Submitted electronically at www.regulations.gov

May 1, 2015

William J. Wilkins, Chief Counsel, IRS
Mark Mazur, Assistant Secretary for Tax Policy, Treasury
Sunita Lough, Commissioner, TEGE

Re: Notice 2015-27 Seeking Recommendations for 2015-2016 Priority Guidance Plan

Dear Mr. Wilkins, Mr. Mazur, and Ms. Lough:

The Association of American Medical Colleges (AAMC) and American Hospital Association (AHA) are writing to express concern about a requirement that first appeared in the final rule, *Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of Section 4959 Excise Tax Return and Time for Filing the Return,* 79 Fed. Reg. at 78954. Specifically:

> A hospital facility's FAP [must] list the providers, other than the hospital facility itself, delivering emergency or other medically necessary care in the hospital facility and to specify which providers are covered by the hospital facility's FAP (and which are not)." 79 Fed. Reg. at 78971

This requirement is codified in §1.501(r)-4(b)(1)(iii)(F). The IRS ("IRS" or "Service") explained the rationale for including this provision by saying that it was "in response to comments and to provide transparency to patients. . . . " Unfortunately, this provision was not included in any proposed regulations nor was it the subject of any requests for comments. Had this requirement been proposed, hospitals would have been able to help the Service understand that it is a significant problem for compliance and would have suggested alternatives that would be better matched to the objective.

Hospitals strongly support transparency and appreciate that patients find it difficult to understand the multiple bills associated with hospital-based care. Howeve, this regulatory requirement was unexpected, is confusing and extraordinarily burdensome for hospitals, and will not provide patients with information they need.

Commenters to whom the Service was responding did not suggest that providers be listed in the FAP. Rather, as the preamble to the final regulation states, "Commenters asked for clarification on the extent to which a hospital facility's FAP must apply to other providers a patient might encounter in the course of a treatment in a hospital facility, including non-employee providers in private physician practice groups or hospital-owned practices." 79 Fed. Reg. at 78971. Even if hospitals had taken it upon themselves to review these comments from other stakeholders, they would not have been on notice that they could be subject to a requirement to list providers in the FAP.

At a minimum, based on past practice of the Treasury and IRS and fundamental fairness, hospitals expect that any new requirement appearing for the first time in the final regulations would be a logical outgrowth from the proposed regulations and specific requests for comments in the preambles to the proposed regulations. **For these reasons and for the reasons described below, we request that the IRS withdraw the requirement in §1.501(r)-4(b)(1)(iii)(F).** Any addition to the regulations should be done through a notice and comment process that begins with a clear articulation of the issue to be addressed and its connection to the statutory requirements.

Subsequent to the publication of the Final Rule, the IRS has suggested in several public forums that meeting this requirement does not mean that patients must be told physician-by-physician who is covered under the FAP. Rather, the FAP can state, for example, that a certain group practice that provides services in the hospital is or is not covered under the FAP. Even with this approach to identify providers, creating the list required under the regulations and keeping it up to date is not an easy task. AHA data from 2013 (the most recent available) shows that of the 2,994 hospitals that reported the data, on average each has 261 privileged physicians, in other words, physicians who would be able to provide emergency or medically necessary care in the hospital. For members of the Council of Teaching Hospitals and Health Systems, large academic hospitals, the average number of privileged physicians is 1,083. The providers on these lists change regularly because physicians move or change aspects of their practice.

Some physicians who provide care at a hospital may be employed or affiliated with a medical group that is known to the hospital, but others may not be. Several examples illustrate the problems and burdens that large hospitals and hospital systems face in attempting to provide this information to patients:

- One large teaching hospital has approximately 2200 members on the medical staff. Physicians who specialize in urology, orthopedics, neurology, ophthalmology, and neurosurgery provide services to emergency room patients on an on-call basis. These physicians are members of the medical staff but are otherwise unaffiliated. Other than naming each physician individually—administratively burdensome for the hospital and of minimal value to a patient who would have to cull through a long list of names—this hospital cannot fully comply with the requirement.
- Another teaching hospital has a system of which eight hospitals are community hospitals. In total, the system has 2700 employed physicians and 1700 physicians who are not employed but have privileges to treat patients in one or more of the hospitals, with a range of 150-300 physicians per community hospital. The system uses a single FAP for all hospitals, and distinguishes physician services based on whether they are provided as inpatient or outpatient services. Some of those physicians work at several community hospitals and may work for a different medical group at each hospital. Providing the patients with a list of which physicians are covered under the FAP, and for which services, is burdensome to the hospital and difficult to present to patients in a way that will be useful.

When a patient is hospitalized, there is no guarantee that the physician she anticipates will provide services in fact will be the one who treats her. For example, a patient may seek a physician in a group that is covered under the FAP or has a financial assistance policy that is consistent with that of the hospital but such a physician may not be available (on vacation, busy with other patients, at another hospital), and the patient may be treated by another physician not covered by the FAP. These circumstances occur every day. Listing providers covered and not covered by the FAP does

not help patients to understand the complexities of billing for hospital-based services. Patients should understand that emergency care will not be denied due to an inability to pay. Beyond that they also should be aware that they may receive bills from multiple providers and that the services of some of those providers may not be covered under the FAP.

The current requirement is unworkable for hospitals. Moreover, it could result in patients being given long lists of provider names that would have to be reviewed line by line to see which providers and which services are covered under the FAP – even though there is no guarantee that specific providers in fact will be the ones providing services during a given hospital episode.

We urge the IRS and Treasury to move swiftly in withdrawing the current requirement so that the change is made well before the regulations go into effect at the end of 2015. The AAMC and AHA would welcome the opportunity to meet with you to answer any questions or provide additional information.

Sincerely,

/s/

Janis M. Orlowski, MD, MACP
Chief Health Care Officer
Association of American Medical Colleges

/s/

Melinda Reid Hatton
Senior Vice President and General Counsel
American Hospital Association

Cc:

Ruth Madrigal, Attorney Advisor, Treasury
Victoria Judson, Associate Chief Counsel, TEGE
Eric San Juan, Senior Technical Advisor, TEGE