



A Passionate Voice for Compassionate Care

July 22, 2010

VIA ELECTRONIC MAIL

Sarah Hall Ingram, Commissioner
Tax Exempt and Government Entities Division
Internal Revenue Service
CC:PA:LPD:PR (Notice 2010-39)
Room 5203
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Request for Comments Regarding Additional Requirements for Tax-Exempt Hospitals, Notice 2010-39

Dear Commissioner Ingram:

The Catholic Health Association of the United States (CHA) is pleased to submit the following comments regarding the application of certain new requirements for tax-exempt hospitals. The recently enacted Patient Protection and Affordable Care Act (Pub. L. 111-148) added a new Section 501(r) to the Internal Revenue Code, which imposes new requirements on hospitals in order to qualify for an exemption under Section 501(c)(3), and added new reporting requirements for such hospitals under Section 6033(b) of the Internal Revenue Code.

CHA represents more than 600 hospitals and 1,400 long-term care and other health facilities in all 50 states. CHA has over twenty years experience in providing guidance to our members and others on many aspects of community benefit, including reporting community benefit; conducting community health needs assessments; developing implementation strategies to respond to community need; and developing financial assistance policies and procedures. We offer these comments based on that experience and what we have learned from community benefit practitioners in the field.

CHA recommends that the IRS utilize the Internal Revenue Form 990, Schedule H as the means for implementing the new requirements. For each hospital facility listed in Part V, "Facility Information," we recommend adding a series of questions regarding compliance with the requirements. IRS Form 990, Schedule H Instructions for the form should describe how the questions should be answered. We are assuming in our comments that hospitals will have a reasonable period after the IRS issues its guidance on Section 501(r) to come into full compliance therewith.



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For the purposes of these comments we are using the term “hospital organization” to mean the organization that files a Form 990 using its Employment Identification Number (“EIN”), and the terms “hospital facility” and “hospital” interchangeably to mean a facility that is required to be licensed registered or similarly recognized by a state as a hospital. Thus, in the case of a “hospital organization” that operates only one “hospital facility” (or “hospital”), the terms are synonymous.

Community Health Needs Assessment

Discussion

A community health needs assessment is central to a hospital’s community benefit programs. It is through review of public health information and working with community partners that community health needs and priorities are identified, and that hospital facilities and their partners can develop plans to address their communities’ most pressing health problems.

Based on over twenty years experience working with community benefit programs and their needs assessment processes, CHA recommends that the IRS consider the following points when implementing the provisions of Section 501(r)(3):

- There are multiple appropriate and acceptable approaches hospitals can take to gather the information needed to assess the community’s health needs: they may conduct an assessment themselves by reviewing public health information and/or collecting new information or engaging a consultant to do so; they can partner with other hospitals and/or other community organizations to gather information; or they can take an existing community health needs assessment prepared by a state (such as a state health plan) or by a local health agency or community organization (such as the United Way) and use that information. CHA recommends that the IRS take a flexible approach that permits hospitals to determine the best way to gather the information needed to undertake the community health needs assessment required under Section 501(r).
- It is important to note that with so many unmet needs in most communities, hospitals often design the scope of their community needs assessments to focus on the community or communities served by the hospital, geographic areas of particular concern, and/or target populations (such as children or the uninsured). Hospitals should be able to define the scope of their assessment in this manner.
- In addition to working with others to gather the assessment data, there are several ways that hospitals can work with community organizations and community members. For example, they may collaborate with others to prioritize needs; to develop implementation strategies; and to provide specific community health



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improvement services. They also may work with individuals and groups to conduct interviews, community forums and other forms of public discourse to seek input from the broad interests of the community. We recommend that that these types of collaborative efforts “count” towards a hospital’s community health needs assessment and implementation strategy.

