FEDERAL REGISTER

Vol. 77 Tuesday,
No. 123 June 26, 2012

Part II

Department of the Treasury

Internal Revenue Service

26 CFR Part 1
Additional Requirements for Charitable Hospitals; Proposed Rule

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[REG–130266–11]

RIN 1545–BK57

Additional Requirements for Charitable Hospitals

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking.

SUMMARY: This document contains proposed regulations that provide guidance regarding the requirements for charitable hospital organizations relating to financial assistance and emergency medical care policies, charges for certain care provided to individuals eligible for financial assistance, and billing and collections. The regulations reflect changes to the law made by the Patient Protection and Affordable Care Act of 2010. The regulations will affect charitable hospital organizations.

DATES: Comments and requests for a public hearing must be received by September 24, 2012.

ADDRESSES: Send submissions to: CC:PA:LPD:PR (REG–130266–11), room 5203, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand-delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (REG–130266–11), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue NW., Washington, DC, or sent electronically via the Federal eRulemaking Portal at *http://www.regulations.gov* (IRS REG–130266–11).

FOR FURTHER INFORMATION CONTACT: Concerning the proposed regulations, Amber L. Mackenzie or Preston J. Quesenberry at (202) 622–6070; concerning submissions of comments and requests for a public hearing, Oluwafunmilayo Taylor at (202) 622–7180 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collection of information contained in this notice of proposed rulemaking has been submitted to the Office of Management and Budget for review and approval under 1545–0047, in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)). Comments on the collection of information should be sent to the Office of Management and Budget, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, SE:W:CAR:MP:T:T:SP, Washington, DC 20224. Comments on the collection of information should be received by August 27, 2012. Comments are specifically requested concerning:

Whether the proposed collection of information is necessary for the proper performance of the functions of the Internal Revenue Service, including whether the information will have practical utility;

The accuracy of the estimated burden associated with the proposed collection of information;

How the quality, utility, and clarity of the information to be collected may be enhanced;

How the burden of complying with the proposed collection of information may be minimized, including through forms of information technology; and

Estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

The collection of information in the proposed regulations is in §§ 1.501(r)–4 and 501(r)–6(c). The collection of information flows from section 501(r)(4) of the Internal Revenue Code (Code), which requires hospital organizations to establish a written financial assistance policy 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 financial assistance policy before engaging in extraordinary collection actions against that individual. The expected recordkeepers are hospital organizations described in sections 501(c)(3) and 501(r)(2).

Estimated number of recordkeepers: 3,377.

Estimated average annual burden hours per recordkeeper: 11.5 hours.

Estimated total annual recordkeeping burden: 38,836.

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 return information are confidential, as required by 26 U.S.C. 6103.

Background

The Patient Protection and Affordable Care Act, Public Law 111–148 (124 Stat. 119 (2010)) (the Affordable Care Act), enacted section 501(r) of the Code, which adds requirements for hospital organizations that are (or seek to be) recognized as described in section 501(c)(3). Section 501(r)(1) of the Code states that an organization described in section 501(r)(2) (a hospital organization) will not be treated as described in section 501(c)(3) unless the organization meets the requirements described in section 501(r)(3) through 501(r)(6). The Affordable Care Act did not otherwise affect the substantive standards for tax exemption that hospital organizations are required to meet under section 501(c)(3).

Section 501(r)(2)(A) defines a hospital organization as: (i) An organization that operates a facility required by a state to be licensed, registered, or similarly recognized as a hospital; and (ii) 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).

Section 501(r)(2)(B)(i) requires a hospital organization that operates more than one hospital facility to meet the requirements of section 501(r) separately with respect to each hospital facility. Section 501(r)(2)(B)(ii) provides that a hospital organization will not be treated as described in section 501(c)(3) with respect to any hospital facility for which the requirements of section 501(r) are not separately met.

Community Health Needs Assessments

Section 501(r)(3) requires a hospital organization to conduct a community health needs assessment (CHNA) at least once every three years and adopt an implementation strategy to meet the community health needs identified through the CHNA. The CHNA must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health. In addition, the CHNA must be made widely available to the public.

Financial Assistance Policy and Emergency Medical Care Policy

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.

The FAP must include: (1) Eligibility criteria for financial assistance, and whether such assistance includes free or

discounted care; (2) the basis for calculating amounts charged to patients; (3) the method for applying for financial assistance; (4) in the case of an organization that does not have a separate billing and collections policy, the actions the hospital organization may take in the event of nonpayment; and (5) measures to widely publicize the FAP within the community to be served by the hospital organization.

The emergency medical care policy must require the hospital organization 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 their eligibility under the organization's FAP.

Limitation on Charges

Section 501(r)(5)(A) requires a hospital organization 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)(5)(B) prohibits the use of gross charges.

Billing and Collections

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 (ECAs) against the individual.

Notice 2010–39

In June 2010, the Department of Treasury (Treasury Department) and the Internal Revenue Service (IRS) issued Notice 2010–39 (2010–24 IRB 756 (May 27, 2010)), which solicited comments regarding the application of the additional requirements imposed by section 501(r). The Treasury Department and the IRS received approximately 125 comments in response to Notice 2010–39. The principal comments considered in drafting these proposed regulations are discussed in this preamble under Explanation of Provisions.

Notice 2011–52

In July 2011, the Treasury Department and the IRS issued Notice 2011–52 (2011–30 IRB 60 (July 8, 2011)), which addressed the CHNA requirements described in section 501(r)(3). Notice 2011–52 described specific provisions related to the CHNA requirements that the Treasury Department and the IRS anticipate will be included in regulations to be proposed under section 501(r) and solicited comments from the public. The comment period for Notice 2011–52 closed on September 23, 2011. The Treasury Department and the IRS received more than 80 comments in response to Notice 2011–52.

Hospital organizations may rely on the guidance in Notice 2011–52 with respect to any CHNA made widely available to the public, and any implementation strategy adopted, on or before the date that is six months after the date further guidance regarding the CHNA requirements is issued.

Explanation of Provisions

These proposed regulations provide guidance on the requirements described in section 501(r)(4) through 501(r)(6) of the Code. Sections 501(r)(4), 501(r)(5), and 501(r)(6) all relate to a hospital facility's FAP or to individuals who are, or may be, FAP-eligible. The proposed regulations under section 501(r)(4) describe the information that a hospital facility must include in its FAP and the methods a hospital facility must use to widely publicize its FAP. They also describe what a hospital facility must include in its emergency medical care policy. The proposed regulations under section 501(r)(5) describe how a hospital facility determines the maximum amounts (that is, the amounts generally billed to individuals who have insurance coverage, or AGB) it can charge FAP-eligible individuals for emergency and other medically necessary care. In the case of an individual who is FAP-eligible but has not applied for financial assistance at the time charges are made, the proposed regulations provide that a hospital facility will not fail to satisfy section 501(r)(5) if it charges the individual more than AGB, provided the hospital facility is complying with all the requirements regarding notifying individuals about the FAP and responding to applications submitted, including correcting the amount charged and seeking to reverse any ECA previously initiated if an individual is later found to be FAP-eligible.

The proposed regulations under section 501(r)(6) describe the actions that are considered ''extraordinary collection actions'' and the ''reasonable efforts'' a hospital facility must make to determine FAP-eligibility before engaging in such actions. In general, to have made reasonable efforts under the proposed regulations, a hospital facility must determine whether an individual is FAP-eligible or provide required notices during a notification period ending 120 days after the date of the first billing statement. Although a hospital facility may undertake extraordinary collection actions after this 120-day notification period, a hospital facility that has not determined whether an individual is FAP-eligible must still accept and process a FAP application from the individual for an additional 120 days. Accordingly, the total period during which a hospital facility must accept and process FAP applications is 240 days from the date of the first billing statement. If a hospital facility receives a FAP application during the application period, it must suspend any ECAs it has started until it has processed the application and, if it determines the individual is FAP-eligible, must seek to reverse the ECAs and promptly refund any overpaid amounts. While debts may be referred to third parties to assist with collection actions at any time, including during the initial 120-day notification period, they may not be sold to third parties during the notification period unless and until an eligibility determination has been made.

These proposed regulations also provide guidance on which entities must meet the requirements described in section 501(r)(4) through 501(r)(6). In particular, the proposed regulations contain a definitions section that defines ''hospital organization,'' ''hospital facility,'' and other key terms used in the regulations.

In crafting proposed regulations to implement these interrelated statutory provisions, the Treasury Department and the IRS sought to ensure that patients who may require financial assistance—and the patient advocacy groups that assist them—will have access to the information about a hospital facility's FAP that the patients need in order to effectively seek financial assistance under the FAP. The Treasury Department and the IRS also sought to preserve hospital facilities' flexibility to determine the best way to meet the particular health needs of the specific communities they serve. Neither the statute nor these proposed regulations establish specific eligibility criteria that a FAP must contain. Moreover, aside from prohibiting hospital facilities from charging FAP-eligible individuals more than AGB, neither the statute nor the proposed regulations dictate the amounts or kinds of financial assistance that a FAP must provide.

As discussed further in this Explanation of Provisions, these proposed regulations do not provide guidance on the CHNA requirements described in section 501(r)(3) or on the consequences described in sections

501(r)(1) and 501(r)(2)(B) for failing to satisfy the section 501(r) requirements. The Treasury Department and the IRS intend to issue additional proposed regulations addressing the CHNA requirements and the consequences for failing to satisfy the section 501(r) requirements and responding to the comments received in response to Notice 2011–52.

1. Hospital Facilities and Organizations

a. Hospital Facilities

Because section 501(r)(2)(B) requires a hospital organization to satisfy the requirements of section 501(r) separately with respect to each hospital facility it operates, a number of commenters requested a definition of ''hospital facility.'' In accordance with section 501(r)(2)(A)(i), the proposed regulations define a hospital facility as a facility that is required by a state to be licensed, registered, or similarly recognized as a hospital. Except as otherwise provided in future published guidance, a hospital organization may treat multiple buildings operated under a single state license as a single hospital facility. Future published guidance also will address whether a hospital organization's operations in a single building under more than one state license are treated as one or multiple hospital facilities.

The proposed regulations refer to hospital facilities taking certain actions. 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.

b. Hospital Organizations

In accordance with section 501(r)(2)(A)(i), the proposed regulations provide that a hospital organization includes any organization recognized (or seeking to be recognized) as described in section 501(c)(3) that operates one or more hospital facilities.

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). These proposed regulations do not include a determination that any other categories of organizations or facilities have the provision of hospital care as their principal function or purpose, but comments are requested regarding whether additional organizations should be included. Moreover, the Treasury Department and the IRS intend that any future regulations regarding any such categories of organizations or facilities will apply only prospectively, after an opportunity for notice and comment. Prior to the effective date of any such future regulations, only organizations operating a facility required by a state to be licensed, registered, or similarly recognized as a hospital will be considered ''hospital organizations'' that must satisfy the requirements under section 501(r).

c. Hospital Facilities Located Outside of the United States

A number of commenters asked whether section 501(r) will apply to an organization as a result of its operating a hospital facility located outside of the United States. The proposed regulations provide that, for purposes of determining whether a facility is required by a state to be licensed, registered, or similarly recognized as a hospital, the term ''state'' includes only the 50 states and the District of Columbia, and not any U.S. territory or foreign country. As a result, a facility located outside of the United States will not be considered a hospital facility under these proposed regulations. Thus, pending any future guidance regarding other categories of hospital organizations or facilities, a hospital organization operating a facility located outside of the United States that is not required to be licensed by any State will not be required to meet the section 501(r) requirements with respect to that facility and an organization will not be considered a hospital organization as a result of operating such a facility.

d. Operating Hospital Facilities Through Partnerships or Disregarded Entities

Notice 2011–52 notes that the Treasury Department and the IRS intend to include within the definition of ''hospital organization'' any organization described in section 501(c)(3) that operates a hospital facility through a disregarded entity, or a joint venture, limited liability company, or other entity treated as a partnership for federal tax purposes. Notice 2011–52 also requested comments regarding whether (or under what circumstances) an organization should not be considered to ''operate'' a hospital facility for purposes of section 501(r) as a result of its owning a small interest (other than a general partner or similar interest) in an entity treated as a partnership for federal tax purposes that operates the hospital facility.

