



Richard J. Davidson
President

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

By E-Mail and U.S. Post

May 1, 2006

The Honorable Charles E. Grassley, Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510-6200

Dear Chairman Grassley:

On behalf of the American Hospital Association's (AHA) 4,800 hospital, health care system, and other health care organization members, and our 35,000 individual members, we thank you for this opportunity to elaborate on our previous conversations with you and your staff on how to address the serious public policy issues that confront hospitals and the people and communities we serve. Specifically, we would like to address the issues raised in your March 8 letter.

First let us say that we appreciate the opportunities we have had to work closely with you and your staff on a variety of issues of concern to our field, including physician-owned limited-service hospitals, protecting community hospitals from Medicare and Medicaid budget cuts, and assisting rural hospitals with the unique challenges they face.

With respect to your request for information ... we will address those issues in the order they appear in your letter.

Option 1 – Improving Financial Assistance for Uninsured Patients of Limited Means

The key word here: “uninsured.” *More than 46 million Americans have no health care insurance.* From this national crisis flows a myriad of problems that beset the health care field today. The AHA has long supported coverage for all Americans and has advocated for incremental steps that increase coverage, as well as for broad-based changes in coverage policy.



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Meanwhile, America's hospitals, as they have done for generations, continue to take care of people regardless of insurance status or ability to pay. In 2004 alone, hospitals provided \$27 billion in uncompensated care, a number that reflects the cost of providing that care. According to a 2005 report by PriceWaterhouseCoopers, the availability of charity care at U.S. hospitals is all that stands "between a thorny policy dilemma and an access crisis for millions of Americans."

Federal Policy is Clearer

Federal policy on providing increased financial assistance to uninsured patients of limited means is clearer; some grey area persists, however. Several studies have concluded that hospitals have been justifiably concerned about how discounting charges or failing to maintain vigorous collection policies for uninsured patients of limited means might put them in the crosshairs of the Medicare program and/or Office of Inspector General (OIG). Among these studies:

- *Unintended Consequences: How Federal Regulations and Hospital Policies Can Leave Patients in Debt*, a 2003 report by the Commonwealth Fund.
- *Acts of Charity, Charity Care Strategies for Hospitals in a Changing Landscape*, a 2005 report by PriceWaterhouseCoopers.
- *Hospitals Share Insights to Improve Financial Policies for Uninsured and Underinsured Patients*, a February 2005 report by the Health Financial Management Association (HFMA) and the AHA.

These concerns were echoed by a former administrator of the Centers for Medicare and Medicaid Services' (CMS) predecessor, the Health Care Financing Administration, in a February 2004 letter to the Department of Health and Human Services (HHS). The letter described the existing Medicare and OIG regulation of hospital billing and collection practices as a "major deterrent to hospitals' implementation of more sensible and more humane policies."

We remain appreciative that in February 2004, HHS – through issuances from CMS and OIG – provided critical guidance on these complicated billing and collection issues. Immediately following those issuances, the AHA urged HHS to supplement these initial efforts by providing a forum for hospitals to directly query federal officials about issues raised by the guidance. To that end, we offered to host a nationwide conference call or work with the agency on any meeting format it found most useful. CMS responded by conducting an Open Door Forum in June 2004 and following up on questions generated at that forum by issuing additional guidance on December 29, 2004, confirming that offering a discount based solely on a patient's uninsured status would not affect a hospital's Medicare payments.

However, “some grey area still exists,” as the PriceWaterhouseCoopers report noted. For example, the guidance suggests that if hospital discounts are determined to be too generous, hospitals could be at risk for inducing federal health program business in violation of OIG rules.

AHA Leadership: Billing and Collection Practices

AHA’s leadership on these issues includes a white paper on the subject of Medicare policies affecting the uninsured. This paper led to the issuance of the aforementioned HHS guidance in February 2004. During that same period, AHA developed and successfully urged the hospital field to adopt Principles and Guidelines (AHA Guidelines) on hospital billing and collection practices (attached). On the subject of policies to provide increased financial assistance or discounts, the AHA Guidelines state:

“Hospitals should have policies to offer discounts to patients who do not qualify under a charity care policy for free or reduced cost care and who, after receiving financial counseling from the hospital, are determined to be eligible under the hospital’s criteria for such discounts . . . Policies should clearly state the eligibility criteria, amount of discount, and payment plan options.”

