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September 24, 2012

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

RE: CC:PA:LPD:PR (REG-130266-11)
Proposed Rule: Additional Requirements for Charitable Hospitals

Dear Commissioner Shulman:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. NHeLP provides technical support to direct legal services programs, community-based organizations, the private bar, providers and individuals who work to preserve a health care safety net for the millions of uninsured or underinsured low-income people.

It is critical that low-income and underserved individuals have access to emergency and medically necessary care at charitable hospitals, particularly if some states do not expand Medicaid eligibility as required by the Affordable Care Act (ACA). The requirements contained in ACA § 9007 are a much-needed step to ensure that no person is deterred from accessing needed hospital care because of cost. We appreciate the ability to provide comments on the proposed regulations implementing those statutory requirements. Our suggestions are based on our long experience advocating for the health rights of low-income and underserved people and aim to strengthen the proposed regulations to promote access to care and protect families from medical debt and bankruptcy.

We commend IRS for drafting a proposed rule that makes it possible for health care consumers to easily access basic information about hospital financial assistance programs for which they might be eligible, and for

providing some assurance that charitable hospitals will not be permitted to engage in certain extraordinary collection activities unless and until it has been determined that a patient does not qualify for financial assistance. In general, we support the standards outlined in the proposed rule. However, we have several specific suggestions to make the rules more meaningful for low-income and underserved individuals, particularly those with Limited English Proficiency (LEP).

I.R.C. § 1.501(r)-1: Definitions

§ 1.501(r)-4(b): Definitions

We recommend that the definition of § 1.504(r)-1(b)(3), Application period, be modified to end a minimum of 365 days after the hospital facility provides the patient with the first billing statement for the care *or* a minimum of 365 days after the patient is discharged from the hospital facility, whichever is later. In many cases, extraordinary collection actions are not commenced until long after 240 days post-discharge, and many patients may not realize that money is owed until after 240 days, particularly if they are insured and believe that outstanding charges will be covered by their insurer. Extending this period to 365 days after discharge or billing will provide a greater window for those patients who may be eligible for financial assistance to apply for it.

Likewise, we recommend that the definition of § 1.504(r)-1(b)(18), Notification Period, be modified to end 120 days after the hospital facility provides the patient with the first billing statement for the care *or* 120 days after the patient is discharged from the hospital facility, whichever is later. This will ensure that patients who spend an extended amount of time in the hospital are not disadvantaged by a rule that takes into account only the hospital's billing cycle, not the patient's particular situation.

Finally, we recommend that § 1.504(r)-4(b)(16), Hospital Organization, be modified to include the language from I.R.C. *§* 501(r)(2)(A)(ii) that a hospital organization also includes any organization that the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption under section 501(c)(3). This will help preclude confusion as to which definition was intended to apply.

RECOMMENDATION: Amend § 1.504(r)-1(b)(3) as follows:

> *Application period* means the period during which a hospital facility must accept and process an application for assistance under its financial assistance policy (FAP) submitted by an individual in order to have made reasonable efforts to determine whether the individual is FAP-eligible. With respect to any care provided by a hospital facility to an individual, the application period begins on the date the care is provided to the individual and ends on the ~~240th~~ ***365th*** day after the hospital facility provides the individual with the first billing statement for the care ***or 365 days after the patient is discharged from the hospital facility, whichever is later***.

RECOMMENDATION: Amend § 1.504(r)-1(b)(16) as follows:

> *Hospital organization* means an organization recognized (or seeking to be recognized) as described in section 501(c)(3) that operates one or more hospital facilities, including a hospital facility operated through a disregarded entity ***and any other organization that the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption under section 501(c)(3).***

RECOMMENDATION: Amend § 1.504(r)-1(b)(18) as follows:

> *Notification period* means the period during which a hospital facility must notify an individual about its FAP in accordance with § 1.501(r)–6(c)(2) in order to have made reasonable efforts to determine whether the individual is FAP-eligible. With respect to any care provided by a hospital facility to an individual, the notification period begins on the first date care is provided to the individual and ends on the 120th day after the hospital facility provides the individual with the first billing statement for the care ***or 120 days after the patient is discharged from the hospital facility, whichever is later***.

I.R.C. § 1.501(r)-4: Financial assistance policy and emergency medical care policy

§ 1.501(r)-4(b): Financial assistance policy

We recognize that ACA § 9007 does not explicitly authorize IRS to create minimum standards for hospital financial assistance policies. We strongly suggest, however, that the preamble to the final rule note that IRS is empowered to take the content of such policies into account when determining whether a hospital has met the burden necessary to qualify as a charitable hospital under I.R.C. § 501(c)(3).

