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July 22, 2010

*BY ELECTRONIC MAIL & HAND DELIVERY*

Douglas H. Shulman  
Commissioner of Internal Revenue  
Attn: CC:PA:LPD:PR (Notice 2010-39)  
Room 5203  
Internal Revenue Service  
Courier's Desk  
1111 Constitution Avenue, N.W.  
Washington, DC 20224

***RE: Notice 2010-39; Request for Comments Regarding Additional Requirements for Tax-Exempt Hospitals***

Dear Commissioner Shulman:

On behalf of the American Hospital Association's (AHA) more than 5,000 member hospitals, health systems and other health care organizations, and its 40,000 individual members; the Healthcare Financial Management Association's (HFMA) more than 35,000 member health care financial executives; the VHA's 1,400 member hospitals and 23,000 non-acute health care organization members; and Premier's alliance of more than 2,300 community-based hospitals and 68,000 other health care sites; we are submitting these comments in response to Notice 2010-39 (Notice), issued by the Internal Revenue Service (Service) on May 27, 2010. In the Notice, the Service asks for comments regarding the application of certain requirements imposed by new Internal Revenue Code ("Code") § 501(r), added to the Code by § 9007(a) of the *Patient Protection and Affordable Care Act of 2010* (ACA), enacted on March 23, 2010.

## **I. BACKGROUND**

Schedule H of IRS Form 990 is required to be completed by an organization that operates at least one facility that is, or is required to be, licensed, registered or similarly recognized by a state as a

hospital. New Code § 501(r) requires that a Code § 501(c)(3) hospital organization meet certain new requirements and that, if the hospital organization operates more than one hospital facility, each of those facilities also must comply with the new requirements. For reasons of efficiency and simplicity, this letter refers to the organization filing the Schedule H and the hospital organization complying with Code § 501(r) as a “hospital” or “hospital organization.”

Although Code § 501(r) was enacted in March 2010, Schedule H, as originally drafted, includes questions that address most of the new requirements. We do not think Schedule H needs a complete overhaul to reflect the new requirements and believe that the Service can revise the Schedule H instructions for certain questions in a manner that will allow the collection of information on Code § 501(r) compliance. The comments that follow include reference to the questions on Schedule H that could be utilized to report on compliance with Code § 501(r). We believe that the only part of Schedule H that would need to be developed is a new Part V.B. that would ask for an indication of hospital facility-by-facility compliance.

## II. NEW REQUIREMENTS

New Code § 501(r) imposes four requirements on hospitals seeking to qualify for and maintain tax-exempt status under Code § 501(c)(3). Although the community health needs assessment requirement is effective for tax years beginning after March 23, 2012, the remaining three requirements are effective immediately. The four requirements are as follows:

- **Community Health Needs Assessment.** Hospitals must conduct a community health needs assessment at least every three years, which must be made widely available to the public and must take into account input from persons who represent the broad interests of the community served by the hospital facility. In addition, hospitals must adopt an implementation strategy for the community health needs identified through such an assessment.
- **Financial Assistance and Emergency Medical Care Policies.** Hospitals must establish a written financial assistance policy that includes: (i) eligibility criteria, 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) if no separate billing and collections policy, the actions the organization may take in the event of non-payment; and (v) measures to publicize the policy within the community. Hospitals also must establish a written emergency medical care policy that requires the organization to provide, without discrimination, care for emergency medical conditions regardless of an individual’s eligibility for financial assistance.
- **Limitation on Charges.** Hospitals must limit the amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy described above to not more than the amounts generally billed to

individuals who have insurance covering such care. Hospitals also must prohibit the use of gross charges, i.e., “chargemaster” rates, when billing individuals who are eligible for financial assistance.

- **Billing and Collection.** Hospitals must not engage in extraordinary collection actions before making reasonable efforts to determine whether the individual is eligible for assistance under its financial assistance policy.

