TransUnion

The TransUnion Healthcare 501(r) toolkit

Use these tools to prepare for 501(r) regulations

501(r) regulations will soon take effect for not-for-profit hospitals nationwide. Are you ready? These complex IRS rules outline how providers ensure access, provide charity assistance and properly collect uncompensated care. The rules can affect your revenue cycle, financial assistance and collections, as well as your Form 990 and tax exemption status.

What's inside:

501(r) charity checklist.
Evaluate your organization's readiness for 501(r) regulations by checking against this list of essential items

High-balance and self-pay financial clearance workflow.
Determine a patient's financial position so that those who need assistance receive it, and those who can afford to pay, do.

Sample financial assistance and patient payment responsibility policy.
This starter document is a good place to start crafting policies to addresses charity care and financial assistance policies.

501(r) charity checklist

Use this checklist to check your organization's readiness for charity and 501(r) requirements. Ensuring the items on this list are complete will help your organization meet compliance and patient charity requirements. Note: Use this checklist as a program guide only; we encourage you to consult with your legal and risk departments to ensure compliance. This guide is not intended as legal advice.

501(r) requirements:

- ❑ FAP (financial assistance policy) language clearly defines non-covered and discounted services
- ❑ FAP specifies amounts charged to patients and how discounts are applied
- ❑ FAP describes the methods in which patients can apply for financial assistance
- ❑ FAP outlines the collections process and actions taken for nonpayment
- ❑ FAP outlines the method, and lists the discount applied, under the AGB provision for the charges ceiling
- ❑ Process for EAC suppression for non-screened patients
- ❑ Procedure for incomplete, not received or in-process financial assistance applications
- ❑ Describes method of how FAP is "widely publicized"
- ❑ ECTP is outlined in FAP and "conspicuous" signage is in place
- ❑ CHNA defines community served and how that community was identified
- ❑ CHNA assesses needs of community and outlines methods used
- ❑ CHNA has a prioritized list of community health needs and criteria used
- ❑ CHNA defines potential resources and measures utilized to meet community needs
- ❑ CHNA is "widely available" to the community

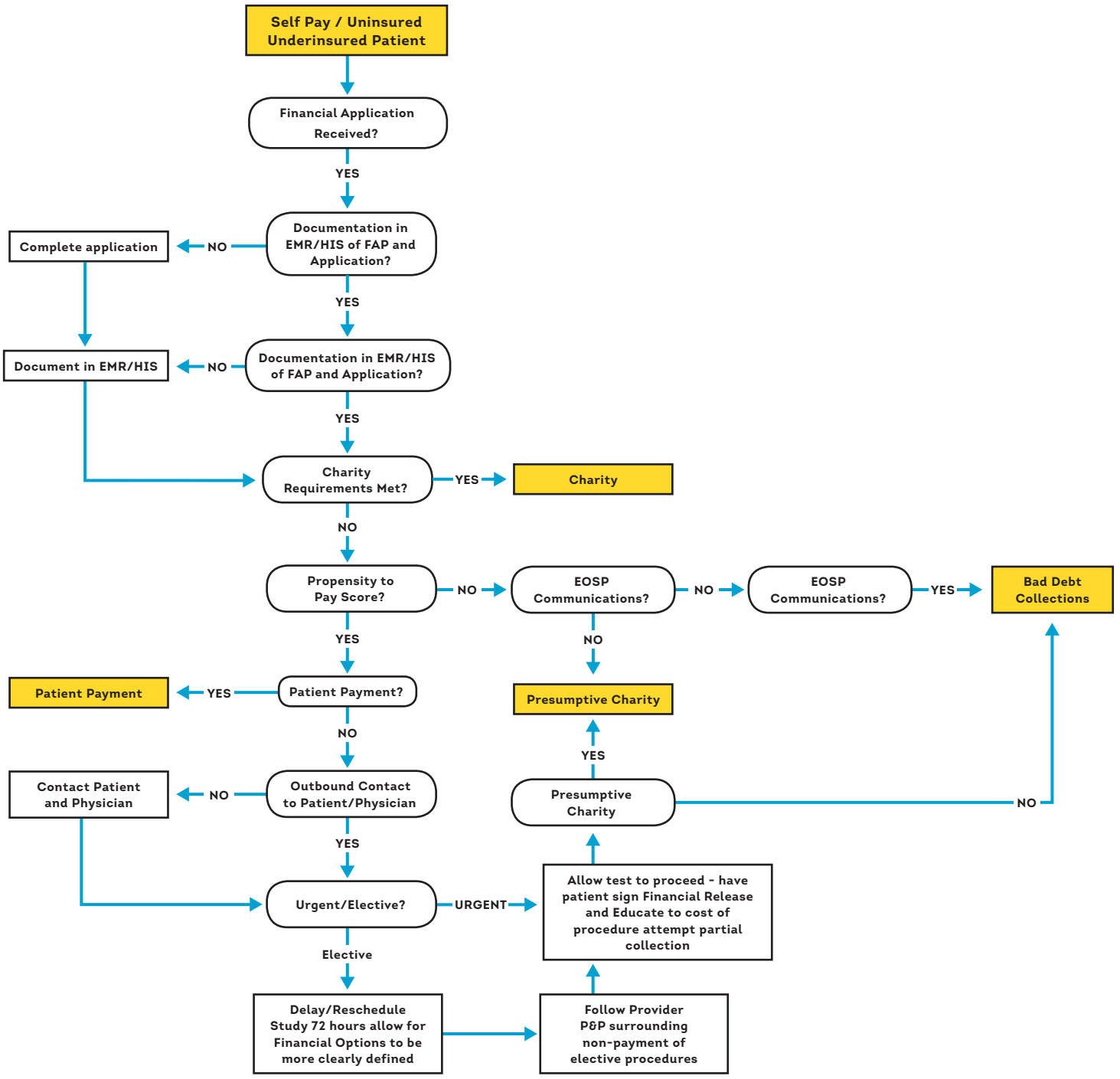
501(r) requirements continued:

