, as of July 2.

Example 2. G, an individual, receives care from Y, a hospital facility, on May 25 of Year 1. G does not pay or submit a FAP application over the next year, despite Y's sending out numerous bills beginning on June 24 that contain the standard written notice about the FAP that Y includes on all of its billing statements in accordance with the requirements under §1.501(r)-4(b)(5). Y also makes numerous attempts to encourage E to apply for financial assistance, including by calling G to inform her about the financial assistance available to eligible patients under Y's FAP and to offer assistance with the FAP application process. By June 24 of Year 2, Y, which had not previously initiated any ECAs against G to obtain payment for the care, notifies G in writing that if G does not pay or complete a FAP application by July 24 of Year 2, Y intends to file a lawsuit seeking a judgment for the amount G owes for the care and to seek court permission to enforce the judgment by either seizing G's bank account or garnishing G's wages. The written notice also includes a plain language summary of the FAP. G fails to pay or submit a FAP application by July 24 of Year 2. Y has made reasonable efforts to determine whether G is FAP-eligible, and may seek a judgment for the amount G owes and court permission to enforce the judgment by seizing G's bank account or garnishing G's wages, as of July 25 of Year 2.

(5) Incomplete FAP applications--(i) In general. With respect to any care provided by a hospital facility to an individual, if an individual submits an incomplete FAP application during the application period, the hospital facility will have notified the individual about how to complete the FAP application and given the individual a reasonable opportunity to do so for purposes of paragraph (c)(3)(ii) of this section only if the hospital facility--

(A) Suspends any ECAs to obtain payment for the care as described in paragraph (c)(8) of this section; and

(B) Provides the individual with a written notice that describes the additional information and/or documentation required under the FAP or FAP application form that must be submitted to complete the FAP application and that includes the contact information described in §1.501(r)-1(b)(24)(v).

(ii) FAP application completed. If an individual who has submitted an incomplete FAP application during the application period subsequently completes the FAP application during the application period (or, if later, within a reasonable timeframe given to respond to requests for additional information and/or documentation), the individual will be considered to have submitted a complete FAP application during the application period, and the hospital facility will have made reasonable efforts to determine whether the individual is FAP-eligible only if it meets the requirements for complete FAP applications described in paragraph (c)(6) of this section.

(iii) Examples. The following examples illustrate this paragraph (c)(5):

Example 1. (i) Assume the same facts as Example 1 in paragraph (c)(4)(iv) of this section and the following additional facts: A submits an incomplete FAP application to T on July 15, which is before the last day of the application period on October 29 but after T has already initiated ECAs. Eligibility for assistance under T's FAP is based solely on an individual's family income and the instructions to T's FAP application form require applicants to attach to their application forms certain documentation verifying family income. The FAP application form that A submits to T on July 15 includes all of the required income information, but A fails to attach the required documentation verifying her family income. On July 22, a member of T's staff calls A to inform her that she failed to attach any of the required documentation of her family income and explains what kind of documentation A needs to submit and how she can submit it. T indicates that the documentation should be provided by September 22. T also sends A a letter that describes the missing documentation that A must submit by September 22 (and how to submit it) and provides a telephone number A can call and room number she can visit to get assistance with the FAP application process. T does not initiate any new ECAs against A and does not take any further action on the ECAs T previously initiated against A between July 15 and September 22. A does not respond to T's letter and does not submit any missing documentation by September 22. T has made reasonable efforts to determine whether A is FAP-eligible, and may initiate or resume ECAs against A, as of September 23.

(ii) On October 10, before the last day of the application period on October 29, A provides T with the missing documentation. Because A has submitted a complete FAP application during the application period, to meet the requirements of paragraph (a) of this section, T must process the FAP application documentation to determine whether A is FAP-eligible and otherwise meet the requirements for complete FAP applications

described in paragraph (c)(6) of this section.

Example 2. (i) B, an individual, receives care from U, a hospital facility, on January 10. U has established a FAP that provides assistance to all individuals whose household income is less than \$y, and the instructions to U's FAP application form specify the documentation that applicants must provide to verify their household income. Shortly after receiving care, B submits a FAP application form to U indicating that he has household income of less than \$y. B's FAP application form includes all of the required income information, but B fails to attach the required documentation verifying household income.