### III. DISCUSSION OF RECOMMENDATIONS

#### A. Definition of “Hospital”

Code § 501(r)(2) defines those organizations that must comply with Code § 501(r) requirements. Paragraph (A)(i) is consistent with the definition of “hospital” for purposes of Schedule H. Schedule H instructions explain that the term “hospital” does “not include a hospital operated by entities organized as separate legal entities from the organization that are treated as a corporation for federal tax purposes (except for members of a group exemption included in a group return filed by the organization).” Also excluded under the Schedule H instructions are hospitals located outside of the United States. These two exclusions also should apply for purposes of Code § 501(r). Code § 501(r)(A)(ii) states that the requirements also apply to:

...any other organization which the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption under subsection (c)(3) (determined without regard to this subsection).

As noted in the Joint Committee’s report, this provision would have to be implemented “in consultation with the Secretary of [Health and Human Services] and after public comment.” (See *Technical Explanation of the Revenue Provisions of the “Reconciliation Act of 2010” As Amended, in Combination with the “Patient Protection and Affordable Care Act”* Joint Committee on Taxation Report, March 21, 2010.) We request that the Service make clear that at this time, the Code § 501(r) provisions will only apply to a hospital facility as described in Code § 501(r)(2)(A)(i). Should the Service wish to exercise the authority in subsection (A)(ii), it should do so through appropriate notice and comment rulemaking. The results of any rulemaking related to subsection (A)(ii) should result in a definition that only is applied prospectively.

#### B. Community Health Needs Assessment

The terms “needs assessment,” “community needs assessment,” and “community health needs assessment” are commonly used, but are not defined in the Code. There should be a definition of “community health needs assessment” (or CHNA) for purposes of Code § 501(r). We

recommend that for these purposes, a “community health needs assessment” be defined as a written document developed by a hospital (alone or in conjunction with others) that includes the following: a description of the process used to conduct the assessment, how the organization took into account input from community members and public health experts, a description of the community served, a description of the health needs identified through the assessment process, a description of which needs the organization intends to address and the reasons those needs were selected, and a summary of the implementation strategy the organization will undertake to address selected needs. Many states require hospitals to prepare community health needs assessments and/or community benefit plans. To minimize burden and increase transparency, we recommend that when a hospital meets state requirements that are substantially equivalent to, or exceed the community health needs assessment requirements in Code § 501(r), the state report should be deemed to have satisfied the corresponding requirements of Code § 501(r).

Code § 6033(b)(15)(A) requires hospital organizations to describe how the organization is addressing the needs identified in the CHNA and to describe the needs that are not being addressed and why. The best way to implement this reporting requirement is to allow hospitals to describe the needs that they will address and to explain why those needs were selected over others. Reasons why some needs are selected for implementation over others could include the mission, expertise or focus of the hospital (for example, a pediatric hospital would concentrate on children); the availability of hospital and community resources for addressing the need; or the likelihood of impacting the need. Hospitals may find that other organizations are already adequately addressing a community health problem and that duplicating their efforts would be inappropriate.

For purposes of making the CHNA “widely available,” we suggest using the same posting and notification methods that are already included in the Form 990 instructions for making tax exemption applications and annual returns “widely available.” We also suggest that a CHNA will be “adopted” for purposes of Code § 501(r) if it has been approved by the appropriate committee of the hospital organization’s Board of Directors or comparable governing body.

Schedule H, Part VI, line 2 requires hospital organizations to describe how the organization assesses the health care needs of the communities it serves. To incorporate the new Code § 501(r) requirements, the instructions for line 2 could be revised to provide that the hospital organization should describe in Part VI, line 1: (1) the definition of the geographic and demographic community the community health needs assessment addresses; (2) which hospital/hospitals, health care organizations or other organizations participated in the conduct of the assessment; (3) the nature of the input from persons who represent the broad interests of the community served; (4) the implementation strategy adopted by the organization; and (5) how the organization is making the assessment available to the public.

