THE
CATHOLIC HEALTH
ASSOCIATION
OF THE UNITED STATES

SR. CAROL KEEHAN, DC
President and Chief Executive Officer

April 13, 2006

The Honorable Charles E. Grassley
Chairman, Committee on Finance
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Thank you very much for your letter of March 8, 2006 regarding charity care and community benefit provided by non-profit hospitals. I appreciate your recognition of the work that CHA has been doing for the more than fifteen years in the area of community benefit and welcome this opportunity to provide you with information about CHA and its members, and to highlight our members' leading practices in the areas outlined in your letter. My hope is that once you have reviewed this material, you will be reassured that CHA members take their responsibilities as tax-exempt organizations seriously.

Let me first address the questions raised in your letter about CHA, our members, and our governance and organizational structure.

1. Who are CHA's members and what is CHA's current membership level?

The Catholic Health Association of the United States (CHA) represents the nation's largest group of non-profit health care sponsors, systems, and facilities. Catholic health care facilities provide a wide range of services across the continuum of care—from birth to death—to patients of all ages, races, and religious beliefs. One in six people hospitalized in the United States is cared for in a Catholic hospital each year, and Catholic health care facilities provide a wide range of community benefits to assist individuals, families and the broader community. Often, Catholic health care providers are the "safety net" to thousands of patients in the communities we serve who cannot afford health care coverage.

CHA's membership is comprised of almost all of the Catholic health care providers in the United States. As of February 2006, our membership includes 57 health systems; 572 hospitals; 633 long-term care/continuing care ministries; 262 sponsors; and 221 other types of Catholic entities.

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2. What is CHA's governance structure and how are board members selected?

CHA is governed by a 25-person Board of Trustees, including (as ex officio members with vote) the Chairperson of the Board, the Speaker of the Membership Assembly, the President, the Vice-Chairperson/Chair-elect, and the Secretary/Treasurer. Board members are elected to serve for three-year terms, and may not be elected for more than two consecutive three-year terms.

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CHA Board members and officers (other than the President, who is appointed by, and serves at the pleasure of, the Board) are elected by the CHA Membership Assembly, which is comprised of representatives of CHA's members. The CHA Nominating Committee, which selects the nominees for the CHA Board and officers (other than the President), is elected by the CHA membership, not by the CHA Board. The Nominating Committee receives broad input on potential candidates for the Board through a member-wide Call for Candidates process. A profile of CHA's current Board is attached for your information.

CHA's bylaws provide that nominees for CHA's officers and Board members must be individuals who (1) possess the capacity and willingness to represent and provide leadership to areas of Association interest and activity; (2) have demonstrated their awareness of an interest in health related issues; and (3) have distinguished themselves through service and dedication to their chosen avocation. In addition, the Nominating Committee pays particular attention to diversity of both gender and ethnicity, as well as to specific competencies needed to address the issues facing the Catholic health ministry.

CHA also has the following Board-level committees that participate in governance: Executive Committee; Finance Committee, Audit and Compliance Committee; Bylaws/Membership Committee; and Advocacy and Public Policy Committee.

3. What are CHA membership fees and what are the benefits of CHA membership?

Representative membership dues are assessed annually and are based on a single dues rate of 20.74 cents per $1,000 of total operating expenses as shown on the most recent audited, consolidated financial statements. CHA members form a community of faith-based health care providers. They work together to address ethical issues confronting our ministry, promote the mission of Catholic health care, and carry out an advocacy agenda that includes as the number one priority quality health care for all persons in this country. Our members have an opportunity to accomplish together what individual organizations could not do alone, such as working with the broader Church and developing resources based on collective experience and information exchange.

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As is the case with other membership associations, benefits of membership include such items as educational programming, member advocacy, opportunities for national convenings and member consultations. In addition, CHA provides its members with a wide range of publications and written resources designed to highlight topical issues and explore the latest developments in health care and related ethical issues surrounding health care delivery and access. Our educational programs are designed to foster a greater knowledge of Catholic health care and its mission and provide leadership forums and resources in areas of interest to our ministry. CHA also provides members with the latest information on federal laws, regulations and policies. Additionally, the association represents our member's interest before Congress and federal administration departments and agencies. Membership benefits include access to CHA events such as the annual Catholic Health Assembly and specialized programs around a topical issue. Members also can access staff expertise on a variety of theological, ethical and public policy issues that effect health care delivery. Finally, member benefits include subscriptions to CHA's publications *Health Progress* and *Catholic Health World*; participation in affinity group meetings such as General Counsels or System Community Benefit network; and the ability to work together to share leading practices such as the recently completed *Core Elements in Sponsorship: A Reflection Guide*, to assist sponsors with accountability in governance of their health ministries.