(ii) On February 9, U sends B the first post-discharge billing statement for the care that contains the standard written notice about the FAP that U includes on all of its billing statements in accordance with §1.501(r)-4(b)(5). With this first post-discharge billing statement, U includes a letter informing B that the income information he provided on his FAP application form indicates that he may be eligible to pay only x% of the amount stated on the billing statement if he can provide documentation that verifies his household income. In addition, this letter describes the type of documentation (which is also described in the instructions to U's FAP application form) that B needs to provide to complete his FAP application and provides a telephone number that B may call and room number he may visit if he has questions or needs assistance with the FAP application process. By the time U is getting ready to send B a third billing statement for the care, B has not provided any response to U's request for the missing documentation. Accordingly, with the third billing statement postmarked May 10, U includes a plain language summary of the FAP plus a written notice informing B that U intends to report B's delinquency to credit reporting agencies if B does not submit the missing documentation or pay the amount due by June 9. U also calls B to inform B about the impending ECA and to see if he has questions about the missing documentation that U has requested. B does not provide any response to U's request for the missing documentation by June 9. U has made reasonable efforts to determine whether B is FAP-eligible, and thus may report B's delinquency to credit reporting agencies, as of June 10.

(6) Complete FAP applications--(i) In general. With respect to any care provided by a hospital facility to an individual, if an individual submits a complete FAP application during the application period, the hospital facility will have made reasonable efforts to determine whether the individual is FAP-eligible for the care only if the hospital facility does the following in a timely manner:

(A) Suspends any ECAs to obtain payment for the care as described in

paragraph (c)(8) of this section.

(B) Makes a determination as to whether the individual is FAP-eligible for the care and notifies the individual in writing of this eligibility determination (including, if applicable, the assistance for which the individual is eligible) and the basis for this determination.

(C) If the hospital facility determines the individual is FAP-eligible for the care, does the following:

(1) If the individual is determined to be eligible for assistance other than free care, provides the individual with a billing statement that indicates the amount the individual owes for the care as a FAP-eligible individual and how that amount was determined and states, or describes how the individual can get information regarding, the AGB for the care.

(2) Refunds to the individual any amount he or she has paid for the care (whether to the hospital facility or any other party to whom the hospital facility has referred or sold the individual's debt for the care) that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible individual, unless such excess amount is less than \$5 (or such other amount set by notice or other guidance published in the Internal Revenue Bulletin).

(3) Takes all reasonably available measures to reverse any ECA (with the exception of a sale of debt and an ECA described in paragraph (b)(1)(iii) of this section) taken against the individual to obtain payment for the care. Such reasonably available measures generally include, but are not limited to, measures to vacate any judgment

against the individual, lift any levy or lien (other than a lien described in paragraph (b)(3) of this section) on the individual's property, and remove from the individual's credit report any adverse information that was reported to a consumer reporting agency or credit bureau.

(ii) Anti-abuse rule for complete FAP applications. A hospital facility will not have made reasonable efforts to determine whether an individual is FAP-eligible if the hospital facility bases its determination that the individual is not FAP-eligible on information that the hospital facility has reason to believe is unreliable or incorrect or on information obtained from the individual under duress or through the use of coercive practices. For purposes of this paragraph (c)(6)(ii), a coercive practice includes delaying or denying emergency medical care to an individual until the individual has provided information requested to determine whether the individual is FAP-eligible for the care being delayed or denied.

(iii) Determination based on complete FAP applications sufficient for reasonable efforts. A hospital facility will have made reasonable efforts to determine whether an individual is FAP-eligible with respect to any ECAs it initiates to obtain payment for care if, before initiating any such ECAs, it determines whether the individual is FAP-eligible for the care based on a complete FAP application and otherwise meets the requirements described in this paragraph (c)(6). If these conditions are satisfied, the hospital facility will have made reasonable efforts to determine whether the individual is FAP-eligible for the care regardless of whether it has notified the individual as described in paragraph (c)(4) of this section or, if applicable, in paragraph (c)(5)(i)(B) of this

section.

(iv) Determining Medicaid eligibility. A hospital facility will not fail to have made reasonable efforts to determine whether an individual is FAP-eligible for care if, upon receiving a complete FAP application from an individual who the hospital facility believes may qualify for Medicaid, the hospital facility postpones determining whether the individual is FAP-eligible for the care until after the individual's Medicaid application has been completed and submitted and a determination as to the individual's Medicaid eligibility has been made.