### **C. Financial Assistance Policy/Emergency Medical Care Policy**

Code § 501(r)(4) provides that a hospital must have a financial assistance policy that includes certain information specified in the statute and a policy relating to emergency medical care.

Schedule H, Part I, lines 1-5 require a hospital organization to report information regarding the organization's charity care policy. These questions specifically address, among other things, the criteria the hospital organization uses to determine eligibility for free and discounted care. To incorporate the new Code § 501(r) requirements, the instructions for Part I, line 1 could be revised to provide that the hospital organization should describe in Part VI, line 1: (1) whether the charity care policy describes the basis for calculating amounts charged to patients; (2) whether the charity care policy describes the method for applying for financial assistance under the policy; (3) if the organization does not have a separate billing and collections policy, whether the charity care policy describes the actions the organization may take in the event of nonpayment; (4) how the organization makes the charity care policy available to the community it serves; and (5) whether the organization has a written emergency medical care policy that requires the organization to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the charity care policy.

We believe the instructions to Schedule H, Part VI, line 3 already describe ways to "widely publicize" a financial assistance policy. Specifically, the current instructions provide as follows:

For example, state whether the organization posts its charity care policy, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of the organization's facilities where eligible patients are likely to be present; provides a copy of the policy, or a summary thereof, and financial assistance contact information to patients as part of the intake process; provides a copy of the policy, or a summary thereof, and financial assistance contact information to patients with discharge materials; includes the policy, or a summary thereof, along with financial assistance contact information, in patient bills; or discusses with the patient the availability of various government benefits, such as Medicare or state programs, and assists the patient with qualification for such programs, where applicable.

Code § 501(r)(4)(B) provides that a hospital must have a written policy requiring the organization to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility for financial assistance. Federal law already requires hospitals to screen for and provide necessary stabilizing treatment for all individuals who present themselves at a hospital, and are found to have an emergency medical condition. Compliance is closely monitored by HHS' Centers for Medicare & Medicaid Services. By the terms of Code § 501(r), the emergency medical care policy is intended to reflect the existing federal law and is not intended to create any new requirements.

#### **D. Limitation on Charges**

Code § 501(r)(5) limits the amounts a hospital may *charge* for emergency or medically necessary care provided to patients who are eligible for assistance under the hospital's financial assistance policy to no more than the *amounts generally billed* to individuals who have insurance coverage.

It also addresses the use of *gross charges*. In developing guidance, it is important that the Service recognize that these are terms of art with long-established meanings across the hospital field. Understanding the difference between the amount a patient is expected to pay and *charges or gross charges*, and *generally billed* will be particularly important.

As a general matter, a bill sent to a patient begins with what are called “gross charges” – the hospital’s full-established rates (charges) for all services rendered to patients. This is to ensure that in calculating payments for Medicare beneficiaries, Medicare only pays its fair share of overhead-type costs. In arriving at the amount a patient is expected to pay, reductions are made from the gross charges. For commercial payers, the gross charge amount is reduced based on the negotiated rate with the insurer. For Medicare or Medicaid, the amount is reduced to the rate mandated by the government. The reduction is most commonly referred to by hospitals as a discount or contractual allowance.

While the statute uses *amounts charged* and *amounts generally billed*, the objective is that patients receiving financial assistance are expected to pay no more than the amounts insured patients are generally expected to pay. To achieve that objective and be consistent with the intent of the law, it should be clear that the prohibition on the use of gross charges only applies when billing patients who are known to qualify for financial assistance. (*See* Joint Committee on Taxation Report, p. 82; *see also* Schedule H, Part III, lines 9a, 9b (recognizing assistance policies can only be followed for patients known to qualify).) If a hospital is not aware that a patient qualifies for assistance, or for individuals who do not qualify for financial assistance, the usual billing process would apply. It also should be clear that the prohibition does not apply to the use of gross charges as the starting point for calculating the amount a patient eligible for financial assistance is expected to pay. That is the general practice across all hospitals, all patients and all payers, and should not be affected by Code § 501(r), as long as an appropriate reduction in gross charges is made based on the amount generally billed to those who have insurance coverage.

