



hfma
healthcare financial management association

September 24, 2012

CC:PA:LPD:PR (REG-130266-11)
Room 5203
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Comments in Response to Section 501(r) Proposed Regulations

Dear Sir or Madam:

The Healthcare Financial Management Association (HFMA) appreciates this opportunity to comment on the Department of the Treasury and Internal Revenue Service's proposed regulations relating to the Patient Protection and Affordable Care Act's (Public Law 111-148 (124 Stat. 119 (2010)) (the Affordable Care Act)) enactment of section 501(r) of the Code, as published in the June 26, 2012, issue of the *Federal Register*. Section 501(r) adds requirements for hospital organizations that are (or seek to be) recognized as described in section 501(c)(3). Section 501(r)(1) of the Code states that an organization described in section 501(r)(2) (a hospital organization) will not be treated as described in section 501(c)(3) unless the organization meets the requirements described in section 501(r)(3) through 501(r)(6).

HFMA is a professional organization of more than 39,000 individuals involved in various aspects of healthcare financial management. HFMA is committed to helping its members improve management of and compliance with the numerous rules and regulations that govern the industry. We appreciate Treasury's efforts to more clearly define the additional procedures hospital organizations must follow for those that are (or seek to be) recognized as described in section 501(c)(3). However, we believe that within the proposed rule, clarification and change is needed in the following areas:

- Duplicative or conflicting procedures and requirements
- Burdensome processes and record keeping
- Inconsistent standards and unintended consequences

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Duplicative or Conflicting Procedures and Requirements

Although we believe the intentions behind the regulation—ensuring that charitable hospitals have a clearly written and communicated financial assistance policy (FAP) and emergency medical care policy (EMCP)—are good, we are concerned that the proposed regulations will require hospital organizations to make duplicative efforts without any gains in the practical utility of the information provided to the Internal Revenue Service.

First, many hospital organizations already have in place written policies that cover most, if not all, of the section 501(r) requirements. **Rather than requiring a rewrite of these policies, the regulations should give hospital organizations the flexibility to incorporate these policies by reference into a consolidating policy.**

Second, we believe that requiring separate policies for each organization will be unnecessary and redundant in many instances. **Multihospital organizations, for example, should be able to adopt system-level policies meeting section 501(r) requirements that qualify as compliant policies for the individual hospitals within the organization.**

Finally, the proposed EMCP requirements both duplicate and conflict with federal Emergency Medical Treatment and Labor Act (EMTALA) requirements. Hospitals have built their emergency department policies and procedures around EMTALA's requirement that emergency medical care be provided to all in need without regard to their ability to pay. The EMTALA regulations already establish ground rules for registration processes and discussions regarding a patient's ability to pay. We urge that the final 501(r) regulations recognize EMTALA's role and not attempt to separately regulate interactions in the emergency department.

When EMTALA obligations have been met and a patient is being discharged, it is customary to discuss financial responsibility and financial assistance, including responsibility for co-pays or deductibles. As written, the proposed rule could prohibit this interaction from occurring. This interaction is a key opportunity for hospitals to interact with their patients in regard to guidelines of their FAP as well as eligibility and application. **EMTALA should continue to be the controlling federal guidance for a hospital's interactions with patients in the emergency department.**

Burdensome Processes and Record Keeping

As mentioned above, we agree that the goal of ensuring that charitable hospitals have clearly written and communicated FAPs and EMCPs is good. However, we are concerned that the processes and record keeping for hospitals to demonstrate "reasonable efforts" in the proposed regulations are unnecessarily burdensome and will require significant expenditures of time and resources, increasing costs within the healthcare system without increasing access to care or benefiting the patient.

