799 9th Street, N.W.
Suite 210
Washington, D.C. 20001

May 27, 2015

Victoria Judson
Associate Chief Counsel
Tax-Exempt and Governmental Entities
Internal Revenue Service
1111 Constitution Avenue, N.W.
Washington, DC 20224

Re: **New Requirement to List and Classify Medical Care Providers in Regulations Issued under Section 501(r)(4)**

On behalf of VHA, I am writing to offer comments on recently released final regulations issued under Section 501 (r) for tax-exempt hospitals. Based in Irving, Texas, VHA is a national network of health care organizations working together to drive maximum savings in the supply chain arena, set new levels of clinical performance, and identify and implement best practices to improve operational efficiency and clinical outcomes. Today, we serve 5,000 health system members and affiliates, representing more than a quarter of the nation's hospitals across all 50 states. We also serve more than 118,000 non-acute health care customers enterprise-wide.

VHA is concerned about the inclusion of a new requirement in the final regulations recently issued under Section 501(r) relating to the Affordable Care Act's statutory requirement that tax-exempt hospitals have a written financial assistance policy ("FAP") as well as a written emergency medical policy. The new regulatory requirement would require that a hospital's FAP, among many other obligations, "list the providers, other than the hospital facility itself, delivering emergency and other medically necessary care in the hospital facility" and "specify which providers are covered by the hospital's FAP and which are not." *See* Treas. Reg. 1.501(r)-4(b)(1)(iii)(F).

VHA objects to this new Provider List/Classification requirement for the following reasons: (1) the requirement is not contained in or consistent with the underlying statute or legislative intent of Congress, (2) the new requirement will impose unreasonable information-gathering burdens on tax-exempt hospitals, and (3) the costly implementation of the new requirement will not effectively assist health care consumers to secure financial assistance. VHA also aligns itself with the recent comments of the American Hospital Association and the Association of American Medical Colleges noting that the inclusion of this new requirement for the first time in final regulations did not give the hospital community adequate opportunity to collaborate with the IRS on a workable solution to the problem sought to be addressed.

Inconsistency of New Regulatory Requirement with Statute/Congressional Intent

Section 501(r)(4) states that an organization meets the requirements of this paragraph if the organization establishes the following policies:

(A) FINANCIAL ASSISTANCE POLICY—A written financial assistance policy which includes--

(i) eligibility criteria for financial assistance, 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) in the case of an organization which does not have a separate billing and collections policy, the actions the organization may take in the event of non-payment, including collections action and reporting to credit agencies, and

(v) measures to widely publicize the policy within the community to be served by the organization.

(B) POLICY RELATING TO EMERGENCY MEDICAL CARE--a written policy requiring the organization to provide, without discrimination, "care for emergency medical conditions" (within the meaning of 42 U.S.C 1395dd) to individuals regardless of their eligibility under the financial assistance policy described in subparagraph (A).

Nowhere in the statute is there any reference to requiring tax-exempt hospitals to list in their FAP those individual or group medical providers operating within a hospital to provide emergency or medically necessary care, and then classifying such providers as to whether they are individually or corporately bound by the hospital's FAP.

The Act's legislative history, as contained in the Senate Finance Committee Report and the Joint Committee on Taxation's Technical Explanation, largely reiterates the statutory requirements.[1] In addition, Finance Committee provides that a hospital's financial assistance policy must indicate how to apply for financial assistance.[2] With respect to the emergency medical assistance policy, the legislative history states that the hospital's policy must "prevent discrimination" in the provision of emergency medical treatment, including denial of service, against those eligible for financial assistance

[1] S. Rep. No. 111-89, at 311 (2009); Staff of the Joint Committee on Taxation, 111th Cong., Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as amended, in combination with the "Patient Protection and Affordable Care Act" ("Technical Explanation), at 82.