- Public health expertise is critically important to community health needs assessment. Hospital facilities may tap that expertise by consulting with federal, state or local health department personnel; consulting with private or public health consultants; or working with academic departments of public health schools. Again, we would recommend the IRS permit flexibility to allow hospitals to select the public health experts they believe would best inform the process.
- In the public health field, the terms “needs assessment,” “community needs assessment” and “community health needs assessment” are commonly used, but do not appear to have precise definitions. For example, the terms can mean the collection of public health data and demographic information or a summary of such information reported by different sources, or a document that contains not only data but also prioritizes identified needs. Given this, CHA strongly believes that for the benefit of the IRS, the public and the hospital sector, there should be a common understanding of what a “community health needs assessment” is for purposes of Section 501(r). We are recommending that for these purposes a “community health needs assessment” is a written document developed by a hospital facility (alone or in conjunction with others) that includes the following: a description of the process used to conduct the assessment; with whom the hospital has worked; how the hospital 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 hospital intends to address and the reasons those needs were selected; and a summary of the implementation strategy the hospital will undertake to address selected needs. It should be noted that many states require hospitals to prepare community health need assessments and/or community benefit plans. We recommend that when a hospital meets state requirements that are substantially equivalent to or exceed the community health needs and implementation strategy requirements in Section 501(r), a hospital should be deemed to have satisfied the requirements of Section 501(r)(3) by meeting those standards.
- Section 6033(b)(15)(A) requires hospital organizations to describe in the Form 990 how each of its hospital facilities is addressing the identified needs and to describe the needs that are not being addressed and why. We recommend that the best way to implement this Section is to allow each hospital to describe the needs that it has chosen to address and to explain why it chose those needs over others. The reasons why specific needs are selected for action over others could include the mission, expertise or focus of the hospital (for example, a pediatric hospital or center



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of excellence in cancer care would concentrate on children and cancer detection respectively); the hospital’s financial capacity; 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. If a hospital has included such a description in its community health needs assessment, then attaching that document to the hospital organization’s Form 990 would be a practical way to meet the Section 6033(b)(15)(A) requirement (and would parallel the requirement of attaching the organization’s audited financial statements under Section 6033(b)(15)(B)).

- Moreover, in many instances community health needs may be ongoing and require the long-term commitment of resources by a hospital that decides to address such needs. When a hospital focuses its efforts on these types of needs, it should be recognized that these needs may continue to be a priority for the hospital over multiple 3-year community health needs assessments and, thus, could limit the hospital’s ability to address other needs of the community. Put another way, a hospital does not necessarily have to add “new” needs to its efforts every three years to be responsive to the intent of Schedule 501(r).
- For purposes of meeting the “widely available” requirement of 501(r), we would suggest using the same posting and notification methods that apply to making the Form 990 “widely available” under Treasury Regulation 301.6104(d)-2. We also suggest that a community health needs assessment will be “adopted” for purposes of 501(r) if it has been approved by the hospital facility’s governing body or a committee thereof or by the hospital organization’s board or committee thereof.

To implement the above recommendations, CHA proposes that the following questions and instructions be added to the IRS Form 990, Schedule H, Part V:

Suggested Questions	Suggested Instructions
<p>Has the hospital facility conducted a community health needs assessment within the past three (3) taxable years?</p> <p>Yes No</p>	<p>A hospital organization can answer “Yes” to this question with respect to a hospital facility if, within the taxable year being reported on the return or in the previous two taxable years, such hospital facility has developed a written community health needs assessment that includes a summary description of:</p> <ol style="list-style-type: none"> 1. The process used to assess the community’s health needs, which may include basing the assessment



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Suggested Questions	Suggested Instructions
	<p>on current information collected by a public health agency or non-profit organization; conducting the assessment on its own or with one or more other organizations, including related organizations; or using other appropriate methods or sources for identifying community health needs</p> <ol style="list-style-type: none"> <li data-bbox="776 730 1308 793">2. Whom the hospital worked with in assessing community health needs. <li data-bbox="776 835 1325 1285">3. How the hospital took into account input from persons representing the broad interests of the community, including persons with special knowledge of or expertise in public health. This could include (but is not limited to), consultation with community members, community groups, or public health experts such as federal, state or local health department personnel or academic departments of public health schools or public health consultants. <li data-bbox="776 1327 1299 1495">4. The community or communities served by the hospital, including geographic boundaries and any target populations (e.g., children or underserved persons). <li data-bbox="776 1537 1318 1877">5. The community health needs identified by the hospital through the process described in part 1 above; which of the identified community health needs the hospital intends to address and the reasons the organization chose to meet certain needs and not others (such reasons may include, but are not limited to, the hospital 's expertise or mission,