(v) Examples. The following examples illustrate this paragraph (c)(6):

Example 1. C, an individual, receives care from W, a hospital facility, on September 1. W has established a FAP that provides assistance only to individuals whose family income is less than or equal to x% of the Federal Poverty Level (FPL), which, in the case of C's family size, is \$y. Upon discharge, W's staff gives C a plain language summary of the FAP and informs C that if she needs assistance filling out a FAP application form, W has a social worker on staff who can assist her. C expresses interest in getting assistance with a FAP application while she is still on site and is directed to K, one of W's social workers. K explains the eligibility criteria in W's FAP to C, and C realizes that to determine her family income as a percentage of FPL she needs to look at her prior year's tax returns. On September 20, after returning home and obtaining the necessary information, C submits a FAP application to W that contains all of the information and documentation required in the FAP application form instructions. W's staff promptly examines C's FAP application and, based on the information and documentation therein, determines that C's family income is well in excess of \$y. On October 1, W sends C her first post-discharge billing statement for the care she received on September 1. With the billing statement, W includes a letter informing C that she is not eligible for financial assistance because her FAP application indicates that she has family income in excess of x% of FPL (\$y for a family the size of C's family) and W only provides financial assistance to individuals with family income that is less than x% of FPL. W has made reasonable efforts to determine whether C is FAP-eligible as of October 1.

Example 2. E, an individual, receives care from P, a hospital facility, from February 24 to 28. E pays a co-payment of \$30 at discharge and is determined by her insurer to be personally responsible for paying another \$550 in deductibles. P sends E several billing statements starting on March 20 indicating that E owes \$550. By July 30,

E has not paid the \$550 or submitted a FAP application. On July 30, P notifies E in writing that if E does not pay or complete a FAP application by August 30, P intends to report B's delinquency to credit reporting agencies. The written notice also includes a plain language summary of the FAP. In addition, P calls E and informs her about the financial assistance available to eligible patients under P's FAP and about how to obtain assistance with the FAP application process. E fails to pay or submit a FAP application by August 30. P subsequently reports E's delinquency to credit reporting agencies. E then provides a complete FAP application to P on November 10, before the last day of the application period on November 15. P promptly examines the application and determines that E is eligible for free care under P's FAP. P contacts the credit reporting agencies to which it had reported E's delinquency and asks them to remove the adverse information from E's credit report. P also sends E a letter that informs her that she is eligible for free care under P's FAP and explains the basis for this eligibility determination and includes with this letter a check for \$30 (the co-payment E had paid). P has made reasonable efforts to determine whether E is FAP-eligible.

Example 3. R, a hospital facility, has established a FAP that provides financial assistance only to individuals whose family income is less than or equal to x% of the Federal Poverty Level (FPL), based on their prior year's federal tax return. L, an individual, receives care from R. While L is being discharged from R, she is approached by M, an employee of a debt collection company that has a contract with R to handle all of R's patient billing. M asks L for her family income information, telling L that this information is needed to determine whether L is eligible for financial assistance. L tells M that she does not know what her family income is and would need to consult her tax returns to determine it. M tells L that she can just provide a "rough estimate" of her family income. L states that her family income may be around \$y, an amount slightly above the amount that would allow her to qualify for financial assistance. M enters \$y on the income line of a FAP application form with L's name on it and marks L as not FAP-eligible. Based on M's information collection, R determines that L is not FAP-eligible and notifies L of this determination with her first billing statement. Because M had reason to believe that the income estimate provided by L was unreliable, R has violated the anti-abuse rule described in paragraph (c)(6)(ii) of this section. Thus, R has not made reasonable efforts to determine whether L is FAP-eligible.

(7) When no FAP application is submitted. Unless and until an individual submits a FAP application during the application period, any paragraphs of this section that are conditioned on an individual's submitting a FAP application (namely, paragraphs (c)(2)(i)(C), (c)(3)(ii), and (c)(3)(iii) of this section) do not apply, and the hospital facility will have made reasonable efforts to determine whether the individual is FAP-eligible for

care, and may initiate one or more ECAs to obtain payment for the care, once it has met the requirements of this section that are not contingent on an individual's submission of a FAP application. For example, unless and until a hospital facility receives a FAP application from an individual during the application period, the hospital facility has made reasonable efforts to determine whether the individual is FAP-eligible for care (and thus may initiate ECAs to obtain payment for the care) once it has notified the individual about the FAP as described in paragraph (c)(3)(i) of this section.

