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Association**

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By Electronic Filing

Internal Revenue Service  
Form 990 Redesign, SE:T:EO  
1111 Constitution Avenue, NW  
Washington, DC 20224

**RE: COMMENTS ON DRAFT SCHEDULE H**

On behalf of our nearly 5,000 member hospitals, health care systems, networks and other health care providers, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to submit comments on the draft Schedule H for Hospitals. We are submitting our comments well in advance of the September 14 due date to give the Internal Revenue Service (IRS) time to consider our comments and request any additional information. The AHA will submit comments on Form 990 and other schedules in a separate letter.

We appreciate the work that the IRS has put into draft Schedule H, and your willingness to hear comments from the hospital community. We particularly appreciate the efforts of IRS officials who participated in our conference calls about Schedule H with hospital leaders, and met with the AHA and other associations representing tax-exempt hospitals to discuss the field's concerns.

In the wake of such an ambitious effort by the IRS, it is not surprising that the tax-exempt hospital community has such concerns. In many instances, Schedule H fails to meet the goals that the IRS set. The IRS explained these goals as follows:

- *Enhancing transparency means providing the IRS and its stakeholders with a realistic picture of the organization and its operations, along with the basis for comparing the organization to similar organizations.*
- *Promoting compliance means the form must accurately reflect the organization's operations and use of assets, so the IRS may efficiently assess the risk of noncompliance.*
- *Minimizing the burden on filing organizations means asking questions in a manner that makes it relatively easy to fill out the form, and that do not impose unwarranted additional recordkeeping or information gathering burdens to obtain and substantiate the reported information.*



As the following comments will demonstrate, draft Schedule H often falls short of these goals and, as a result, will be of limited use to the IRS and other reviewers. In too many instances, hospitals would experience extraordinary burdens gathering and reporting the requested information – information that is often unrelated to compliance. At the same time, the information requested would fail to provide reviewers with a comprehensive view of the filing organization, particularly hospital systems, and thereby increase the risk that the IRS would suspect noncompliance when none was present. And the information requested could be presented in a misleading and/or overly abbreviated manner that would confuse instead of inform reviewers.

Our concerns about Schedule H can be summarized as follows:

- The filing deadline is far too short. It should be extended to tax year 2010.
- Schedule H should be redesigned to:
  - focus on the five pillars of the community benefit standard;
  - incorporate the full value of community benefit that hospitals provide; and
  - eliminate burdensome and misleading questions that are unrelated to community benefit or compliance.

We recognize that, until the questions are revised and coupled with instructions and worksheets, it is not possible to identify all the issues hospitals may face in implementing Schedule H. However, we have tried to identify as many issues as possible that we believe the Service needs to address.

### **SCHEDULE H FAILS TO ACHIEVE THE GOALS THE IRS SET FOR ITSELF**

The overarching problems with Schedule H are two-fold: First, it neither limits itself to nor properly incorporates the pillars of the community benefit standard. While we appreciate the complexity involved in the IRS' development and release of so many important and complicated documents, the AHA opposes any effort to change the community benefit standard, including through the expedient of a form.

Second, it departs, sometimes radically, from discretionary reporting that the tax-exempt hospital community has agreed provides value in the service of transparency, even though the burden of providing such information is substantial.

### **SCHEDULE H FAILS TO ADHERE TO THE COMMUNITY BENEFIT STANDARD**

The community benefit standard, which requires the promotion of health in accordance with community needs in the absence of private benefit, is the legal basis for hospitals' tax exemption. Therefore, to be consistent with the basis on which tax exemption is granted to hospitals, the IRS should incorporate the community benefit standard into Schedule H, in the same manner it is incorporated into other forms and reflected in the IRS' own rulings and legal precedent. Further, the IRS should rely on it exclusively to determine compliance.