Suggested Questions	Suggested Instructions
	<p>the likelihood of impacting the need, the availability of hospital and community resources, and the desire to avoid duplicating efforts of other organizations already addressing identified community health needs).</p> <p>6. The implementation strategy the hospital will undertake to respond to the community health needs it intends to address.</p> <p><i>Note: a hospital that meets state community needs/community benefit plan requirements that are substantially equivalent to or exceed the above requirements can answer “yes” to this question</i></p>
<p>Has the hospital facility adopted an implementation strategy to meet the community health needs identified through such assessment?</p> <p>Yes No</p>	<p>A hospital organization can answer “Yes” to this question with respect to a hospital facility if the implementation strategy described in the hospital’s written community health needs assessment has been approved by the hospital’s governing body or a committee thereof, the hospital organization’s governing body or a committee thereof.</p>
<p>Has the hospital facility made its written community health needs assessment widely available to the public?</p> <p>Yes No</p>	<p>A hospital organization can answer “Yes” to this question with respect to a hospital facility if when the hospital disseminates its written community health assessment it follows the posting and notice requirements for making annual returns “widely available” under Treasury Regulation 301.6104(d)-2.</p>



<p>Describe how each hospital facility is addressing the needs identified in its written community health needs assessment and a description of any such needs that are not being addressed together with the reasons why.</p>	<p>If the hospital facility’s written community health needs assessment describes the items set forth in Question 1, part 5 above, then attaching such hospital facility’s written community health needs assessment to the hospital organization’s Form 990 will satisfy the requirements of IRC Section 6033(b)(15)(A).</p>
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Financial Assistance Policy

Discussion

Section 501(r)(4) requires hospital facilities to establish a written financial assistance policy, which includes a description of the measures used to “widely publicize the policy” and a policy relating to emergency medical care.

In recent years, most Catholic and other not-for-profit organizations have significantly revised and improved their financial assistance policies. Excellent guidance has been made available by the Hospital Financial Management Association (HFMA) and other national organizations to assist hospitals in describing and clarifying criteria for free and discounted care and spelling out procedures for determining eligibility.

In *A Guide to Planning and Reporting Community Benefit*, CHA recommends that the terms of financial assistance policies be communicated both internally and externally, so the public and patients are aware of the policies as are all employees who interact with patients concerning the cost of their care. What we have learned, however, is that financial assistance policies are often multi-page documents which address in great detail how the hospital will apply discounts and free care to a variety of situations. From a patient communication standpoint it is much better to have hospitals disseminate **a summary** of the financial assistance policy, which could include income eligibility requirement information and clear guidance on where patients can go to receive additional information about whether they might qualify for assistance. This is similar to the approach used in the New York state notification requirements. See N.Y. Pub. Health Law § 2807-k(9-a)(c).

Given the above, we recommend that a hospital facility will have satisfied the “widely publicized” requirements of Section 501(r)(4)(A)(v) if its financial assistance policy requires (1) posting both the policy and the summary of its financial assistance policy on its website, and (2) making the summary available in emergency rooms, admissions offices and other public areas where patients check in to receive services (such as in an outpatient setting).



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To implement the above, CHA recommends that the following questions and instructions be added to the IRS Form 990, Schedule H, Part V:

Suggested Questions	Suggested Instructions
<p>Does the hospital facility have a written financial assistance policy?</p> <p>Yes No</p>	<p>A hospital organization can answer “Yes” to this question with respect to a hospital facility if the hospital facility has a written financial assistance policy that includes:</p> <ul style="list-style-type: none"> • Eligibility criteria for financial assistance, and whether such assistance includes free or discounted care; • The basis for calculating amounts charged to patients; in the case of a hospital facility which does not have a separate billing and collections policy, the actions the hospital may take in the event of nonpayment, including collections action and reporting to credit agencies; • The method for applying for financial assistance; and • Measures to widely publicize the policy within the community served by the hospital facility, including 1) posting both the policy and a summary of the policy on the hospital’s website, and 2) making the summary of the policy available in the hospital, including in emergency departments, in admissions offices and in other public areas where patients check in for services (e.g., outpatient settings).