The proposed regulations provide that a hospital organization includes any organization that operates a hospital facility through a disregarded entity. The Treasury Department and the IRS are considering the comments received in response to Notice 2011–52 regarding the operation of hospital facilities through partnerships and will address this issue in separate guidance.

e. Government Hospital Organizations

A number of commenters requested that the Treasury Department and the IRS provide an exception from the requirements imposed by section 501(r) for certain government hospital organizations. For example, some commenters suggested that the requirements of section 501(r) should not apply to a hospital organization that excludes its income from gross income under section 115 but has nonetheless applied for and received recognition as an organization described in section 501(c)(3). Other commenters suggested that the section 501(r) requirements should not apply to any hospital organization that is a governmental unit or an affiliate of a governmental unit as described in Rev. Proc. 95–48 (1995–2 CB 418) (relieving such organizations from the annual filing requirement under section 6033).

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). Section 501(r) does not explicitly address government hospital organizations, nor does it include a specific exception for government hospital organizations. Accordingly, as indicated in Notice 2011–52, 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). As a result, the proposed regulations do not contain any exceptions or special rules for government hospital organizations and are intended to apply to any government hospital organization recognized as described in section 501(c)(3). However, in recognition of the unique position of government hospitals, the Treasury Department and the IRS request comments regarding alternative methods a government hospital may use to satisfy the requirements of section 501(r)(4) through 501(r)(6).

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

Numerous commenters requested guidance on the consequences of failing to meet one or more of the requirements of section 501(r). The Treasury Department and the IRS are continuing to consider comments regarding the consequences of failing to meet the

requirements of section 501(r) and will address this issue in separate guidance.

3. Community Health Needs Assessments

As described in the Background section of this preamble, the comment period for Notice 2011–52, which solicited comments on anticipated regulatory provisions regarding the CHNA requirements, closed on September 23, 2011. The Treasury Department and the IRS are considering the comments received in response to Notice 2011–52 and will address the CHNA requirements in separate guidance. Accordingly, these proposed regulations do not provide further guidance regarding the CHNA requirements. Hospital organizations may continue to rely on the anticipated regulatory provisions described in Notice 2011–52 with respect to any CHNA made widely available to the public, and any implementation strategy adopted, until six months after the date further guidance regarding the CHNA requirements is issued.

4. Financial Assistance Policies and Emergency Medical Care Policies

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

a. Financial Assistance Policies

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

In general, a hospital facility's FAP must include: (1) Eligibility criteria for financial assistance, and whether such assistance includes free or discounted care; (2) the basis for calculating amounts charged to patients; (3) the method for applying for financial assistance; (4) in the case of an organization that does not have a separate billing and collections policy, the actions the organization may take in the event of nonpayment; and (5) measures to widely publicize the FAP within the community served by the hospital facility.

While the FAP itself must generally include each of these items of information and must be made available on a Web site and without charge upon request in public locations in the hospital facility and by mail, the proposed regulations otherwise permit a hospital facility to widely publicize its FAP using summaries that do not contain all of the information in the FAP. In addition, the Treasury Department and the IRS recognize that certain details related to the FAP are likely to change regularly and that it may be inefficient in certain circumstances for a hospital facility to have to update its FAP to reflect every such change. As a result, the proposed regulations give hospital facilities the option of providing certain information separately from the FAP, as long as the FAP explains how members of the public can readily obtain this information free of charge on a Web site and in writing.

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

A few commenters noted that section 501(r)(4) does not appear to mandate that FAPs contain any particular eligibility criteria and asked that hospital facilities be given the flexibility to develop FAP eligibility criteria that respond to local needs. Other commenters asked the Treasury Department and the IRS to require all FAPs to include certain minimum eligibility criteria.

Consistent with the statute, the proposed regulations do not mandate any particular eligibility criteria and require only that a FAP specify the financial assistance, including all discounts and free care, available under the FAP and all of the specific eligibility criteria that an individual must satisfy to receive each such discount, free care, or other level of assistance. If applicable, a FAP must also specify the amounts, such as gross charges, to which any discount percentages specified in the FAP will be applied.

At least one commenter recommended that hospital facilities be required to consult with members of the community, including representatives of vulnerable or disadvantaged community members, as they develop or revise their FAPs. Although the proposed regulations do not include such a requirement, the Treasury Department and the IRS are considering the potential link between the needs of a hospital facility's community, as determined through the hospital facility's most recent CHNA, and a hospital facility's FAP. Comments are requested on this issue.

In addition, because section 501(r)(5)(A) requires a hospital facility to limit amounts charged for emergency or other medically necessary care provided to FAP-eligible individuals to not more than the amounts generally billed to individuals who have insurance covering such care (AGB), the proposed regulations require the FAP to state that following a determination of FAP-eligibility, an individual will not be charged more than AGB for emergency or other medically necessary care.

The FAP must also state which of the permitted methods (described in the section of this preamble on Limitation on Charges) the hospital facility uses to determine AGB. Finally, if applicable, the FAP must either state the percentage(s) of gross charges the hospital facility applies to determine AGB (the AGB percentage(s)) and how these AGB percentage(s) were calculated or explain how members of the public may readily obtain this information in writing and free of charge.

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 proposed regulations require a hospital facility's FAP to describe how an individual may apply 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 or documentation the hospital facility may require an individual to submit as part of his or her FAP application and provide certain contact information that an individual can use to obtain assistance with the FAP application process. Financial assistance may not be denied based on the omission of information or documentation if such information or documentation is not specifically required by the FAP or FAP application form.

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

Section 501(r)(4)(A)(iv) requires a hospital facility that does not have a separate billing and collections policy to describe in the FAP the actions the hospital facility may take in the event of nonpayment. The statute does not define what it means for a hospital facility to have a separate billing and collections policy. The Treasury Department and the IRS propose to define the term ''billing and collections policy'' as a separate written policy that describes the actions a hospital facility may take in the event of nonpayment in a manner that would be sufficient to satisfy section 501(r)(4)(A)(iv) if the hospital facility had chosen to include

the description in its FAP. The Treasury Department and the IRS also propose to define the term ''actions a hospital organization may take in the event of nonpayment'' to include any extraordinary collection actions described in section 501(r)(6) that a hospital organization may take only after making reasonable efforts to determine whether an individual is FAP-eligible.

Accordingly, to implement the requirement under section 501(r)(4)(A)(iv), the proposed regulations require either the FAP, or a separate written billing and collections policy, to describe the actions that the hospital facility (or other authorized party) may take related to obtaining payment of a bill for medical care provided by the facility, including, but not limited to, any extraordinary collection actions described in section 501(r)(6). Either the FAP or billing and collections policy must also describe the process and time frames the hospital facility (or other authorized party) will use in taking these actions, including any reasonable efforts to determine whether an individual is FAP-eligible described in section 501(r)(6). In addition, the FAP or billing and collections policy must describe 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 extraordinary collection actions against the individual.

In the case of a hospital facility that fulfills these requirements in a separate written billing and collections policy rather than in the FAP, the proposed regulations require the hospital facility's FAP to 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 both on a Web site and upon request.

iv. Widely Publicizing the FAP

In accordance with section 501(r)(4)(A)(v), the proposed regulations require a FAP to include measures to widely publicize the FAP. One commenter asked that ''widely publicize'' be defined by example but that it not be defined too narrowly or prescriptively because hospital facilities need flexibility to address their particular circumstances. Other commenters recommended requiring use of one or a combination of the following specific measures to widely publicize a FAP:

- Posting information on the hospital facility's Web site;
- Distributing information at the hospital facility's patient access points;
- Notifying patients upon admission;
- Distributing information with discharge materials;
- Posting information conspicuously in public areas of the hospital facility (including admissions areas, emergency rooms, waiting rooms, billing offices, outpatient reception areas, etc.);
- Including information with or on billing statements;
- Mentioning the FAP when discussing an individual's bill over the telephone;
- Making the FAP available for public inspection and/or copying without charge at the hospital facility's principal, regional, and district offices during regular business hours;
- Publicizing the FAP to physicians and community health centers in the community;
- Including information regarding the FAP in hospital newsletters or magazines;
- Including information regarding the FAP in appropriate reports filed with state governments;
- Publicizing the FAP through local news media; and/or
- Publicizing the FAP through social service agencies.

In addition, several commenters asked that hospital facilities be allowed to publicize a summary of the FAP instead of the FAP itself. According to these commenters, summaries of a FAP are often more easily understood by members of the public. Some commenters also asked that such summaries of the FAP, or the FAP itself, be translated into languages spoken by a significant part of the community served by the hospital facility.

The proposed regulations require a FAP to include four types of measures that the hospital facility will take to widely publicize the FAP. Hospital facilities have the option of summarizing these measures in the FAP itself or explaining in the FAP how members of the public may readily obtain a free written summary of these measures.

First, the FAP must include measures the hospital facility will take to make paper copies of the FAP, the FAP application form, and a plain language summary of the FAP available upon request and without charge, both for distribution in public locations in the hospital facility and by mail. Each of these documents must be made available in English and in the primary language of any populations with limited proficiency in English that constitute more than 10 percent of the residents of the community served by the hospital facility. A similar 10 percent threshold is used in certain state laws requiring notification about financial assistance, as well as certain federal regulations requiring notices or summaries to be issued in non-English languages. See, for example, 26 CFR 54.9815–2719T(e)(3); 29 CFR 2520.102–2(c)(2); 45 CFR 147.136(e)(3).

Second, the FAP must include measures the hospital facility will take to inform and notify visitors to the hospital facility about the FAP through a conspicuous public display or other measure(s) reasonably calculated to attract the attention of visitors to the hospital facility. Such measures could include, for example, conspicuously posting signs and displaying brochures that provide basic information about the FAP in public locations in the hospital facility.

Third, the FAP must include measures the hospital facility will take to inform and notify members 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. Such measures could include, for example, the distribution of information sheets summarizing the FAP to local public agencies and nonprofit organizations that address the health needs of the community's low-income populations.

For purposes of these proposed regulations, ''informing and notifying'' hospital visitors and community members about a FAP does not require a hospital facility to provide these individuals with the FAP or all of the information in the FAP. Rather, provision of a summary of the FAP or notification of the FAP's existence, combined with instructions on how to obtain more information about the FAP, will suffice.

The proposed regulations also make clear that whether a measure is reasonably calculated to attract visitors' attention or reach members of the community likely to require financial assistance will depend on all of the facts and circumstances, including the primary languages spoken by the residents of the community served by the hospital facility and other attributes of the community and the hospital facility.

Finally, the FAP must include measures the hospital facility will take to make the FAP, FAP application form, and a plain language summary of the

FAP widely available on the hospital facility or hospital organization's Web site or on a Web site established and maintained by another entity. The hospital facility must conspicuously post complete and current versions of these documents, both in English and in the primary language of any populations with limited proficiency in English that constitute more than 10 percent of the residents of the community served by the hospital facility.