4. What are CHA policies and procedures for ensuring members comply with CHA guidelines and what sanctions does CHA impose on members who do not comply with CHA guidelines?

CHA does not impose sanctions or measures of compliance upon its members—we are a voluntary organization of health care systems and facilities that share common principles based on Catholic social teaching and the Church's long tradition of reaching out to those in need in the surrounding community. As Catholic, mission-based organizations, the systems and facilities that make up CHA are bound by their commitment to fulfill those missions not to act in any way contrary to them or contrary to the long-established social justice traditions of the Church. As both a membership organization in the traditional sense and a representative of the Church's health care ministry, our goal at CHA is to promote among members a common understanding of who they are and how they should operate as Catholic health care providers, and to update as often as needed our voluntary guidelines as the situations and circumstances of health care delivery change in the United States. CHA sponsors and cosponsors programs to help improve the understanding of and compliance with the Community Benefit guidelines. As an example, in March 2006 more than 300 hospital leaders attended a three-day conference on Community Benefit guidelines cosponsored by CHA and VHA.

An important step CHA has taken this year has been creation of a Community Benefit Task Force comprised of CEOs and governing Board leaders to work with the entire ministry to get an even greater public commitment to consistent and transparent reporting. Their work has been well received by system CEOs and sponsors.

5. Does CHA have any plans to reach out to the Internal Revenue Service or the Financial Accounting Standards Board to improve accounting and reporting practices?

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In response to the IRS's continued focus on community benefit issues, CHA met with IRS officials in February 2006 to discuss our long-standing work regarding standardized and consistent reporting and accounting for community benefits. Since that time, we have maintained contact with IRS staff and have shared with them our Community Benefit Reporting Guide. We also discussed the plans IRS has to address community benefits in the future and how CHA may be of help as it continues to explore this issue. CHA also worked with the Health Care Financing Management Association throughout 2005 to develop principles and standards for accounting for community benefit. Additionally, we are in discussions with the American Institute of Certified Public Accounts' health committee as they revise their auditing guidelines in order to promote consistent accounting methodologies.

Leading Practices

Your letter also raised questions about CHA's members' leading practices with respect to a variety of areas. Before addressing these in detail as you requested, I thought it might be helpful to provide some context in which these practices have been developed and are implemented. As you know, tax-exempt health care providers in the United States are subject to a myriad of federal, state and local laws. Compliance with these is of the utmost importance to CHA's members. Certainly, there are areas in which our ministries can improve, and we have discussed many of these areas within the membership. However, I think that the "leading practices" described below should provide you with a better understanding of the numerous policies, processes, and practices that demonstrate our members' commitment to "doing the right thing."

Some of the leading practices of our members include the following:

- **Joint Ventures**
  In order to further their charitable mission of promoting health, most of our members enter into joint ventures. In today's environment, there are many benefits for communities in having health care services provided as part of a joint venture relationship. Joint venturing offers the potential to strengthen collaborative efforts with partners who have common commitments to quality, excellence and efficiency.

In most cases, the joint ventures undertaken by our members are of a clinical nature, often with other non-profit organizations. When deciding whether to enter into a joint venture, our members generally undertake a discernment process that includes consideration of some or all of the following criteria:

- The opportunity to create or expand services to address unmet needs in the community
- Enhancement of quality and delivery of health services
- Compatibility with joint venture partners in areas of mission, vision and quality
- Enhancement of access to capital for expensive technology
- Consideration of the joint venture's ability to:
  - Adopt and implement a charity care policy
  - Provide services to Medicare and Medicaid and charity care patients on a nondiscriminatory basis
  - Have safeguards in place so that the charitable purposes will override profit motive

A common practice of our members is to require their joint ventures to adopt a charity care policy (often the same as that of the hospital involved) and to accept Medicare and Medicaid patients. In addition, many require their clinical joint ventures to participate in their corporate compliance programs, and, in some cases, are subject to the hospital's internal audit processes. Of course, these safeguards are in addition to structuring the joint ventures to comply with Anti-Kickback, Stark and other applicable legal requirements.

