Comparison of California and IRS Requirements Regarding Financial Assistance Policies

Below is a side-by-side comparison of existing California law and the similar laws and final regulations under Section 501(r) of the IRC.

(1) WHAT TYPE OF POLICY IS REQUIRED UNDER EACH LAW?

CALIFORNIA	*IRS*
Each hospital must maintain an understandable written policy regarding discount payments for financially qualified patients, as well as an understandable written charity care policy. Health and Safety Code Section 127405(a)(1)	Under IRC Section 501(r)(4), a hospital facility must establish a written financial assistance policy (FAP) and a written emergency medical care policy. Section 1.501(r)-4(a) of the Final Regulations, published Dec. 31, 2014 [79 Fed. Reg. 78954 (Dec. 31, 2014)]. The Final Regulations are part of Title 26 of the Code of Federal Regulations.

(2) WHICH HOSPITALS ARE COVERED BY EACH LAW?

CALIFORNIA	*IRS*
Each hospital licensed under Health and Safety Code Section 1250 (a), (b), and (f). This includes each hospital licensed as a general acute care hospital, acute psychiatric hospital or special hospital. Exempt hospitals include those operated by the California Departments of Corrections and Rehabilitation and State Hospitals. Rural hospitals, as defined in Health and Safety Code Section 124840, may have less generous patient eligibility requirements (as discussed below). Even if separately licensed hospitals are owned by one entity, each separately licensed hospital must comply individually with the requirements.	A facility that is owned by an organization that is tax-exempt under Section 501(c)(3) and is required by a state to be licensed, registered, or similarly recognized as a hospital must comply with the requirements. Section 1.501(r)-1(b)(18) of the Final Regulations Even if separately licensed hospitals are owned by one entity, each separately licensed hospital must comply individually with the requirements.

(3) WHAT TYPE OF CARE MUST BE COVERED BY THE HOSPITAL'S POLICY?

CALIFORNIA	IRS
Not specifically addressed. Probably applies to all hospital services.	The FAP must apply to all emergency and other medically necessary care provided by the hospital. Section 1.501(r)-4(b) of the Final Regulations

(4) WHAT MUST BE INCLUDED IN THE HOSPITAL'S POLICY?

CALIFORNIA	IRS
A hospital's discount payment policy must clearly state eligibility criteria based upon income consistent with the application of the federal poverty level. The discount payment policy must also include an extended payment plan to allow payment of the discounted price over time. The policy must provide that the hospital and the patient will negotiate the terms of the payment plan. If they cannot agree, a default payment plan applies. Health and Safety Code Section 127405(b) The charity care policy must state clearly the eligibility criteria for charity care. Assets, if considered, may not include retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans. The first ten thousand dollars ($10,000) of a patient's monetary assets and 50 percent of a patient's monetary assets over the first ten thousand dollars ($10,000) may not be counted in determining eligibility. Health and Safety Code Section 127405(c) The written policy regarding discount payments must include a statement that an emergency physician, as defined in Health and Safety Code Section 127450, who provides emergency medical services in a hospital is required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level. Health and Safety Code Section 127405(a)(1)(B)	The FAP must include: • The eligibility criteria for financial assistance and whether this assistance includes free or discounted care; • The basis for calculating amounts charged to patients; • The method for applying for financial assistance; • In the case of a hospital facility that does not have a separate billing and collections policy, the actions that may be taken related to obtaining payment, including, but not limited to, any extraordinary collection actions (ECAs); the process and time frames for these actions, including the "reasonable efforts" the hospital will make to determine whether an individual is FAP-eligible before engaging in ECAs; and the office, department, committee or other body with the final authority or responsibility for determining that the hospital has made reasonable efforts to determine whether an individual is FAP-eligible and may, therefore, engage in ECAs. (**"Reasonable efforts"** are defined in the Final Regulations — the requirements and time frames are very detailed; *see chapter 8 of the* California Hospital Compliance Manual *for further information.)* The hospital may include this information in a separate billing and collections policy. In this case, the FAP must state that the actions the hospital may take in the event of nonpayment are described in a separate billing and collections policy, and explain how to obtain a free copy of that policy; • If applicable, information the hospital uses to determine eligibility other than information from the individual seeking financial assistance, and the circumstances under which it uses prior eligibility determinations to determine presumptive eligibility; and • A list of any providers, other than the hospital itself, delivering emergency or other medically necessary care in the hospital that specifies which providers are covered by the FAP and which providers are not covered. Section 1.501(r)-4(b)(1) of the Final Regulations *(continued on next page)*