<p>Does the hospital facility have a policy relating to emergency medical care?</p>	<p>A hospital organization can answer “Yes” to this question with respect to a hospital facility if the hospital facility has a written policy requiring the hospital to (1) comply with USC 42 §1395dd (EMTALA) when providing individuals with treatment for emergency medical conditions (within the meaning of USC 42 §1395dd(e)); and (2) provide such treatment to individuals without discrimination and regardless of their eligibility under the hospital’s financial assistance policy.</p>
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Limitation on Charges

Discussion

Under Section 501(r)(5), hospitals must limit amounts charged for emergency or other medically necessary care that is provided to individuals eligible for assistance under the organization’s financial assistance policy. The amount charged to these patients must be not more than the amounts generally billed to individuals who have insurance covering such care. This Section also addresses the use of gross charges in billing patients.

There are several critical issues contained in this requirement that are in need of clarification:

- The first issue relates to identifying the patients to whom the prohibition on gross charges applies. It seems clear from the Joint Tax Committee report that this provision was meant to prohibit the use of gross charges “when billing individuals who qualify for financial assistance.” Thus, the IRS should clarify that there is not a prohibition against the using gross charges for persons who are not eligible for financial assistance.
- Second, CHA believes that the Section 501(r)(5) provisions only make sense if they are read to apply to patients who are **known** to qualify for financial assistance. (This approach is consistent with current Schedule H, Part III, lines 9a-9b, which recognizes that assistance policies can only be followed for patients known to qualify). That is, once the eligibility determination has been made, the limitation on amounts charged would be in effect. However, in situations where the hospital does not know a patient’s eligibility status at the time a bill is sent, the hospital should be permitted to send the patient a bill using gross charges together with a summary of the hospital’s financial assistance policy. Once eligibility for financial assistance has been established, the hospital would then send the patient a new bill reflecting the amount due (if any) after application of the financial assistance policy.



- Further, it should be understood that gross charges are the starting point for all patient bills, including those sent to Medicare and commercial payers. When determining the amount of the bills, the discount or negotiated rate is calculated off of gross charges. Therefore, the prohibition against the use of gross charges should not be interpreted to prohibit the use of gross charges as the **starting point** for calculating the amount that a patient eligible for financial assistance will be expected to pay, if any. For this reason, even bills that include a discount will likely reflect the gross charge amount to which the discount is applied.
- Another issue related to limitation on charges is how to calculate the “amount generally billed to individuals who have insurance” for purposes of Section 501(r). We recommend that a variety of means should be permitted to make this calculation. The Joint Committee report states, “It is intended that the 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 rate.” For example, for a hospital relying on the average of the three best negotiated commercial rates, the “amount generally billed” would be based on the average percent of gross charges that such insurers would pay the hospital on behalf of their insureds. The hospital would then apply that percentage to determine the most that an eligible patient would pay.
- In addition to the above, there should be other ways to determine the “amount generally billed.” For example, compliance with state law should be deemed to meet this test in states such as New York, California, Massachusetts and Illinois, where the law controls the amounts that may be billed to patients. Also, in those states where hospitals are mandated to publicly report information on the discounts for the insured, that information should be acceptable to use as the “amount generally billed.” So long as the underlying intent is met – to provide those receiving financial assistance with the benefit of reductions provided the insured – a variety of means to do so should be permitted.
- Finally, hospitals should not be required to determine the “amount generally billed” for Section 501(r) purposes more often than once per fiscal year.

