



**American Hospital
Association**

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August 23, 2012

Office of Management and Budget
Attn: Desk Officer for the Department of the Treasury
Office of Information and Regulatory Affairs
Washington, DC 20503

Internal Revenue Service
Attn: IRS Reports Clearance Officer
SE:W:CAR:MP:T:T:SP
Washington, DC 20224

Dear Sir/Madam:

The American Hospital Association (AHA) is submitting this letter on behalf of our more than 5,000 member hospitals, health systems and other health care organizations in response to the request for comments contained in the June 22 notice of proposed rulemaking (NPRM) from the Department of the Treasury and the Internal Revenue Service (IRS). The NPRM includes a collection of information (COI) that is subject to review by the Office of Management and Budget (OMB) pursuant to the *Paperwork Reduction Act* (PRA). To assist OMB in evaluating the proposed COI, the preamble to the proposed regulations requests comments regarding: (1) the necessity of the COI for the proper performance of the functions of the IRS, (2) the accuracy of the IRS's estimated burden associated with the COI, and (3) ways in which the burden may be minimized.

Section 501(r) was added to the Internal Revenue Code of 1986 as amended (the Code) by the *Patient Protection and Affordable Care Act of 2010* (ACA), and contains new requirements for tax-exempt status that must be met for each hospital facility (hospital) that an organization operates. In addition to the requirements of Section 501(r) addressed by the proposed regulations at issue here, Section 501(r)(3) of the Code requires a hospital 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. Notably, the NPRM does not provide guidance on the CHNA requirement. In the preamble to the proposed regulations, the agencies acknowledged that proposed regulations addressing the CHNA requirement will be forthcoming. When issued, these proposed regulations will impose additional COI requirements on hospitals.



The NPRM was issued by Treasury and the IRS to implement Sections 501(r)(4) through 501(r)(6) of the Code. These sections require that each hospital maintain a financial assistance policy (FAP), as well as an emergency medical care policy, limit amounts charged to individuals determined to be eligible under a facility's FAP (FAP-eligible) and refrain from taking extraordinary collections actions (ECAs) until the facility has made reasonable efforts to determine an individual's FAP-eligibility. The AHA is fully committed to these requirements.

While we appreciate the agencies' efforts, the proposed regulations fall short of meeting the preamble's goal of preserving flexibility for hospitals while assuring access to information for patients who need financial assistance. Instead, the proposed regulations are frequently excessively complex and prescriptive. Too often, the proposed regulations dictate uniformity rather than offer flexibility for meeting the ACA's requirements and, in doing so, appear to foreclose better and perhaps more effective methods of achieving transparency and accountability for financial assistance and billing and collection practices. For instance, the proposed regulations allow hospitals a choice of only two methods for calculating an amount that can be charged to an FAP-eligible individual and preempt the use of methods authorized under state law that could be superior. In another example of this tendency, the proposed regulations prescribe only one procedure that a hospital must follow to establish that the hospital made reasonable efforts to determine an individual's FAP-eligibility and thereby foreclose hospitals from determining eligibility presumptively on a sliding scale or using equally effective alternatives to evaluate the need for financial assistance.

To comply with the proposed regulations, many hospital organizations will have to implement new administrative procedures to replace those already being used to comply with these 501(r) requirements as they appeared in the ACA. Changing information systems to meet these newly proposed requirements will divert resources from patient care and other efforts underway to meet the myriad other ACA requirements, many of which are intended to further improve quality and efficiency.

We believe that the annual commitment of time required to comply with the COI contained in the proposed regulations will vastly exceed the 11.5 hours estimated. Input from AHA members indicates that hospitals will be required to spend anywhere from 250 hours annually to more than 2,000 hours annually to comply with the proposed regulations. These estimates appear entirely commensurate with the procedures detailed in the proposed regulations. To illustrate that congruity, we have attached a chart that summarizes the procedures that each hospital would have to implement and follow.

As requested by the NPRM, the AHA will provide comments to the agencies regarding the proposed regulations. Our comments will advocate for flexibility in complying with Section 501(r) requirements, which will reduce the annual time commitment and, thereby, the costs borne by hospitals under this COI. According to the PRA, before OMB approves a COI, an agency must demonstrate that it has taken "every reasonable step" to ensure that the proposed COI is the least burdensome necessary for the proper performance of the agency's functions to

Office of Management and Budget
Internal Revenue Service
August 23, 2012
Page 3 of 3

comply with legal requirements and achieve program objectives. As part of its approval process, OMB also must decide whether the burden of a COI is justified by its practical utility. Prior to approving this COI, the AHA urges OMB to evaluate the time commitment and commensurate costs imposed on hospitals and to review the comments that the AHA will submit to the IRS (and forward to this office) as evidence that alternative and more efficient means can be employed to achieve the goals of Section 501(r), to which the AHA remains fully committed.

