



# IOWA HEALTH SYSTEM

22 July 2010

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Internal Revenue Service  
CC:PA:LPD:PR (Notice 2010-39)  
Room 5203  
P.O. Box 7604  
Ben Franklin Station  
Washington D.C. 20044

Re: Response to Request for Comments Regarding Additional Requirements for Tax-Exempt Hospitals – (Notice 2010-39)

The comments included herein are in response to the solicitation of comments for the application of requirements imposed by new section 501(r), added to the Internal Revenue Code (Code) by section 9007(a) of the Patient Protection and Affordable Care Act (Affordable Care Act), enacted March 23, 2010, Pub. L. No. 111-148.1 Section 501(r) affecting hospital organizations that are currently described in section 501(c)(3) of the Code as exempt from Federal income taxation. Iowa Health System (IHS) is a 501(c)(3) organization and as such is exempt from federal income taxation.

Iowa Health System is the state of Iowa's first and largest integrated health system, serving nearly one of every three patients in Iowa. Through relationships with 24 hospitals in metropolitan and rural communities and more than 140 physician clinics, IHS provides care throughout Iowa and western Illinois. IHS entities employ the state's largest nonprofit workforce, with nearly 20,000 employees working toward innovative advancements to deliver the best outcome for every patient every time. Each year, through more than 2.5 million patient visits, IHS hospitals and clinics provide a full range of care to patients and families. With annual revenues of \$2 billion, IHS is the sixth largest nondenominational health system in America and provides community benefit programs and services to improve the health of people in its communities.

There are certain administrative functions that our affiliate hospitals have chosen to perform at a system level, rather than at each affiliate. Billing is one of those functions, and thus, billing of patients occurs through the Central Billing Office of the Iowa Health System. In addition to this group, each affiliate hospital has a Chief Financial Officer who directly monitors the finances and financial policies of each affiliate hospital (including the financial assistance policies). It is this group of individuals who request the clarification set forth in these comments.

Prior to our pointed request for clarification regarding new 501(r) requirements, some background on our efforts in the area of community benefit and charity care seems appropriate. Our health system fulfills its non-profit mission, in part, by providing benefits to our affiliate communities in identified areas of need for that particular region. For 2009 IHS' affiliate hospitals provided the following community benefits:

Charity Care at Cost	\$ 38,524,684
Unreimbursed Medicaid	\$ 48,163,953
<b>Total Charity Care and Means-Tested Programs</b>	<b>\$ 86,688,637</b>
Community Health Improvement Services and Community Benefit Operations	\$ 11,153,911
Health Professions Education	\$ 9,119,903
Subsidized Health Services	\$ 9,486,172
Research	\$ 896,509
Cash and In-Kind Contributions to Community Groups	\$ 11,114,203
<b>2009 COMMUNITY BENEFIT SUMMARY</b>	
<b>Total Other Benefits</b>	<b>\$ 41,770,698</b>
<b>Total Community Benefit</b>	<b>\$ 128,459,335</b>

In addition, for many years we have had a written financial assistance and charity care policy which sets forth the standards which each of our affiliate hospitals abide by when seeking payment from vulnerable populations. In our policy, full charity care is available for uninsured patients up to 200% the FPIG. Assistance is also available to needy and underinsured patients, up to 1000% FPIG, under specified circumstances. Our financial assistance policy is attached as Exhibit 1.

New section 501(r)(1) imposes four additional requirements that organizations described in section 501(r)(2) ("hospital organizations") must satisfy to retain the tax exempt status conferred by designation pursuant to Section 501(c)(3). Our comment is to request clarification on the statutory wording and IRS Technical on the requirements of section 501(r)(5) - Limitation on Charges. The new law requires a hospital organization to limit amounts charged for emergency or other medically necessary care that is provided to individuals eligible for assistance under the organization's financial assistance policy to not more than the amounts generally billed to individuals who have insurance covering such care. The IRS Technical Explanation states that it is intended that amounts billed be based on either the best, or an average of the three best, negotiated commercial rates, or Medicare rates.

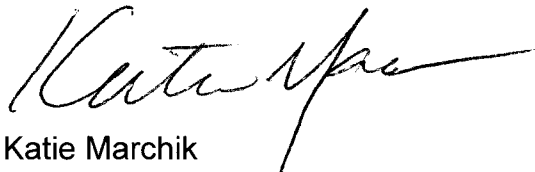
We believe the words of the statute and the Technical Explanation of how hospitals are to implement this provision are unclear. We request clear guidance on the

methodology with which hospitals may calculate the “best, or an average of the three best, negotiated commercial rates” and advocate for a specific approach.

We suggest the following procedures be recommended by the IRS: First, we propose that the IRS require hospitals to establish a collection rate per contract based on the historical negotiated average commercial rates. If the average collection rate for the three best negotiated contracts for the last three years was, for example, 69% of billed charges, 70% of billed charges, and 71% of billed charges, then the average "best rate" would be 70 % of billed charges. The 70% would become the charge limitation for the uninsured meeting the financial assistance policy guidelines for that fiscal year. Each year, we would perform a three year look back and adjust the "best rate" if such adjustment is warranted. This would allow hospitals to look at past data to set charges, as it would be very difficult for hospitals to have to change rates to charge the uninsured each time during the fiscal year that a new contract was negotiated with a payer, potentially impacting the “best” negotiated rate calculation. For uninsured patients that qualify for financial assistance, we recommend that the total billed charges be reduced by the applicable discount (30% in the example above) prior to application of the financial assistance policy to such bill. Last, we recommend that underinsured patients also should have the benefit of the “best, or an average of the three best, negotiated commercial rates” and under the scenario above, an underinsured patients responsibility should also be equal to or less than 70% of total billed charges.

These procedures, in our mind, satisfies congressional intent that the uninsured are not paying more for health care services than their insured neighbors. Further, such procedures allow hospitals to offer transparent pricing information to such patients throughout the year and continue seamless operation of our billing practices during any given fiscal year. Thank you for the opportunity to provide comments on this topic. Questions regarding our billing operations may be directed to Vivian Boyd, Vice President, Revenue Cycle at [BoydVR@ihs.org](mailto:BoydVR@ihs.org).

Sincerely,



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