In addition, to ensure that patients are aware of the assistance offered by hospitals, the AHA Guidelines state:

“Hospitals should make available to the public information on hospital-based charity care policies and other known programs of public assistance.”

To date, 4,263 hospitals have signed a pledge – the Confirmation of Commitment – indicating their adherence to the AHA Guidelines or their work toward such adherence in a timely manner.

A 2005 study by the Center for Studying Health System Change (HSC) confirmed that hospitals are responding. *Balancing Margin and Mission: Hospitals Alter Billing and Collection Practices for Uninsured Patients* reported that:

“In every HSC community, most hospitals have either recently changed their pricing and collection policies or tried to improve the clarity of information provided to patients. Most of the hospitals interviewed had increased the income threshold for full charity care or discounted services.”

Exploring Options

Your leadership on the issue of public accountability was clear in your remarks to Independent Sector’s October 2005 CEO Summit. You urged the hospital field to “*come forward with its own substantive proposals for . . . reforms in areas such as . . . charitable care, charges to the uninsured [and] debt collection.*”

The AHA proposals in this letter respond specifically to your request. On the topic of charity care and the uninsured of limited means, the AHA calls upon all hospitals to adopt the following policies going forward:

- Provide financial assistance and counseling for uninsured people of limited means, without regard to race, ethnicity, gender, religion or national origin.
 - Financial assistance provided by hospitals to uninsured people of limited means should in no way substitute for the obligation of federal and state governments to provide or expand coverage to the uninsured. At a minimum, state Medicaid programs should be required to sustain a “maintenance of effort” keeping eligibility at least at current levels. Further, the federal government should enact legislation to expand Medicaid coverage to *all* individuals at or below the poverty level. We would like to work with you and other members of the Finance Committee to achieve this important objective

- Until the time that we mutually achieve such comprehensive Medicaid coverage, provide services to uninsured patients below 100 percent of the federal poverty level at no charge. Existing clinical and geographical criteria used by hospitals to determine eligibility for certain services would apply.

- Provide financial assistance to all uninsured patients between 100 percent and 200 percent of the federal poverty level by (based on a hospital’s choice) asking them to pay *no more than*:
 - A price paid to the hospital under contract by a public or private insurer;
 - or*
 - 125 percent of the Medicare rate for applicable services (given that, in the aggregate, Medicare pays less than the cost of care).For these patients, hospitals may choose to charge on a sliding scale up to the stated limits. Hospitals also may choose to provide greater assistance.

- Make information about a hospital’s financial assistance policy easily available to the public.

In addition, hospitals may offer financial assistance to uninsured patients with incomes in excess of 200 percent of the federal poverty level at the discretion of the hospital.

Cosmetic surgery and other non-medically necessary services would be exempt.

Hospital financial assistance is contingent upon the cooperation of a patient in providing the information necessary for a hospital to qualify that patient for its programs of assistance or for public or other coverage or assistance that may be available. Patients receiving financial assistance from hospitals shall have a responsibility to pay according to the terms of that policy.

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Hospitals that have policies that meet or exceed those listed above should receive immunity from class action lawsuits.

Some of the above elements may be appropriate for legislation, including relief for hospitals that in recent years have been plagued by class action lawsuits challenging their billing and collection practices. As you are aware, nearly all of the class action lawsuits have been dismissed in the federal courts. Several of those opinions severely criticized the class action attorneys for misreading the Constitution and misguidedly bringing suit against hospitals. Having failed in the federal courts, the same class action attorneys are now filing in state courts cases that are very similar to those defeated in federal courts ... even against hospitals whose policies meet or exceed the AHA Guidelines. The diversion of scarce hospital resources required to defend these lawsuits is enormous. Therefore, we strongly urge that immunity from these suits be legislated without delay.