(8) Suspending ECAs while a FAP application is pending. With respect to any care provided by a hospital facility to an individual, if an individual submits a FAP application during the application period, the hospital facility (or other authorized party) will have suspended ECAs for purposes of this paragraph (c) only if, after receiving the application, the hospital facility (or other authorized party) does not initiate, or take further action on any previously-initiated, ECAs (with the exception of an ECA described in paragraph (b)(1)(iii) of this section) to obtain payment for the care until either--

(i) The hospital facility has determined whether the individual is FAP-eligible based on a complete FAP application and otherwise met the requirements of paragraph (c)(6) of this section; or

(ii) In the case of an incomplete FAP application, the individual has failed to respond to requests for additional information and/or documentation within a reasonable period of time given to respond to such requests.

(9) Waiver does not constitute reasonable efforts. For purposes of this paragraph (c), obtaining a signed waiver from an individual, such as a signed statement

that the individual does not wish to apply for assistance under the FAP or receive the information described in paragraphs (c)(4) or (c)(5) of this section, will not itself constitute a determination that the individual is not FAP-eligible and will not satisfy the requirement to make reasonable efforts to determine whether the individual is FAP-eligible before engaging in ECAs against the individual.

(10) Agreements with other parties. With the exception of sales described in paragraph (b)(2) of this section, if a hospital facility sells or refers an individual's debt related to care to another party, the hospital facility will have made reasonable efforts to determine whether the individual is FAP-eligible for the care only if it first enters into (and, to the extent applicable, enforces) a legally binding written agreement with the party that is reasonably designed to ensure that no ECAs are taken to obtain payment for the care until reasonable efforts have been made to determine whether the individual is FAP-eligible for the care. At a minimum, such an agreement must provide the following:

(i) If the individual submits a FAP application after the referral or sale of the debt but before the end of the application period, the party will suspend ECAs to obtain payment for the care as described in paragraph (c)(8) of this section.

(ii) If the individual submits a FAP application after the referral or sale of the debt but before the end of the application period and is determined to be FAP-eligible for the care, the party will do the following in a timely manner:

(A) Adhere to procedures specified in the agreement that ensure that the individual does not pay, and has no obligation to pay, the party and the hospital facility

together more than he or she is required to pay for the care as a FAP-eligible individual.

(B) If applicable and if the party (rather than the hospital facility) has the authority to do so, take all reasonably available measures to reverse any ECA (other than the sale of a debt or an ECA described in paragraph (b)(1)(iii) of this section) taken against the individual as described in paragraph (c)(6)(i)(C)(3) of this section.

(iii) If the party refers or sells the debt to yet another party during the application period, the party will obtain a written agreement from that other party including all of the elements described in this paragraph (c)(10).

(11) Clear and conspicuous placement. A hospital facility may print any written notice or communication described in this paragraph (c), including any plain language summary of the FAP, on a billing statement or along with other descriptive or explanatory matter, provided that the required information is conspicuously placed and of sufficient size to be clearly readable.

(12) Providing documents electronically. A hospital facility may provide any written notice or communication described in this paragraph (c) electronically (for example, by email) to any individual who indicates he or she prefers to receive the written notice or communication electronically.

§1.501(r)-7 Effective/applicability dates.

(a) Effective/applicability date. The rules of §§1.501(r)-1 through 1.501(r)-6 apply to taxable years beginning after December 29, 2015.

(b) Reasonable interpretation for taxable years beginning on or before December

29, 2015. For taxable years beginning on or before December 29, 2015, a hospital facility may rely on a reasonable, good faith interpretation of section 501(r). A hospital facility will be deemed to have operated in accordance with a reasonable, good faith interpretation of section 501(r) if it has complied with the provisions of the proposed or final regulations under section 501(r) (REG-130266-11 and/or REG-106499-12).

Accordingly, a hospital facility may rely on §1.501(r)-3 of the proposed or final regulations, or another reasonable interpretation of section 501(r)(3), for any CHNA conducted or implementation strategy adopted before the first day of the hospital organization's first taxable year beginning after December 29, 2015.

Par. 4. Section 1.6012-2 is amended by redesignating paragraphs (i) through (k) as paragraphs (j) through (l) and adding new paragraph (i) to read as follows:

§1.6012-2 Corporations required to make returns of income.