In addition, any individual with access to the Internet must be able to access, download, view, and print a hard copy of these documents, without requiring special computer hardware or software (other than software that is readily available to members of the public without payment of any fee) and without payment of a fee to the hospital facility, hospital organization, or other entity maintaining the Web site. Finally, the hospital facility or hospital organization must provide 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 direct Web site address, or URL, where these documents are posted.

b. Emergency Medical Care Policy

A number of commenters opined that the requirement under section 501(r)(4)(B) that a hospital facility establish an emergency medical care policy is intended to reflect existing federal law under the Emergency Medical Treatment and Labor Act (EMTALA) and is not intended to create any new requirements other than to set forth pre-existing obligations under federal law in a written policy.

To satisfy the requirements of section 501(r)(4)(B), the proposed regulations provide 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 EMTALA) to individuals, regardless of whether they are FAP-eligible. The proposed regulations further provide 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, the chapter regarding the Centers for Medicare and Medicaid Services' standards and certification and including the regulations under EMTALA.

Any hospital policy or procedure that discourages individuals from seeking emergency medical care, such as demanding that emergency department patients pay before receiving treatment or permitting debt collection activities in the emergency department, may jeopardize a hospital facility's compliance with EMTALA and with the requirement under 501(r)(4)(B) to establish a nondiscriminatory emergency medical care policy. Accordingly, the proposed regulations provide that unless a hospital facility's emergency medical care policy prohibits debt collection activities from occurring in the emergency department or in other hospital venues where such activities could interfere with the treatment of emergency medical conditions without discrimination, the hospital's policy will not meet the requirements of section 501(r)(4)(B).

c. Establishing the FAP and Other Policies

The proposed 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 organization has adopted the policy for the hospital facility and the hospital facility has implemented the policy. For these purposes, an authorized body of a hospital organization means: (1) The hospital organization's governing body (that is, the board of directors, board of trustees, or equivalent controlling body); (2) a committee of the governing body that is permitted under state law to act on behalf of the governing body; or (3) other parties authorized by the governing body of the hospital organization to act on its behalf (such as, for example, one or more executives of the hospital facility), to the extent permitted under state law. In the case of a hospital facility (operated by a hospital organization) that is recognized as an entity under state law but is a disregarded entity for federal tax purposes, an authorized body of the hospital organization may also include the governing body of that hospital facility or a committee of, or other parties authorized by, that governing body, as permitted under state law.

A hospital facility has implemented a policy if it has consistently carried out the policy.

One commenter asked whether, for purposes of complying with section 501(r)(4), a policy established for a system of multiple hospital facilities will qualify as a policy for each hospital facility in the system. The proposed regulations provide that, while a hospital organization operating multiple hospital facilities must separately establish a FAP and emergency medical care policy for each hospital facility it operates, such policies may contain the same operative terms. The proposed regulations do note, however, that different AGB percentages and methods of determining AGB and the unique attributes of a hospital facility or the community it serves could necessitate that hospital facilities include in their FAPs (or otherwise make available) different information about AGB or different measures to widely publicize the FAP. For example, if a hospital organization operates two hospital facilities, only the first of which serves a community that includes a population with limited proficiency in English that constitutes more than 10 percent of the community's residents, only the first hospital facility must include in its FAP (or otherwise make available a summary of) measures to widely publicize the FAP in a language other than English.

5. Limitation on Charges

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

a. Amounts Generally Billed

In discussing methods to determine AGB, numerous commenters pointed to the Joint Committee on Taxation's (JCT) statement in the Technical Explanation of the Affordable Care Act that ''[i]t is intended that amounts billed to those who qualify for financial assistance may be based on either the best, or an average of the three best, negotiated commercial rates, or Medicare rates.'' 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). A few commenters recommended requiring hospital facilities to use Medicare rates in determining AGB, while at least one commenter requested that hospital facilities not be required to use Medicare rates. Numerous commenters asked that hospital facilities be

permitted to determine AGB by applying an average percentage of gross charges that commercial insurers and the patients they cover are, together, expected to pay.

A number of commenters recommended that AGB should be determined at least annually, and a few commenters asked that AGB be calculated based on past claims paid by commercial insurers, such as claims paid over the last six months or over the prior year. In addition, several commenters asked that hospital facilities be permitted to make separate AGB determinations for inpatient and outpatient services.

The proposed regulations provide two methods for hospital facilities to use to determine AGB. The first method is a ''look-back'' method based on actual past claims paid to the hospital facility by either Medicare fee-for-service only 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 Treasury Department and the IRS believe that the three ''best'' commercial rates may be difficult to determine because different commercial insurers may negotiate the lowest rates for different items and services. Basing AGB on the claims paid by all private health insurers and Medicare avoids this difficulty by eliminating the need to determine which private health insurers have the lowest rates. Although such an approach allows a hospital facility to include the higher rates paid by health insurers that are not the lowest (or three lowest), it also requires the hospital facility to include the rates paid by Medicare. In addition, basing AGB on the claims paid by all private health insurers and Medicare is arguably more consistent with the statutory phrase ''amounts generally billed to individuals who have insurance'' than basing AGB only on claims paid by those private health insurers with the lowest, or three lowest, rates. However, the Treasury Department and the IRS request comments regarding whether hospital facilities should also have the option of basing AGB on claims paid by the private health insurer with the lowest rate or by the three private health insurers with the three lowest rates, and how the lowest rate(s) should be determined. The Treasury Department and the IRS also request comments regarding whether hospital facilities should have the option of basing AGB on claims paid by all private health insurers paying claims to the hospital facility, without also including claims paid by Medicare.

The second method for determining AGB is ''prospective,'' in that it requires 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. This prospective method is based only on Medicare because the Treasury Department and the IRS expect that such a method is only administrable if based on a single insurer's billing and coding processes. The Treasury Department and the IRS request comments regarding whether a hospital facility should also have the option of determining AGB prospectively by estimating the amount the facility would charge the insured individual and the private health insurer with the lowest rate (or the insured individuals and three private health insurers with the three lowest rates).

These two methods of determining AGB are mutually exclusive, and a hospital facility may use only one method to determine AGB. After choosing a particular method, a hospital facility must continue to use that method. The Treasury Department and the IRS request comments on whether a hospital facility should be allowed to change its method of calculating AGB under certain circumstances or following a certain period of time and, if so, under what circumstances or how frequently.

Several commenters asked whether Medicare Advantage should be included in the determination of AGB. The proposed regulations clarify that for purposes of determining AGB, amounts paid under ''Medicare'' only include amounts paid under ''Medicare fee-for-service,'' which is defined as including only Medicare Part A and Part B and excluding Medicare Advantage (or Medicare Part C). For purposes of the proposed regulations, claims paid under Medicare Advantage are treated as claims paid by a private health insurer.

Finally, a number of commenters recommended that in states that require specific discounts or otherwise control the amount that may be billed to patients with financial need, those requirements should establish AGB. Given the wide variation among state laws and the advantage of uniformity in applying the federal rules, the Treasury Department and the IRS are proposing to adopt a single federal regulatory definition of AGB.

i. Look-Back Method

Under the look-back method for determining AGB, a hospital facility must determine AGB for any emergency or other medically necessary care provided to a FAP-eligible individual by multiplying the gross charges for that care by one or more percentages of gross charges, called AGB percentages. The hospital facility must calculate its AGB percentage(s) no less frequently than annually by dividing the sum of certain claims paid to the hospital facility by the sum of the associated gross charges for those claims. More specifically, these 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 either Medicare fee-for-service alone or by Medicare fee-for-service and all private health insurers together as the primary payer(s) of these claims during a prior 12-month period. For these purposes, a hospital facility may include in ''all claims that have been paid in full'' both the portions of the claims paid by Medicare or the private insurer and the associated portions of the claims paid by Medicare beneficiaries or insured individuals in the form of co-insurance, copayments, or deductibles. 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).

The Treasury Department and the IRS request comments regarding this look-back method generally, and regarding three aspects of this method in particular. First, comments are requested regarding whether a hospital facility using the look-back method should have the option to base its AGB percentage(s) on a representative sample of claims (rather than all claims) that have been paid in full over a prior 12-month period. Specifically, comments should address how a hospital facility would ensure that such samples are representative and reliable. Second, comments are requested regarding whether a hospital facility needs more than 45 days between the end of the 12-month period used in calculating the AGB percentage(s) and the date it must begin applying the AGB percentage(s). Third, comments are requested 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 will result in charges that exceed the amounts that are in fact generally billed

to those with insurance at the time of the charges. If so, comments are requested regarding whether safeguards should be implemented to offset increases in gross charges after the calculation of the AGB percentage(s), including, for example, requiring AGB to be determined by applying an AGB percentage not to current gross charges but rather to current gross charges reduced by any percentage increases in gross charges since the AGB percentage was last calculated.

As previously noted, numerous commenters asked that hospital facilities be permitted to determine AGB by applying one average percentage of gross charges. The proposed regulations provide that a hospital facility using the look-back method may calculate one average AGB percentage 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.

ii. Prospective Medicare Method

Under the prospective Medicare method, a hospital facility may determine AGB for any emergency or other medically necessary care that the hospital facility provides 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. The hospital facility may then set AGB for that care at the amount the hospital facility determines would be the amount Medicare and the Medicare beneficiary together would be expected to pay for the care.

b. Gross Charges

Section 501(r)(5)(B) prohibits the use of gross charges. The proposed regulations define a gross charge (also known as the ''chargemaster rate'') as a hospital facility's full, established price for medical care that the hospital facility consistently and uniformly charges all patients before applying any contractual allowances, discounts, or deductions.

A number of commenters recommended that section 501(r)(5)(B)'s prohibition on gross charges should apply only to FAP-eligible individuals, noting that such an interpretation is consistent with the JCT's statement in the Technical Explanation that ''[a] hospital facility may not use gross charges * * * when billing individuals who qualify for financial assistance.'' Technical Explanation, at 82. The proposed regulations adopt this recommendation. The proposed regulations also clarify that the prohibition on the use of gross charges applies to any medical care, not just emergency and medically necessary care, provided to a FAP-eligible individual.

Numerous commenters requested that hospital facilities not be prohibited from including the amount of gross charges on a hospital bill as an explanatory item or a starting point for itemizing certain discounts. Commenters stated that this practice is standard in the healthcare industry and should not be affected by section 501(r)(5)(B). The proposed regulations make clear that including the gross charges on hospital bills as the starting point to which various contractual allowances, discounts, or deductions are applied is permissible, as long as the gross charges are not the actual amount a FAP-eligible individual is expected to pay.

c. Safe Harbor for Certain Charges in Excess of AGB

A number of commenters noted that if an individual has yet to submit a FAP application, a hospital facility will not know at the time of initial and subsequent billing whether the individual is FAP-eligible. The proposed regulations provide that whether an individual is FAP-eligible is determined without regard to whether the individual has applied for assistance under a hospital facility's FAP. However, the proposed regulations also provide a safe harbor under which a hospital facility will not violate section 501(r)(5) if it charges more than AGB for emergency or other medically necessary care, or charges gross charges for any medical care, to a FAP-eligible individual who has not submitted a complete FAP application as of the time of the charge, as long as the hospital facility made and continues to make reasonable efforts to determine whether the individual is FAP-eligible (within the meaning of and during the periods required under section 501(r)(6), including by correcting the amount charged if the individual is subsequently found to be FAP-eligible). The Treasury Department and IRS request comments regarding the proposed safe harbor and whether the patient protections provided in section 1.501(r)–6, including the requirements that a hospital facility refund amounts overcharged and seek to reverse previously taken ECAs (except sales of debts) once an individual has been determined to be FAP-eligible, are sufficient.