The focus of the regulation is on the patient completing an application for financial assistance. In reality, this is an area that consumes considerable resources and produces significant frustration for hospitals because of patients' reluctance or unwillingness to provide complete and timely information. Hospitals do not wish to pursue or take extraordinary collection actions (ECAs) against patients who have no ability to pay. Such actions waste valuable resources, do not provide charity care to persons

who have no ability to pay, and do not result in payment. But hospitals must determine whether a patient is eligible for charity care or medically indigent before they can know whether some form of financial assistance is appropriate or whether collection efforts should be pursued. "Reasonable efforts" in making this determination are an expensive endeavor. If patients fail or refuse to apply for financial assistance and do not pay for the services rendered, hospitals must be able to determine whether the patient is presumptively eligible for financial assistance or whether the patient has the ability to pay. **If hospitals can document that they have taken the required steps to verify eligibility but have not had the cooperation of the patient in providing the information requested in a timely manner, or are unable to establish presumptive charity from other records, they should be deemed to have satisfied the requirement of "seeking to determine whether an individual is financial assistance policy (FAP)-eligible".**

"Reasonable efforts" should include obtaining documentation of a patient's eligibility for financial assistance on presumptive eligibility grounds. For example, if a patient is subsequently incarcerated, recently filed an affidavit of indigence in a court proceeding, or has income that qualifies for financial assistance as documented in other public records such as a SearchAmerica Report, the hospital facility may reasonably determine eligibility for financial assistance without the patient's cooperation. Public records may also reflect income sufficient to pay the amounts due. In addition, a hospital facility's FAP may apply only to uninsured patients. In this case, if the hospital obtains documentation that a patient has some level of health insurance coverage (such as a payment from an insurance company or evidence of Medicaid eligibility), then "reasonable efforts" should be considered satisfied. The hospital facility should not have to undertake all of the detailed "reasonable efforts" procedures prior to ECAs in these circumstances.

Given hospitals' difficulties in obtaining complete and timely information from patients, we also request that the Treasury make income verification (Adjusted Gross Income) as reported by IRS more readily available to hospital organizations through an automated, online process, such as an EDI 270/271 transaction, to assist hospital organizations in determining patient eligibility for financial assistance. Hospital organizations can get this information today by faxing a Form 4506-T to the IRS or calling for verification. Streamlining that process for healthcare organizations through an automated process would both minimize the burdens of determining eligibility and provide administrative simplification, one of the original goals of the Affordable Care Act.

We also recommend—given the fact that FAPs can be several pages long—that a hospital organization should be deemed to have met the community and patient notification requirements of section 501(r) through the use of summaries, which may fit on a single page or an informational pamphlet and provide more readily understood and accessible information to patients.

Additionally, we are concerned that the proposed regulations' requirement that a paper plain-language summary of the FAP be included with all (and at least three) billing statements during the 120 day notification period will add significantly to the cost of mailing the billing statements and be a waste of paper. Instead, we recommend that a paper plain language summary be included in the first statement only, with a direct website address or URL for the plain language summary of the FAP on subsequent statements. We would also suggest that other forms of mobile delivery, SMS text, or email delivery be considered sufficient methods of notification in instances where patients have access to these forms of communication.

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Finally, hospital facilities are required to calculate amounts generally billed (AGB) under the "look-back" method using "emergency and other medically necessary" claims and charges only. That requirement is very burdensome for hospitals to perform. Calculated discounts will not vary materially for medically necessary versus elective or non-medically necessary care. It would thus be preferable to base the calculations on all claims and all charges.

Inconsistent Standards and Unintended Consequences

The definition of ECAs includes methods that are standard practice not only in the hospital industry, but also in other not-for-profit organizations, commercial businesses, and governmental entities. These methods include reporting to a credit agency or credit bureau and selling debt to third-party collectors. Unless the federal government plans to consider such methods extraordinary for all not-for-profit organizations (e.g., universities, FQHCs, etc.), we believe that these methods, which are all routine and normal actions, should be excluded from the definition of ECAs. Defining one set of requirements for not-for-profit hospitals and a different set for other not-for-profit organizations creates inconsistency within the standards to which organizations are held accountable under section 501(c)(3) of the Code.