We believe that hospital facilities should be required to consult with members of the community, including representatives of vulnerable or disadvantaged community members, as they develop, implement and revise their financial assistance policies. Working with community partners in developing materials, reaching out to vulnerable populations, and identifying areas for improvement can help hospitals more effectively connect patients to care. Community input on financial assistance could be incorporated as part of the overall framework for community health needs assessments, or at other points as hospitals review their financial assistance policies.

We strongly support the proposed requirement that hospital financial assistance policies be applicable to all emergency and medical care provided by the hospital facility. We also encourage IRS to issue specific guidance addressing the extent to which a non-profit hospital's financial assistance policy should apply to other providers a patient

might encounter in the course of treatment at a hospital, such as hospital-owned physician practices, non-employee physicians, and other providers.

We encourage IRS to extend the requirements of § 501(r) to all providers that provide treatment in a hospital facility. The patient, by and large, has no control over who provides emergency or medically necessary care in the hospital setting. His or her protections under § 9007 and these rules should not depend on the provider's contractual relationship with the hospital, relationships over which the patient has no control. Failing to cover all providers that provide treatment in a hospital facility would also set up a system under which the hospital might be incentivized to circumvent the intent of § 9007 and this rule by moving patients and procedures to providers that, while operating inside the hospital, fall outside their reach.

§ 1.501(r)-4(b)(3): Method for applying for financial assistance

We support the requirement contained in § 1.501(r)-4(b)(3) that covered hospitals describe the information and documentation required to be submitted as part of the FAP application. To strengthen this requirement, we recommend that IRS:

- Add language to ensure that lack of documentation of eligibility is not a barrier to financial assistance. For example, an affidavit signed by the applicant should be sufficient if no other documentation is reasonably available.
- Prohibit hospitals from requiring applicants to provide a Social Security number. Many persons eligible under the FAP may not have such a number, or may be wary of providing it.
- Allow hospitals to use patient-friendly methods to presumptively qualify patients for financial assistance. This could include verifying eligibility for other means-tested program that require proof of income and/or assets, including Medicaid, food stamps, or reduced or free school lunch programs. Under no circumstances should lack of enrollment in any such program be used to disqualify, presumptively or otherwise, a patient from the hospital's FAP.
- Be required to provide all materials in languages appropriate to the community served by the hospital, as noted elsewhere in these comments.

§ 1.504(r)-4(b)(4): Actions that may be taken in the event of nonpayment

The proposed rule does not require hospitals to translate the separate billing and collections policy populations with limited English proficiency (LEP). We request that IRS adopt the same standard for translating the billing and collections policy documents as for the FAP and all other patient materials covered by these rules. Hospitals should be required to provide translations for each eligible LEP language group that constitutes five percent or 500 individuals, whichever is less, of the population of persons eligible to be served. Doing so will satisfy the intent of the regulation, which is that hospitals take reasonable measures to inform individuals about the FAP. The billing and collections policy contains information that is important to FAP applicants and therefore must be translated in order for LEP individuals to fully understand their rights and obligations.

RECOMMENDATION: Amend § 1.504(r)-4(b)(4)(C)(ii) as follows:

> *(ii)* In the case of a hospital facility that satisfies paragraph (b)(1)(iv) of this section by establishing a separate written billing and collections policy, the hospital facility's FAP must state that the actions the hospital facility may take in the event of nonpayment are described in a separate billing and collections policy and explain how members of the public may readily obtain a free copy of this separate policy. ***The separate billing and collection policy must satisfy the translation requirements found in § 1.501(r)-4(b)(5)(B).***

We suggest changes to 1.501(r)-4(b)(5)(B) below.

§ 1.501(r)-4(b)(5): Widely publicizing the FAP

We commend IRS for explicitly defining the steps non-profit hospitals must take to "widely publicize" their financial assistance policies. We recommend that final rules retain the requirement that non-profit hospitals make free copies of the full financial assistance policy, application form, and a plain language summary available upon request and on the Web. Similarly, we strongly support the requirement that non-profit hospitals "inform and notify" community residents and hospital visitors about financial assistance, with special emphasis placed on communities most likely to need that assistance. We also recommend that IRS work with HHS to link hospital policies on a national, searchable website, such as www.healthcare.gov.

However, we strongly recommend changes to the requirements regarding language access. To meet the requirement that FAPs be "widely publicized" within the community served by the organization, charitable hospitals must ensure that limited English proficient (LEP) individuals know of and understand the benefits of the hospital's FAP and related documents. IRS should require that hospitals do this for populations that use, or are eligible to use, the charitable hospital's services.