- ❑ CHNA reflects collaboration and input from a health department's community resources at the local, state or regional level
- ❑ CHNA describes how the broad interests of the community were represented
- ❑ CHNA reflects input received from underserved, low-income and minority populations in the community
- ❑ CHNA outlines how the hospital's implementation strategy intends to meet community needs AND clearly defines which community needs it does NOT intend to meet
- ❑ CHNA outlines the hospital's implementation strategy's anticipated impact and plan to evaluate impacts
- ❑ FAP policies reviewed annually
- ❑ Debt collection policy reviewed annually
- ❑ Website's charity assistance information is prominent
- ❑ Charity signage in place at all waiting/intake areas
- ❑ Statement language for charity assistance is in place
- ❑ Financial waiver/HIPAA/HITECH opt-out form is in place
- ❑ Financial counselors (or CAS) educated to new rules
- ❑ Documentation of FAP in EMR/HIS/Other (each patient)
- ❑ EOSP/TPCA education and P and Ps updated
- ❑ AGB/LNR calculated annually and staff can apply the discount
- ❑ Documentation that AGB/LNR was applied for qualified patients

High-balance and self-pay financial clearance workflow

Patients should pay within their abilities. Using the workflow and standard work below can help you determine a patient's financial position, ensuring that folks who need financial assistance and charity care receive it, and those who can afford to pay their bills, do. At the very least, you place people into the appropriate collections workflow to maximize your collection efforts.

High-balance patient account workflow



Sample financial assistance and patient payment responsibility policy

*(**Note**: This sample document is an example for educational and illustrative purposes only. It is not a policy representing or warranting compliance with local, state or federal laws. Consult with hospital legal counsel and risk management departments for a thorough review of the rules and regulations as they relate to the policy provisions under their specific facilities related to financial assistance.)*

PURPOSE

As a tax-exempt, nonprofit organization, [Hospital Name] serves the healthcare needs of its community and is committed to providing charity care to persons who have healthcare needs. Consistent with its mission to deliver compassionate, high-quality, affordable healthcare services, and to advocate for those who are poor and underserved, [Hospital Name] strives to ensure that the ability to pay for healthcare is not a barrier for needed healthcare services and does not prevent them from seeking or receiving care. [Hospital Name] will provide care, without discrimination, for emergency medical conditions regardless of people's ability to pay. This policy will be made readily available to prospective and current patients and to the community at large.

DEFINITIONS

Charity care: Healthcare services that have been or will be provided but are never expected to result in cash inflows. Charity care results from a provider's policy to provide healthcare services free or at a discount to individuals who meet the established criteria.

Family: A group of two or more people who reside together and who are related by birth, marriage or adoption. Patient has claimed someone as a dependent on their income tax return; they may be considered a dependent for purposes of the provision of financial assistance.

Family income: Determined through computing federal poverty guidelines. It includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Non-cash benefits (such as food stamps and housing subsidies) are excluded.

Uninsured: The patient has no insurance, third-party assistance or funding mechanism to fund their payment obligations.

Underinsured: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed their financial abilities. This is defined as out-of-pocket costs, excluding premiums, over the prior 12 months that are equal to 10% or more of household income; or out-of-pocket costs, excluding premiums, that are equal to 5% or more of household income if income is under 200% of the federal poverty level; or an unmet deductible that is 5% or more of household income.