6. Billing and Collection

The proposed regulations provide that a hospital organization meets the requirements of section 501(r)(6) with respect to a hospital facility it operates if the hospital facility does not engage in ECAs against an individual before making reasonable efforts to determine whether the individual is FAP-eligible. For these purposes, a hospital facility will be considered to have engaged in ECAs against an individual if the hospital facility engages in ECAs against any other individual who has accepted or is required to accept responsibility for the first individual's hospital bills. In addition, a hospital facility will be considered to have engaged in an ECA against an individual 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.

a. Extraordinary Collection Actions

In discussing the scope of the term ''extraordinary collection actions'' (ECAs), many commenters pointed to the JCT's statement in the Technical Explanation that ''extraordinary collections include lawsuits, liens on residences, arrests, body attachments, or other similar collection processes.'' Technical Explanation, at 82. A number of these commenters argued that ECAs should be limited to the examples listed in the Technical Explanation, with the term ''other similar collection processes'' being limited to actions that must be initiated through a legal or judicial process.

Other commenters recommended that additional actions related to collections should constitute ECAs or even be prohibited altogether, including such actions as deferring or denying care based on a pattern of nonpayment, selling patient debts to third parties, referring debts to debt collection agencies, charging interest on patient debts, and any other action beyond sending a patient a bill. A number of commenters also recommended that reporting to credit agencies should constitute ECAs and pointed to the statement in the Technical Explanation that reasonable efforts include certain actions before ''reporting to credit rating agencies is initiated.'' Technical Explanation, at 82. In addition, several commenters suggested that the express approval of a hospital organization's governing body should be required before a hospital facility it operates is permitted to engage in such actions as

wage garnishment, freezing bank accounts, or placing liens on patients' homes or cars.

The proposed regulations state that ECAs include any 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. ECAs that require a legal or judicial process include, but are not limited to, actions to—

- Place a lien on an individual's property;
- Foreclose on an individual's real property;
- Attach or seize an individual's bank account or any other personal property;
- Commence a civil action against an individual;
- Cause an individual's arrest;
- Cause an individual to be subject to a writ of body attachment; and
- Garnish an individual's wages.

In addition, the Treasury Department and the IRS understand that the reporting of adverse information about an individual to consumer credit reporting agencies or credit bureaus is a part of the process of obtaining payment of a hospital bill that can cause significant financial harm to an individual for many years. Reporting to credit agencies is also an activity that is restricted in some state laws governing debt collection by hospitals. The proposed regulations provide that ECAs include reporting to credit agencies.

The final action listed in the proposed regulations as an ECA is the sale of an individual's debt to another party. A number of commenters suggested that the proposed regulations prohibit the sale of debt altogether. Such a prohibition is contained in at least one state law governing debt collection by hospitals. The proposed regulations provide that the sale of debt is an ECA because the Treasury Department and the IRS understand that after a hospital facility has sold a debt, it may have a more limited ability to control the purchaser's actions to collect the debt. By contrast, when a hospital facility refers an individual's debt to a debt collection agent or other party without selling the debt (for example, by entering into a contract under which the other party conducts all of the facility's billing and collections activities pursuant to the hospital facility's billing and collections policy), a hospital facility can presumably maintain greater control over its third party agent. As a result, the proposed regulations do not define ECAs to include referring an individual's debt without selling it. The Treasury Department and the IRS request comments regarding whether a hospital facility can maintain sufficient control over the collection actions of parties to which it refers or sells debt and whether either referring debt or selling debt (or both) should constitute ECAs.

The proposed regulations do not define ECAs to include deferring or denying care based on a pattern of nonpayment, requiring deposits before providing care, or charging interest, although policies allowing certain of these actions may not satisfy the emergency medical care policy provision noted in section 4.b of this preamble. In addition, the Treasury Department and the IRS understand that some state laws restrict the degree to which hospitals can engage in these activities and request additional comments on whether such activities should constitute ECAs.

The proposed regulations also do not require a hospital facility to obtain governing body approval before engaging in ECAs. Comments are requested regarding what additional procedural protections, if any, may be appropriate as a part of the reasonable efforts to determine FAP-eligibility that a hospital facility must make before engaging in ECAs, discussed in the immediately following section 6.b of this preamble.

b. Reasonable Efforts

In discussing the scope of the term ''reasonable efforts,'' many commenters pointed to the JCT's statement in the Technical Explanation that reasonable efforts were intended to include ''notification by the hospital of its FAP upon admission and in written and oral communications with the patient regarding the patient's bill, including invoices and telephone calls.'' Technical Explanation, at 82. A few commenters recommended that providing one written summary of a FAP in at least one invoice mailed or otherwise provided to an individual following the provision of hospital services and prior to referring the account to a collection agency should be deemed to constitute ''reasonable efforts'' to determine the individual's FAP-eligibility. Other commenters recommended that a hospital facility be required to provide at least three notices about the FAP (as well as contact information to request additional information) and wait at least 120 days from the first notice or billing statement before engaging in ECAs. One commenter noted that hospitals have traditionally handled their receivables internally and then turned them over to collections agencies after 120 days. Several commenters suggested that individuals be given more than 120 days, such as one year, to apply for financial assistance.

The proposed regulations provide that, 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 if the hospital facility: (1) Notifies the individual about the FAP; (2) in the case of an individual who submits an incomplete FAP application, provides the individual with information relevant to completing the FAP application; and (3) in the case of an individual who submits a complete FAP application, makes and documents a determination as to whether the individual is FAP-eligible (and meets certain other specified requirements described later in this preamble).

For purposes of meeting these requirements, the proposed regulations describe both a ''notification period'' and an ''application period.'' The notification period is the period during which the hospital facility must notify an individual about the FAP. Under the proposed regulations, this period begins on the date care is provided to the individual and ends on the 120th day after the hospital facility provides the individual with the first billing statement for the care. If a hospital facility has met all of the notification requirements and the individual has failed to submit a FAP application by the end of the notification period, the hospital facility may engage in ECAs against the individual. However, a hospital facility must accept and process FAP applications submitted by an individual during a longer ''application period'' that ends on the 240th day after the hospital facility provides the individual with the first billing statement for the care. The Treasury Department and the IRS have proposed including both a shorter notification period and a longer application period as a way of balancing the individual's need for sufficient time to seek financial assistance with the hospital facility's interest in efficiently carrying out its billing processes. The Treasury Department and the IRS request comments regarding other possible ways to achieve this balance.

The Treasury Department and the IRS are proposing a notification period of 120 days from the first billing statement because a few commenters suggested that hospital billing cycles are typically 45 days and the Treasury Department and the IRS intend that individuals will receive notice about the FAP with at least three billing statements and then have at least 30 days after the third

billing statement to apply for financial assistance before ECAs are initiated. In addition, a 120-day notification period was selected because hospitals are used to dealing with a 120-day period in the context of deeming debts to be bad debts under the Medicare program and because such a period is consistent with some state requirements or recommendations to wait 120 days before taking such collection actions as commencing lawsuits, reporting to credit agencies, or referring to collection agencies. Similarly, a 240-day period to apply for financial assistance is roughly in the middle of the range of application periods required under various state laws and recommended by some commenters. The Treasury Department and the IRS request comments regarding the proposed lengths of the notification period and the application period and/or whether it would be preferable to have only one concurrent period.

Finally, the Treasury Department and the IRS recognize that some inpatients staying at a hospital facility for a prolonged period of time may start receiving billing statements in the mail before being discharged. Comments are requested regarding whether the notification and application periods for such inpatients should start on a date later than the date of the first billing statement (such as the date of discharge) and on the feasibility of this and other approaches to addressing this issue.

i. Notification About the FAP

To satisfy the notification component of ''reasonable efforts'' with respect to any care provided to an individual, the proposed regulations require a hospital facility to distribute a plain language summary of the FAP, and offer a FAP application form, to the individual before discharge from the hospital facility. A hospital facility must also include a plain language summary of the FAP with all (and at least three) billing statements for the care and all other written communications regarding the bill provided to the individual during the notification period. In addition, the hospital facility must inform the individual about the FAP in all oral communications regarding the amount due for the care that occur during the notification period. Finally, the hospital facility must provide the individual with at least one written notice that informs the individual about the ECAs the hospital facility (or other authorized party) may take if the individual does not submit a FAP application or pay the amount due by a date (specified in the notice) that is no earlier than the last day of the notification period. The hospital facility must provide this written notice at least 30 days before the deadline specified in the notice.

The proposed regulations define a ''plain language summary'' of the FAP as a written statement that notifies an individual that the hospital facility offers financial assistance under a FAP and also includes the following items of information in language that is clear, concise, and easy to understand:

- A brief description of the eligibility requirements and assistance offered under the FAP;
- The direct Web site address, or URL, and physical location(s) where the individual can obtain copies of the FAP and FAP application form;
- Instructions on how the individual can obtain a free copy of the FAP and FAP application form by mail;
- The contact information of hospital facility staff who can provide the individual with information about the FAP and the FAP application process, as well as of any nonprofit organizations or government agencies the hospital facility has identified as capable and available sources of assistance with FAP applications;
- A statement of the availability of translations of the FAP, FAP application form, and plain language summary in other languages, if applicable; and
- A statement that no FAP-eligible individual will be charged more for emergency or other medically necessary care than AGB.

The proposed regulations provide that if an individual submits a complete or incomplete FAP application to a hospital facility during the application period, the hospital facility will be deemed to have met the notification requirements with respect to the individual as of the time the FAP application is submitted. Thus, once a hospital facility receives a FAP application from an individual, the hospital facility no longer needs to continue notifying that individual about the FAP. However, the submission of a FAP application form during the application period triggers other requirements that the hospital facility must satisfy to have made reasonable efforts to determine whether the individual is FAP-eligible, which are discussed in the immediately following sections 6.b.ii and 6.b.iii of this preamble.

Many commenters noted that even when a hospital facility makes reasonable efforts to notify an individual about its FAP and FAP application process, some individuals will decline to apply for financial assistance under the FAP, leaving the hospital facility without the information it needs to determine FAP-eligibility. These commenters asked that a hospital facility not be foreclosed from initiating ECAs when it makes reasonable efforts to notify an individual about its FAP and the individual does not respond.

The Treasury Department and the IRS recognize that some FAP-eligible individuals will not submit a FAP application, notwithstanding a hospital facility's efforts to notify individuals about its FAP. As a result, the proposed regulations provide that, with respect to any care provided to an individual, a hospital facility has made reasonable efforts to determine whether the individual is FAP-eligible if the hospital facility meets, and documents that it met, the notification component of reasonable efforts and the individual does not submit a FAP application by the end of the notification period (or, if later, the deadline specified by the hospital facility). Once the hospital facility has made reasonable efforts to determine whether an individual is FAP-eligible as a result of notifying the individual during the 120-day notification period, it may engage in one or more ECAs against the individual. However, even after a hospital facility is permitted to engage in ECAs against an individual, it must still process FAP applications submitted before the end of the application period in order to have made reasonable efforts to determine whether the individual is FAP-eligible, as described in the immediately following sections 6.b.ii and 6.b.iii of this preamble.

ii. Incomplete FAP Applications

The proposed regulations provide that if an individual submits an incomplete FAP application during the application period, a hospital facility will have made reasonable efforts to determine whether the individual is FAP-eligible only if it takes three steps. First, if applicable, the hospital facility must suspend any ECAs against the individual (meaning it does not initiate any new ECAs or take further action with respect to previously-initiated ECAs). Second, the hospital facility must provide the individual with a written notice that describes the additional information and/or documentation the individual must submit to complete his or her FAP application and include a plain language summary of the FAP with the written notice. Third, the hospital facility must provide the individual with at least one written notice that informs the individual about the ECAs that the hospital facility or other authorized party may initiate or resume if the individual does not complete the

application or pay the amount due by a completion deadline (specified in the notice) that is no earlier than the later of 30 days from the date of the written notice or the last day of the application period. The hospital facility must provide this written notice regarding ECAs at least 30 days before the completion deadline.