[2] Id.

under the facility's financial assistance policy or those eligible for government assistance.[3] Nothing in the legislative history suggests that Congress expected hospitals to report on whether individual physicians or physician groups, who bill separately for their services, were bound by the hospital's FAP or some other FAP.

Because there is no evidence that Congress thought it was appropriate or necessary for a hospital to list and classify the FAP-status of other providers in promulgating its own financial assistance policy, this new section of the regulations (i.e., the Provider List/Classification requirement) represents a gross administrative over-reach and should be immediately withdrawn.

Imposition of Unreasonable Information-Gathering Burdens on Hospitals

By requiring every hospital with a FAP to compile a list of "any providers other than the hospital facility itself, delivering emergency or other medically necessary care in the hospital facility," the IRS is imposing an obligation of uncertain scope. Notably, the Final Regulations do not contain a definition of the term "provider." Thus, the administratively required list of "providers" delivering "emergency or other medically necessary care" within the hospital could include a very large number of individual employees and independent contractors, as well as medical groups organized as limited liability companies (LLCs), professional corporations or nonprofit organizations. In the case of many large academic medical centers, the number of medical providers delivering medically necessary care in the hospital will likely number several hundreds, if not over a thousand.

Having compiled this massive list, it will then be necessary for each hospital to classify each provider listed as to whether the provider is "covered by the hospital facility's FAP" or is not covered. In most cases, this classification will require knowledge of the individual's status as an employee or independent contractor of the hospital. However, in the case of providers who are employees of a medical group, the classification will also require knowledge of the medical group's relationship with the hospital and an understanding of the group's tax status (e.g., whether the group structured as a hospital-controlled partnership or disregarded entity for tax purposes).

The IRS requirement to list and classify medical providers thus imposes an unreasonable compliance burden on tax-exempt hospitals. As explained above, this compliance burden was not intended by Congress, and is not consistent with legislative intent. As further explained below, this compliance burden is particularly unreasonable because it does not appear to accomplish much of anything for those individuals seeking to maximize financial assistance with their medical bills.

[3] Id.

Inefficacy of Compiling a Provider List and Including It in Hospital's FAP

VHA acknowledges that a legitimate goal of the FAP requirement is to assist those who are eligible for financial assistance to be able to obtain such assistance. However, VHA does not believe that the requirement to list and classify hundreds of medical providers as being subject to the hospital's FAP or not will contribute to serve that goal in any meaningful or effective way. Many of the providers seeing patients in a hospital are not hospital employees, and thus are not automatically subject to the hospital's FAP. However, they may be employees of a medical group that has its own charity care policy or FAP. Furthermore, as AHA and AAMC noted in their submission, individuals coming to a hospital to receive emergency or medically necessary care cannot control who is available to attend to their medical needs at any particular time. Thus, it appears to us that while tax-exempt hospitals should be expected to equip their own financial assistance counselors with a reasonable understanding of the various types of providers operating within the hospital (and the charity care resources that those providers may offer), requiring hospitals to list and classify providers in a special section of an already overly detailed and lengthy FAP document serves no useful purpose.

Conclusion

In sum, VHA objects to the inclusion of the provider list requirement as contained in the final regulations because (1) it goes far beyond the scope of the statute and the legislative history, (2) it imposes a costly and unreasonable burden on tax-exempt hospitals to report information on non-employees and unrelated entities, and (3) even if fully implemented, it is not an effective way of helping patients to maximize the financial assistance for which they may be eligible.

If you have any questions about this submission, please do not hesitate to give me a call at (202) 354-2608 or to contact me via e-mail at cperrin@vha.com.

Sincerely,

Cidette Perrin
Senior Director, Government Relations, VHA Inc.

cc: Ruth Madrigal, Attorney-Advisor, Treasury Department

Preston Quesenberry, Office of Chief Counsel, Internal Revenue Service
Eric San Juan, Senior Technical Advisor, Tax-Exempt and Governmental Entities, Internal Revenue Service
Kathleen M. Nilles, Holland & Knight LLP