



*A Passionate Voice for Compassionate Care*

September 24, 2012

Sarah Hall Ingram  
Commissioner  
IRS Tax-Exempt & Government Entities Division  
Internal Revenue Service  
P.O. Box 7604  
Ben Franklin Station  
Washington, DC 20044

Re: **REG-130266-11, Additional Requirements for Charitable Hospitals, Proposed Rule**

Dear Commissioner Ingram:

The Catholic Health Association of the United States (CHA), representing Catholic sponsored hospitals and other health care facilities, sponsoring organizations and health care systems, is pleased to provide comments on the Internal Revenue (IRS) June 22, 2012 Notice of Proposed Rulemaking (NPRM) concerning requirements for charitable hospitals relating to financial assistance and emergency medical care policies, charges for certain care provided to individuals eligible for financial assistance, and billing and collections. The proposal implements section (501)(r) of the Internal Revenue code, added by Section 9007 of the Patient Protection and Affordable Care Act (ACA).

The Catholic health ministry is committed to making sure that health care is affordable and accessible for everyone, including those who cannot afford to pay some or all of the cost of the medical care they need. Since 1989, with publication of our *Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint*, CHA has advocated for and worked to promote financial assistance policies (FAP) and procedures that are just, compassionate, and respectful. CHA supported the financial assistance and billing provisions in the Act and supports the intent of the NPRM.

We believe Section 501(r) is primarily concerned with creating transparency and accountability in charitable hospitals' policies, and that should be reflected in the implementing regulations. This is the approach the IRS took in its notice on the community health needs assessment (CHNA) (2011 – 52), which asks hospitals to describe how they are carrying out the requirements rather than telling hospitals exactly what

they must do. We recommend the IRS follow that model in the regulations on FAP, billing and collections. We are pleased that the proposal emphasizes accountability over substantive requirements with respect to the content of FAPs and of FAP applications. **In other areas, however, we are concerned that the degree of detail in the requirements could hinder the underlying goal - making sure patients eligible for assistance under hospitals' FAPs get the help they need in a timely and manageable manner.**

Our members' concerns are heightened by the lack of guidance on the consequences of failing to meet the proposed requirements. Will all forms of noncompliance face the same penalties? Will there be an opportunity for remediation for some or all violations? Understanding the risk of noncompliance is an important element in analyzing the reasonableness and burden of proposed regulations. A reasonable and balanced enforcement structure is essential for both patients and hospitals. **We suggest the IRS provide guidance and seek comments on enforcement before finalizing the rule.**

We would like to offer the following specific recommendations and requests for clarification:

#### **Financial Assistance Policies**

**We agree with the approach taken in the proposed regulations that hospitals determine their own financial assistance policies;** for example, which categories of patients are eligible and which levels of assistance are available. **It would be helpful if the IRS could further emphasize this point in the preamble to the final rules.** One area of uncertainty that has arisen is the point of time used to determine financial eligibility following a treatment episode. A hospital should be able to determine that point – at the time of service, perhaps, or at the time of application – as long as it is stated clearly in the FAP. It would also be helpful to clarify that amounts generally billed (AGB) constitutes the maximum amount a FAP-eligible patient may be charged, but hospitals are free to design policies that allow additional discounts .

#### *Widely Publicizing the FAP*

We support the concept that information about FAPs should be made widely available so that those who need medical care but fear the cost of a hospital stay will not hesitate to seek treatment. Using the web; making paper copies available; providing a plain language summary; posting information in the hospital; and making sure the community is informed are all appropriate ways to publicize FAPs. We appreciate the inclusion in the proposal of examples of which activities might constitute widely publicizing the FAP. **However, we ask that the final regulation make clear that these examples are not the**

**only way to meet the widely publicized requirement. Hospitals must be able to publicize their FAPs in a manner that will be most effective given the needs and situation of the community they serve and a hospital's geographic primary service area.**