If a hospital facility provides this required information and suspends any ECAs against the individual, and the individual fails to complete the FAP application by the completion deadline, the hospital facility will have made reasonable efforts to determine whether the individual is FAP-eligible and thus may initiate or resume ECAs against the individual.

If the individual completes the FAP application by the completion deadline, the proposed regulations provide that the individual will be considered to have submitted a complete FAP application during the application period, and thus the requirements for complete FAP applications, discussed in the immediately following section 6.b.iii of this preamble, apply.

The Treasury Department and IRS request comments on ways to encourage timely completion of incomplete applications so that hospital facilities may determine whether individuals are FAP-eligible while still providing individuals with sufficient time to apply for financial assistance.

iii. Complete FAP Applications

The proposed 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 against the individual, 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. In addition, if the hospital facility has determined that the individual is FAP-eligible, the hospital facility must take three additional steps in a timely manner. First, it must provide the individual with a billing statement that indicates the amount the individual owes as a FAP-eligible individual. This billing statement must also show—or describe how the individual can get information regarding—the AGB for the care provided and how the hospital facility determined the amount the individual owes as a FAP-eligible individual. Second, the hospital facility must refund any excess payments made by the individual. Third, the hospital facility must take all reasonably available measures to reverse any ECA (with the exception of a sale of debt) taken against the individual to collect the debt at issue. Accordingly, the hospital facility generally must take measures to vacate any judgment against the individual, lift any liens or levies on the individual's property, and remove from the individual's credit report any adverse information reported to a consumer reporting agency or credit bureau.

The Treasury Department and the IRS request comments regarding the feasibility of reversing various ECAs when the hospital facility determines that an individual is FAP-eligible, including in circumstances in which an individual's debt has been referred or sold to another party.

As a general matter, once a hospital facility has taken all of the required steps after receiving a complete FAP application, it has made reasonable efforts to determine whether the individual is FAP-eligible and thus may initiate or resume ECAs against the individual. However, the proposed regulations also contain an anti-abuse rule that provides that a hospital facility will not have made reasonable efforts to determine whether an individual is FAP-eligible if the hospital facility bases a determination that the individual is not FAP-eligible on information 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.

In addition, the proposed regulations provide 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 its FAP based on information other than that provided by the individual as part of a complete FAP application. For example, a hospital facility could make reasonable efforts by determining that an individual is eligible for the most generous assistance offered under its FAP based on information establishing that the individual is eligible for assistance under one or more means-tested public programs.

The Treasury Department and the IRS seek comments on how to provide additional flexibility under the regulations to hospital facilities seeking to determine whether an individual is FAP-eligible so that the procedural protections provided under section 501(r)(6) are respected but do not unnecessarily interfere with a hospital facility's reasonable financial management. Comments are requested on how a hospital facility might reasonably determine whether an individual is FAP-eligible in ways other than soliciting and processing FAP applications.

Specifically, the Treasury Department and the IRS understand that many individuals who are not FAP-eligible (for example, because they are relatively affluent and/or have adequate insurance coverage) will never submit a complete FAP application. A hospital facility may wish to make a FAP-eligibility determination based on reliable information early in the billing cycle in order to avoid unwarranted interference with its routine billing practices and to avoid the administrative burdens of notifying these non-FAP-eligible individuals about the FAP and tracking each individual's notification and application periods. The Treasury Department and the IRS request comments regarding whether, and under what circumstances, a hospital facility should be permitted to use reliable information, other than that provided by an individual with a complete FAP application, to make a determination that the individual is not FAP-eligible or is eligible for assistance that is less than the most generous assistance offered under the FAP. Comments are also requested 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. The Treasury Department and the IRS request comments regarding what sources of information can reliably and accurately be used to determine FAP-eligibility and whether hospital facilities should therefore have the flexibility to use such sources of information rather than being limited to making determinations based only on complete FAP applications.

iv. Agreements With Other Parties

The proposed regulations provide 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 (and, to the extent applicable, enforces) a legally binding written agreement from the other party to abide by certain requirements. First, a party to which the individual's debt is referred during the notification period must agree to refrain from engaging in ECAs against the individual until the hospital facility has made reasonable

efforts to determine whether the individual is FAP-eligible.

Second, if the individual submits a FAP application during the application period, the party must suspend any ECAs against the individual until the hospital facility has made reasonable efforts to determine whether the individual is FAP-eligible.

Third, if the individual submits a FAP application during the application period and the hospital facility determines that the individual is FAP-eligible, the party must adhere to procedures specified in the agreement that ensure that the FAP-eligible individual does not pay, and will have no obligation to pay, the party and hospital facility together more than he or she is required to pay as a FAP-eligible individual. If the party, rather than the hospital facility, has the authority to do so, the party must also take all reasonably available measures to reverse any ECA (with the exception of a sale of debt) taken against the individual to collect the debt at issue.

Fourth, if the party refers or sells the debt to yet another party during the application period, the party must obtain a written agreement from the other party to abide by the three previously-mentioned requirements.

The Treasury Department and the IRS request comments regarding the feasibility of a hospital facility imposing these requirements on the parties to which it sells or refers debt by means of a written agreement. In particular, comments are requested regarding how the regulations should balance the need to ensure that hospital facilities satisfy the requirements of section 501(r)(6) with the goal of avoiding unnecessary disruptions and inefficiencies in their billing processes.

v. Miscellaneous Issues

In order to ensure that individuals have sufficient opportunity to consider whether they might be eligible for assistance under the hospital facility's FAP, the proposed regulations also provide that a hospital facility will not have made reasonable efforts to determine whether an individual is FAP-eligible simply because it obtains a signed waiver from the individual. Thus, a signed statement that the individual does not wish to apply for assistance under the FAP or to receive certain notifications about the FAP will not constitute a determination of FAP-eligibility or satisfy the requirement to make reasonable efforts to determine FAP-eligibility before engaging in ECAs against the individual.

Finally, the proposed regulations provide that a hospital facility may print any written notice or communication described in this section 6 of the preamble, including any plain language summary of the FAP, on a billing statement or along with other descriptive or explanatory matter, as long as the required information is conspicuously placed and of sufficient size to be clearly readable.

Effective/Applicability Dates

Consistent with the statutory effective date, the proposed regulations provide that, except for the requirements of section 501(r)(3), section 501(r) applies to taxable years beginning after March 23, 2010. The requirements of section 501(r)(3) apply to taxable years beginning after March 23, 2012.

The regulations under section 501(r)(4) through 501(r)(6) are proposed to apply for taxable years beginning on or after the date these rules are published in the **Federal Register** as final or temporary regulations. Taxpayers may rely on these proposed regulations until final or temporary regulations are issued. The Treasury Department and the IRS invite comments on whether, and what type of, transitional relief may be necessary.

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.

Special Analyses

It has been determined that this notice of proposed rulemaking 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 has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to this proposed regulation. It is hereby certified that these regulations will not have a significant economic impact on a substantial number of small entities. This certification is based on the fact that the regulations are consistent with the requirements imposed by statute and that the collection of information in the regulation that is subject to the Regulatory Flexibility Act will impose a minimal burden upon the affected organizations. Consistent with the statute, the regulations require 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 need only be performed once. 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, as a general matter, the regulations describing how a hospital facility makes reasonable efforts to determine eligibility for assistance under its FAP and widely publicizes 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. Thus, the collection of information in this regulation that is subject to the Regulatory Flexibility Act will not impose a significant economic burden upon the affected organizations. Accordingly, 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, this regulation has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small entities.

Comments and Requests for Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any comments that are submitted timely to the IRS as prescribed in this preamble under the ''Addresses'' heading. The Treasury Department and the IRS request comments on all aspects of the proposed rules. All comments will be available at *www.regulations.gov* or upon request.

A public hearing will be scheduled if requested in writing by any person that timely submits written comments. If a public hearing is scheduled, notice of the date, time, and place for the public hearing will be published in the **Federal Register**.

Drafting Information

The principal authors of these proposed regulations are Preston J. Quesenberry and Amber L. Mackenzie, 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 in 26 CFR Part 1

Income taxes, Reporting and recordkeeping requirements.

Proposed Amendments to the Regulations

Accordingly, 26 CFR part 1 is proposed to be 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) Billing and collections policy.
(5) Completion deadline.
(6) Disregarded entity.
(7) Emergency medical care.
(8) Emergency medical conditions.
(9) Extraordinary collection action (ECA).
(10) Financial assistance policy (FAP).
(11) FAP application.
(12) FAP application form.
(13) FAP-eligible individual.
(14) Gross charges.
(15) Hospital facility.
(16) Hospital organization.
(17) Medicare fee-for-service.
(18) Notification period.
(19) Plain language summary.
(20) Primary payer.
(21) Private health insurer.
(22) Referring.

§ 1.501(r)–2 Failures to satisfy section 501(r) requirements. [Reserved]

§ 1.501(r)–3 Community health needs assessments. [Reserved]

§ 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.
(c) Emergency medical care policy.
(1) In general.
(2) Interference with provision of emergency medical care.
(3) Relation to federal law governing emergency care.
(4) Examples.
(d) Establishing the FAP and other policies.
(1) In general.
(2) Authorized body.
(3) Implementing a policy.
(4) Establishing a policy for more than one hospital facility.

§ 1.501(r)–5 Limitation on charges.

(a) In general.
(b) Amounts generally billed.
(1) Look-back method.
(2) Prospective Medicare method.
(3) Examples.
(c) Gross charges.
(d) Safe harbor for certain charges in excess of AGB.

§ 1.501(r)–6 Billing and collection.

(a) In general.
(b) Extraordinary collection actions.
(c) Reasonable efforts.
(1) In general.
(2) Notification.
(3) Incomplete FAP applications.
(4) Complete FAP applications.
(5) Suspending ECAs while a FAP application is pending.
(6) Waiver does not constitute reasonable efforts.
(7) Agreements with other parties.
(8) Clear and conspicuous placement.

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

(a) Statutory effective/applicability date.
(1) In general.
(2) Community health needs assessment.
(b) Effective/applicability date of regulations.

Par. 3. Section 1.501(r)–1 is 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)(1) to determine the AGB for any emergency or other medically necessary care it provides to a FAP-eligible individual.

(3) *Application period* means the period during which a hospital facility must accept and process an application for assistance under its financial assistance policy (FAP) submitted by an individual in order to have made reasonable efforts to determine whether the individual is FAP-eligible. With respect to any care provided by a hospital facility to an individual, the application period begins on the date the care is provided to the individual and ends on the 240th day after the hospital facility provides the individual with the first billing statement for the care.

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

(5) *Completion deadline* means the date after which a hospital facility may initiate or resume extraordinary collection actions against an individual who has submitted an incomplete FAP application if that individual has not provided the hospital facility with the missing information and/or documentation necessary to complete the application. The completion deadline must be specified in a written notice (as described in § 1.501(r)–6(c)(3)(i)(C)) and must be no earlier than the later of—

(i) 30 days after the hospital facility provides the individual with this written notice; or

(ii) The last day of the application period described in paragraph (b)(3) of this section.