With respect to your question on numbers, by state, of uninsured and those covered by Medicare and Medicaid, we would direct you to the database maintained by the Kaiser Family Foundation that contains most of the requested information. That database can be accessed at <http://www.statehealthfacts.org>. We are not aware of a database that would provide a comprehensive list of other state or government programs providing medical benefits to low-income individuals.

Option 2 – Uniform Reporting of Community Benefit

How Hospitals Benefit their Communities

Not-for-profit hospitals provide an enormous amount and range of benefit to the communities they serve, beyond the \$27 billion worth of uncompensated care provided by all hospitals in 2004. The AHA has traditionally worked with our members and their state hospital associations to foster greater community involvement on all levels, including innovative ways to provide care and services to uninsured patients of limited means.

Among our efforts is support for the Association for Community Health Improvement (ACHI), a national membership association with a mission to strengthen community involvement through education, peer networking and the dissemination of practical tools. ACHI is the premier national association for community health, healthy communities and community benefit. ACHI delivers professional educational programs on community benefit planning and practice to hospitals nationwide, serves as the educational affiliate of AHA's NOVA Community Health Award program, and works with other national organizations on community benefit education. ACHI hosts two public Web pages with community benefit resources for hospitals and leads a national community benefit advisory committee.

AHA's most recent innovative effort on community benefit includes a publication entitled *Community Connections: Making Communities Healthier*. This booklet provides hospitals with numerous examples of model outreach programs that have helped to improve access, coverage and quality of life, address social and basic needs and promote healthier living. The *Community Connections* publication reflects the many ways that hospitals are providing meaningful community benefit. Some examples:

- McKay-Dee Hospital Center in Ogden, Utah – Children's Health Connection is a two-day health fair that provides medical, dental, vision and other screenings as well as necessary follow-up medical visits for children from low-income families.
- The Mercy Hospital of Pittsburgh in Pittsburgh, Pennsylvania – Operation Safety Net® is an innovative outreach program to assist the homeless population by walking the streets with 30 volunteer health professionals who provide medical services, testing and counseling among other services to the homeless.
- St. Peter's Hospital in Helena, Montana – Heart of the Matter is a free community event that provides community residents with the opportunity to visit with cardiologists, to be tested for heart disease, monitor their blood pressure and body fat and participate in demonstrations of CPR and defibrillators.
- John C. Lincoln Health Network in Phoenix, Arizona – Wee Care is a day care facility for sick children that allow parents to have their children cared for by trained pediatric caregivers when they are unable to be at home with them.

The response to the booklet has been gratifying. Since receiving the publication, many hospital leaders, justifiably proud of their teams' work in the community, have asked that their own model community outreach program be included in future *Community Connections* reports.

Beyond these important examples of community benefit, we are encouraged that 97 percent of the hospitals responding to our annual survey reported that the hospital's mission statement includes a focus on community benefit, and that 93 percent reported that they have resources for community benefit activities.

CHA/VHA Model for Reporting Community Benefit

At Independent Sector's CEO Forum, you said:

“[t]here is little or no common policy among hospitals. We're finding there aren't even common definitions about such critical areas as charity care and community care.”

You strongly encouraged the hospital field to come forward with its own proposal for “common definitions” and other reforms.

The Catholic Health Association of the United States (CHA) and VHA Inc., have provided leadership in the area of uniform reporting of community benefit and developed reporting guidelines that are published in a document entitled *Community Benefit Reporting, Guidelines and Standard Definitions for Community Benefit Inventory and Social Accountability*. These Community Benefit Guidelines capture the range and diversity of how hospitals benefit their communities and provide a standard platform for identifying, describing, quantifying and reporting this benefit.

Specifically, the Community Benefit Guidelines address three areas.

- They include a general description of what constitutes a community benefit and a list of criteria for determining whether a program or service should be counted.
- They provide a glossary of definitions, so that in identifying, describing or calculating community benefit, hospitals are guided by the same set of terms.
- They provide guidance on how to count and quantify community benefit, recognizing that some benefit is not easily counted and, therefore, is better portrayed through a narrative.

