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Re: Definition of the Term "Patient" for Purposes of the Definition of "Patient Care"

Dear Mses. Judson and Cook:

The American Institute of CPAs (AICPA) is pleased to submit comments with respect to who constitutes a "patient" for purposes of the definition of "patient care." The AICPA recommends that the Internal Revenue Service (IRS) issue guidance, in the form of additional examples to Rev. Rul. 68-376, recognizing that the term "patient" encompasses individuals directly or indirectly receiving clinical diagnosis and/or treatment through telemedicine modalities. The examples, which we provide in this letter, clarify that the income from the provision of telemedicine services by a tax-exempt hospital is not unrelated business taxable income (UBTI).

I. <u>Background</u>

In response to Notice 2017-28, the AICPA submitted recommendations for the Department of the Treasury ("Treasury") 2016-2017 Priority Guidance Plan[1] that included a request for the IRS to issue guidance on the definition of a "patient." This letter provides additional information and recommendations for our request.

Under current federal tax law, a tax-exempt hospital generally treats, as a patient of the hospital, an individual who visits the hospital's facilities, or is touched by a hospital employee or agent. Income received by the tax-exempt hospital for services provided to those individuals is generally not subject to tax.

Telemedicine services do not fit into the traditional tax analysis of the definition of a patient. The services provided to individuals through telemedicine are not necessarily provided to them in the brick-and-mortar structure of the service-provider hospital, nor do employees of the service-provider hospital physically "touch" the patient receiving the

[1] See AICPA Recommendations for 2017-2018 Guidance Priority List, page 5, item 15 under the heading "Exempt Organizations Taxation Technical Resource Panel."

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services. Therefore, tax-exempt hospitals do not have clear guidance on whether the provision of telemedicine services may give rise to UBTI.

Telemedicine Defined

The World Health Organization defines telemedicine as:

> The delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities.[2]

The American Telemedicine Association (ATA) notes that "the use of telemedicine has spread rapidly and is now becoming integrated into the ongoing operations of hospitals, specialty departments, home health agencies, private physician offices as well as consumer's homes and workplaces."[3]

The telemedicine technological applications of today are far more advanced than in the 1960s when the tax rules governing the definition of a patient were developing. "Patient consultations via video conferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs, continuing medical education, consumer-focused wireless applications and nursing call centers are just some of the related applications"[4] through which telemedicine services are provided. Therefore, it is necessary to update the definition of a patient to account for technological advances.

II. Analysis

Origin of Definition of "Patient"

The current IRS definition of "patient" originated in 1968. In Rev. Rul. 68-376, the IRS set forth examples of relationships that determine whether a person is a patient of a hospital for purposes of section 513(a)(2).[5] Section 513(a)(2) sets forth the convenience exception to the definition of unrelated trade or business, and provides that it does not include any trade or business carried on by a tax-exempt organization primarily for the convenience of its patients. According to Rev. Rul. 68-376, the following categories of persons are considered "patients" for purposes of section 513(a)(2):[6]

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[2] See Telemedicine Opportunities and Developments in Member States: Report on the Second Global Survey on eHealth (Global Observatory for eHealth Series Volume 2) World Health Organization, 2010, page 9.
[3] See http://www.americantelemed.org/about/about-telemedicine.
[4] *Id.*
[5] See https://www.irs.gov/pub/irs-tege/rr68-376.pdf.
[6] *Id.*

- Person admitted to the hospital as inpatient;
- Person receiving services from outpatient facilities of a hospital;
- Person directly referred to outpatient facilities by private physician for treatment;
- Person refilling prescription written during treatment as hospital patient;
- Person receiving medical services as part of a hospital-administered home care program (as an extension of inpatient and outpatient care); and
- Person receiving medical care and services in a hospital-affiliated extended care facility.

The current definition of a "patient" contemplates a bricks-and-mortar structure at which patients receive treatment. Several subsequent private letter rulings (PLRs) (listed below) permitted the term "patient" to extend to recipients of services conducted by professional employees, even though performed at a variety of locations, and other situations not directly covered by Rev. Rul. 68-376 in which the services provided contribute importantly to the carrying out of exempt purposes.