(6) *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.

(7) *Emergency medical care* means care provided by a hospital facility for emergency medical conditions.

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

(9) *Extraordinary collection action* (*ECA*) means an action described in § 1.501(r)–6(b).

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

(11) *FAP application* means the information and accompanying documentation that a hospital facility requires an individual to submit to apply for financial assistance under the facility's FAP. A FAP application is considered complete if it contains information and documentation sufficient for the hospital facility to determine whether the applicant is FAP-eligible and incomplete if it does not contain such information and documentation.

(12) *FAP application form* means the application form (and any accompanying instructions) that a hospital facility requires an individual to submit as part of his or her FAP application.

(13) *FAP-eligible individual* means an individual eligible for financial assistance under a hospital facility's

FAP, without regard to whether the individual has applied for assistance under the FAP.

(14) *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 all patients before applying any contractual allowances, discounts, or deductions.

(15) *Hospital facility* means a facility that is required by a state to be licensed, registered, or similarly recognized as a hospital. Except as otherwise provided in published guidance, a hospital organization may treat multiple buildings operated under a single state license as a single hospital facility. For purposes of this paragraph (b)(15), 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 action through or on behalf of the hospital facility.

(16) *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, including a hospital facility operated through a disregarded entity.

(17) *Medicare fee-for-service* means health insurance available under Medicare Part A and Part B of Title XVIII of the Social Security Act.

(18) *Notification period* means the period during which a hospital facility must notify an individual about its FAP in accordance with § 1.501(r)–6(c)(2) in order to have made reasonable efforts to determine whether the individual is FAP-eligible. With respect to any care provided by a hospital facility to an individual, the notification period begins on the first date care is provided to the individual and ends on the 120th day after the hospital facility provides the individual with the first billing statement for the care.

(19) *Plain language summary* 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) The direct Web site address (or URL) and physical location(s) (including a room number, if applicable) where the individual can obtain copies of the FAP and FAP application form;

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

(iv) The contact information, including the telephone number(s) and physical location (including a room number, if applicable), of hospital facility staff who can provide an 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;

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

(vi) A statement that no FAP-eligible individual will be charged more for emergency or other medically necessary care than AGB.

(20) *Primary payer* means a health insurer (whether a private health insurer or a public payer such as Medicare) that pays first on a claim for medical care (usually after a deductible has been paid by the insured) up to the limits of the policy or program, regardless of other insurance coverage the insured may have. Primary payers are distinguished from secondary payers that pay second on a claim for medical care to the extent payment has not been made by the primary payer.

(21) *Private health insurer* means any organization that offers insurance for medical care that is not a governmental unit described in section 170(c)(1). For purposes of § 1.501(r)–5(b), claims paid under Medicare Advantage (Part C of Title XVIII of the Social Security Act) are treated as claims paid by a private health insurer.

(22) *Referring* an individual's debt to a debt collection agency or other party includes contracting with, delegating, 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.

Par. 4. Sections 1.501(r)–2 and 1.501(r)–3 are added and reserved to read as follows:

§ 1.501(r)–2 Failures to satisfy section 501(r) requirements. [Reserved].

§ 1.501(r)–3 Community health needs assessments. [Reserved].

Par. 5. Sections 1.501(r)–4, 1.501(r)–5, 1.501(r)–6, and 1.501(r)–7 are added to read as follows:

§ 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 if the hospital organization establishes for that hospital facility—

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

(2) A written emergency medical care policy that meets the requirements described in 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 apply to all emergency and other medically necessary care provided by the hospital facility and include—

(i) Eligibility criteria for financial assistance and whether such assistance includes free or discounted care;

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

(iii) The method for applying for financial assistance;

(iv) 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; and

(v) Measures to widely publicize the FAP within the community served by the hospital facility.

(2) *Eligibility criteria and basis for calculating amounts charged to patients*—(i) *In general.* To satisfy paragraphs (b)(1)(i) and (b)(1)(ii) of this section, the FAP must—

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

(B) Specify all of the eligibility criteria that an individual must satisfy to receive each such discount, free care, or other level of assistance;

(C) State that following a determination of FAP-eligibility, a FAP-eligible individual will not be charged more for emergency or other medically necessary care than the amounts generally billed to individuals who have insurance covering such care (AGB);

(D) Describe which method under § 1.501(r)–5(b) the hospital facility uses to determine AGB; and

(E) If the hospital facility uses the look-back method described in § 1.501(r)–5(b)(1) to determine AGB, either state the hospital facility's AGB percentage(s) and describe how the hospital facility calculated such percentage(s) or explain how members of the public may readily obtain this information in writing and free of charge.

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

Example 1. 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'' and specifies that all emergency and other medically necessary care provided by Q is covered under the FAP. 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 50 percent. The FAP states, further, that Q calculated the AGB percentage of 50 percent based on all claims paid in full to Q by Medicare and private health insurers and the individuals they insured 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.

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 50 percent of gross charges and the most a FAP-eligible individual will be charged is 50 percent of gross charges. Q's FAP satisfies the requirements of this paragraph (b)(2).

Example 2. 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'' and specifies that all emergency and other medically necessary care provided by R is covered under the FAP. 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 annual household income.
>$c–$b	20% of gross charges, up to the lesser of AGB or y% of annual household income.
≤$c	$0 (free).

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 paid under Medicare. In addition, the FAP provides a web 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 percent of gross charges for inpatient care and 60 percent of gross charges for outpatient care. It also states that these percentages were based on all claims paid to R for emergency or other medically necessary inpatient and outpatient care by Medicare and Medicare beneficiaries 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) 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 submit as part of his or her FAP application and provide the contact information described in § 1.501(r)–1(b)(19)(iv). The hospital facility may not deny financial assistance under the FAP based on an applicant's failure to provide information or documentation that the hospital facility's FAP or FAP application form does not require an individual to submit as part of a FAP application.

(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 three months 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 the applicant's most recent federal tax return, payroll check stubs from the last three months, documentation of the applicant's qualification for certain specified state means-tested programs, or other reliable evidence of the applicant's earned and unearned household income. S does not require FAP applicants to submit any information or documentation not mentioned in the FAP application form instructions. S's FAP application form instructions also provide the contact information of hospital facility staff who can provide an applicant with information about the FAP and 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)(iv) of this section, either a hospital facility's FAP or a separate written billing and collections policy established by the hospital facility must describe—

(A) Any actions that the hospital facility (or other authorized party) may take relating to obtaining payment of a bill for medical care, including, but not limited to, any extraordinary collection actions 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 extraordinary collection actions, 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 extraordinary collection actions against the individual.

(ii) *Separate billing and collections policy.* In the case of a hospital facility that satisfies paragraph (b)(1)(iv) 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 paragraph (b)(1)(v) of this section, a FAP must include, or explain how members of the public may readily obtain a free written description of, measures taken by the hospital facility to—

(A) Make the FAP, FAP application form, and a plain language summary of the FAP (as defined in § 1.501(r)–1(b)(19)) widely available on a Web site, as described in paragraph (b)(5)(iv) of this section;

(B) Make paper copies of the FAP, FAP application form, and plain language summary of the FAP available upon request and without charge, both in public locations in the hospital facility and by mail, in English and in the primary language of any populations with limited proficiency in English that constitute more than 10 percent of the residents of the community served by the hospital facility;

(C) Inform and notify visitors to the hospital facility about the FAP through conspicuous public displays or other measures reasonably calculated to attract visitors' attention; and

(D) Inform and notify 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.

(ii) *Meaning of inform and notify.* For purposes of paragraphs (b)(5)(i)(C) and (b)(5)(i)(D) of this section, a measure will inform and notify visitors to a hospital facility or residents of a community 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.

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

(iv) *Widely available on a Web site.* For purposes of paragraph (b)(5)(i)(A) of this section, a hospital facility makes its FAP, FAP application form, and plain language summary of the FAP widely available on a Web site only if—

(A) The hospital facility conspicuously posts complete and current versions of these documents in English and in the primary language of any populations with limited proficiency in English that constitute more than 10 percent of the residents of the community served by the hospital facility on—

(*1*) The hospital facility's Web site;

(*2*) 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

(*3*) 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 on which the document is posted, along with clear instructions for accessing the document on that Web site;

(B) Any individual with access to the Internet can access, download, view, and print a hard copy of these documents without requiring special computer hardware or software (other than software that is readily available to members of the public without payment of any fee) and without payment of a fee to the hospital facility, hospital organization, or other entity maintaining the Web site; and

(C) The hospital facility 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 direct Web site address, or URL, of the web page on which these documents are posted.

(v) *Limited English proficient populations.* For purposes of paragraphs (b)(5)(i)(B) and (b)(5)(iv)(A) of this section, a hospital facility may determine whether any language minority with limited proficiency in English constitutes more than 10 percent of the residents of the community served by the hospital facility based on the latest data available from the U.S. Census Bureau or other similarly reliable data.

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

Example 1. (i) Z is a hospital facility whose FAP states that Z will make its FAP, FAP application form, and a plain language summary of its FAP widely available through its Web site. In accordance with its FAP, 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 a telephone number and room number of Z that individuals can call or visit for more information about the FAP, as well as the name and contact information of a few nonprofit organizations and government agencies that Z has identified as capable and available sources of 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. 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. Z's FAP includes measures to make the FAP widely available on a Web site within the meaning of paragraph (b)(5)(i)(A) of this section.

(ii) Z's FAP also states that Z will 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 its billing office, admissions and registrations areas, and emergency room, and will inform and notify visitors to the hospital facility about the FAP in these same locations using signs and brochures. In accordance with its FAP, Z conspicuously displays a sign in large font regarding the FAP in its billing office, admissions and registrations 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 and room number of Z that individuals can call or visit with questions about the FAP or 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)(19)). Z makes these brochures available in quantities sufficient to meet visitor demand. Z also makes paper copies of its FAP and FAP application form available upon request and without charge in these same locations and by mail. Z's FAP includes measures to widely publicize the FAP within the meaning of paragraphs (b)(5)(i)(B) and (b)(5)(i)(C) of this section.

(iii) In addition, Z's FAP states that Z will inform and notify members of the community served by the hospital facility about the FAP through its quarterly newsletter and by distributing copies of its FAP brochures to physicians and local nonprofit organizations and public agencies that address the health needs of low-income people. In accordance with its FAP, Z distributes copies of the brochure 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 also provides readers with the URL of the Web page where Z's FAP and FAP application form can be accessed and a telephone number and room number of Z that individuals can call or visit with questions about the FAP or the FAP application process. Z's FAP includes measures to widely publicize its FAP within the meaning of paragraph (b)(5)(i)(D) of this section.

(iv) Because Z's FAP includes 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's FAP meets the requirements of this paragraph (b)(5).

Example 2. Assume the same facts as *Example 1,* except that Z serves a community in which 11 percent of the residents speak Spanish and have limited proficiency in English. Z's FAP states that Z will provide all of the information described in *Example 1,* including the FAP itself, in both Spanish and English. In accordance with its FAP, 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 Spanish versions of these documents in its hospital facility and in the Spanish-speaking portions of the community it serves, using all of the measures described in *Example 1.* 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. Z's FAP meets the requirements of this paragraph (b)(5) by including measures to widely publicize the FAP within the community served by Z.