Almost 20% of the population speaks a language other than English at home. Over 24 million, or 8.7% of the population, speak English less than very well and should be considered limited English proficient (LEP) for healthcare purposes.[1] This includes 47% of Spanish speakers, 33% of speakers of other Indo-European languages, 49% of speakers of Asian and Pacific Islander languages, and 30% of speakers of other languages.

Numerous studies have documented the problems associated with a lack of language services, including one by the Institute of Medicine, which stated that:

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1 American Community Survey, 2006-2008, *Selected Social Characteristics in the United States: 2006-2008*; also American Community Survey, 2008, *Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over,* Table B16001, available at http://factfinder.census.gov.

> Language barriers may affect the delivery of adequate care through poor exchange of information, loss of important cultural information, misunderstanding of physician instruction, poor shared decision-making, or ethical compromises (e.g. difficulty obtaining informed consent). Linguistic difficulties may also result in decreased adherence with medication regimes, poor appointment attendance, and decreased satisfaction with services. (Cites omitted.)[2]

According to the Institute of Medicine:

> Compelling evidence exists that patients with limited English-language proficiency encounter significant disparities in access to health care, decreased likelihood of having a usual source of care, increased probability of receiving unnecessary diagnostic tests, more serious adverse outcomes from medical errors, and drug complications.[3]

Hospitals need to assist LEP individuals to ensure compliance with ACA § 1557 and Title VI and identify any potential discrimination or healthcare disparities. Given existing requirements for providing language services under Title VI, we believe IRS' regulations should adopt the same thresholds these hospitals should already utilize for translating "vital documents"[4] as the FAP certainly is a vital document for individuals who are uninsured and need assistance paying their medical bills.

We recommend that the final rule address language access issues in regard to follow-up communications with LEP individuals once they have submitted a financial assistance application. We request that the rule require that all future communications with the individual regarding their financial assistance application be provided in the same language as the submitted application. This provision is necessary to achieve the purpose of the proposed rule.

The proposed rule only includes a percentage threshold for requiring charitable hospitals to translate FAP materials. It merely requires translation of notices when 10% of the community served by the hospital population is LEP. First, we believe a 10% threshold is too high, especially when many hospitals are already subject to guidance

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2 Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health*, at 17 (2002).

3 Institute of Medicine, Report Brief: Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement (2009) at 2.

4 HHS' "LEP Guidance" states "Whether or not a document (or the information it solicits) is ''vital'' may depend upon the importance of the program, information, encounter, or service involved, and the consequence to the LEP person if the information in question is not provided accurately or in a timely manner." *See,* HHS, Office for Civil Rights*, Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, http://www.gpo.gov/fdsys/pkg/FR-2003-08-08/pdf/03-20179.pdf.

from HHS' Office for Civil Rights that expects translation when a language group is 5% or 1,000 individuals.5

A 10% threshold used in conjunction with a county-level service area would lead to an exemption from translating FAP materials for every non-profit hospital in 27 States. Only 177 counties in the mainland United States would contain hospitals required to translate materials. No hospital in the city of Chicago—a diverse metropolis and the third largest city in the United States—would be required to translate FAP materials using a ten percent threshold. Yet there are 461,000 LEP individuals in Chicago alone.

We thus request that IRS adopt a dual threshold with both a numeric and percentage alternative, requiring translation when either is met, for translating charitable hospital's financial assistance plan documents. Hospitals should translate FAP materials for each LEP language group that constitutes five percent or 500 of the individuals eligible to be served by the hospital (not those actually served, since some LEP individuals may fail to be served by the hospital precisely because of language difficulties). The proposed rule cites 26 CFR 54.9815—2719T(e) as an example of a similar federal regulation requiring notices or summaries to be issued in non-English languages. That regulation uses a 500 person numerical threshold in addition to a percentage of the community served threshold, a policy we strongly support.6

Existing Department of Labor (DOL) regulations and the LEP Guidance from the Department of Justice and HHS recognize the need for a dual standard that includes both numeric and percentage thresholds.7 The DOJ and HHS guidances provided a safe harbor recipients of Federal funds could follow and be sure they were in compliance with Title VI: the HHS recipient provides written translation of vital documents for each eligible LEP language group that constitutes five percent or 1,000, whichever is less, of the population of persons eligible to be served.

By omitting a numeric threshold, the standard for providing translated notices is now weaker after the enactment of the ACA than before, and will provide fewer covered individuals with language assistance. It also sets up a dual standard for charitable hospitals that are likely federal fund recipients and thus subject to comply with the HHS LEP Guidance as well as this regulation. We therefore recommend that IRS adopt a combined threshold utilizing the existing DOL regulations and DOJ/HHS LEP guidances, and that the threshold should be 500 LEP individuals or 5% of a plan's enrollees. The 5% is utilized in both the DOJ/HHS LEP guidances as well as recently

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5 *See Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons* (LEP Guidance) available at http://www.justice.gov/crt/about/cor/lep/hhsrevisedlepguidance.php.