The Community Benefit Guidelines are dynamic, revised periodically to reflect new areas of community benefit and to address questions that may arise about existing areas. They are sufficient to encompass local and regional variations in community benefit as well as variations among different types of hospitals.

Options on Community Benefit

On the topic of community benefit, the AHA calls upon all (private) not-for-profit hospitals to adopt the following policies going forward:

- Conduct a periodic community needs assessment, with a frequency to be determined by the hospital (can be done collaboratively with other community organizations).
- Assign responsibility for a community benefit plan to a hospital employee.
- Calculate community benefit for purposes of reporting using the Community Benefit Guidelines document; when calculating community benefit for each category, however, hospitals should include direct and indirect costs of subsidized health care services, charity care, bad debt, and the unpaid costs of government-sponsored health care (including Medicaid, Medicare and public and/or indigent care programs).
- Report community benefit, as calculated above, as an attachment to the Form 990.

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We believe there is general agreement, albeit not consensus, among the not-for-profit hospital field that the Community Benefit Guidelines, with the accommodations reflected above, are an appropriate model for achieving more standardized community benefit reporting at the federal level. The accommodations reflect certain current practices of a number of states, including Texas and Illinois. We recognize that special consideration may be required for hospitals that face particular financial or staffing challenges, and we welcome the opportunity to discuss those issues further at your convenience.

On the question of whether we plan to modify the AHA Annual Survey of Hospitals: We continually review the survey and update it as appropriate in consideration of advances in medicine and other important trends in the hospital field.

On the question of AHA constituency sections, we attach the *Guide to AHA Governance and Policy Development* (AHA Guide), which describes the association's constituency sections.

Option 3 – Recommendations Including Those of the Panel on the Nonprofit Sector

In 2004, you and Senator Max Baucus invited Independent Sector, an organization that represents charities, foundations and other not-for-profit organizations, to convene an independent national panel of experts from the not-for-profit sector (Panel). Their purpose: to make recommendations that strengthen good governance, ethical conduct and effective practice of public charities and private foundations. The invitation expressed concern about “transactions with and within charitable organizations that are inappropriately exploiting charities’ tax-exempt status and that may be wrongly enriching individuals and corporations.”

America's hospitals support key recommendations of the Panel that call for increased transparency and accountability of governance in hospitals and other not-for-profit organizations. We believe that many of the Panel's recommendations are a thoughtful and meaningful response to the concerns that have been raised, and provide a roadmap to improved transparency and accountability. We are particularly pleased that the report calls for improvement within the not-for-profit sector itself through the adoption of best practices and self-regulation, as well as more effective oversight and changes in law and regulatory requirements.

The AHA recently accepted Independent Sector's invitation to participate in a special Advisory Committee on Self-Regulation of the Charitable Sector. The goal of the committee is to help the Panel make recommendations for strengthening the not-for-profit sector's efforts to regulate itself. When the work of the special Advisory Committee and the Panel is complete, we anticipate endorsing additional recommendations for self-regulation.

Support for Recommendations that Strengthen Transparency, Governance and Accountability

AHA calls upon all (private) not-for-profit hospitals to adopt the following policies going forward:

- Have the CEO, CFO or highest ranking officer sign-off on Form 990.
- Attach audited financial statements for the Form 990 for hospitals with \$1 million or more in annual revenues; for hospitals with revenues of \$250,000 to \$1 million, a required review of submitted financial statements by an independent public accountant. For health systems, allows for a single, system-wide audit to be performed.
- Prohibit loans to board members or executives.
- Disclose on the Form 990 whether a hospital has a travel policy.
- Disclose on the Form 990 whether a hospital has a conflict of interest policy.

Recommendations Pose Particular Difficulties for Hospitals

We do not support several of the Panel's recommendations because they would have unintended negative consequences for some hospital systems.