- In PLR 8122013, a tax-exempt hospital was not liable for unrelated business income tax (UBIT) on its provision of laboratory services to patients of private physicians because such services contributed importantly to meeting the health needs of the community. In discussing Rev. Rul. 68-376, the IRS noted: "[I]t is important that the Service take cognizance of the changes in health care delivery brought about by modern technology. For example, the technology is now in place for a hospital to monitor the results of an electrocardiogram attached to a patient who is 80 miles away. The point is that who is legitimately considered a patient of a hospital today is not necessarily the same as 12 years ago, when the cited revenue ruling was published."[7]

- In PLR 9837031 (9/11/1998), the IRS considered whether income from certain ancillary services provided by non-physician health care professionals, who were employed by tax-exempt healthcare providers, constituted UBTI when the services were provided away from the provider campuses (at medical institutions that were not part of a system or at employer locations). In some cases, the tax-exempt providers billed the unrelated medical provider or employer while in others the individuals receiving the services were billed.

  According to the ruling:

  > The provision of professional ancillary medical services including radiology services, such as magnetic resonance imaging, respiratory, speech and physical therapy, occupational and industrial medicine, home health and hospice and case management services by non-physician health care professionals employed by [the exempt

[7] See PLR 8122013.

> healthcare providers] on [their campuses] or at medical institution [sic] that are not part of the system furthers the exempt purposes of [the exempt healthcare providers]. Therefore, income received from the provision of these services is not unrelated business income, even though some of the patients receiving these services are registered as patients of other institutions and the billing procedures vary according to the factual situation. Direct professional healthcare services undertaken by [each exempt healthcare provider] through its professional employees are substantially related to [their exempt purposes].[8]

- In PLR 9445024 (11/10/1994), the IRS reviewed a transaction in which a tax-exempt hospital contracted with unrelated nursing homes and continuing care residences to provide respiratory therapy services to residents of the respective facilities. Prior to the provision of these services, none of the residents were patients of the hospital. According to the ruling, hospital employees conducted the respiratory services at the nursing homes on an "as needed basis." The hospital charged the nursing home (not the patients) on a "salary equivalent" basis for the services rendered. The nursing home, in turn, billed the residents or their insurance providers for the respective services.

  In concluding that the services provided by hospital personnel were not considered an unrelated trade or business, the IRS looked to the hospital/patient nexus relying on the fact that the services were provided directly by hospital employees. According to the ruling, "the critical factor in establishing a hospital/patient nexus is whether the services are provided directly by the hospital, its employees, or its agents, not the location where those services are provided."[9] As a result, the IRS concluded that the contractual arrangement between the hospital and the nursing homes furthered the hospital's exempt purpose of providing and promoting health care in the community.

<u>The Role of Tax-Exempt Hospitals under the Affordable Care Act in Promoting Telemedicine</u>

Federal healthcare reform initiatives are redefining healthcare delivery, which creates the need for an updated definition of who constitutes a patient. One example of how healthcare delivery is being redefined is demonstrated in the participation of charitable hospitals in accountable care organizations (ACO). In Notice 2011-20, the IRS addressed the application of the provisions of the Internal Revenue Code ("Code") governing tax-exempt organizations to exempt hospitals or other health care organizations participating in the Medicare Shared Savings Program (MSSP) described in the Patient Protection an

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[8] See PLR 9837031 (9/11/1998).
[9] See PLR 9445024 (11/10/1994).

Affordable Care Act (ACA).[10] Goals of the MSSP are to promote accountability for care of Medicare beneficiaries, to improve the coordination of Medicare fee-for-service items and services, and to encourage investment infrastructure and redesigned care processes for high quality and efficient service delivery. ACOs participating in the MSSP are groups of service providers and suppliers that will manage and coordinate care for their assigned Medicare fee-for-service beneficiaries.

ACOs participating in the MSSP are subject to various requirements and are accountable for the quality, cost, and overall care of their assigned beneficiaries. Accordingly, one requirement of an ACO is to "define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies."[11]

In Notice 2011-20, the IRS demonstrates that it is cognizant of the potential tax implications of the participation of charitable hospitals in ACOs, and specifically indicates "the IRS is soliciting comments as to whether existing guidance relating to the Code provisions governing tax-exempt organizations is sufficient for those tax-exempt organizations planning to participate in the MSSP through an [ACO] and, if not, what additional guidance is needed."[12] The ability of a tax-exempt hospital to provide telemedicine services directly to individuals (or indirectly to individuals through other healthcare providers) in furtherance of its charitable healthcare purposes, without generating taxable income, is an area in need of additional guidance and clarification.