- **Taxable Subsidiaries**

Some of our members have established taxable subsidiaries within their health care systems. These usually have been established to conduct activities that are related to, complimentary or supportive of, the charitable mission of the health care system, but do not qualify as exempt activities. Because these activities would generate unrelated business income if conducted by an exempt organization, the IRS has generally approved the establishment of properly structured separate corporations (which pay applicable federal taxes) to conduct these types of activities. Some examples of the types of activities conducted within these taxable subsidiaries include laundries, medical office buildings, outpatient pharmacies and paging services.

In instances where our members have taxable subsidiaries they generally are subject to the same oversight/accountability as described above with respect to joint ventures. The criteria most often considered in determining whether to create a taxable subsidiary includes (1) would it help ensure the quality of a product or service

used by the Catholic health ministry that otherwise would have to be purchased from a third party; (2) does it pursue activities that are important to our ministry; and (3) is it in accordance with our mission and values?

- **Contracts for Management and Administrative Services**
  As is necessary in today's environment, most of our members do have contracts with third parties for a variety of services. Where services are to be performed by those who are in a position to refer patients, our members have robust compliance programs in place to make sure that such arrangements comply with Stark, Anti-Kickback and other applicable laws. In 2000 CHA, in conjunction with its members and PricewaterhouseCoopers, LLP, developed an on-line compliance training program known as Complistar, which is widely used throughout the ministry to educate employees on a variety of compliance-related topics including Fraud and Abuse, Stark, HIPAA, Coding, Laboratory Administration, Home Health, Hospice, DME, Physician and Nursing Documentation. We also are currently developing a new EMTALA course. To date, ministry colleagues have completed more than one-half million of these on-line compliance courses.

  With respect to contracts with vendors and other third parties for routine services such as food services, supply chain management, management of specific clinical services by those with expertise (such as rehabilitation), housekeeping, security, etc., our members have various processes and procedures in place to determine compliance with Rev. Proc. 97-13 regarding the use of bond finance space. These include maintenance of a list of "private use" of bond-financed space; periodic audits of space use; conducting due diligence reviews with bond counsel; and development of a "bond manual" and template contracts which comply with the term limits and other requirements of Rev. Proc. 97-13 for use throughout the system.

- **Executive Compensation**
  As the Committee is aware, in implementing Section 4958 of the Internal Revenue Code, the IRS has set forth a detailed process for establishing a "rebuttable presumption" of reasonableness when setting the compensation of "disqualified persons," which includes at least the Chief Executive Officer of an exempt organization. As we understand it, most of our members follow this process in a very deliberate manner, including the establishment of Compensation Committees comprised completely of independent directors to set the compensation of "disqualified persons." In most cases where outside compensation consultants are used, the consultant is hired by and reports directly to the Compensation Committee, not management.

Another leading practice involving executive compensation is establishing explicit goals within the executive performance review and/or executive compensation programs that are tied to the organization's achievement of its charitable mission and community benefit. In many cases, an executive's variable compensation is directly dependent on achievement of these mission-based goals.

- **Travel and Expense Reimbursement**
  Our members employ a range of travel and expense reimbursement policies, all of them aimed at providing adequate reimbursement for legitimate business costs while encouraging reasonable and appropriate uses of travel services and other expenses. These policies generally restrict air travel to coach or economy class (some policies do provide for business class travel on overseas flights), and many of them recommend IRS guidelines for travel, including mileage reimbursement. As is common practice, our members ensure compliance with their individual policies through an internal audit process. In almost all cases, the same travel policies apply to our members' board members as well as their employees.

- **Billing and Collection Practices**
  This issue is one of great concern to all our members. To ensure that Catholic health care facilities continue a tradition of providing service to such vulnerable populations as the uninsured and underinsured, CHA members continue to strive for the improvements necessary so that billing and collection practices are as fair, equitable and as transparent as possible.

  Our members have established standards regarding billing and collection practices. These standards vary between differing hospital systems and regions of the country, as is appropriate in meeting the needs of differing populations in areas that have vastly different costs of living and median incomes from one another. That said, some general commonalities and practices should provide you with the range of our member's response to billing and collection issues. Many of our members' billing policies specify that charity care be provided for patients earning up to 200 percent of the Federal Poverty Level (FPL) who are uninsured and ineligible for any publicly funded health insurance program. Others specify charity care for this group in a range of 100-200 percent of the FPL and/or provide for discounted care that should not exceed a certain percentage of the patient's adjusted gross income. For those above 200 percent of FPL, most policies employ a sliding scale of discounts ranging from 200 to anywhere from 300 to 500 percent of FPL. Some policies include additional billing discounts such as special rules for catastrophic care charges exceeding certain percentages of income. Other policies utilize

the Department of Housing and Urban Development's income guidelines for discounting decisions.