(4) WHAT MUST BE INCLUDED IN THE HOSPITAL'S POLICY? (CONTINUED)

CALIFORNIA	IRS
	In addition, the FAP must: • 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; • Specify all of the eligibility criteria that an individual must satisfy to receive each discount, free care, or other level of assistance; • 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 (AGB) to individuals who have insurance covering such care; • Describe the methodology the hospital facility uses to determine AGB; and • If the hospital facility uses the look-back method 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. Section 1.501(r)-4(b)(2)(i) of the Final Regulations

(5) ARE THERE SPECIFIC REQUIREMENTS REGARDING ELIGIBILITY FOR CHARITY CARE AND DISCOUNT CARE?

CALIFORNIA	IRS
Yes. Uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level must be eligible to apply for participation under a hospital's charity care policy or discount payment policy. Health and Safety Code Section 127405(a)(1)(A) Rural hospitals may establish eligibility levels for financial assistance and charity care at less than 350 percent of the federal poverty level, as appropriate to maintain their financial and operational integrity. Health and Safety Code Section 127405(a)(2) For purposes of determining eligibility for discounted payment, documentation of income is limited to recent pay stubs or income tax returns and documentation of assets may include information on all monetary assets, but may not include statements on retirement or deferred compensation plans. Health and Safety Code Section 127405(e)(1)-(2)	No. The Regulations allow hospitals to develop appropriate eligibility criteria. The IRS specifically indicated that neither the statute nor the regulations establish specific eligibility criteria that a FAP must contain. [79 Fed. Reg. at 78972] In examples of appropriate eligibility criteria, the IRS indicated that eligibility based on family income could be appropriate. Section 1.501(r)-4(b)(2)(ii) of the Final Regulations

(6) WHAT ARE THE REQUIREMENTS AND RESTRICTIONS RELATED TO BILLING AND COLLECTIONS ACTIVITY?

CALIFORNIA	*IRS*
Each hospital must make all reasonable efforts to obtain from the patient (or his or her representative) information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered by the hospital to a patient, including: • Private health insurance, including coverage offered through the California Health Benefit Exchange (Covered California). • Medicare. • Medi-Cal, the Healthy Families program, the California Children's Services program, or other state-funded programs designed to provide health coverage. Health and Safety Code Section 127420(a) If a hospital bills a patient who has not provided proof of third party coverage, as a part of that billing, the hospital must provide the patient with a clear and conspicuous notice that includes all of the following: • A statement of charges for services rendered by the hospital. • A request that the patient inform the hospital if the patient has health insurance coverage, Medicare, Healthy Families, Medi-Cal, or other coverage. • A statement that if the consumer does not have health insurance coverage, the consumer may be eligible for Medicare, Healthy Families, Medi-Cal, California Children's Services Program, Covered California, other state- or county-funded programs, or charity care. • A statement indicating how patients may obtain applications for the Medi-Cal and Healthy Families programs, Covered California, or other state- or county-funded programs, and that the hospital will provide these applications. The hospital must also provide patients with a referral to a local consumer assistance center housed at legal services offices. If the patient does not indicate third-party payer coverage, or requests a discounted price or charity care, the hospital must provide an application for Medi-Cal, Healthy Families, or other state- or county-funded health coverage programs to the patient. This application must be provided prior to discharge if the patient has been admitted, and to patients receiving emergency or outpatient care. *(continued on next page)*	In general, hospitals must make "reasonable efforts," as described in the law, to determine whether an individual is eligible under a hospital's FAP before engaging in extraordinary collection actions (ECAs), either directly or indirectly through any purchaser of debt, collection agency or other party to which the hospital facility has referred the individual debt. The Regulations contain very detailed requirements and time frames regarding what constitutes "reasonable efforts." *(See chapter 8 of the* California Hospital Compliance Manual *for details.)* Section 1.501(r)-6(a) of the Final Regulations. ECAs include actions relating to seeking payment for care covered by the hospital's FAP that involve: • Selling an individual's debt to another party (however, exceptions may apply; *see chapter 8 of the* California Hospital Compliance Manual *for details)*; • Reporting adverse information about the individual to consumer credit reporting agencies; • Placing a lien on an individual's property. However, a lien that a hospital is entitled to assert under state law on the proceeds of a judgment, settlement, or compromise owed to an individual as a result of personal injuries for which the hospital provided care is not an ECA; • Foreclosing on real property; • Attaching or seizing an individual's bank account or other personal property; • Commencing a civil action against an individual; • Causing an individual's arrest or writ of body attachment; • Garnishing an individual's wages; • Deferring or denying medically necessary care because of non-payment of a bill for previously provided care covered under the hospital's FAP; • Requiring a payment before providing medically necessary care because of outstanding bills for previously provided care. Section 1.501(r)-6(b)(1)-(7) of the Final Regulations.