While the AHA strongly supports calls for stronger oversight and greater independence of the governance of not-for-profit hospitals and organizations, the recommendations requiring at least one-third of board members to be independent could, for example, hurt the leadership of religiously sponsored hospitals and health systems. Many of these organizations are sponsored by a governing board or council of a single or multiple religious congregations, which appoint a governing board of lay and religious leaders who work in partnership with the sponsoring council to provide effective oversight. Based on a review of the recommendations and summary information, it appears that the sponsoring boards of these organizations would not meet this independence requirement.

The AHA also is concerned about recommendations that would require Type III supporting organizations to distribute a specified percentage of their income or assets each year and limit the number of organizations that could be supported. Those recommendations pose particular difficulties for hospital systems that aggregate assets and capital in a Type III supporting organization in an effort to improve efficiency and organize purchases. In addition, several hospital systems that are organized as a Type III support more than five charitable organizations. The new limit would thus disrupt important work being done by these charities. Since the Panel's recommendations were aimed at donor-supported Type III organizations, applying these new restrictions to hospital systems is not only unnecessary, but also disruptive.

Practices in Other Areas

You asked us to comment on hospital practices in a number of areas, some of which are rather broadly defined. We believe we can most usefully contribute to furthering the Committee's knowledge by responding on these areas:

- Joint ventures and other financial arrangements – In questions that you directed to various hospital systems, the concern raised about joint ventures pertained to those between hospitals and physicians. The AHA believes that some joint ventures are defensive measures taken in response to a reimbursement system that encourages the development of specialty or limited-service hospitals. These specialty hospitals siphon off resources that community hospitals must have in order to provide a broad range of services that include emergency care and burn units that rarely if ever pay for themselves. They also deprive community hospitals of the services of physicians needed to provide on-call emergency care to meet instant, 24-hour demand.

We applaud your leadership on the specialty hospital issue and encourage you to continue your investigation of these hospitals, including their investment structures, whether physician investors are truly at risk, and the proportionality of investment related to financial return.

- Executive compensation – We believe that the Internal Revenue Service's (IRS) current approach under its intermediate sanctions rules – which create a “rebuttable presumption of reasonableness” if hospitals take certain procedural precautions in determining executive compensation – is the correct approach. Those precautions include advance approval by an authorized body composed entirely of individuals without a conflict of interest, a determination by this body that the entire compensation arrangement is reasonable based on comparability data and contemporaneous documentation.
- Travel and expense reimbursement – The AHA endorses the Independent Sector proposal that charitable organizations should be required to disclose on their Form 990 whether they have a travel policy.
- Billing and debt collection practices – The AHA is a partner with other leading health groups in the Patient Friendly Billing Project®. That project is a national effort to make financial communications to patients – including hospital bills – clear, concise and correct. More information is available on this important project at www.patientfriendlybilling.org.

On the topic of debt collection, AHA calls upon all hospitals to adopt the following policies going forward:

- Maintain written policies about when and under whose authority patient debt is advanced for collection and liens are placed on a primary residence.
- Obtain written assurances that any outside organization used to assist with debt collection complies with The Fair Debt Collection Practices Act and the ACA International Code of Ethics and Professional Responsibility.
- Conflicts of interest – The AHA endorses the Independent Sector proposal that the IRS should require every charitable organization to disclose on its Form 990 whether it has a conflict of interest policy.
- Accounting, reporting, public disclosure, and general transparency – These issues are addressed throughout this letter.

We also note that the CHA provided additional useful information on these and other topics in its April 13, 2006 response to your inquiry.

AHA Governance Structure and Policies

You have asked several questions about the AHA's governance and membership structure, our policies, and our plans to work with outside and federal agencies to address some of the issues identified in the letter. In addition to the following response, we attach the AHA Guide, which addresses some of the same issues in greater detail.

AHA Governance and Board Structure

The AHA governance structure consists of a Board of Trustees that serves as the decision-making body of the association and is responsible for the approval of all major policy and governance activities. The Board includes a chair, chair-elect, immediate past chair, the AHA president, representatives (chairs) of the nine Regional Policy Boards (RPBs), 12 at-large trustees who represent a cross-section of the association's institutional membership (based on type of hospital or health system, geographic location, ownership, profession), and state hospital associations. In addition, up to two independent members (typically not affiliated with a member hospital) may serve.