For almost 40 years, the community benefit standard, set forth in Revenue Ruling 69-545, has been the standard used by the IRS, the courts and the tax-exempt community in determining tax-exemption for hospitals and health care organizations. The reasons for that ruling and for the movement away from a “financial-ability” standard are still compelling. As the U.S. Supreme Court recognized in 1976:

“[T]he concept of the nonprofit hospital and its appropriate and necessary activity has vastly changed and developed since the enactment of the Nonprofit Institutions Act in 1938. The intervening decades have seen the hospital assume a larger community character. Some hospitals, indeed, truly have become centers for the ‘delivery’ of health care. The nonprofit hospital no longer is a receiving facility only for the bedridden, the surgical patient, and the critical emergency. It has become a place where the community is readily inclined to turn, and because of increasing costs, physician specialization, shortage of general practitioners, and other factors is often compelled to turn, whenever a medical problem of import presents itself.” Abbott Laboratories v. Portland Retail Druggists Ass’n, 425 U.S. 1, 11 (1976).

The Court recognized that hospitals have evolved into community organizations whose mission, appropriately, is to promote the health of the entire community. In numerous rulings since 1969, the IRS has recognized that the “promotion of health” is a charitable purpose in and of itself.

Revenue Ruling 69-545 recognized that a variety of factors are the pillars of the “community benefit” standard, including operating an emergency room open to all regardless of ability to pay; having an independent board of trustees composed of representatives of the community; having an open medical staff policy with privileges available to all qualified physicians; providing care to all persons in the community able to pay either directly or through third-party payers; and utilizing surplus funds to improve the quality of patient care, expand facilities and advance medical training, education and research.

Those same factors are reflected in the form hospitals use to apply for tax exemption: Form 1023, Application for Recognition of Tax-Exempt Status, Schedule C. It is additionally concerning that Schedule H does not incorporate that same focus and inquire about those factors in seeking to determine compliance. At the very least, this inconsistency could unfairly increase the likelihood of a hospital being subjected to an IRS audit.

Since 1969, the IRS has applied the community benefit standard by looking at how its five pillars relate to the facts and circumstances of particular hospitals and their communities. This has allowed hospitals to meet the unique needs of their communities, instead of adhering to a rigid “one size fits all” standard. This standard, for example, has allowed hospitals to:

- develop programs that provide uninsured and underinsured patients with free or discounted prescription medications;
- operate dental clinics in public elementary schools;

- help women in the community receive annual breast and pelvic exams;
- strengthen their community's emergency preparedness;
- prepare and support disadvantaged children for school by providing free immunizations and school supplies, as well as after school care;
- provide chaplain visits and counseling for patients;
- support ongoing medical research projects;
- support nurse education and development programs;
- provide counseling and education to prevent and/or address domestic violence;
- make neighborhoods healthier and safer with programs to repair dilapidated or abandoned homes and other neighborhood preventive health services; and
- provide many other services tailored to, and needed by, the community.

Because the mission of hospitals is not just to tend to the sick and injured, but also to promote the health of their communities, many hospital programs and activities go beyond traditional health care. Often, the local hospital provides the social safety net that others have abandoned. Hospitals should be rewarded for assuming this mantle of responsibility and their efforts should be recognized as community benefit. To do otherwise, would, in effect, permit the IRS to substitute its judgment about a community's needs for that of an independent board of hospital trustees who truly know and represent the community served by the hospital.

### **SCHEDULE H SHOULD BE DELAYED UNTIL 2010**

The hospital community has demonstrated in many ways its commitment to transparency. However, even under ideal conditions, the burden of reconfiguring financial and data record-keeping systems to capture by January 1, 2008 the substantial amount of information required just for Schedule H is a daunting task. It is made virtually impossible without the necessary instructions, definitions and worksheets that the IRS does not expect to finalize until the following June. Even if the IRS completes the revised form and instructions before June 2008, it is impossible for hospitals to predict what will need to be changed to permit data collection by January 1, 2008.

The tax-exempt hospital community has agreed that reporting a diversity of community benefit in a uniform manner, as reflected in part by the Catholic Hospital Association's and VHA's *Guide for Planning and Reporting Community Benefit* (Guide), is another important step toward transparency. However, the IRS should not lose sight of the practical challenges and costs that commitment entails. For example, a rural hospital that has had some experience with the Guide reports that it requires between 20-22 days of staff time to collect and report the required information.