(6) WHAT ARE THE REQUIREMENTS AND RESTRICTIONS RELATED TO BILLING AND COLLECTIONS ACTIVITY? (CONTINUED)

CALIFORNIA	IRS
• Information regarding the financially qualified patient and charity care application, including the following: – A statement that indicates that if the patient lacks, or has inadequate, insurance, and meets certain low- and moderate-income requirements, the patient may qualify for discounted payment or charity care. – The name and telephone number of a hospital employee or office from whom or which the patient may obtain information about the hospital's discount payment and charity care policies, and how to apply for that assistance. Health and Safety Code Section 127420(b) Each hospital must have a written policy regarding under whose authority patient debt is collected, whether the collection activity is conducted by the hospital, an affiliate or subsidiary of the hospital, or by an external collection agency. Health and Safety Code Section 127425(a) Each hospital is required to establish a written policy defining standards and practices for debt collection. Health and Safety Code Section 127425(b) Each hospital must obtain a written agreement from any collection agency used by the hospital that it will adhere to the hospital's standards and scope of practices, including the definition and application of a "reasonable payment plan." Health and Safety Code Section 127425(b) For a patient who lacks coverage or has high medical costs, the hospital or its agent may not report adverse information to a credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 150 days after initial billing. Health and Safety Code Section 127425(d). The timeline for reporting must be extended if there is a pending appeal regarding the coverage for the services. Health and Safety Code Section 127426(a) For patients attempting to qualify for eligibility under a charity care or discount payment policy and attempting in good faith to settle an outstanding bill, the hospital may not send the unpaid bill to collections unless the collecting entity has agreed to comply with the HFPP law. Health and Safety Code Section 127425(e) Any hospital, affiliate or subsidiary of the hospital, may not, in dealing with patients eligible under the hospital's charity care or discount payment policies, use wage garnishments or liens on primary residences as a means of collections. Health and Safety Code Section 127425(f)(1) *(continued on next page)*	

(6) WHAT ARE THE REQUIREMENTS AND RESTRICTIONS RELATED TO BILLING AND COLLECTIONS ACTIVITY? (CONTINUED)