#### *Plain Language Summary*

There is some confusion over whether the name and phone number of a specific contact person must be included in the plain language summary of the FAP. This could potentially create an unnecessary obstacle to someone seeking information about a FAP if the staff person identified in the summary leaves or changes location and phone number. **To prevent confusion for those seeking assistance, IRS should clarify that the plain language summary would identify the location and phone number of the appropriate office or department to contact for FAP information, without naming a specific staff person.**

#### **Emergency Medical Care Policies**

CHA agrees that nothing should delay, interfere with or discourage one from seeking emergency medical treatment. The *Emergency Medical Treatment and Labor Act* (EMTALA) requires that emergency medical care be provided to all, regardless of ability to pay. Hospitals have designed their policies concerning registration procedures in the emergency department, including when in the process it is appropriate to ask for copays, to comply with EMTALA. **We believe EMTALA provides adequate protections and we recommend that the IRS not include in the final regulations additional requirements beyond EMTALA.** A written statement that the hospital's policy complies with EMTALA should suffice.

The proposed regulations also are vague about which activities are prohibited or permitted in the emergency department. It is not clear whether emergency department patients with insurance may be asked to provide a copay after treatment, during discharge or before treatment, if done in a manner that does not delay or deny care. The prohibition against "debt collection activities in the emergency department" casts doubt on the ability to begin to inform patients about their potential eligibility under the hospital's FAP following treatment and after EMTALA obligations have been met. Having a person-to-person conversation at the point of service is an effective way to identify and assist FAP-eligible patients. This interaction can be especially important in the case of someone with very low literacy skills, who may not be able to understand adequately the written information that is provided. **Allowing hospitals to satisfy the emergency**

**medical care policies by complying with EMTALA will eliminate this confusion and facilitate patient access to the FAP.**

### **Limitation on Charges**

#### *Calculation of Amounts Generally Billed*

Section 501(r) of the code limits the amount hospitals may charge FAP-eligible individuals to no more than the amount generally billed (AGB) to insured patients. The proposed rule would require hospitals to use one of two approaches for calculating AGB. The look-back method would use either Medicare payments or a combination of Medicare and all private health insurers over a 12-month period. The prospective method would use Medicare rates as the AGB.

We believe this approach is more restrictive than was intended by the statute. Our members are concerned that both of the proposed methods include Medicare claims payments, which are increasingly inadequate to cover the cost of care. Allowing hospitals to use a method that does not include Medicare is clearly consistent with the intent behind Sections 501(r). The Joint Committee on Taxation in its Technical Explanation of the Affordable Care Act uses permissive language and clearly contemplated that hospitals could choose among several different methods for determining AGB, including ones that do not include Medicare rates: "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."

In addition, several states have requirements on how much uninsured or low-income patients can be charged. It would be unduly burdensome to require hospitals in those states to set up two different calculation methods to comply with both state and federal law. If a hospital complies with state law on patient discounts and clearly discloses in the FAP what the discounts are and how they are calculated, the goals of 501(r) will have been met: to provide reduced cost care to FAP-eligible patients in a transparent manner. **We recommend that a variety of means should be permitted to calculate AGB, including state mandated discounts. At the very least, a third option under the look-back method should be added that excludes Medicare and allows the use of only claims paid from private health insurers.**

#### *Application to Insured Patients*

Many hospitals provide assistance to both uninsured patients and patients who are insured but have difficulty paying deductibles or copays. The structure of the proposed

rule seems to assume that FAP-eligible patients will be uninsured and is vague about how the rules would apply to assistance offered to insured patients. For example, the proposed limitations on what a hospital may charge apply to “amounts charged *for care it provides* to any individual who is eligible for assistance under its ... FAP” (emphasis added). The proposed regulations appear to suggest that a hospital could only provide financial assistance for the insured if the hospital applies “amounts generally billed.” But hospitals should be able to continue to charge insurance companies negotiated rates for care provided to insured patients, not AGB, even if the individuals qualify under the hospital’s policies for assistance with copays and deductibles. We are concerned that failure to clarify this point could have the unintended consequence of some hospitals curtailing their assistance to insured patients, if they must otherwise bill AGB, not negotiated rates, for their care. **The proposal should be revised to clarify that AGB does not apply to insured individuals, allowing hospitals to continue to include in their FAPs insured patients who struggle to pay deductibles and copays.**

### **Billing and Collection**

The proposed rule would prohibit a hospital from engaging in extraordinary collection actions (ECAs) against an individual before it makes reasonable efforts to determine whether he or she is eligible for assistance under the FAP. The proposed definition of ECAs includes legal or judicial actions, selling debt to a third party, or providing information to a credit reporting agency. The IRS asks for comments on whether selling or referring debt should be considered an ECA.