Gross/billed charges: The total charges at the organization's full established rates for the provision of patient care services, exclusive of any net deductions in revenue or discounting.

Emergency medical conditions: Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Medically necessary: As defined by Medicare (services or items reasonable and necessary for the diagnosis or treatment of illness or injury).

SCOPE

Patients who are eligible for financial assistance–free or discounted (partial charity) care–under this program are any [Hospital Name] patients with services on an inpatient or outpatient account, who are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care based on their individual financial situation. Financial assistance under this policy is available to residents of the hospital's service area (Addendum A). There are no geographical restrictions on services to Medicaid beneficiaries; however, there are enrollment caps to Medicaid beneficiaries as indicated in this policy. This policy [OPTION: [ ] DOES; [ ] DOES NOT] apply to the hospital's owned and operated clinics.

"Charity" or "financial assistance" refers to healthcare services provided by [Hospital Name] without charge or at a discount to qualifying patients. The following healthcare services are eligible for discounting under this policy:

1. Emergency medical services provided in an emergency room setting
2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual, as defined by a physician
3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting, as defined by a physician

This policy serves the purposes as outlined under IRS Section 501(r) as enacted in 2016.

EXCLUDED SERVICES

1. Cosmetic procedures and all associated costs related to provision of these services.
2. Audiology supplies, including hearing aids, hearing aid accessories and battery packs.
3. Lab kit draw fees, venipuncture fees and outpatient TB skin tests are excluded if not performed in conjunction with other [Hospital Name] laboratory services.
4. Procedures that are already discounted to prevailing market rates (UCR), including but not limited to self-pay fee schedules for imaging and lab services, self-referred screening studies, and any other procedures deemed at [Hospital Name]'s discretion to be determined as "discounted."
5. Physician services provided by [Hospital Name].
6. All pediatric, adult physical rehabilitation services, and all behavioral health services except those where the patient is directly admitted through the emergency room or is a direct EMTALA (Emergency Medical Treatment and Active Labor Act) transfer.
7. High-cost implantable devices and chemotherapy drugs: [Hospital Name] will make every attempt to have high-cost devices and chemotherapy drugs provided at no cost by the vendors for patients eligible for charity discounting. In the event the high-cost implantable or pharmaceutical cannot be donated, [Hospital Name] will discount these items down to the purchase price (hospital cost), and the patient will be financially responsible for this component of their care.
8. Services not covered or deemed medically necessary by the Medicare/Medicaid programs.
9. [OPTION: LIST SPECIFICALLY ALL NON-COVERED SERVICES]

APPLICATION

Patients may apply or reapply for financial assistance before, during or after care, or after collection agency assignment if their situation changes, by contacting a financial counselor at [XXX-XXX-XXXX] to make an appointment. Their office is on [STREET, CITY, STATE, and ZIP]. Financial assistance is also available in person through direct request at any of our facilities. Additional financial assistance information can be obtained through our website at www.[hospitalwebsite].org

Insured patients with Medicare and/or commercial insurance may apply for financial assistance as a mechanism for secondary funding. Eligibility and discounting will be applicable under the provisions of this policy. Prompt-pay discounts are also available according to the guidelines within this policy. Payment plans may also be requested and may be granted according to this policy on a case-by-case basis.

It is preferred, but not required, that a request for charity and a determination of financial need occur prior to rendering of non-emergent medically necessary services. However, the determination may be done at any point in the collection cycle. The need for financial assistance shall be reevaluated at each subsequent time of services if the last financial evaluation was completed more than one year prior, or at any time additional information relevant to the eligibility of the patient for charity becomes known.

PROCEDURE

All patients will be expected to pay for hospital services on the day they receive services. Patients with health insurance coverage will be expected to pay deductible balances, estimated coinsurance, and/or any copays due the day they receive services. Deductible and copays are required in accordance with laws and regulations governing the programs and/or benefit plan. Patients without insurance will be expected to pay a discounted rate within their ability to pay and apply for financial assistance as required.

Exceptions for pre-payment:

- Emergency or obstetric services, as defined by EMTALA
- Approved payment plan contract in effect with hospital
- Medically urgent or emergent services as determined by a physician
- Participants in clinical trials or grant programs
- [OPTION: OTHER HOSPITAL-DEFINED SERVICES]

In processing charity applications and determining eligibility, reasonable efforts by [Hospital Name] will review all of the patient's outstanding account receivables for prior services rendered and the patient's payment history, and take into account the patient's available assets, and all other financial resources available to the patient. [Hospital Name] will explore appropriate alternative sources of payment and coverage from public and private payment programs, and agrees to assist patients to apply for such programs. [Hospital Name] may use external publically available data sources that provide information on a patient's or a patient's guarantor's ability to pay (such as credit or community "non-credit" scoring). [Hospital Name] may elect, for certain services, to limit the number of enrollees under Medicaid. This is including but not limited to physician clinics and rehabilitation [OPTION: LIST OTHER SERVICES FOR MEDICAID CAPS AS APPLICABLE].