CALIFORNIA	IRS
A collection agency not affiliated with the hospital may not, in dealing with patients qualified under the hospital's charity care or discount payment policies, use as a means of collecting unpaid hospital bills, any of the following: • A wage garnishment, except by order of the court under limited circumstances where the patient is determined to have the ability to pay, taking into consideration potential future health conditions. • Notice or conduct a sale of the patient's primary residence during the life of the patient or certain family members of patient. Health and Safety Code Section 127425(f)(2) The hospital and the patient must negotiate a payment plan. If the hospital and the patient cannot agree, the law defines a **"reasonable payment plan,"** which means monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for "essential living expenses "(as defined in the law). Health and Safety Code Section 127400(i) Extended payment plans offered by a hospital to patients eligible under the hospital's charity care policy, discount payment policy, or any other policy adopted by the hospital for assisting low-income patients with no insurance or high medical costs, must be interest free. Health and Safety Code Section 127425(g) A hospital, collection agency, or assignee may not report adverse information to a consumer credit reporting agency or commence a civil action against the patient or responsible party for nonpayment prior to the time the extended payment plan is declared to be no longer operative. Health and Safety Code Section 127425(g) Prior to commencing collections activities, the hospital or the party seeking to collect the debt must provide the patient with a clear and conspicuous written notice containing: • A plain language summary of the patient's rights pursuant to the HFPP law, the California Rosenthal Fair Debt Collection Practices Act, and the Federal Fair Debt Collection Practices Act. The summary must include a statement that the Federal Trade Commission enforces the Federal Fair Debt Collection Practices Act. *(continued on next page)*	

(6) WHAT ARE THE REQUIREMENTS AND RESTRICTIONS RELATED TO BILLING AND COLLECTIONS ACTIVITY? (CONTINUED)

CALIFORNIA	*IRS*
• The summary is sufficient if it appears in substantially the following form: "State and Federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (382-4357) or online at www.ftc.gov." • A statement that nonprofit credit counseling services may be available in the area. Health and Safety Code Section 127430	

(7) WHAT LIMITATIONS ON CHARGES DOES EACH LAW REQUIRE?

CALIFORNIA	*IRS*
Hospitals are required to limit charges to patients at or below 350 percent of the federal poverty level and eligible under its discount payment policy to the amount of payment the hospital would expect to receive for providing services from Medicare, Medi-Cal, the Healthy Families Program, or another government-sponsored health program of health benefits in which the hospital participates, whichever is greater. Where there is no established payment by Medicare or any other government-sponsored program, the hospital must establish an appropriate discounted payment. Health and Safety Code Section 127405(d).	Hospitals are restricted from billing patients eligible under its FAP for emergency or other medically necessary care to not more than the amounts generally (AGB) billed to individuals who have insurance coverage. For all other medical care, the charges must be less than the gross charges for such care. Section 1.501(r)–5(a) of the Final Regulations The regulations provide two methodologies for determining how AGB may be determined. A hospital may use only one method at a time, but may change methods at any time. • 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, 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), or Medicaid either alone or in combination with Medicare fee-for-services and/or private health insurers. • The second method for determining AGB is "prospective," and requires the hospital facility to estimate the amount it would be paid by Medicare and a Medicare fee-for-service beneficiary or Medicaid and a Medicaid beneficiary. A hospital may use a single average percentage of gross charges or multiple percentages for separate categories of care or separate items or services. **"Charged"** means the amount the patient is responsible for paying. The bill can show gross charges and contractual allowance, discounts, and other adjustments. For insured patients, the amount paid by the insurer plus the amount charged to the patient can exceed the maximum levels so long as the patient is not responsible for more than the allowed maximum. Section 1.501(r)-5 of the Final Regulations

(8) WHAT ARE A HOSPITAL'S OBLIGATIONS TO REFUND CHARGES?

CALIFORNIA	*IRS*
Hospitals are required to reimburse patients for payments above what is required by the FAP, including interest. However, a hospital is not required to reimburse the patient or pay interest if the amount due is less than five dollars ($5.00). The hospital must give the patient a credit for the amount due at least 60 days from the date the amount is due. Health and Safety Code Section 127440	All excess payments over and above what is owed under the FAP must be promptly refunded. Section 1.501(r)–6(c)(6)(i)(C)(2) of the Final Regulations

(9) WHAT ARE THE NOTIFICATION AND PUBLICATION REQUIREMENTS UNDER EACH LAW?