We conservatively estimate that only half of the nation's tax-exempt hospitals have had practical experience gathering and reporting data using the Guide. Those that have not will therefore require additional time to, among other tasks, redesign or purchase and install the necessary new software systems. And if other areas of questioning remain on Schedule H, they would require substantial additional work and cost.

We believe that, had the IRS conducted an analysis of the burden of complying with the new Schedule H, the analysis would have demonstrated a clear need for at least a two-year delay.

Given the number of concerns and questions about Schedule H, we urge the IRS to provide a second draft in 2008, followed by a review period, with a goal of finalizing the schedule and instructions by December 31, 2008. That would give hospitals all of 2009 to revise their financial and data record-keeping systems so that they accurately capture the new information that would be reported for tax year 2010.

### **MEDICARE UNDERPAYMENTS AND BAD DEBT ARE COMMUNITY BENEFIT**

The IRS should incorporate the full value of the community benefit that hospitals provide by counting Medicare underpayments as quantifiable community benefit and modifying the chart, instructions and worksheets accordingly. That is because:

- Providing care for the elderly and serving Medicare patients is an essential part of the community benefit standard.
- Medicare, like Medicaid, does not pay the full cost of care. Currently, Medicare reimburses hospitals only 92 cents for every dollar they spend to take care of Medicare patients. The Medicare Payment Advisory Commission (MedPAC) in its March 2007 report to Congress cautioned that underpayment will get even worse, with margins reaching a 10-year low at *negative* 5.4 percent.
- Many Medicare beneficiaries, like their Medicaid counterparts, are poor. More than 46 percent of Medicare spending is for beneficiaries whose income is below 200 percent of the federal poverty level. Many of those Medicare beneficiaries are also eligible for Medicaid -- so-called ‘dual eligibles.’”

There is every compelling public policy reason to treat Medicare and Medicaid underpayments alike. Medicare underpayment must be shouldered by the hospital in order to continue treating the community’s elderly and poor. These underpayments represent a real cost of serving the community and should count as a quantifiable community benefit.

Patient bad debt is a community benefit. Like Medicare underpayment, there also are compelling reasons that patient bad debt should be counted as quantifiable community benefit.

- A significant majority of bad debt is attributable to low-income patients, who, for many reasons, decline to complete the forms required to establish eligibility for hospitals’ charity care or financial assistance programs. A 2006 Congressional Budget Office (CBO) report, *Nonprofit Hospitals and the Provision of Community Benefits*, cited two studies indicating that “the great majority of bad debt was attributable to patients with incomes below 200% of the federal poverty line.”
- The CBO concluded that its findings “support the validity of the use of uncompensated care [bad debt and charity care] as a measure of community benefits” assuming the

findings are generalizable nationwide; the experience of hospitals around the nation reinforces that they are generalizable.

Despite hospitals' best efforts, patient bad debt is a fact of life. The IRS should not ignore it or attribute it to a lack of industry on the part of the tax-exempt hospital community. It is, rather, part of the evolving burden hospitals must shoulder in helping patients who, for many reasons, decline to take advantage of available financial assistance. It is a real cost of serving the community and the IRS should recognize any reasonable method to count patient bad debt as a quantifiable community benefit.

### **THE SCHEDULE H FORM NEEDS TO BE CHANGED**

In addition to incorporating questions necessary to determine compliance with the community benefit standard, to the extent that the IRS intends to ask discretionary questions, we have a number of recommendations for streamlining the form to eliminate unnecessary burden and for improving the questions that remain.

#### **Eliminate Questions Unrelated to Community Benefit**

The proposed chart on draft Schedule H, Part II relating to billing should be eliminated for many reasons. First, because the information sought in the chart has no relationship to the community benefit standard, it does not contribute to the IRS' goal of promoting compliance.

Second, providing the information required by the billing chart is burdensome, and thereby undermines the IRS' goal of minimizing burden. By necessity, hospital billing operations are complicated. Hospitals do not retain the data in the same discrete categories requested by the IRS. For example, many, if not most, hospitals classify patients as "self pay," not "insured" and "uninsured" as the chart suggests. Sorting data to satisfy the chart's requirements would be immensely burdensome. In its comment letter to the IRS, one Texas hospital estimated that "it may require up to a month of extra staff work" just to provide this information. Similarly, a hospital in New Hampshire estimated it would require "in excess of 1,000 hours of extra staff work to provide."