* * * * *

(i) Hospital organizations with noncompliant hospital facilities. Every hospital organization (as defined in §1.501(r)-1(b)(18)) that is subject to the tax imposed by §1.501(r)-2(d) shall make a return on Form 990-T. The filing of a return to pay the tax described in §1.501(r)-2(d) does not relieve the organization of the duty of filing other required returns.

* * * * *

Par. 5. Section 1.6012-3 is amended by adding new paragraph (a)(10) to read as follows:

§1.6012-3 Returns by fiduciaries.

(a) * * *

(10) Hospital organizations organized as trusts with noncompliant hospital facilities. Every fiduciary for a hospital organization (as defined in §1.501(r)-1(b)(18)) organized as a trust described in section 511(b)(2) that is subject to the tax imposed by §1.501(r)-2(d) shall make a return on Form 990-T. The filing of a return to pay the tax described in §1.501(r)-2(d) does not relieve the organization of the duty of filing other required returns.

* * * * *

Par. 6. Section 1.6033-2 is amended by adding paragraphs (a)(2)(ii)(l) and (k)(4) to read as follows:

§1.6033-2 Returns by exempt organizations (taxable years beginning after December 31, 1969) and returns by certain nonexempt organizations (taxable years beginning after December 31, 1980).

(a) * * *

(2) * * *

(ii) * * *

(l) In the case of a hospital organization (as defined in §1.501(r)-1(b)(18)) described in section 501(c)(3) during the taxable year--

(1) A copy of its audited financial statements for the taxable year (or, in the case of an organization the financial statements of which are included in consolidated financial statements with other organizations, such consolidated financial statements);

(2) Either a copy of the most recently adopted implementation strategy, within the

meaning of §1.501(r)-3(c), for each hospital facility it operates or the URL of each Web page where it has made each such implementation strategy widely available on a Web site within the meaning of §1.501(r)-1(b)(29) along with or as part of the report documenting the community health needs assessment (CHNA) to which the implementation strategy relates;

(3) For each hospital facility it operates, a description of the actions taken during the taxable year to address the significant health needs identified through its most recently conducted CHNA, within the meaning of §1.501(r)-3(b), or, if no actions were taken with respect to one or more of these health needs, the reason(s) why no actions were taken; and

(4) The amount of the excise tax imposed on the organization under section 4959 during the taxable year.

* * * * *

(k) * * *

(4) The applicability of paragraph (a)(2)(ii)(I) of this section shall be limited to returns filed on or after **[INSERT DATE OF FILING (PUBLIC INSPECTION) IN THE FEDERAL REGISTER]**.

PART 53--FOUNDATION AND SIMILAR EXCISE TAXES

Par. 7. The authority citation for part 53 continues to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

Par. 8. Section 53.4959-1 is added to read as follows:

§53.4959-1 Taxes on failures by hospital organizations to meet section 501(r)(3).

(a) Excise tax for failure to meet the section 501(r)(3) requirements--(1) In general. If a hospital organization (as defined in §1.501(r)-1(b)(18)) fails to meet the requirements of section 501(r)(3) separately with respect to a hospital facility it operates in any taxable year, there is imposed on the hospital organization a tax equal to \$50,000. If a hospital organization operates multiple hospital facilities and fails to meet the requirements of section 501(r)(3) with respect to more than one facility it operates, the \$50,000 tax is imposed on the hospital organization separately for each hospital facility's failure. The tax is imposed for each taxable year that a hospital facility fails to meet the requirements of section 501(r)(3).

(2) Examples. The following examples illustrate this paragraph (a):

Example 1. (i) U is a hospital organization that operates only one hospital facility, V. In Year 1, V conducts a community health needs assessment (CHNA) and adopts an implementation strategy to meet the health needs identified through the CHNA. In Years 2 and 3, V does not conduct a CHNA. V fails to conduct a CHNA by the last day of Year 4. Accordingly, U has failed to meet the requirements of section 501(r)(3) with respect to V in Year 4 because V has failed to conduct a CHNA in Years 2, 3, and 4. U is subject to a tax equal to \$50,000 for Year 4.

(ii) V also fails to conduct a CHNA by the last day of Year 5. Accordingly, U has failed to meet the requirements of section 501(r)(3) with respect to V in Year 5 because V has failed to conduct a CHNA in Years 3, 4, and 5. U is subject to a tax equal to \$50,000 for Year 5.