CALIFORNIA	*IRS*
Each hospital must provide patients with a written notice that contains information about availability of the hospital's discount payment and charity care policies, including information about eligibility, as well as contact information for a hospital employee or office from which the person may obtain further information about these policies. Health and Safety Code Section 127410(a) The notice must also be provided to patients who receive emergency or outpatient care and who may be billed for that care, but who were not admitted. Health and Safety Code Section 127410(a) Notice of the hospital's policy for financially qualified and self-pay patients must be clearly and conspicuously posted in locations that are visible to the public, including, but not limited to, all of the following: • Emergency department, if any; • Billing office; • Admissions office; and • Other outpatient settings. Health and Safety Code Section 127410(b)	The FAP, FAP application form, and a plain language summary of the FAP must be made widely available on a website. Section 1.501(r)–4(b)(5)(i)(A) of the Final Regulations Paper copies of the FAP, FAP application form, and a plain language summary of the FAP must be made available upon request and without charge, both by mail and in public locations in the hospital facility (including, at a minimum, in the emergency room (if any) and admissions areas). Section 1.501(r)– 4(b)(5)(i)(B) of the Final Regulations The hospital must inform and notify members of the community served by the hospital facility about the FAP in a manner reasonably calculated to reach those members who are most likely to require financial assistance. Section 1.501(r)–4(b)(5)(i)(C) of the Final Regulations The hospital must notify and inform individuals who receive care from the hospital about the FAP by: 1. Offering a paper copy of the plain language summary of the FAP to patients as part of the intake or discharge process; 2. Including a conspicuous written notice on billing statements about the availability of financial assistance under the FAP, includes the telephone number of the hospital facility office that can provide information about the FAP and application process and the web site address; and 3. Setting up conspicuous public displays that notify and inform patients about the FAP in public locations in the hospital including, at a minimum, the emergency room (if any) and admissions areas. Section 1.501(r)-4(b)(5)(i)(D) of the Final Regulations Additional notice requirements apply before commencing extraordinary collection actions (ECAs) *(see chapter 8 of the* California Hospital Compliance Manual *for details)*. Section 1.501(r)-6(c) of the Final Regulations

(10) WHAT ARE THE LANGUAGE REQUIREMENTS UNDER EACH LAW?

CALIFORNIA	*IRS*
All notices related to the FAP must be provided in any non-English language spoken by a substantial number (probably 5% or more) of persons served by the hospital. Health and Safety Code Section 127410(a).	The full FAP, the plain language summary, the application, and all notices related to the FAP must be provided in the language of any populations with limited English proficiency (LEP) that constitute the lesser of 1,000 individuals or 5 percent of the community served by the hospital facility or the population likely to be affected or encountered by the hospital. If a hospital has a billing and collection policy that is separate from the FAP, it must also be translated and made available. The hospital may use any reasonable method to determine the number or percentage of LEP patients. Section 1.501(r)-4(b)(5)(ii) of the Final Regulations

(11) WHAT ARE THE GOVERNING BODY AUTHORIZATION AND IMPLEMENTATION REQUIREMENTS UNDER EACH LAW?

CALIFORNIA	*IRS*
No explicit requirements for governing body approval are mentioned in the law, but such approval is implicit in the overall statutory scheme.	A hospital organization is considered by the IRS to have "established" a FAP, a billing and collections policy, or an emergency medical care policy for a hospital facility only if: 1. An authorized body of the hospital organization has adopted the policy for the hospital facility and 2. The hospital facility has implemented the policy by consistently carrying it out. Section 1.501(r)–4(d)(1)-(3) of the Final Regulations

(12) IS AGENCY REPORTING REQUIRED UNDER EACH LAW?

CALIFORNIA	*IRS*
Each hospital must provide to the Office of Statewide Health Planning and Development (OSHPD) copies of its discount payment policy, charity care policy, eligibility procedures for those policies, review process, and the application for charity care or discounted payment programs. This information must be provided at least biennially on or before January 1, or when a significant change is made. If no significant change has been made since the information was previously provided, notifying the office of the lack of change is sufficient. Health and Safety Code Section 127435	Although Section 501(r) of the Internal Revenue Code (IRC) and the Final Regulations do not include express reporting requirements, Schedule H to the Form 990 (Return for Organization Exempt from Income Tax) includes numerous questions about the hospital's FAP. *See www.irs.gov/pub/irs-pdf/i990sh.pdf*

(13) PENALTIES FOR FAILURE TO COMPLY WITH EACH LAW.