**We agree with the proposal to exclude debt referral from the ECA definition.** By engaging professional collection agencies to manage patient financial obligations, hospitals can continue to focus their attention on care giving. It is the norm for a hospital’s contractual arrangement with a collection agency to specifically provide what the agency is and is not permitted to do with respect to its collection efforts on behalf of the hospital. It is expected that whatever the final regulations require a hospital to do (and not do) with regard to collection efforts, including the commencement of ECAs, would be reflected in the collection agency agreements.

However, we are concerned about the proposal to make hospitals strictly liable for the actions of the contracted collection agency, particularly because at this point the consequences of even a single mistake by the agency would appear to be revocation of the hospital’s tax exemption. This is well beyond many current federal regulatory approaches involving delegation of statutory responsibilities to third parties.

For example, under HIPAA, hospitals must enter into written contracts with entities to which they provide protected health information requiring them to safeguard the privacy of such information. However, HHS does not require hospitals to monitor or oversee the means by which such entities carry out the privacy safeguards under the contract. Nor is the hospital responsible or liable for the actions of such entity. Instead, under the HHS approach, if a hospital finds out about a material breach or violation of the contract by the entity, it must take reasonable steps to cure the breach or end the violation, and, if unsuccessful, terminate the contract with the entity.

We believe that a similar approach should be applied in the context of hospitals and collection agencies with respect to Section 501(r) responsibilities.

Finally, there is some confusion about whether and how the proposed rules on billing and collection would apply to a person who has been identified as FAP-eligible and billed in conformity with the rule, but the patient then does not pay some or all of the amount properly billed. In that situation it appears the 501(r) regulations have been fully complied with and the hospital would be free to pursue the debt using whichever methods it deems appropriate, without further IRS requirements. **It would be helpful if IRS could clarify that, once the requirements under 501(r) have been met, hospitals are free to pursue unpaid debt at their discretion.**

#### **Reasonable Efforts to Determine FAP Eligibility**

The IRS has proposed a detailed series of steps within a drawn out timeline that hospitals must follow before they can be deemed to have made reasonable efforts to determine whether an individual is eligible for assistance under the FAP. We urge the IRS to streamline this process for the benefit of both hospitals and patients.

#### *Required Forms of Contact/Notice*

While making sure potentially eligible patients are aware of a hospital's FAP and are able to apply for assistance are key elements of a FAP, the proposals' notice requirements are costly and burdensome. Hospitals must give patients a FAP application prior to discharge; include a plain language summary of the FAP in bills, of which there must be at least three, and all other written communications concerning the bill; and inform the individual about the policy in all oral communications regarding the amount due.

**We believe this approach is overly restrictive and recommend the IRS give hospitals more flexibility in how they provide information about FAPs in bills given their own existing billing practices and available resources.** For example, a hospital might choose

to include a prominent statement on their bills indicating that financial assistance is available and how to find out more about it. Another hospital may choose to add a plain language summary in the first bill with such a statement but not subsequent ones.

We are also concerned about making it a *requirement* that ALL oral communications about amounts due include information about the FAP. While it seems logical that such discussions would include information about financial assistance, human beings are not perfect and having one telephone call in which the patients is not “informed about” the FAP should not negate the exercise of reasonable efforts by the hospital. Indeed, once the individual is informed about the policy and in the process of applying, there is no need to “inform” the patient about the policy as they already know about it. Finally, this requirement is an open invitation to “he said-she said” disputes. As mentioned above in the context of allowing discussions about bills to occur in the ED, we recognize the importance of oral communication, especially for those with limited literacy skills. **However, the requirement that all oral communications inform the individual about the FAP is overly burdensome and should be dropped.**