Example 2. P is a hospital organization that operates only one hospital facility, Q. In Year 1, Q conducts a CHNA and adopts an implementation strategy to meet the health needs identified through the CHNA. In Years 2 and 3, Q does not conduct a CHNA. In Year 4, Q conducts a CHNA but does not adopt an implementation strategy to meet the health needs identified through that CHNA by the 15th day of the fifth month of Year 5. Accordingly, P has failed to meet the requirements of section 501(r)(3) with respect to Q in Year 4 because Q has failed to adopt an implementation strategy by the 15th day of the fifth month after the end of the taxable year in which Q conducted its CHNA. P is subject to a tax equal to \$50,000 for Year 4.

Example 3. R is a hospital organization that operates two hospital facilities, S and T. In Year 1, S and T each conduct a CHNA and adopt an implementation strategy to meet the health needs identified through the CHNA. In Years 2 and 3, S and T do not conduct a CHNA. S and T each fail to conduct a CHNA by the last day of Year 4. Accordingly, R has failed to meet the requirements of section 501(r)(3) with respect to both S and T in Year 4. R is subject to a tax equal to \$100,000 (\$50,000 for S's failure plus \$50,000 for T's failure) for Year 4.

(b) Interaction with other provisions--(1) Correction. Unless a hospital organization's failure to meet the requirements of section 501(r)(3) involves an omission or error that is described in and corrected in accordance with §1.501(r)-2(b) (and is thus not considered a failure), a failure to meet the requirements of section 501(r)(3) will result in a tax being imposed on the organization under this section, notwithstanding the organization's correction and disclosure of the failure in accordance with the guidance described in §1.501(r)-2(c).

(2) Interaction with other taxes. The tax imposed by this section is in addition to any tax imposed by §1.501(r)-2(d) or as a result of revocation of a hospital organization's section 501(c)(3) status.

(c) Effective/applicability dates. Paragraph (a) of this section applies on and after **[INSERT DATE OF FILING (PUBLIC INSPECTION) IN THE FEDERAL REGISTER]**.

Par. 9. Section 53.6011-1 is amended by:

1. Removing from the first sentence of paragraph (b) the language "or 4965(a)," and adding "4959, or 4965(a)," in its place.
2. Adding a sentence at the end of paragraph (b).
3. Removing paragraphs (c) and (g).
4. Redesignating paragraphs (d) through (f) as (c) through (e).

The addition reads as follows:

§53.6011-1 General requirement of return, statement, or list.

* * * * *

(b) * * * In the case of a tax imposed by section 4959 on a hospital organization (as defined in §1.501(r)-1(b)(18)), the annual return must include the required information for each of the organization's hospital facilities that failed to meet the requirements of section 501(r)(3) for the taxable year.

* * * * *

§53.6011-1T [Removed]

Par. 10. Section 53.6011-1T is removed.

Par. 11. Section 53.6071-1 is amended by revising paragraphs (h) and (i)(2) to read as follows:

§53.6071-1 Time for filing returns.

* * * * *

(h) Taxes on failures by charitable hospital organizations to satisfy the community health needs assessment requirements of section 501(r)(3). A hospital organization (as defined in §1.501(r)-1(b)(18)) liable for tax imposed by section 4959 must file a Form 4720 as required by §53.6011-1(b), on or before the 15th day of the fifth month after the end of the hospital organization's taxable year for which it failed to meet the requirements of section 501(r)(3).

(i) * * *

(2) Paragraph (h) of this section applies on and after August 15, 2013.

§53.6071-1T [Removed]

Par. 12. Section 53.6071-1T is removed.

PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

Par. 13. The authority citation for part 602 continues to read as follows:

Authority: 26 U.S.C. 7805.

Par. 14. In §602.101, paragraph (b) is amended by adding the following entries in numerical order to the table to read as follows:

§602.101 OMB Control numbers.

* * * * *

(b) * * *

CFR part or section where identified and described	Current OMB Control No.
* * * * *	
1.501(r)-3	1545-0047
1.501(r)-4	1545-0047
1.501(r)-6	1545-0047
* * * * *	

John M. Dalrymple

Deputy Commissioner for Services and Enforcement.

Approved: December 22, 2014

Mark J. Mazur

Assistant Secretary of the Treasury (Tax Policy).

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