Financial assistance and charity is not a replacement for financial responsibility. Patients are expected to fully cooperate with [Hospital Name]'s financial assistance application process and procedures for obtaining charity or other forms of payment or financial assistance, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so to ensure access to healthcare services, personal health and for the insulation of their individual assets.

PRESUMPTIVE ELIGIBILITY

In the event [Hospital Name] lacks evidence to support a patient's eligibility for charity care, [Hospital Name] will use outside agencies and/or data sources in determining estimated income amounts for the basis of determining charity care eligibility and potential discount amounts. Patients without health insurance or other verified funding sources, who meet any of the following criteria, can be granted eligibility presumptively by [Hospital Name]:

- Verified resident address of the [Shelter/Homeless/Other Name], without a signed financial assistance application on file
- Presence of a financial assistance application on file
- Verified "homeless" or "transient" status, without a signed financial assistance application on file
- For medically urgent or emergent services, that are verified with current eligibility in a Medicaid or other public assistance program in a state other than [Hospital State], of which [Hospital Name] is not an enrolled provider
- Account is identified in official bankruptcy notice
- Accounts in which the patient is deceased and there are no estate assets
- Undocumented patients as applicable under Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens

PROCEDURAL GUIDELINES FOR DISCOUNTED SERVICES

Services eligible under this policy will be discounted to the patient on a sliding scale, in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of the determination. This discount will be applied to individuals eligible for financial assistance who have completed a [Hospital Name] financial assistance application and provided all necessary documentation for qualification required for the financial assistance program. The basis for the amounts [Hospital Name] will charge patients qualifying for financial assistance are as follows:

- Patients whose family income is at or below [XXX]% of the FPL are presumptively eligible to receive a 100% discount off of billed charges
- Patients whose family income is above [XXX]% but not more than [YYY]% of the FPL are eligible to receive services at amounts no greater than the amounts generally billed
- Patients whose family income exceeds [YYY]% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of [Hospital Name]; however, the discounted rates shall not be greater than the amounts generally billed to (received by the hospital for) commercially insured [or Medicare] patients

Any patient eligible for discounting will be required to pay their copay or percentage due upon determination of their eligibility, or they must sign an approved payment plan contract. Discounts will be applied to any and all outstanding hospital bills of a patient determined to be currently eligible for any charity or public assistance program that [Hospital Name] participates in, including Medicaid.

Discounted charges will not exceed the lowest average commercial and/or Medicare payer reimbursement rate, whichever is lower. [Hospital Name] will limit the amounts that the hospital will collect for emergency or other medically necessary care provided to individuals eligible for financial assistance to amounts generally billed (received by) the hospital for commercially insured and Medicare patients. This amount generally billed will be calculated not less than annually within three (3) months of the fiscal year.

PROMPT-PAY DISCOUNTING

Patients without health insurance or those who choose not to elect insurance billing, who do not qualify for charity discounting, and who pay in full prior to receiving services will be eligible for a [XX%] prompt-pay discount. For medically urgent or emergency admissions where it is not practical to collect payment in advance of receiving services, the [XX%] prompt payment discount will be accepted for 72 hours following discharge. If actual billed charges exceed the estimated amount paid at the time of service, a [XX%] prompt-pay discount will be applied to the total charge amount. When actual charges exceed the amount originally estimated by the hospital, an effort will be made on a case-by-case basis to adjust the charges if requested by the patient. Charity discount and a prompt-pay discount cannot be combined together, nor combined with any other discount offered by the hospital or its affiliates. Discounting is not available for the "EXCLUDED SERVICES" listed under this policy.

COLLECTION PRACTICES

[Hospital Name]'s debt collection policies are available upon request. [Hospital Name] reserves the right to take certain actions in the event of nonpayment or non-participation in the financial assistance application process, including, but not limited to, collections action and reporting to credit agencies. For patients who have submitted a financial assistance application, provided all requested documentation, and are cooperating in good faith to resolve their hospital bills, [Hospital Name] will cease extraordinary collection practices for a period of 180 days from discharge. [Hospital Name] will ensure extraordinary collections actions such as wage garnishments, liens or other legal actions do not occur without documented reasonable efforts to provide notice and to determine whether that patient is eligible for charity care under this financial assistance policy.