To implement the above, CHA recommends that the following questions and instructions be added to the IRS Form 990, Schedule H, Part V:

Suggested Questions	Suggested Instructions
<p>Does the hospital facility limit amounts charged for emergency or other medically necessary care that is provided to individuals determined eligible for assistance under the hospital facility’s financial assistance</p>	<p>A hospital organization can answer “Yes” to this question with respect to a hospital facility if the hospital facility’s financial assistance policy specifies that individuals known to be eligible for the financial assistance are billed no more</p>



Suggested Questions	Suggested Instructions
<p>policy to no more than what is generally billed to individuals who have insurance covering such care?</p> <p>Yes No</p>	<p>than the “amount generally billed”.</p> <p>The amount generally billed can be determined by using the best or an average of the best three negotiated commercial rates; the Medicare rate; rates derived under state law; or by any other reasonable calculation.</p>

Billing and Collections

Discussion

Section 501(r)(6) prohibits a hospital facility from engaging in extraordinary collection actions before it has made reasonable efforts to determine whether the individual is eligible for assistance under the hospital’s financial assistance policy.

CHA recommends that the term “extraordinary collections actions” be understood to mean “any collection action which requires court proceedings to initiate.” This would be consistent with the Joint Committee’s explanation that this provision is meant to restrict the use of “lawsuits, liens on residences, arrests, body attachment, or other similar efforts.” This also would clarify that referral to a collection agency or reporting to a credit agency is not an “extraordinary collection action”.

CHA recommends that a hospital will have engaged in “reasonable efforts” if, in addition to making its financial assistance policy “widely publicized” through the measures set forth in such policy, it has a policy in place to include a summary of its financial assistance policy in at least one bill mailed or otherwise provided to the patient following the provision of hospital services.

To implement the above, CHA recommends that the following questions and instructions be added to the IRS Form 990, Schedule H, Part V:

Suggested Questions	Suggested Instructions
<p>Does the hospital facility have a policy that it does not engage in extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for</p>	<p>A hospital facility can answer “yes” to this question if :</p> <ul style="list-style-type: none"> • It has a policy requiring “reasonable efforts” to determine a patient’s eligibility for financial assistance

Suggested Questions	Suggested Instructions
<p>assistance under its financial assistance policy?</p> <p>Yes No</p>	<p>under its financial assistance policy before the initiation of “extraordinary collection actions.”</p> <ul style="list-style-type: none"> • “Reasonable efforts” means that in addition to making its financial assistance policy “widely publicized” through the measures described in such policy, a hospital has a policy in place requiring it to include a summary of the financial assistance policy in at least one invoice mailed or otherwise provided to the patient following the provision of hospital services. • “Extraordinary collection efforts” means any collection action which requires court proceedings to initiate.

Application of § 501(r) on a Facility-by-Facility Basis

Discussion

Section 501(r)(2)(B)(ii) 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 § 501(r) separately with respect to each facility. 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 § 501(c)(3). Accordingly, one facility’s failure to meet the new requirements does not negate the tax-exemption of the hospital organization. Section 501(r), however, does not specify whether the facility will be treated as tax-exempt under some other provision of § 501(a) 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 filing organization’s Form 990.

We urge the IRS to issue guidance that clarifies that this provision would be triggered only if (and for the tax year during which) there were a substantial failure to meet the requirements as measured on a facility-by-facility basis, and then only when that substantial failure relates to a requirement other than the community health needs assessment to which the \$50,000 penalty already applies. Moreover, if a failure to satisfy one of the Section 501(r)



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requirements is “cured” by the end of the fiscal year being reported, such should not be deemed to be a failure 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 (including, but not limited to, those available under IRC Section 7121) to resolve any reporting issues rather than resorting to other unduly burdensome and impractical consequences such as requiring the filing of a Form 990-T; requiring a determination of exemption for such facility under some other provision of Section 501(a); or causing the organization to lose exemption for its other hospitals that have been compliant. If the Service determines it lacks sufficient authority to issue guidance establishing such a reasonable cure period for any failure to meet the new requirements, we would urge the Treasury and the Service to seek legislative action granting it the necessary authority.

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Again, thank you for requesting input on these important issues. Please feel free to contact me at (202) 721-6319 if you would like to discuss our comments further.

Sincerely,

A handwritten signature in black ink, appearing to read "Lisa J. Gilden". The signature is fluid and cursive, with the first name "Lisa" and last name "Gilden" clearly distinguishable.

Lisa J. Gilden
Vice President, General Counsel