#### *Time Periods Involved*

The entire process of notification and application as proposed can last up to nine months – a 120 day notice period, followed by a 120 application period, followed by, in the case of an incomplete application filed at the end of period, an additional 30 days. Until that point, a hospital cannot proceed with collection methods defined as ECAs with any certainty. **We believe this period is too long and urge the IRS to limit the entire process to no more than 180 days, with flexibility for hospitals on how they apportion the notice and application periods.** Six months should be adequate time for the hospital to take reasonable steps to inform an individual about its FAP and to allow the individual to begin the application process. Some of our members report that longer application periods can be counterproductive as people are less likely to respond to communications or submit an application as time goes by.

#### *Additional Methods of Determining Eligibility or Ineligibility*

The proposed rule ties reasonable efforts to determine eligibility directly and exclusively to compliance with a detailed application process. Certainly the application process is an important tool in identifying and assisting those who need help in paying for their medical care. However, hospitals frequently are able to determine eligibility for their FAPs without

an application, using information about the patient such as homelessness, employment status, and eligibility for government assistance programs. Further, in recent years several innovative electronic systems have been developed for hospital finance offices. These automated systems can help hospitals determine eligibility for financial assistance and generate bills in an efficient and standardized way. **We urge the IRS in the final rule to allow hospitals' use of alternate methods of determining eligibility to constitute reasonable effort.** While we appreciate that the proposal includes a presumptive eligibility safe harbor, we believe it is too narrow. The safe harbor is only available if the individual is given the most generous form of assistance allowed under the FAP. It offers no protection for hospitals that provide sliding scales of assistance at different income levels.

The proposed rule does not appear to provide hospitals with a way to efficiently identify those who are not FAP-eligible. As noted above, the rule is unclear on how it applies to individuals with insurance. The rule also defines FAP-eligible individuals as those eligible under the FAP regardless of whether they have applied or not. Finally, the rule expressly provides that use of a waiver does not constitute a reasonable effort to determine eligibility. The result seems to be that hospitals must treat all patients as potentially eligible under the FAP. **The IRS should include a way for hospitals to identify as early as possible those who are clearly ineligible for the FAP without submitting such individuals to the application process.** As one example, while allowing broad use of waivers may not be wise, waivers could be permitted if used in a targeted manner and revocable should new information arise.

The approach taken in the NPRM seems to assume that FAP-eligibility is tied to a particular instance of medical treatment and that eligibility is to be reassessed for each treatment event. While we agree hospitals should have the option to take this approach under the regulation, many hospitals will continue to treat an individual as FAP-eligible for a certain period following the initial determination. **We recommend the IRS give hospitals the option to determine how long FAP-eligibility status may last, as long the FAP discloses this and allows status to be adjusted to a more generous level if the patient's financial situation changes.**



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### **Enforcement**

As stated earlier, we urge IRS to issue further guidance and seek comment on how it plans to enforce the proposed rule. **CHA recommends that the enforcement mechanism give hospital facilities the opportunity to correct any failure to comply with these rules, to develop a plan of correction and to be found in compliance after corrective action is taken.**

### **Conclusion**

CHA and the Catholic health ministry are firmly committed to providing financial assistance to patients who cannot afford the cost of care in a timely, compassionate and transparent manner. We appreciate the work of the IRS in developing regulations to implement Section 501(r) and we believe the proposal can be strengthened by increasing the focus on transparency rather than prescriptive requirements. Doing so will help to create a smoother and more manageable process that will enhance access to financial assistance for those who need it.

If you have any questions about these comments or if we can be of any assistance as you continue to develop these policies, please do not hesitate to contact Julie Trocchio ([Jtrocchio@chausa.org](mailto:Jtrocchio@chausa.org); 202 721 6320) or Kathy Curran ([Kcurran@chausa.org](mailto:Kcurran@chausa.org) 202 296 3993).

Sincerely,

A handwritten signature in cursive script that reads "Michael Rodgers".

Michael Rodgers  
Senior Vice President  
Advocacy and Public Policy