The “amount generally billed” should similarly be interpreted for Code § 501(r) purposes consistent with the general practices of hospitals. The Joint Committee Report indicates that those eligible for financial assistance should receive the benefit of the negotiated rates for insured patients or Medicare rates. The amount “generally billed” will, therefore, be a function of a hospital’s arrangements with the various insurers or payors covering hospital patients. For a hospital relying on a negotiated commercial rate, the “amount generally billed” would be based on the average percent of gross charges (“percent of charges”) that patients covered by this insurer are expected to pay. That same percent of charges would be applied to the gross charges of those eligible for financial assistance to arrive at the amount a patient is expected to pay. The “percent of charges” would be calculated using the following formula: (gross charges less contractual allowances or discounts) divided by gross charges for all patients covered by the insurer. By way of example, the Joint Committee Report includes the best, or average three best, negotiated commercial rates, or Medicare rates, as ways to demonstrate “generally billed.” The percent of charges should be calculated at least annually.

The Service also should recognize other means to demonstrate the “amounts generally billed” by a hospital. For example, in states that require specific discounts or otherwise control the

amounts that may be billed to patients with financial need, those requirements should establish the amounts generally billed. In other states that mandate financial reporting by hospitals, information on the percentage discounts for the insured may be publicly available and that data should be acceptable to demonstrate the “amounts generally billed.” So long as the underlying intent is met – to provide those receiving financial assistance with the benefit of reductions provided to the insured – a variety of means to do so should be permitted.

Lastly, guidance should make clear that whether a hospital is in compliance with Code § 501(r)(5) is based on its overall performance, not on an individual patient basis.

A new question and accompanying instructions could be added under Part V or Part VI of Schedule H to secure the information. In the alternative, this information request could be added to the instructions for Part 1, line 1, as discussed in III. C. above.

#### **E. Billing and Collection**

New Code § 501(r)(6) provides that a hospital must forego “extraordinary collection” actions until it has made “reasonable efforts” to determine whether an individual is eligible for financial assistance. The Technical Explanation states that reasonable efforts include notification by the hospital of its financial assistance policy upon admission and in written and oral communication with the patient regarding the patient's bill, including invoices and phone calls. It further suggests that such “reasonable efforts” to determine whether an individual qualifies for financial assistance should be made before starting any collection action or reporting to credit agencies. The billing and collection provision requires further guidance in several respects.

First, the Service should clarify what constitutes “extraordinary collection” action. The Technical Explanation states that “extraordinary collection actions include lawsuits, liens on residences, arrests, body attachments, or other similar collection processes.” Guidance from the Service should follow the legislative history and include these items as examples. However, guidance also should provide a general definition of the term. What all of these examples have in common is that they are actions that cannot be initiated without resorting to some kind of legal or judicial process (i.e., initiating a lawsuit, filing a lien). Only if a general definition is provided, should guidance from the Service include the phrase “other similar collection processes.” If there is no over-all definition of an “extraordinary collection action,” this phrase should either be further defined by example or simply dropped. Otherwise, it will lead to inconsistent results and uncertainty.

Second, the Service should clarify that the Joint Committee’s suggestion regarding the timing of when “reasonable efforts” should be undertaken (i.e., before any collection action or reporting to credit agencies) is not intended to suggest that reporting to credit agencies is – in and of itself – an extraordinary collection measure. Further, while we agree that hospitals should generally try to determine whether individuals qualify for the financial assistance policy before any collection action or credit agency reporting, sometimes this is not possible. A hospital may take all the

right steps to publicize its policy and to determine an individual's eligibility, but such determinations generally depend on the individual patient's willingness to respond. Some patients are reticent to share financial information even if they qualify for assistance. In such cases, hospitals should not be permanently foreclosed from ever taking extraordinary actions — particularly where the individual is not (or was not) actually eligible for financial assistance.