Regarding collection practices, many members employ outside collection services where appropriate to assist in handling unpaid bills. These members utilize several methods to ensure that the collection services uphold standards and methods of treating patients that are reflective of our members' missions. Some specific examples include instructions against "body attachments" and prohibitions against certain foreclosures and liens, such as those on homes. Others specify a review period and prior approval by an entity outside the collection agency before undertaking legal action. These services are monitored by our members in various ways, including audits, reviews, logging/recording of communications between agency employees and patients, and creation of "ghost accounts."

Patients receive information about our members' billing and collection policies through a variety of means, including posting them in public areas of hospitals; in brochures and other printed material available in admission areas; and notices on billing statements. Additionally, these materials are almost always available in languages other than English, particularly in areas served wherein the predominant language is one other than English. In addition to providing information about an individual hospital or health system's billing policies, many of our hospitals proactively work with uninsured patients to ascertain whether they would be eligible for enrollment in publicly funded programs.

In addition to the above, many of our members have long operated clinics and other outreach clinical programs which provide free care for the very poor and sliding scale payments for the working poor.

CHA's revised Community Benefit Guidelines recommend that health care organizations make every effort to identify persons unable to pay for their care and to separate those accounts from those of persons unwilling to pay (bad debt). The guidelines, developed in consultations with the Healthcare Financial Management Association, further recommend that identification of persons unable to afford care be accomplished as soon as possible. However, when early identification is not possible because of lack or information, the determination can be made at any time during the care or billing process. In addition, the guidelines recommend that all employees who come in contact with patients, especially admissions and billing staff, be well acquainted with the organization's charitable mission and its financial assistance policies. The CHA website, referenced in the guidelines, features a sample PowerPoint presentation that can be used in an educational program for these staff members.

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Charity Care and Discount Policies for the Uninsured

To help you understand how these work in various communities, I am enclosing several examples of the discounting policies of a number of our health systems in multiple areas of the country. I believe they will show that the primary concern of our ministries toward the uninsured population is for the uninsured that are poor, and those made poor by catastrophic medical expenses. And while the policy details reflect the differing circumstances among these systems, I also assure you that our members provide several resources such as patient advocacy programs and financial counseling to help our uninsured patients understand all the options available to them.

System #1 – its policy is free care for the uninsured below 200% of the Federal Poverty Level (FPL). Between 201%-400% FPL there is a significant discount given, and for the uninsured that have an income greater than 401% FPL the discounts are similar to those given commercial payers. This system also provides special discounts in the event of a catastrophic illness that could overwhelm a family normally able to afford its medical expenses.

System #2 – its policy is 100% write off for the uninsured earning up to 200% FPL. For those patients that make between 200%-399% of the FPL there is a sliding scale. To give you some idea of how this sliding scale works, for outpatient care where the charges are below $5,000 the sliding scale is a 0%-100% discount at a rate of 1% discount for each 2% of household income that is below 400% FPL. For inpatient charges and outpatient charges that are greater than $5,000 the discount is equal to the greatest discount given to any managed care plan or the overall managed care realization rate, whichever produces the higher discount for the patient. For those over 400% FPL outpatient charges below $5,000 do not receive a discount while inpatient and outpatient charges greater than $5,000 receive the lowest discount given to a managed care plan.

System #3 – its policy is free care for uninsured families making below 200% FPL. Those making between 201% - 300% are charged the Medicare rate. Those between 301%-500% FPL are charged the prevailing rate of managed care and commercial care but it can not be more than 50% higher than the Medicare rate. Those greater than 500% FPL may be eligible for a discount, especially if the illness is a catastrophic illness.

System #4 – its policy is a 100% discount for the uninsured under 200% FPL. Between 200%-300% FPL there is a sliding scale based on the ability to pay but the charges can never be more than the Medicare rate. Greater than 300% there is a sliding scale based on the

ability to pay and consideration of assets, but the charge can never be more than the private pay discounting services amount.