Example 3. Assume the same facts as *Example 1,* except that instead of including generalized summaries of the measures Z will take to widely publicize its FAP in the FAP itself, Z's FAP states that a task force established by Z with control over a set budget will meet at least annually to develop and adopt a plan to widely publicize Z's FAP. The FAP further states that the task force will summarize this plan in a one-page information sheet that will be made available upon request in Z's billing office and posted on the Web page through which Z makes its FAP and FAP application form widely available. In year 1, the task force considers the needs of Z's patients and the surrounding community and adopts and implements a plan to take all of the measures described in *Example 1.* The task force prepares a one-page information sheet summarizing this plan that is made available as described in the FAP. Z's FAP meets the requirements of this paragraph (b)(5) in year 1 by including measures to widely publicize the FAP within the community served by Z.

(6) *Readily obtainable information.* For purposes of this paragraph (b), members of the public may readily obtain information if a hospital facility makes the information available free of charge both on a Web site and in writing upon request in a manner similar to that described in paragraphs (b)(5)(i)(A) and (b)(5)(i)(B) of this section.

(c) *Emergency medical care policy*—(1) *In general.* To satisfy paragraph (a)(2) of this section, a hospital facility must establish a written policy 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 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.

(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 to provide 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 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. 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 states that G prohibits any actions that would discourage individuals from seeking emergency medical care, such as by permitting debt collection activities in any areas of the hospital facility where such activities could interfere with the provision, without discrimination, of emergency medical care. 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 organization has adopted the policy for the hospital facility and the hospital facility has implemented the policy.

(2) *Authorized body.* For purposes of this paragraph (d), an authorized body of a hospital organization means—

(i) The governing body (that is, the board of directors, board of trustees, or equivalent controlling body) of the hospital organization;

(ii) A committee of the governing body, which may be composed of any individuals permitted under state law to serve on such a committee, to the extent that the committee is permitted by state law to act on behalf of the governing body;

(iii) To the extent permitted under state law, other parties authorized by the governing body of the hospital organization to act on its behalf; or

(iv) In the case of a hospital facility (operated by the hospital organization) 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 disregarded entity (or a committee of or other parties authorized by that governing body as described in paragraphs (d)(2)(ii) or (d)(2)(iii) of this section).

(3) *Implementing a policy.* For purposes of this paragraph (d), a

hospital facility has implemented a policy if the hospital facility has consistently carried out the policy.

(4) *Establishing a policy for more than one hospital facility.* Although a hospital organization operating more than one hospital facility must separately establish a FAP and emergency medical care policy for each hospital facility it operates, such policies may contain the same operative terms. However, different AGB percentages and methods of determining AGB and the unique attributes of the communities that different hospital facilities serve may require the hospital facilities to include in their FAPs (or otherwise make available) different information regarding AGB and different measures to widely publicize the FAP in order to meet the requirements of paragraphs (b)(2) and/or (b)(5) 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 if the hospital facility 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, less than the gross charges for such care, as described in paragraph (c) of this section.

(b) *Amounts generally billed.* In order to meet the requirements of paragraph (b)(1) of this section, a hospital facility must determine AGB for emergency or other medically necessary care using a method described in either paragraph (b)(1) or (b)(2) of this section. A hospital facility may use only one of these methods to determine AGB. After choosing a particular method, a hospital facility must continue to use that method.

(1) *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 provided to the individual by one or more percentages of gross charges (AGB percentages). The hospital facility must calculate its AGB percentage(s) at least annually by dividing the sum of all claims for emergency and other medically necessary care described in either paragraph (b)(1)(i)(A) or (b)(1)(i)(B) of this section that have been paid in full to the hospital facility during a prior 12-month period by the sum of the associated gross charges for those claims:

(A) Claims paid by Medicare fee-for-service as the primary payer, including any associated portions of the claims paid by Medicare beneficiaries in the form of co-insurance or deductibles; or

(B) Claims paid by both Medicare fee-for-service and all private health insurers as primary payers, together with any associated portions of these claims paid by Medicare beneficiaries or insured individuals in the form of co-payments, co-insurance, or deductibles.

(ii) *One or multiple AGB percentages.* A hospital facility's AGB percentage that is calculated using the method described in this paragraph (b)(1) 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.

(iii) *Start date for applying AGB percentages.* For purposes of determining AGB under this paragraph (b)(1), with respect to any AGB percentage that a hospital facility has calculated, the hospital facility must begin applying the AGB percentage by the 45th day after the end of the 12-month period the hospital facility used in calculating the AGB percentage.

(2) *Prospective Medicare method.* As an alternative to the method described in paragraph (b)(1) of this section, 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 beneficiary and setting AGB for the care at the amount the hospital facility determines would be the amount Medicare and the Medicare beneficiary together would be expected to pay for the care.

(3) *Examples.* The following examples illustrate this paragraph (b):

Example 1. On January 15 of year 1, Y, a hospital facility, generates data on all claims paid to it in full for emergency or other medically necessary care by all private health insurers and Medicare fee-for-service as primary payers over the immediately preceding calendar year. Y determines that it received a total of $360 million on these claims from the private health insurers and Medicare and another $40 million from their insured patients and Medicare beneficiaries in the form of deductibles, co-insurance, and co-payments. Y's gross charges for these claims totaled $800 million. Y calculates that its AGB percentage is 50 percent of gross charges ($400 million/$800 million × 100). Y determines AGB for any emergency or other medically necessary care it provides to a FAP-eligible individual between February 1 of year 1 (less than 45 days after the end of the 12-month claim period) and January 31 of year 2 by multiplying the gross charges for the care provided to the individual by 50%. Y has determined AGB in accordance with this paragraph (b).

Example 2. On September 20 of year 1, X, a hospital facility, generates data on all claims paid to it in full for emergency or other medically necessary care by Medicare fee-for-service as the primary payer over the 12 months ending on August 31 of year 1. X determines that, of these claims for inpatient services, it received a total of $80 million from Medicare and another $20 million from Medicare beneficiaries in the form of co-insurance or deductibles. X's gross charges for these inpatient claims totaled $250 million. Of the claims for outpatient services, X received a total of $100 million from Medicare and another $25 million from Medicare beneficiaries. X's gross charges for these outpatient claims totaled $200 million. X calculates that its AGB percentage for inpatient services is 40 percent of gross charges ($100 million/$250 million × 100) and its AGB percentage for outpatient services is 62.5 percent of gross charges ($125 million/$200 million × 100). Between October 15 of year 1 (45 days after the end of the 12-month claim period) and October 14 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 in accordance with this paragraph (b).

Example 3. Z is a hospital facility. Whenever Z 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 determines AGB in accordance with this paragraph (b).

(c) *Gross charges.* A hospital facility must charge a FAP-eligible individual less than the gross charges for any medical care provided to that individual. However, a billing statement issued to a FAP-eligible individual for

medical care provided by a hospital facility may state the gross charges for such care as the starting point to which various contractual allowances, discounts, or deductions are applied, as long as the actual amount the individual is expected to pay 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) provided to a FAP-eligible individual if—

(1) The FAP-eligible individual has not submitted a complete FAP application to the hospital facility as of the time of the charge; and

(2) The hospital facility has made and continues to make reasonable efforts to determine whether the individual is FAP-eligible, as described in § 1.501(r)–6(c), during the applicable time periods described in that section (including by correcting the amount charged if the individual is subsequently found to be FAP-eligible).

§ 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 if the hospital facility does not engage in extraordinary collection actions (ECAs), as defined in paragraph (b) of this section, against an individual before the hospital facility has, consistent with paragraph (c) of this section, made reasonable efforts to determine whether the individual is eligible for assistance under its financial assistance policy (FAP). 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 against any other individual who has accepted or is required to accept responsibility for the individual's hospital bills; and

(2) The hospital facility will be deemed to have engaged in an ECA against the individual 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.

(b) *Extraordinary collection actions.* ECAs are 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 or involve selling an individuals' debt to another party or reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus. For purposes of this paragraph (b), actions that require a legal or judicial process include, but are not limited to, actions to—

(1) Place a lien on an individual's property;

(2) Foreclose on an individual's real property;

(3) Attach or seize an individual's bank account or any other personal property;

(4) Commence a civil action against an individual;

(5) Cause an individual's arrest;

(6) Cause an individual to be subject to a writ of body attachment; and

(7) Garnish an individual's wages.

(c) *Reasonable efforts*—(1) *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 only if the hospital facility—

(i) Notifies the individual about its FAP during the notification period (as defined in § 1.501(r)–1(b)(18)), as described in paragraph (c)(2) of this section;

(ii) In the case of an individual who submits an incomplete FAP application during the application period (as defined in § 1.501(r)–1(b)(3)), meets the requirements described in paragraph (c)(3) of this section; and

(iii) In the case of an individual who submits a complete FAP application during the application period, meets the requirements described in paragraph (c)(4) of this section.

(2) *Notification*—(i) *In general.* Except as provided in paragraph (c)(2)(ii) of this section, with respect to any care provided by a hospital facility to an individual, a hospital facility will have notified the individual about its FAP for purposes of paragraph (c)(1)(i) of this section only if the hospital facility—

(A) Distributes a plain language summary of the FAP (as defined in § 1.501(r)–1(b)(19)) and offers a FAP application form to the individual before discharge from the hospital facility;

(B) Includes a plain language summary of the FAP with all (and at least three) billing statements for the care and all other written communications regarding the bill provided to the individual during the notification period;

(C) Informs the individual about the FAP in all oral communications with the individual regarding the amount due for the care that occur during the notification period; and

(D) Provides the individual with at least one written notice that—

(*1*) Informs the individual about the ECAs the hospital facility or other authorized party may take if the individual does not submit a FAP application or pay the amount due by a deadline (specified in the notice) that is no earlier than the last day of the notification period; and

(*2*) Is provided to the individual at least 30 days before the deadline specified in the written notice.

(ii) *Notification when FAP application is submitted.* If an individual submits a complete or incomplete FAP application to a hospital facility during the application period, the hospital facility will be deemed to have notified the individual about its FAP for purposes of paragraph (c)(1)(i) of this section as of the day the application is submitted. However, to have made reasonable efforts to determine whether such an individual is FAP-eligible, the hospital facility must meet the requirements of paragraphs (c)(3) and (c)(4) of this section, as applicable.

(iii) *When no FAP application is submitted.* If an individual fails to submit a FAP application during the notification period (or, if later, by the deadline specified in the written notice described in paragraph (c)(2)(i)(D) of this section) and the hospital facility has notified (and documented that it has notified) the individual as described in paragraph (c)(2)(i) of this section, the hospital facility will have satisfied paragraph (c)(1)(i) of this section. Until and unless the individual subsequently submits a FAP application during the remainder of the application period, paragraphs (c)(1)(ii) and (c)(1)(iii) do not apply. As a result, the hospital facility will have made reasonable efforts to determine whether the individual is FAP-eligible and may engage in one or more ECAs against the individual.

(iv) *Example.* The following example illustrates this paragraph (c)(2):

Example. Individual A receives care from hospital facility T on February 1 and February 2. When A is discharged from T on February 2, T gives A its FAP application form and a plain language summary of its FAP. On March 1, April 15, and May 30, T sends A billing statements that include a one-page insert that provides a plain language summary of the FAP. With the May 30 billing statement, T also includes a letter that informs A that if she does not pay the amount owed or submit a FAP application form by June 29 (120 days after the first billing statement was provided on March 1), T may report A's delinquency to credit reporting agencies, seek to obtain a judgment against A, and, if such a judgment is obtained, seek to attach and seize A's bank account or other personal property, which

are the only ECAs that T (or any party to which T refers A's debt) may take in accordance with T's billing and collections policy. T does not have any other written or oral communications with A about her bill before June 29. T keeps electronic records showing that it provided a plain language summary and FAP application to A on discharge and included the letter regarding ECAs and the plain language summaries with the billing statements sent to A. A does not submit a FAP application form by June 29. T has made reasonable efforts to determine whether A is FAP-eligible, and thus may engage in ECAs against A, as of June 30.