CALIFORNIA	*IRS*
Compliance with HFPP law is a condition of licensure for hospitals. The California Department of Public Health (CDPH), Licensing and Certification Division, enforces licensing rules. CDPH may issue penalties between $10,000 and $31,625 per violation, depending upon the extent of non-compliance, the amount of financial harm to the patient, and the willfulness of the violation. Title 22, California Code of Regulations, Sections 70951-70960.	Failure to meet the obligations under Section 501(r) of the IRC may result in revocation of tax exempt status or imposition of taxes on income for the taxable year or years during which the hospital facility was a non-compliant facility. Section 1.501(r)-2(a)-(d) of the Final Regulations In determining whether revocation of exemption is appropriate, the IRS will consider all the relevant facts and circumstances, including, but not limited to, the following: • Whether the organization has previously failed to meet the requirements of Section 501(r), and, if so, whether the same type of failure previously occurred; • The size, scope, nature, and significance of the organization's failure(s); • In the case of an organization that operates more than one hospital facility, the number, size, and significance of the facilities that have failed to meet the applicable requirements relative to those that have complied with these requirements; • The reason for the failure(s); • Whether the organization had, prior to the failure(s), established practices and procedures (formal or informal) reasonably designed to promote and facilitate overall compliance with the requirements; • Whether the practices and procedures had been routinely followed and the failure(s) occurred through an oversight or mistake in applying them; • Whether the organization has implemented safeguards that are reasonably calculated to prevent similar failures from occurring in the future; • Whether the organization corrected the failure(s) as promptly after discovery as is reasonable given the nature of the failure(s); and • Whether the organization took measures to implement safeguards to prevent similar failures and correct the failures promptly after discovery before the IRS discovered the failure(s). Section 1.501(r)–2(a)(1)-(9) of the Final Regulations The Final Regulations also provide latitude for certain minor or inadvertent omissions and errors that are corrected prior to the IRS contacting the hospital for examination (audit), and allow certain failures to be excused if the hospital corrects and discloses the failures, provided the failures are not willful or egregious. Section 1.501(r)–2(b)-(c) of the Final Regulations; IRS Notice 2014-3

(14) LAW AND GUIDANCE REGARDING PREEMPTION

CALIFORNIA	*IRS*
The rights, remedies, and penalties established by the HFPP law does not supersede the rights, remedies, or penalties established under other laws. Health and Safety Code Section 127443 Nothing in Section 127425 of the HFPP law, which deals with billing and collection activities, diminishes or eliminates any protections consumers have under existing federal and state debt collection laws, or any other consumer protections available under state or federal law.	In its commentary to the Final Regulations, the IRS noted that many commenters argued that in states that have laws addressing some or most of the subject matter relating to financial assistance policies and debt collection, compliance with such laws should be sufficient. The IRS rejected these arguments, noting that commenters failed to cite any state laws that conflict with the regulations in a way that would make it impossible to comply with both the state and federal requirements. Thus, tax-exempt hospitals must comply with the federal regulations regardless of compliance with similar state laws.

(15) EFFECTIVE DATES FOR EACH LAW

CALIFORNIA	*IRS*
The HFPP law became effective on January 1, 2007.	IRC Section 501(r) applies to taxable years beginning after March 23, 2012. The final regulations implementing that statute apply to taxable years beginning after Dec. 29, 2015. For taxable years beginning on or before Dec. 29, 2015, a hospital may rely on a reasonable, good faith interpretation of Section 501(r). A hospital will be deemed to have operated in accordance with a reasonable, good faith interpretation if it has complied with the provisions of the proposed regulations or Final Regulations.