Several committees report directly to the Board. Several are focused on external policy matters, while others focus internally on such matters as operations, audit, investments and executive compensation. The Operations Committee is responsible for monitoring the association's overall financial performance, as well as directly managing the relationship with our independent, external auditors.

The AHA's RPBs assist in the development of AHA policy by providing input on issues to be considered by the Board of Trustees. The RPBs include the RPB chair, representatives from each state in the region, constituency and membership section representatives, and regional physician and trustee delegates.

Other committees reporting to the Board include: an Executive Committee, a Long-Range Policy Committee, a Nominating Committee, several Constituency Sections representing various segments of the hospital field (e.g. small or rural hospitals, metropolitan hospitals, and long-term care and rehabilitation facilities), and several specialty committees (e.g. hospital trustees and volunteers).

The Committee on Nominations, which consists of the four most recent Board chairs and four at-large association members, annually recommends a slate of candidates for AHA chairman-elect, open Board seats, and most RPB positions. These are subsequently elected by the Board. Any member may nominate someone for a seat on the Board.

Benefits of AHA Membership

AHA is a voluntary, not-for-profit association of health care provider organizations that are committed to health improvement in their communities. The AHA is the national advocate for its members, which include 4,800 hospitals, health care systems and other health care organizations and 35,000 individual members. We represent their interests before the Congress, federal agencies, the judiciary and the media.

In addition to our advocacy and representation initiatives in Washington, the association addresses a wide range of issues and emerging trends that affect our member hospitals and the patients and communities they serve through research, education and policy development activities in areas such as quality and patient safety, hospital and health care governance and community health improvement.

AHA members have access to a wide range of information and resources on important issues and trends. In addition, AHA members receive continuous communications to help them implement new federal regulations or better serve patients and communities.

Institutional membership dues are based on a formula correlated with hospital expenses as reported on the AHA Annual Survey of Hospitals. If expenses were not submitted, dues are estimated based on the number of hospital-staffed beds multiplied by the national average expense per bed. Based on updated expenses, dues increases from one year to the next are capped at a percentage rate increase that is established annually by the Board of Trustees. Dues for non-hospital providers, provisional members, government groups, and associate members are billed at a flat rate.

The AHA attempts to help all hospitals improve performance by highlighting outstanding accomplishments in the field. In a variety of ways, including highlighting best practices in AHA publications or shining a spotlight on the exemplary performance through an

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AHA-sponsored leadership award, we help hospital members better serve their patients and communities. For instance, AHA-sponsored leadership awards in quality, community health improvement and end-of-life care provide a roadmap for others to follow.

With regard to your question about AHA's interaction with the IRS, the AHA has been in regular contact and consultation with IRS officials regarding standards and rules governing tax-exempt hospitals. Most recently, AHA provided written comments on proposed regulations on tax-exempt financing, written comments on proposed changes to the Form 990, and advised our members, after consultation with IRS officials, on IRS examinations of how hospitals should determine executive compensation and how they should meet the community benefit standard. In December 2005, Lawrence Brauer, Acting Manager, Technical Group 1, Exempt Organizations, Internal Revenue Service, addressed AHA members on the IRS 2006 not-for-profit hospital agenda. A dialogue between AHA and key IRS officials on matters of concern to tax-exempt hospitals continues.

Conclusion

Senator Grassley, the AHA looks forward to working with you to address in a comprehensive manner the problems that confront the more than 46 million Americans who lack health insurance coverage. Hospitals will continue to care for all Americans, regardless of their ability to pay. However, more must be done by all with a stake in the problem, including physicians, commercial insurers, industry and policymakers.

Please contact Tom Nickels, our senior vice president of federal relations at (202) 626-2314 or tnickels@aha.org if we can provide additional information.

Sincerely,



Dick Davidson
President

Courtesy Copy:

Senator Max Baucus (w/attachments)

Senator Ron Wyden (w/attachments)

Attachments:

AHA Principles and Guidelines

Guide to AHA Governance and Policy Development