(3) *Incomplete FAP applications*—(i) *In general.* With respect to any care provided by a hospital facility to an individual, if the individual submits an incomplete FAP application during the application period, the hospital facility will have made reasonable efforts to determine whether the individual is FAP-eligible only if the hospital facility—

(A) Suspends any ECAs against the individual as described in paragraph (c)(5) of this section;

(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 the individual must submit to the hospital facility to complete his or her FAP application and includes a plain language summary of the FAP with this notice; and

(C) Provides the individual with at least one written notice that—

(*1*) Informs the individual about the ECAs the hospital facility or other authorized party may initiate or resume if the individual does not complete the FAP application or pay the amount due by a completion deadline (specified in the notice) that is no earlier than the later of the last day of the application period or 30 days after the hospital facility provides the individual with the written notice; and

(*2*) Is provided to the individual at least 30 days before the completion deadline.

(ii) *FAP application completed by the completion deadline.* If an individual who has submitted an incomplete FAP application during the application period completes the FAP application by the completion deadline, the individual will be considered to have submitted a complete FAP application during the application period, and the hospital facility will therefore only have made reasonable efforts to determine whether the individual is FAP-eligible if it meets the requirements for complete FAP applications described in paragraph (c)(4) of this section.

(iii) *FAP application not completed by the completion deadline.* If an individual who submits an incomplete FAP application to a hospital facility during the application period fails to complete the FAP application by the completion deadline and the hospital facility has met the requirements described in paragraph (c)(3)(i) of this section, the hospital facility will have made reasonable efforts to determine whether the individual is FAP-eligible and may initiate or resume ECAs against the individual after the completion deadline.

(iv) *Examples.* The following examples illustrate this paragraph (c)(3):

Example 1. (i) Assume the same facts as the example in paragraph (c)(2)(iv) of this section and the following additional facts: A submits an incomplete FAP application to T on October 13, two weeks before the last day of the application period on October 27 (240 days after the first billing statement was provided on March 1). 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 certain documentation verifying family income to their application forms. The FAP application form that A submits to T on October 13 includes all of the required income information, but A fails to attach the required documentation verifying her family income. After receiving A's incomplete FAP application on October 13, T does not initiate any new ECAs against A and does not take any further action on the ECAs T previously initiated against A. On October 15, 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 explain what kind of documentation A needs to submit and how she can submit it. On October 16, T sends a letter to A explaining the kind of documentation of family income that A must provide to T to complete her application and informing A about the ECAs that T (or any other authorized party) may initiate or resume against A if A does not submit the missing documentation or pay the amount due by November 15 (30 days after October 16). T includes a plain language summary of the FAP with the letter. T has met the requirements of this paragraph (c)(3).

(ii) On November 15, A provides T with the missing documentation. Because A provides the missing documentation by the completion deadline, she has submitted a complete FAP application during the application period. As a result, to have made reasonable efforts to determine whether A is FAP-eligible, T must assess the documentation to determine whether A is FAP-eligible and otherwise meet the requirements for complete FAP applications described in paragraph (c)(4) of this section.

Example 2. Individual B receives care from hospital facility U 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. Upon discharge, U's staff gives B a plain language summary of the FAP and a copy of its FAP application form. On January 20, B submits a FAP application form to U indicating that he has household income of less than $y. The FAP application form includes all of the required income information, but B fails to attach the required documentation verifying household income. On February 1, U sends B the first billing statement for the care and includes with the statement another plain language summary of the FAP. U also includes with the billing statement 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 (also described in the instructions to U's FAP application form) that B needs to provide to complete his FAP application. By August 30, B has not provided the missing documentation. U sends B a written notice on August 30 informing him about the ECAs U (or any other authorized party) may initiate against B if B does not submit the missing documentation or pay the amount due by September 29 (240 days after the first billing statement was provided on February 1 and the last day of the application period). B fails to provide the missing documentation by September 29. U has made reasonable efforts to determine whether B is FAP-eligible, and thus many engage in ECAs against B, as of September 30.

(4) *Complete FAP applications*—(i) *In general.* With respect to any care provided by a hospital facility to an individual, if the 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 only if the hospital facility does the following in a timely manner—

(A) Suspends any ECAs against the individual as described in paragraph (c)(5) of this section;

(B) Makes and documents a determination as to whether the individual is FAP-eligible;

(C) Notifies the individual in writing of the eligibility determination (including, if applicable, the assistance for which the individual is eligible) and the basis for this determination;

(D) If the hospital facility determines the individual is FAP-eligible, does the following—

(*1*) Provides 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;

(*2*) If the individual has made payments to the hospital facility (or any other party) for the care in excess of the amount he or she is determined to owe as a FAP-eligible individual, refunds those excess payments; and

(*3*) Takes all reasonably available measures to reverse any ECA (with the exception of a sale of debt) taken against the individual to collect the debt at issue; such reasonably available measures generally include, but are not limited to, measures to vacate any judgment against the individual, lift any lien or levy 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) *Determination based on complete FAP applications.* If a hospital facility has met the requirements described in paragraph (c)(4)(i) of this section and not violated the anti-abuse rule described in paragraph (c)(4)(iii) of this section, the hospital facility has made reasonable efforts to determine whether the individual is FAP-eligible and may initiate or resume ECAs against the individual. To have made reasonable efforts to determine the FAP-eligibility of an individual who has submitted a complete FAP application during the application period, the hospital facility must meet the requirements described in this paragraph (c)(4) regardless of whether the hospital facility has previously made such reasonable efforts under paragraphs (c)(2)(iii) or (c)(3)(iii) of this section.

(iii) *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)(4)(iii), a coercive practice includes delaying or denying emergency medical care to an individual until the individual has provided the requested information.

(iv) *Presumptive eligibility permitted.* A hospital facility will have made reasonable efforts to determine whether an individual is FAP-eligible if the hospital facility determines that the individual is eligible for the most generous assistance (including free care) available under the FAP based on information other than that provided by the individual as part of a complete FAP application and the hospital facility meets the requirements described in paragraph (c)(4)(i) of this section.

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

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 90 percent off of gross charges up to a maximum amount due of $1,000. On March 3, D, an individual, receives care from V, the gross charges for which are $500. 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 determines that D is eligible under V's FAP to receive the most generous assistance under the FAP, resulting in D owing $50 (90 percent off of the $500 in gross charges) for the March 3 care. V documents this determination, and, on March 21, sends D a billing statement that informs him that V determined he was eligible for the 90% discount based on his eligibility for the benefits under the state program and the fact that his bill, after the discount, was not more than $1,000. This billing statement indicates an amount owed of $50, shows that V arrived at $50 by applying a 90 percent discount to the gross charges for the care, and provides a telephone number D can call to obtain the AGB for the care he received. V has made reasonable efforts to determine whether D is FAP-eligible as of March 21.

Example 2. Individual C receives care from hospital facility W 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 a FAP application form and informs C that if she needs assistance in filling out the 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 $y. On October 1, W sends C her first billing statement for the care she received on September 1. With the billing statement, W includes a letter informing C that she is not eligible for financial assistance because her FAP application indicates that she has family income in excess of x% of FPL ($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 3. E, an individual, receives care from P, a hospital facility, in February. P provides E with the first billing statement for the care on March 1. P notifies E about its FAP as described in paragraph (c)(2)(i) of this section, but E fails to submit a FAP application by P's specified deadline of June 30 (120 days after the initial March 1 billing statement and the last day of the notification period). In September, P seeks and obtains a judgment against E, in which the court determines that E owes P $1,200 for the care P provided and states that E has 30 days to pay this amount. E does not pay any of the $1,200 in 30 days. By October 20, P has seized E's bank account and obtained a total of $450 in funds from the account. E submits a complete FAP application to P on October 20, before the last day of the application period on October 27 (240 days after the initial March 1 billing statement). Upon receiving this application, P does not seize any additional funds from E's bank account and also does not initiate any additional ECAs against E. P promptly examines the application and determines that E is eligible under P's FAP to receive a discount that results in E only owing $150 for the care she received. P also determines that the AGB for the care is $500. P documents this determination, seeks to vacate the judgment against E, lifts the levy on E's bank account, and sends E a letter that informs her about the FAP discount for which she is eligible and explains the basis for this eligibility determination. P includes with this letter a check for $300 (the $450 that P seized from E's bank account minus the $150 that E owes as a FAP-eligible individual) and a billing statement that indicates a $300 refund, shows how P applied the FAP discount for which E is eligible to arrive at an amount owed of $150, and states that the AGB for the care is $500. P has made reasonable efforts to determine whether E is FAP-eligible.

Example 4. 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), as based on their prior year's federal tax return. Individual L 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)(4)(iii) of this section. Thus, R has not made reasonable efforts to determine whether L is FAP-eligible.

(5) *Suspending ECAs while a FAP application is pending.* If an individual submits a complete or incomplete FAP application during the application period, the hospital facility will have made reasonable efforts to determine whether the individual is FAP-eligible only if the hospital facility does not initiate any ECAs, or take further action on any previously-initiated ECAs, against the individual after receiving the application and until either—

(i) The hospital facility has met the requirements described in paragraph (c)(4) of this section; or

(ii) In the case of an incomplete FAP application, the completion deadline has passed without the individual having completed the FAP application.

(6) *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)(2) or (c)(3) of this section, will not constitute a determination of FAP-eligibility 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.

(7) *Agreements with other parties.* 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 (and, to the extent applicable, enforces) a legally binding written agreement from the party that—

(i) In the case of any debt referred to the party during the notification period, the party will refrain from engaging in ECAs against the individual until the hospital facility has met (and documented that it has met) the requirements necessary to have made reasonable efforts under paragraph (c)(2)(iii), (c)(3)(iii), or (c)(4)(ii) of this section;

(ii) If the individual submits a FAP application during the application period, the party will suspend any ECAs against the individual as described in paragraph (c)(5) of this section;

(iii) If the individual submits a FAP application during the application period and the hospital facility determines the individual to be FAP-eligible, 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 as a FAP-eligible individual; and

(B) If applicable and if the party (rather than the hospital facility) has the authority to do so, takes all reasonably available measures to reverse any ECA (other than the sale of a debt) taken against the individual as described in paragraph (c)(4)(i)(D)(*3*) of this section; and

(iv) 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)(7).

(8) *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, as long as the required information is conspicuously placed and of sufficient size to be clearly readable.

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

(a) *Statutory effective/applicability date*—(1) *In general.* Except as provided in paragraph (a)(2) of this section, section 501(r) applies to taxable years beginning after March 23, 2010.

(2) *Community health needs assessment.* The requirements of section 501(r)(3) apply to taxable years beginning after March 23, 2012.

(b) *Effective/applicability date of regulations.* The rules of § 1.501(r)–1 and §§ 1.501(r)–4 through 1.501(r)–6 apply to taxable years beginning on or after the date these regulations are published as final regulations in the **Federal Register**.

Sarah Hall Ingram,

Acting Deputy Commissioner for Services and Enforcement.

[FR Doc. 2012–15537 Filed 6–22–12; 11:15 am]

BILLING CODE 4830–01–P