6 See subparagraph (ii) – "For a plan that covers 100 or more participants at the beginning of a plan year, if the plan and issuer provide notices upon request in a non-English language in which the lesser of 500 or more participants, or 10 percent or more of all plan participants, are literate only in the same non-English language." 26 CFR 54.9815—2719T(e)

7 See http://www.lep.gov/guidance/guidance_index.html.

revised regulations from the Centers for Medicare & Medicaid Services governing marketing by Medicare Part C & D plans.

We do understand that certain circumstances may occur for an exception to translating vital documents for small language groups. The HHS LEP guidance addressed this issue by noting that if there are fewer than 50 people in a language group that reaches the five percent threshold, the hospital must provide written notice of the right to receive competent oral interpretation of the written materials, free of cost. We suggest IRS adopt a similar requirement.

RECOMMENDATION: Amend § 1.504(r)-4(b)(5)(iv)(A) and add new subparagraph (D) as follows:

(A) The hospital facility conspicuously posts complete and current versions of these documents in English and the primary language of any population with limited proficiency in English that constitute more than ~~*10 percent*~~ ***5 percent*** ~~*of the residents of the community served by the hospital*~~***, or 500 individuals eligible to be served in that community.***

. . .

(D) the hospital facility posts taglines on the website in the top 15 most common languages spoken by LEP individuals that provide contact information for entities that can provide oral assistance to an LEP individual.

§1.501(r)-4(b)(5)(D)(iii): Meaning of Reasonably Calculated

The definition of "reasonably calculated" does not establish any thresholds for when hospitals must translate notifications within and outside of the hospital into non-English languages for LEP populations. We request that IRS adopt the same dual threshold for FAPs. Hospitals should translate notices for any LEP language group that constitutes five percent or 500 of the individuals eligible to be served.

It is critical that hospitals translate notices into non-English languages for LEP populations. LEP populations will not know the FAP exists if they are unable to read the notices posted throughout the hospital or in the community, and the will not know to ask hospital staff for a written copy of the FAP. The FAP notices are a necessary link between the LEP population and the FAP materials, therefore hospitals must translate the notices along with the FAP materials.

In addition, we request that IRS require hospitals to provide tag lines in various languages on the plain language summary of the form that provide contact information for who an LEP individual can call for assistance.

RECOMMENDATION: Amend §1.501(r)-4(b)(5)(iii) as follows:

> *(iii)* *Meaning of reasonably calculated.* Whether one or more measures to widely publicize a hospital facility's FAP are reasonably calculated to inform and notify visitors to a hospital facility or residents of a community about the hospital facility's FAP in the manner described in paragraphs (b)(5)(i)(C) and (b)(5)(i)(D) of this section will depend on all of the facts and circumstances, including the primary language(s) spoken by the residents of the community served by the hospital facility and other attributes of the community and the hospital facility. ***With regard to limited English proficient individuals, a measure is reasonably calculated to inform and notify visitors if it is provided in non-English languages if 5 percent of the residents of the community served by the hospital facility or 500 individuals eligible to be served in that community are limited English proficient in a particular language.***

Further, we recommend that the final rule address language access issues in regard to follow-up communications with LEP individuals once they have submitted a financial assistance application. We request that the rule require that all future communications with the individual regarding their financial assistance application be provided in the same language as the submitted application. This provision is necessary to achieve the purpose of the proposed rule.

RECOMMENDATION: *Add § 1.501(r)-4(b)(5)(E):*

> ***(E)*** ***Any and all follow-up written and oral communications with an LEP individual who submitted a translated FAP Application described in paragraph (b)(5)(B) must be provided in same language as the translated application.***

§ 1.501(r)-4(c): Emergency medical care policy

We support the language contained in the proposed rule requiring covered hospitals to maintain a written policy to provide, without discrimination, emergency medical care for emergency medical conditions to individuals regardless of whether they are eligible under the hospital's FAP. We strongly support the proposed rule's prohibition on engaging in actions that discourage individuals from seeking emergency medical care, including demanding that patients pay before receiving treatment for emergency conditions or permitting debt collection activities in the emergency department or other areas of the hospital where such activities could interfere with the provision of emergency medical care, and recommend that they appear in the final rule.