System #5 - At less than 120% FPL there is a 100% write-off. Between 121%-300% FPL there is a sliding scale. To give you some idea of how this sliding scale works the system takes the average income amount of the household minus 120% FPL divided by 300% of FPL minus 120% FPL equaling X. Then 1 minus X times 100 equals the percentage discount. As an example:

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Family of 6 earning $60,000.

$60,000 - $30,252 = $29.748
(120%FPL)

$29,748 ÷ $72,630 - $30,252 = .65
(300% FPL) (120%FPL)

1 - .65 x 100 = 35% discount

System #6 – its policy is 100% write off for the uninsured making less than 100% FPL. For those between 100%-200% FPL there is a deep discounted sliding scale. For those greater than 200% FPL there is a sliding scale program tailored to the individual community in which the local hospital resides. For other uninsured who are able to pay, charges are discounted to the highest payer the local hospital has with the ability to add up to 5% more on top of that to account for the prompt pay discount large insurers receive. However, this discount must also be offered to the uninsured for prompt payment.

System #7 - bases its charity care eligibility on HUD's 130% of Very Low Income Guidelines based on geography. The system believes that the HUD Very Low Income Guidelines are more responsive to the communities it serves, and offers the uninsured write off eligibility ranging from 25%-100% of charges. An example of this based on the HUD Very Low Income Guidelines is a family of four with a gross annual income that does not exceed $35,815, which would be eligible for a 100% charity write off. Those with incomes up to $41,720 would be eligible for a 75% discount from charges, with lesser discounts offered to those with incomes above that amount.

These examples are illustrative of the commitment and compassion of many of our systems. I will certainly be happy to provide you with other examples if you are interested. I would also point out that the vast majority charge no interest on amounts due from patients who have payment plans extended over a long period of time.

- **Conflict of Interest and Other Governance Issues**
  CHA members have adopted conflict of interest policies that require members of boards and certain employees in management or executive positions to adhere to those entities' standards governing conflicts of interest. These policies include various means to ensure compliance, such as requiring annual statements to ascertain potential conflicts and requiring prompt disclosure of changes in status during the intervening period. Most of our members have voluntarily taken steps to enhance their governance in the spirit of the Sarbanes-Oxley law, such as through the establishment of a separate, independent Audit Committee: the rotation of audit partners; the limitation of non-audit work by outside auditors; required executive sessions without management present. Compliance is monitored through audit committees or the work of general counsels and compliance officers, and those with potential conflicts are excluded from discussions or decisions regarding the conflicting topic.

  Other governance issues that may be of interest to the Committee include the socially responsible investing policies adopted by most of our members. Our members also are increasing their commitments to transparency following the increase in the past several years in electronic availability of financial forms and statements. Many of our members already make this type of information publicly available, often through their websites, while others have indicated their intention to move in this direction in the near future. Of course, our members follow the IRS Form 990 public disclosure requirements, and, as I am sure you are aware, this information is available on www.guidestar.org.

  In addition, most of our members distribute annual reports describing the various ways that they have contributed to the health of the communities they serve. We recommend to our members that these reports include:
  - Executive summary and one-page community benefit summary
  - A description of core values and social teaching that guide the organization
  - A history of an organization's commitment to the community and its development over time
  - A description of community needs and resources
  - Objective measures of community benefit, including dollars spent, numbers served, and the impact on the community
  - A narrative report to explain the value of the services provided beyond the dollars spent or numbers served

The above leading practices are meant to be illustrative rather than an exhaustive list of everything our members do to make sure that their

operations are in compliance with applicable laws and regulations. Highlighting these examples should not be read to suggest that organizations that do not have some or all of these practices in place are not also committed to their obligations as tax-exempt entities. Instead, it is my hope that these illustrations will give you and the Committee a better understanding of how our members are striving to uphold their responsibilities as tax-exempt entities and, most importantly, as health care providers for those who are often the most vulnerable in our society.

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As the Committee staff is aware, CHA is finalizing the revised Community Benefit Guidelines. The staff has been very helpful as we made the revisions, and I would like to express our thanks to them. I look forward to sharing a copy with you when they are published in May.

I would very much appreciate the opportunity to meet with you in person to discuss the points in this letter in more detail, and to answer any further questions that you may have. Let me thank you again for this opportunity to provide you with this information on behalf of the more than 2,000 Catholic health care sponsors, systems, facilities, and related organizations in the United States.

Sincerely,

Sr. Carol Keehan, DC

cc: Senator Max Baucus
Senator Ron Wyden