The AHA welcomes an opportunity to meet with OMB representatives to discuss our comments. Please feel free to contact me at mhatton@aha.org or 202-626-2336 with any questions or comments.

Sincerely,

A handwritten signature in black ink, appearing to read "Melinda Hatton". The signature is stylized with a large initial "M" and "H".

Melinda Reid Hatton
Senior Vice President and General Counsel

Attachment

**PROCEDURES REQUIRED TO COMPLY WITH THE PROPOSED REGULATIONS
UNDER SECTIONS 501(r)(4)-501(r)(6)**

Financial Assistance Policy (“FAP”)
<u>Task</u>
<ul style="list-style-type: none"> • Prepare and periodically update FAP documents, as follows: <ul style="list-style-type: none"> ➤ A regulations-compliant FAP ➤ A plain language summary of the FAP ➤ An FAP application form ➤ An FAP application form instructions ➤ If necessary, a separate billing and collections policy
<ul style="list-style-type: none"> • Determine whether a facility is a “hospital facility” as defined by the Treasury Regulations • Determine the community that is served by the hospital facility
<ul style="list-style-type: none"> • Determine whether a language minority constitutes more than 10% of the community served by hospital • Translate and publish all the FAP documents in the language(s) of minority population(s) served by the hospital
<ul style="list-style-type: none"> • Take actions to widely publicize the FAP, including each of the following: <ul style="list-style-type: none"> ➤ Post and maintain the FAP and all FAP-related documents on a website ➤ Distribute the FAP and FAP-related documents by mail upon request ➤ Create, post and periodically update public displays regarding the FAP ➤ Inform and notify members of the community served by the hospital facility about the FAP
<ul style="list-style-type: none"> • Adopt the FAP by an authorized body of the hospital organization or the hospital facility
Emergency Medical Care Policy (“EMCP”)
<u>Task</u>
<ul style="list-style-type: none"> • Create and periodically update a regulations-compliant EMCP • Adopt the EMCP by an authorized body of the hospital organization or the hospital facility
Limitation on Charges
<u>Task</u>
<ul style="list-style-type: none"> • Determine the methodology to be used
<ul style="list-style-type: none"> • If using the look-back method: <ul style="list-style-type: none"> ➤ Determine whether to calculate a single amounts generally billed (“AGB”) percentage for all emergency and medically necessary care or multiple AGB percentages for separate categories of care ➤ Review at least annually all claims for emergency or medically necessary care that have been paid in full in the preceding 12 months ➤ Calculate the AGB percentage
<ul style="list-style-type: none"> • If using the prospective Medicare method: <ul style="list-style-type: none"> ➤ Determine the amount Medicare and the Medicare beneficiary together would be expected to pay for the care
Billing and Collection
<u>Task</u>
<ul style="list-style-type: none"> • Create, revise or otherwise establish regulations-compliant billing and collections policies

<ul style="list-style-type: none"> • Notify a patient about the FAP, by taking at least each of the following actions: <ul style="list-style-type: none"> ➤ Provide the plain language FAP summary before discharge ➤ Attach the plain language FAP summary to at least 3 billing statements ➤ Inform the patient about the FAP in all oral communications regarding amounts due ➤ Prepare a notice warning of extraordinary collections actions (“ECAs”) that may be taken in the event an FAP application is not submitted within 120 days after the first billing statement was sent
<ul style="list-style-type: none"> • Process incomplete FAP applications by taking each of the following actions: <ul style="list-style-type: none"> ➤ Notify individuals of additional information required to complete the FAP application ➤ Prepare a notice warning of ECAs that may be taken in the event a complete FAP is not submitted at the earliest within 240 days after the first billing statement was sent
<ul style="list-style-type: none"> • Process complete FAP applications by taking each of the following actions: <ul style="list-style-type: none"> ➤ Establish or authorize a decision-making body to render determinations regarding FAP-eligibility ➤ Make and document determinations regarding FAP-eligibility ➤ Notify patients in writing regarding a determination of FAP-eligibility ➤ With respect to a FAP-eligible individual, if applicable, send revised billing statement, process any refunds, and take measures to reverse any ECAs already taken ➤ If applicable, render and process a determination of FAP-eligibility based on sources other than the FAP applicable form
<ul style="list-style-type: none"> • Draft and negotiate agreements with debt collection agencies related to ECAs that an agency may take