§ 1.501(r)-4(d): Establishing the FAP and other policies

We support the requirement of this section that a hospital organization will be deemed to have established a required policy only if that hospital facility has actually implemented the policy. However, we recommend that IRS provide additional guidance as to when a hospital will have been deemed to have “consistently carried out” the required policy. We recommend that a hospital organization be deemed to have “consistently carried out” a required policy only if it applies the policy in all cases.

RECOMMENDATION: **Amend § 1.501(r)-4(d)(3) as follows:**

> For purposes of this paragraph (d), a hospital facility has implemented a policy if the hospital facility has consistently carried out the policy. ***A hospital facility will be deemed to have consistently carried out the policy only if it attests that a policy that meets all requirements of this section is followed in all cases.***

§ 501(r)-5: Limitations on charges

§ 501(r)-5(a): In general

We strongly recommend against adopting the proposed rule’s limitation on the prohibition on the use of gross charges to those patients eligible under the hospital’s FAP. This interpretation is not in accordance with either the goals or plain language of ACA § 9007. The relevant section of § 9007 is broken down into two paragraphs. Paragraph (A) limits amounts charged for emergency or medically necessary care *provided to individuals eligible for assistance under the financial assistance policy* (emphasis added) to not more than the lowest amounts charged to individuals with insurance covering such case. Paragraph (B) simply prohibits the use of gross charges.8 As a matter of statutory construction, the language in paragraph (A), limiting its reach only to individuals eligible under the hospital’s FAP, applies only to that paragraph. Paragraph (B), which does not contain that limitation, applies to all hospital patients.

We are aware that the Joint Committee on Taxation (JCT) has opined that both paragraphs were intended to apply only to patients eligible under the FAP.9 However, that interpretation does not have the force of law, should not be taken to reflect the intent of Congress, and should be given little weight by IRS, particularly since it directly contradicts the plain language of the statute. 10

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8 *See Patient Protection and Affordable Care Act,* Pub. L. 111-148 (2010), as amended by the *Health Care and Education Reconciliation Act*, Pub. L. 111-152 (2010), at 9007.
9 *Staff Report, Joint Committee on Taxation*, “Technical Explanation of the Revenue Provisions of the “Reconciliation Act of 2010,” as amended, in combination with the “Patient Protection and Affordable Care Act.” JCX-18-10 (March 21, 2010), at 82.
10 *See McDonald v. Commissioner,* 764 F.2d 322, 336-337 n. 25 (5th Cir. 1985) (JCT report "does not directly represent the views of the legislators or an explanation available to them when acting on the bill.").

There is no reason to believe that Congress did not intend to bar the imposition of gross charges on all patients. In fact, this interpretation is far more consistent with the intent of this section. "Gross charges" have little connection to the actual cost of care, but rather are used as a starting point for negotiations with payers such as private insurers, Medicaid and Medicare. Failing to prohibit the use of gross charges for all patients would mean that those individuals who are "too rich" to qualify for a particular hospital's FAP but "too poor" to be able to pay the cost of care will be charged an inflated gross charge, rather than a cost they may be able to afford. This absurd result is contrary to the intent of § 9007.

<u>RECOMMENDATION:</u> **Amend § 1.501(r)-5(a) as follows:**

> (a) *In general.* A hospital organization meets the requirements of section 501(r)(5) with respect to a hospital facility it operates if the hospital facility limits the amount charged for care it provides ~~to any individual who is eligible for assistance under its financial assistance policy (FAP)~~ to—
> (1) ***For any individual who is eligible for assistance under its financial assistance policy (FAP),*** in the case of emergency or other medically necessary care, not more than the amounts generally billed to individuals who have insurance covering such care (AGB), as determined under paragraph (b) of this section; and
> (2) ***For all patients,*** in the case of all other medical care, less than the gross charges for such care, as described in paragraph (c) of this section.

§ 1.501(r)-5(b): Amounts generally billed

We believe it is imperative that the methods used to calculate the Amounts Generally Billed (AGB) provide consumers and the general public with maximum transparency and fairness in the cost of care. Therefore, we strongly recommend that the AGB calculation be based on Medicare fee-for-service payment rates alone, and not include private payer rates. In general, the rates negotiated between hospitals and private insurers are neither public nor discoverable by the public, and so are impossible to know *ex ante* and verify *ex post*. Medicare fee-for-service payments are not based on proprietary contracts between insurers and providers and are therefore transparent and publicly available, allowing patients and advocates to verify hospitals' compliance with the law, as well as to predict, to some extent, charges for services before they are rendered.