The Role of Charitable Hospitals under the ACA in Promoting Community Health

The provisions of section 501(r), which added the community health needs assessment requirement for charitable hospitals, contemplate that charitable hospitals will play a greater role in population health management by addressing the significant health needs identified within the community served by the hospital. The final section 501(r) regulations state that these community health needs may include the need to address financial and other barriers to accessing care, to prevent illness, to ensure adequate nutrition, and to address social, behavioral, and environmental factors that influence health in the community.

The provision of certain telemedicine services is an effective way to increase access to healthcare services. Broadening the definition of "patient" for purposes of UBTI (to account for patients receiving certain telemedicine services specifically, as well as patients who are part of a population health management program generally) is consistent with other areas of the Code and Treasury regulations that impact healthcare institutions.

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[10] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148.
[11] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Title III, Subtitle A, Part III, §3022.
[12] See https://www.irs.gov/pub/irs-drop/n-11-20.pdf.

No Existing Clear Guidance from the IRS on who is a "Patient" in Telemedicine

In the existing guidance, all examples of "hospital/patient nexus" involve in-person interaction between the patient and the provider of medical care. Where there is no in-person interaction, it is not clear whether the IRS would find sufficient hospital/patient nexus. This gap in the tax law has led to inconsistent application of the tax rules within the healthcare provider community relating to whether the income from telemedicine services is UBTI.

III. Recommendations

Modernize the Definition of "Patient"

Recommendation

The AICPA recommends that the IRS issue guidance, recognizing that the term "patient" encompasses individuals directly or indirectly receiving clinical diagnosis or treatment through telemedicine modalities. The AICPA recommends that the IRS update Rev. Rul. 68-376 to include examples reflective of the definition of a patient in the modern healthcare environment.

Analysis

The term "patient" is not statutorily defined for federal tax purposes. However, under federal tax law, the term is not limited to individuals who are provided care within the four walls of a hospital or touched by hospital employees or agents.

The concepts of telemedicine and telehealth are integral parts of the ACA and expand the historical notion of a patient. The inconsistency of outdated interpretations of the term "patient" with current healthcare trends is detrimental to tax-exempt hospitals because their use of telemedicine technologies may result in taxable income. The unintended result is to discourage the use of and investment in this type of technology by tax-exempt hospitals, rather than encourage its use.

A resolution of the analytical gap in terms of the definition of a patient is achieved through a logical application of existing precedent to provider telemedicine activity. Consistent with provisions of the ACA and modern healthcare trends, the AICPA thinks that when a charitable hospital (whether or not participating in an ACO) uses medical information exchanged from one site to another via electronic communications to improve an individual's clinical health status, the individual is considered a patient of the hospital sufficient to create a hospital/patient nexus for purposes of a UBTI analysis.

The above definition of a patient recognizes the use of the medical/professional judgment of the tax-exempt hospital, its employees or agents, to diagnose or treat a patient's medical

condition, regardless of location. Our interpretation is consistent with IRS PLRs that hinge on the provision of professional healthcare services by employees or agents of a hospital to maintain the requisite hospital/patient nexus for purposes of a UBTI analysis. Our interpretation is also consistent with provisions of the ACA that encourage the use of telemedicine for purposes of improving quality of care, improving access to care, and reducing the cost of care.

Charitable healthcare organizations conduct their exempt activities in a broader way today than at the time Rev. Rul. 68-376 was released. Consistent with section 513(a)(2) and the accompanying Treasury regulations, Rev. Rul. 68-376 should recognize that a "patient" is not necessarily limited to a person receiving care or services from hospital-based facilities, clinics or programs, but rather from any organization described in section 501(c)(3).

We suggest that the IRS add examples to Rev. Rul. 68-376 to clarify that "patients" exist in many contexts which includes, but is not limited to, laboratory services, sales of durable medical equipment, and telemedicine services. Although this position is a logical application of existing precedent to provider telemedicine activity, new guidance is necessary to clarify current conflicting interpretations within the healthcare provider community.