Third, guidance is needed on what constitutes “reasonable efforts” to determine whether an individual is eligible for financial assistance. We think that the Service should follow the Technical Explanation in adopting a flexible approach. We also think that if the hospital provides a written summary of its financial assistance policy in at least one invoice mailed or otherwise provided to the patient following the provision of hospital services and prior to referring the account to a collection agency, it should be deemed to have made “reasonable efforts” to determine a patient's eligibility for financial assistance.

Schedule H, Part III, line 9 requires a hospital organization to report information regarding the organization's written debt collection policy. To incorporate the new Code § 501(r) requirements, the instructions to Part III, line 9b could be revised to provide that the organization should also describe in Part VI, line 1, whether it's written collection policy requires the hospital organization to make reasonable efforts to determine whether the individual is eligible for assistance under the organization's charity care policy.

#### **F. Application of § 501(r) on a Facility-by-Facility Basis**

New Code § 501(r) applies to hospital organizations on a facility-by-facility basis. Consequently, if a hospital organization operates more than one hospital facility, the organization is required to meet the additional requirements of Code § 501(r) separately with respect to each facility. This information could be reported under Part V of Schedule H. By the language of the statute, if one facility within a hospital organization fails to meet the new requirements, only that facility will not be treated as tax-exempt under Code § 501(c)(3). Accordingly, one facility's failure to meet the new requirements does not negate the tax-exemption of the hospital organization. The ACA, however, does not specify whether the facility will be treated as tax-exempt under Code § 501(a) as another type of Code § 501(c) organization, or as an unrelated business of the hospital organization, nor does the statute provide any guidance for how to report the facility's revenue and expense for the year in which the facility fails to meet the requirements on the hospital organization's Form 990.

We urge the Service to issue guidance that clarifies that this provision would be triggered only if there were a substantial failure to meet the requirements as measured on a facility-by-facility basis. A violation of one of the new requirements or a violation that is “cured” by the end of the fiscal year being reported should not be deemed to be a failure to meet the requirements that results in adverse consequences. In the unlikely scenario that a substantial failure was not cured within the fiscal year being reported, we urge the Service to utilize existing administrative remedies to resolve any reporting issues rather than require the filing of a Form 990-T. A hospital organization may not discover a facility's failure to meet the new requirements until

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midway into the following fiscal year and converting books and records to provide for Form 990-T reporting would be a significant undertaking.

Filing a Form 990-T with respect to a facility that fails to meet the requirements of Code § 501(r) is a tax consequence that is unduly burdensome and completely impractical. Although unlikely, a substantial failure at a particular facility might not be discovered until the preparation of the Form 990 in the months following the end of the hospital organization's fiscal year. Accordingly, we urge the Treasury and the Service to seek formal legislative action to establish a reasonable "cure" period for any failure to meet the new requirements, such as the later of 90 days or the end of the fiscal year in which the failure is discovered.

#### IV. CONCLUSION

We look forward to working with the Service on implementation of new Code § 501(r). In that regard, we respectfully request a meeting that includes the undersigned and other hospital groups to discuss our comments and the next steps in the implementation process.

Sincerely,



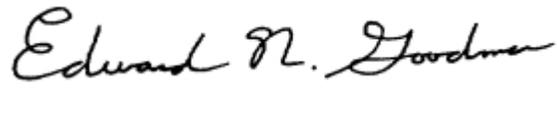
Melinda Reid Hatton  
Senior Vice President & General Counsel  
AHA



Richard L. Clarke, DHA, FHFMA  
President and CEO  
HFMA



Margaret Reagan  
Corporate Vice President  
Premier, Inc.



Edward N. Goodman  
Vice President, Public Policy  
VHA Inc.