§ 501(r)-6: Billing and collection

§ 1.501(r)-6(a): In general

We commend IRS for extending the prohibition on extraordinary collection actions (ECA) to include ECAs against any individual who has accepted or is requires to accept responsibility for a covered individual's hospital bills. We further support the proposed

rule's requirement that a hospital facility will be deemed to have engaged in an ECA if any purchaser of the individual's debt or any debt collection agency or other party to which the hospital facility has referred the individual's debt has engaged in an ECA against the individual. If the rule did not apply in such situations, hospitals would be provided with an incentive to quickly sell off debt obligations to third-party collectors, thereby negating the intent of the law.

§ 1.501(r)-6(b): Extraordinary collection actions

We support the non-exhaustive list of ECAs included in the proposed § 501(r)-6(b) and strongly recommend their inclusion in the final rules. The impact of these more extreme collection actions can follow patients for years after a debt is resolved, leading to numerous problems including reducing access to care. We recommend the following actions also be explicitly deemed ECAs for purposes of the final rules:

- Deferring or denying emergency or medically necessary care based on non-payment;
- Requiring deposits before providing emergency or medically necessary care;
- Charging interest on patient bills;
- Requiring an individual to submit to binding arbitration regarding a medical debt;
- Selling all or any portion of the medical debt, or any interest in that debt, to a third party.

We strongly suggest that causing an individual's arrest be prohibited in any and all circumstances related to the collection of a medical debt for purposes of this rule, including where that arrest is for contempt of court or similar action. There is no circumstance in which causing a person to be arrested because they are unable to pay a medical debt is reconcilable with the intent of this rule or the charitable mission of hospital organizations described under § 501(c)(3).

§ 1.501(r)-6(c): Reasonable efforts

In general, we support the Notice's requirements regarding notification of individual patients of the hospital's financial policies. To encourage timely completion of incomplete applications, we recommend hospitals use applications that are simple, easy to read, and require only the information necessary to determine eligibility. We suggest the final rule explicitly require hospitals to rely on a determination that a patient is eligible for the FAP for a period of one year after that determination is made, and, in that circumstance, ask the patient only those questions relevant to determine if some change has occurred that would make the patient ineligible under the hospital's FAP.

<u>§ 1.501(r)-6(c)(1)(i)): Notification period</u>

As noted in comments to § 1.501(r)-1, above, we recommend that the notification period be modified to end 120 days after the hospital facility provides the patient with the first

billing statement for the care *or* 120 days after the patient is discharged from the hospital facility, whichever is later.

<u>§ 1.501(r)-6(c)(1)(ii)): Application period</u>

As noted in comments to § 1.501(r)-1, above, we strongly recommend that the application period be modified to end 365 days after the hospital facility provides the patient with the first billing statement for the care *or* 365 days after the patient is discharged from the hospital facility, whichever is later.

Further, we recommend that the final rule address language access issues in regard to follow-up communications with LEP individuals once they have submitted a financial assistance application. We request that the rule require that all future communications with the individual regarding their financial assistance application be provided in the same language as the submitted application. This provision is necessary to achieve the purpose of the proposed rule.

<u>RECOMMENDATION</u>: **Amend § 1.501(r)-6(c)(1) to add new (iv):**

> (1) In general. With respect to any care provided by a hospital facility to an individual, the hospital facility will have made reasonable efforts to determine whether the individual is FAP-eligible only if the hospital facility***...***
> ***(iv) conducts those efforts in a culturally and linguistically sensitive manner.***

<u>§ 1.501(r)-6(c)(2): Notification</u>

We generally support the inclusion of requirements to notify individual patients about financial assistance. We strongly support the requirements that hospitals cease ECAs against any individual who has submitted a FAP application, whether complete or incomplete. We incorporate our comments regarding language access to the required notifications, and strongly suggest that all such communications, whether written or oral, be required to be conducted in a culturally and linguistically appropriate manner. In particular, the “plain language summary” defined in § 1.501(r)–1(b)(19)) must be linguistically appropriate as previously outlined. We further suggest that the final rule be amended to note that the individual may not necessarily need to pay the debt in full by a deadline. Many patients may be able to enter into a payment plan and make good-faith payments on a debt but not be able to completely pay it off before the deadline; these patients should not be subject to ECAs.