If hospitals have effectively communicated their FAP, the proposed 120-day notification period should allow sufficient time for patients to complete a FAP application. To add a second 120-day application period during which a hospital's ability to engage in any collection actions that require a legal or judicial process may be suspended is extremely detrimental to a facility's ability to recover from patients with resources available to pay the amounts due. In addition, the Fair Debt Collection Practices Act (FDCPA) already allows 30 days after a person has been notified of a debt to respond and dispute that the debt is valid. Therefore, **we strongly urge that the application period be removed from the regulations, allowing hospitals to commence ECAs without further delay following expiration of the 120-day notification period. We also recommend that the FDCPA's 30-day notice for validation of debt be applied after the provider turns an account over to a third-party collection agency. Additional periods are unnecessary.**

If both the notification and application periods remain in the regulations, hospitals will need to develop aging processes to be able to track the number of days subsequent to when the hospital "provides the individual the first billing statement" during the notification period or the number of days subsequent to when the hospital has informed a patient of an incomplete application during the application period. **There are significant costs involved in multiple aged accounts receivable with new and separate workflows to ensure that the generation of statements complies with the regulations for potential FAP patients.**

Many hospitals offer assistance to individuals who have insurance but need help with their balances after insurance payment. The proposed regulations could make the extension of such assistance economically unfeasible and reduce assistance otherwise provided. As proposed, the regulations appear to require that financial assistance for the insured may be provided only if the AGB is applied. The congressional objective for the limitation on charges was to provide those lacking adequate insurance coverage the benefit of rates paid by the insured. Requiring that assistance for the insured is provided at

the same level as the uninsured would create confusion and misapplication of the standard. **The final regulations should confirm that hospitals may continue to offer assistance to the insured, at their discretion, through their financial assistance policies and clarify that the AGB does not apply to assistance for the insured.**

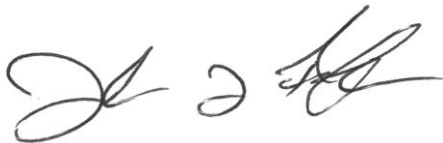
AGB determination options should match congressional intent to include a method that does not incorporate Medicare payments. Hospitals have established their AGB using the guidance provided by Congress when these provisions were enacted. The proposed regulations provide only two methods for calculating AGB, and both methods require that payments received from Medicare be included in the calculation. However, in many cases, Medicare does not cover the costs for providing care to its beneficiaries and therefore a formula based on payments that do not cover costs is economically unfeasible and limits the ability of hospitals to extend assistance to those who are truly in need. **We urge that the final regulations permit flexibility and, at a minimum, allow use of the options Congress expressly contemplated, including a method that does not incorporate Medicare payments.**

Finally, the regulations do not provide guidance to hospital organizations regarding how they are to handle the period that began beginning with the tax year that began after the Affordable Care Act was signed (March 23, 2010) and the date that the final regulations (as drafted in the notice of proposed rulemaking) become effective. **In the event a hospital facility discovers it is not in compliance with the regulations, the facility should be provided an opportunity to cure the deficiencies.**

HFMA looks forward to any opportunity to provide assistance or comments to support the effort to create a simplified, standardized, and non-duplicative program. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, CMS, OMB, and advisory groups.

We are at your service to help gain a balanced perspective on this complex issue. If you have additional questions, you may reach me or Richard Gundling, Vice President of HFMA's Washington, DC, office, at (202) 296-2920. The Association and I look forward to working with you.

Sincerely,

A handwritten signature in black ink, appearing to read 'J. Fifer', with a stylized flourish at the end.

Joseph J. Fifer, FHFMA, CPA
President and Chief Executive Officer
Healthcare Financial Management Association

About HFMA

The Healthcare Financial Management Association (HFMA) provides the resources healthcare organizations need to achieve sound fiscal health in order to provide excellent patient care. With more than 39,000 members, HFMA is the nation's leading membership organization of healthcare finance executives and leaders. HFMA helps its members achieve results by providing education, analysis, and guidance, and creating practical tools and solutions that optimize financial management. The organization is a respected and innovative thought leader on top trends and challenges facing the healthcare finance industry. From addressing capital access to improved patient care to technology advancement, HFMA is the indispensable resource for healthcare finance.