Third, the data requested could be competitively sensitive. In markets across the country that are characterized by a shrinking number of health insurance plans, asking for information about discounts is tantamount to revealing confidential information on the discounts insurers demand from hospitals. This cannot be the sort of transparency the IRS was seeking.

The AHA is committed to helping the IRS get the information it needs to meet its goals. However, in this instance, it is difficult to determine precisely what relevant information is unavailable. If the IRS is seeking more information on Medicare and Medicaid revenues, that can be found in draft Form 990; if it seeks more information on charity care, that can be found in the section on quantifiable community benefit; if it seeks more information on a hospital's financial assistance practices and policies, those subjects are covered by other questions in Schedule H. If more detail is required on any of those subjects, portions of the Form or schedule

can be enhanced to include them. The IRS should not create defacto new reporting requirements through the expedient of this billing chart.

### **Include Community Building Activities as Quantifiable Community Benefit**

The IRS should reinstate reporting for community-building activities, which would include community activities undertaken by hospitals that contribute to the overall mental, physical and social well-being of the community.

In its decision cited earlier, the U.S. Supreme Court recognized that hospitals had evolved beyond the activities anticipated in 1938. Likewise, hospital activities have evolved beyond those anticipated by the Court in 1976. They now include serving as a community's health care safety net, with activities such as providing transitional housing for patients, maintaining and updating emergency preparedness, leadership in addressing environmental concerns, and many other less-traditional activities that have become part of the "larger community character" hospitals have adopted responsibility for because, quite simply, no one else is meeting those needs.

The programs now labeled as "community building" contribute to prevention of illness or otherwise address concerns that ultimately affect the community's health and well-being. Moreover, these programs are part of the responsibility assumed by every tax-exempt hospital's independent board of trustees, which is composed of representatives of the community. Once again, the IRS should not substitute its judgment about a community's needs for the judgment of those who are part of the community. Also, the IRS should be concerned that any decision not to include this category could discourage the provision of these community benefits by hospitals, and therefore, leave the community without services upon which it relies.

### **Other Recommended Improvements to the Form:**

1. Information on nonquantifiable benefits should precede other requests for information.

The IRS should reconfigure the form to ensure that questions related to the community benefit standard and discretionary questions on nonquantifiable benefits precede the chart now labeled "Community Benefit Report."

2. The information provided by a hospital should be placed in context.

IRS should, at the front of the form, add a new section with checkboxes allowing the filing organization to indicate the type of facility or facilities making the report, as follows:

Part I	1. Name of filing organization	Employer identification number
	2. Type of facility: (check all that apply):	
	<input type="checkbox"/> Children's hospital	<input type="checkbox"/> Sole Community hospital
	<input type="checkbox"/> Critical access hospital	<input type="checkbox"/> Teaching hospital
	<input type="checkbox"/> Research hospital	<input type="checkbox"/> Urban hospital
	<input type="checkbox"/> Rural hospital	<input type="checkbox"/> Other service attributes (please describe)
	_____	
	_____	

- The IRS should permit live links to hospital information or attachments.

For a number of questions, including those pertaining to assessing community health needs, community benefit reports and charity care policies, where the amount of space provided is not sufficient to fully describe the hospital's activities, programs or policies, the IRS should permit (not require) the insertion of live links to such information on a hospital Web site, or allow attachments. The IRS already allows attachments to draft Form 990 and should do so here or permit live links.

- The question on emergency room policies should be reformulated.

The current question on emergency room policies and procedures should be included among those questions on the front of the form that pertain to the community benefit standard. It also should be streamlined to eliminate confusion and provide information consistent with the community benefit standard and with the experience gained by the IRS in asking similar questions as part of its Compliance Check Questionnaire project.

We recommend the question be changed to read as follows:

“Does the organization operate an emergency room?  yes  no.  
 If yes, is it operated 24 hours a day?  yes  no.  
 Other than being at capacity, did your emergency room deny services to anyone who needed services?  yes  no.  
 If yes, explain.”