<u>RECOMMENDATION</u>: **Amend § 1.501(r)-6(c)(2)(i)(D)(1) as follows:**

> Informs the individual about the ECAs the hospital facility or other authorized party may take if the individual does not submit a FAP application or pay the

> amount due ***or enter into an approved payment plan*** by a deadline (specified in the notice) that is no earlier than the last day of the notification period; and
> …

<u>§ 1.501(r)-6(c)(3): Incomplete FAP applications</u>

We strongly support the proposed rule's protections for patients who submit incomplete financial assistance applications. To encourage timely completion of incomplete applications, we recommend hospitals use applications that are simple, easy to read, and ask only for the information necessary to determine eligibility. We further suggest that the written notice that describes the additional information and/or documentation required be written in plain language and in a culturally and linguistically appropriate manner, as detailed elsewhere in these comments. We suggest expressly permitting hospitals to rely on a determination of eligibility for financial assistance for up to one year after the completed application is filed, with the stipulation that patients be allowed to resubmit an application any time their financial situation has changed. Finally, as with section § 1.501(r)-6(c)(2), we suggest amending the language to note that the individual may not necessarily need to pay the debt in full by a deadline.

<u>RECOMMENDATION</u>: **Amend § 1.501(r)-6(c)(3)(i)(c)(1) as follows:**

> Informs the individual about the ECAs the hospital facility or other authorized party may initiate or resume if the individual does not complete the FAP application or pay the amount due ***or enter into an approved payment plan*** by a completion deadline (specified in the notice) that is no earlier than the later of the last day of the application period or 30 days after the hospital facility provides the individual with the written notice; and

<u>§ 1.501(r)-6(c)(4): Complete FAP applications</u>

In general, we support the proposed requirements in this section. We strongly support the requirement in proposed § 501(r)-6(c)(4) that hospitals refund excess payments and take all reasonably available measures to reverse ECAs if a patient has been found to be eligible for financial assistance. We also strongly support permitting the use of presumptive eligibility measures.

We note that the requirement in this section that hospitals suspend any ECAs against the patient and takes all reasonably available measures to reverse any ECA taken against the individual further supports our suggestion above that hospitals be prohibited, in all cases, from pursuing actions that could lead to the arrest of the patient for nonpayment of debt. An arrest is, by its very nature, incapable of being suspended once it has occurred. We reiterate that causing an arrest is in all cases incompatible with the charitable nature of the hospitals covered by this rule.

<u>§ 1.501(r)-6(c)(5): *Suspending ECAs while a FAP application is pending*</u>

In general, we support the requirement that ECAs be suspended while an application is pending. However, we are concerned that it is not clear what is meant by the prohibition on taking “further action” on a previously-initiated ECA. We suggest that the final rule require that the hospital formally withdraw, or cause to be withdrawn, any previously-initiated ECAs. The nature of many ECAs is that, once begun, they are difficult to end without action by the hospital. It is not enough that the hospital not take further action on previously-initiated ECAs; it must take positive action to reverse the course of those ECAs.

<u>RECOMMENDATION</u>: **Amend § 1.501(r)-6(c)(5) as follows:**

> If an individual submits a complete or incomplete FAP application during the application period, the hospital facility will have made reasonable efforts to determine whether the individual is FAP-eligible only if the hospital facility does not initiate any ECAs, ***and makes all reasonable efforts to reverse previously-initiated ECAs,*** ~~or take further action on any previously-initiated ECAs~~, against the individual after receiving the application and until either—
> …

<u>§ 1.501(r)-6(c)(6):</u> *Waiver does not constitute reasonable efforts*

> We support the inclusion of this section in the final rule.

<u>§ 1.501(r)-6(c)(7):</u> *Agreements with other parties*

> We support the inclusion of this section in the final rule.

Additional comments

<u>Oral Language Assistance</u>

The proposed rule does not address the provision of oral language assistance. Oral language assistance is an essential method for ensuring effective communication with LEP individuals, especially if translated materials are unavailable or LEP individuals have questions about translated materials. We request that the provision of oral language assistance be addressed in the final rule in a way that is consistent with previous HHS guidance.

The Department of Health and Human Services LEP Guidance under Title VI built upon Executive Order 13166, which required federal agencies to publish guidance on how their recipients can provide meaningful access to LEP persons. In that Guidance, HHS recognized that “The more frequent the contact with a particular language group, the more likely that enhanced language services in that language are needed.”[11] The

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11 HHS, Office for Civil Rights, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, http://www.gpo.gov/fdsys/pkg/FR-2003-08-08/pdf/03-20179.pdf at 47314.

Guidance provided a safe harbor for compliance with Title VI for oral assistance in addition to the one provided for translations: if there are fewer than 50 people in a language group that reaches the five percent threshold, the recipient can provide written notice of the right to receive competent oral interpretation of the written materials, free of cost.12 These criteria were practicable for all recipients of Federal financial assistance for more than eight years, likely including all hospitals subject to this rule since they receive federal financial assistance. Maintaining the criteria in regards to FAPs is critical as they offer a vital lifeline for many low-income individuals from medical costs and bankruptcy. Further, the LEP Guidance recognizes that all LEP individuals, regardless of meeting a threshold for translating written documents, must be afforded oral language assistance when needed.13

Definition of Community Served

We request that IRS define "community served by the hospital" in greater detail. IRS should define the term in a way that leads to an accurate representation of both the actual demographics of individuals who use the hospital facility as well as demographics of individuals that are *eligible* to use the hospital facility but may not currently use the hospital.