Proposed Additional Examples for Rev. Rul. 68-376

Example 1 – A person receiving medical diagnosis/treatment through remote access to physicians:

To increase access to appropriate medical care, Hospital A creates an online care service that allows individuals remote access to physicians and/or other caregivers using interactive audio and video technology on a smartphone, tablet or computer. Similar to onsite visits, online services are documented in an electronic medical record. Physicians and caregivers assess the individual's medical condition(s) and recommend an appropriate course of treatment. Because the visits are generally for common, treatable concerns, most participants will not need a follow up visit to a hospital or clinic. Since the online physicians and/or caregivers use their professional judgment, experience, and training to diagnose and/or treat an individual's medical condition(s), that individual is a patient of Hospital A. Thus, Hospital A's treatment of that individual contributes importantly to the carrying out of its exempt purposes, and is not an unrelated trade or business within the meaning of section 513.

Example 2 – A person's healthcare provider receiving assistance with the individual's medical diagnosis/treatment through remote access to medical specialist:

Hospital A does not currently have access to certain medical specialties. Rather than submit an individual to a costly and risky transport to another facility, Hospital A engages Hospital B for remote assistance. When appropriate, Hospital A provides Hospital B with

remote access to the applicable individual's health record(s), as well as real-time monitoring of vital signs, medical status, etc. While Hospital A's physician or caregiver remains primary, the Hospital B physician or caregiver consults with Hospital A and assists with diagnoses and/or recommendations for treatment.

Hospital A bills the individual and/or the individual's insurance. Hospital B is paid for its services by Hospital A. Hospital B's consulting physician or caregiver provides professional judgment, experience, and training to assist in the diagnosis and to treat the individual's medical condition. Therefore, the individual is a patient of both hospitals for purposes of section 513. Hospital B's revenue from this activity is related to its exempt function.

Example 3 – A person's healthcare provider receiving assistance with the individual's medical diagnosis/treatment through remote access to medical specialist, and including access to ancillary services of consulting hospital:

Hospital A does not currently have access to certain medical specialties. Hospital A sends images, tissue sample, test results and/or medical records to Hospital B, an unrelated hospital, for assistance in determining or confirming an individual's diagnosis and/or creating a course of treatment. Hospital B does not have direct contact with the patient, either in person or electronically.

Hospital A bills the individual and/or the individual's insurance. Hospital B is paid for its services by Hospital A. Even though Hospital B does not have direct contact with the individual, the physicians and/or caregivers of Hospital B have actively participated in the treatment of the individual sufficient to create a patient relationship. The individual is a patient of both Hospital A and Hospital B. Hospital B's revenue from this activity, including revenue for professional/diagnostic services as well as revenue for laboratory processing of the tissue sample, is not taxable as an unrelated trade or business activity.

Example 4 – A person belonging to a population health management program receiving healthcare services from outside of the program:

This example assumes that a tax-exempt healthcare system either owns or operates a population health management program (whether alone or in conjunction with another owner or owners), and such ownership/operation of the population health management program is consistent with its tax-exempt purposes. As such, the healthcare system is responsible for a defined community's health and receives a fixed or similar payment for those members.

For a variety of possible reasons, such as travel outside the service area or the need to see a specialist, a member of the population health program visits an unrelated physician, clinic or hospital to receive medical treatment. The payment received by the healthcare system

for the individual's participation in the population health management program is unchanged and remains related to patient care.

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The comments and recommendations included in this letter were developed by the AICPA Exempt Organizations Taxation Technical Resource Panel and approved by the AICPA Tax Executive Committee.

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We appreciate your consideration of our recommendation and welcome the opportunity to discuss this issue further. If you have any questions, please feel free to contact me at (408) 924-3508, or annette.nellen@sjsu.edu; Elizabeth E. Krisher, Chair, AICPA Exempt Organizations Taxation Technical Resource Panel, at (412) 535 5503, or bkrisher@md-cpas.com; or Ogochukwu Eke-Okoro, Lead Manager – AICPA Tax Policy & Advocacy, at (202) 434-9231, or ogo.eke-okoro@aicpa-cima.com.

Sincerely,

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