Individuals may live within the hospital facility's service community but not use the facility because the hospital lacks adequate language access services or for other reasons. For example, many people who do not currently access the hospital because of inability to pay may become eligible for Medicaid or other insurance coverage in 2014. This is a population of millions of people who may not be currently served by the hospital but who may be in the hospital's catchment area and in need of services from the hospital. Other people eligible to use the hospital may currently fail to do so because of language access issues.

It is critical that the hospital facility assess the language needs of the population eligible to use their facilities in addition to the needs of the population that actually uses the hospital. This concept is outlined in HHS' Office for Civil Rights' "LEP Guidance" which says that a hospital receiving federal financial assistance must take reasonable steps to provide meaningful access to LEP individuals. As part of the analysis of what services to provide, the hospital should undertake a self-assessment that balances factors including "(1) The number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee."14

We further request that IRS define "community served" in a manner that does not exempt hospitals from translating FAP documents for many LEP individuals because IRS uses too broad a geographic area for LEP populations to ever meet the thresholds

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[12] *Id.* at 47319.
[13] *Id.*
14 HHS, Office for Civil Rights*, Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, http://www.gpo.gov/fdsys/pkg/FR-2003-08-08/pdf/03-20179.pdf.

for translation. The definition of “community served” has wide ranging implications for whether an LEP person will receive translated FAP documents. For example, as noted previously, if the proposed 10% threshold is applied on a county level, hospitals in 27 states would likely be excluded from translating any documents because no counties contain 10% LEP individuals. Only 255 counties in the entire country (78 of which are in Puerto Rico) meet the 10% threshold that would require hospitals to translate FAP materials for LEP populations.15 If IRS adopted a stricter definition of “service area”, hospitals applying the 10% threshold to smaller geographic areas may be more likely to constitute a high enough percentage of the population to trigger translation.

Exclusion of Government Hospitals

The Notice requests comments regarding whether IRS should create exceptions or special rules for government hospitals. We do not support any such exceptions or special rules. No such exceptions are permitted by the language of § 9007, and IRS has no discretionary authority to create them. From the standpoint of the patient, there should be no difference in whether a hospital organized under § 501(c)(3) is also a government hospital, just as it should make no difference whether a hospital organized under § 501(c)(3) happens to be operated by a religious organization, charitable society, or nonprofit corporation. All hospital organizations organized under § 501(c)(3) should be covered by the final rule, as required by § 9007.

Medically Necessary Care

The proposed rule does not define “medically necessary care,” an extremely important term. We suggest that the final rule adopt the definition of “medically necessary care” to be: “services or items reasonable and necessary for the diagnosis or treatment of illness or injury.” We further suggest that this determination be made solely by the examining physician or medical team, and that the hospital be permitted to overrule the determination of the examining physician or medical team only to find that care is medically necessary when the examining physician or medical team found that it was not.

Procedural Protections

The Notice requests comments on additional procedural protections for patients. We suggest that RS explicitly state that it is the intent of the Service that noncompliance with the requirements of this section and eligibility for the hospital’s FAP may be raised by a patient as affirmative defenses in any action to recover the medical debt, even after the application period for the FAP has run. For a variety of reasons including failure to receive notices, fear, perceived inability to pay, and language access issues, some patients who would be eligible for the FAP may fail to apply during the application period. These patients should be permitted to raise FAP eligibility, and any failure of the hospital to comply with the requirements of the final rule, in any ECA action. We also suggest that the final rule explicitly state that the time periods in the rule are minimums,

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[15] See http://allianceforajustsociety.org/wp-content/uploads/2011/09/Left-in-the-Dark-FINAL.pdf

and that a hospital may, at its discretion, accept and consider an application for financial assistance at any time.

The proposed rule does not require that a hospital provide a patient that has received an adverse eligibility determination with notice and the opportunity to appeal or provide additional information. We strongly support the inclusion of a requirement that every adverse FAP determination be accompanied by an easy to understand statement explaining why the determination was reached, together with a procedure for supplying additional information that might affect this determination.

Conclusion

We appreciate the opportunity to comment on these proposed rules and look forward to working with IRS on their implementation. If you have any questions regarding these comments, please contact Corey Davis at (919) 968-6308 or davis@healthlaw.org. Thank you for your consideration.

Sincerely,

Emily Spitzer
Executive Director