- The schedule should highlight a hospital's fundraising efforts for community benefit programs.

To reflect the commendable efforts of many hospitals in raising additional funds for community benefit programs and activities, the IRS should add a question allowing the hospital to provide information about those activities, whether undertaken by the hospital itself or through related organizations. The worksheets also should properly reflect the value of this fundraising, giving hospitals full financial credit for these efforts as well.

- Questions on management companies and joint ventures should be merged into other forms or eliminated.

Hospitals are required to provide information on joint ventures three times in three different forms: Form 990, Schedule H and Schedule R. This redundancy does nothing to enhance transparency or minimize burden. As a result, these questions should be eliminated from Schedule H.

If these questions are significant to the IRS, then the entire tax-exempt sector should be required to respond to them. Questions on potential private inurement or benefit arising from ventures, for example, pertain to all exempt organizations, not just hospitals. It is unfair to hospitals, and ultimately to reviewers, to limit those questions to Schedule H.

7. Who must file should be clarified.

As drafted, all organizations that respond “yes” to the question “Did the organization operate, or maintain a facility to provide hospital or medical care?” must complete Schedule H. This question is too broad and will sweep up facilities that are not hospitals. A definition of “hospital” should be added as follows:

“A hospital is a health care organization that has a governing body, an organized medical staff and professional staff, and inpatient facilities and provides medical, nursing, and related services for ill and injured patients 24 hours per day, seven days per week. *A hospital is a facility (and all of its components) that is licensed in its state as a:*

- √ *hospital*
- √ *chronic disease hospital or hospital for treating certain disease categories*
- √ *rehabilitation hospital*
- √ *acute long term care hospital*
- √ *children's hospital*
- √ *psychiatric hospital*
- √ *research hospital*

A hospital does not include:

- √ *a nursing facility (including a skilled nursing facility, convalescent home, or home for the aged)*
- √ *free standing outpatient clinic*
- √ *community mental health or drug treatment/rehabilitation center*
- √ *physicians' offices*
- √ *facility for mentally retarded/developmentally disabled*
- √ *facility for treating alcohol and drug abuse*
- √ *hospital wing of a school, prison or convent*
- √ *faculty practice plan*

8. The question on charity care policies should be reformulated.

The question now labeled 13b on charity care policies should be revised as follows: “[i]nclude in the description whether the organization (a) bases eligibility for free or discounted care on federal poverty guidelines, income or asset levels, (b) applies such policy to all of its facilities and allows its facilities to adapt its policy to particular community or individual needs, and (c) budgets annually for charity care.”

Hospitals are often faced with situations where patients in need don’t neatly fit into a predetermined category, and hospitals need to deviate from their policies to provide assistance. The question should anticipate that hospital policies will need to be flexible enough to accommodate those situations.

We would also suggest that the IRS consider labeling this question “financial assistance policies.”

9. As drafted, Schedule H must be completed in the aggregate for all facilities/hospitals under a single EIN. Part IV Facility Information asks for each “facility” to be listed. Filers with multiple hospitals under a single EIN should have the option to complete Schedule H on either an aggregate basis or by completing it for each hospital included in the EIN.
10. For the section labeled “Quantifiable Community Benefits,” in addition to moving it, change the chart heading from “Charity Care” to “Unreimbursed Costs for Care Provided,” and change the column (b) header from “Persons Served” to “Patient Encounters.” Omit the references to community benefit in the column (c) and (e) headers and restate as “Total expense” and “Net expense.”
11. Instructions relating to community benefit operations should clarify that this category may include permissible physician recruitment expenses if part of an overall community benefit strategy in line with Revenue Ruling 97-12.
12. Improvements to Worksheets 5 (health professions education) and 7 (research) that will be submitted to the IRS by the Association of American Medical Colleges (AAMC) should be incorporated into worksheets for Schedule H.
13. Line 12a should be revised to ask whether the organization *or a related organization* prepares an annual community benefit report. This reflects the fact that, within a health system, an affiliated foundation of a hospital or the parent holding company may actually prepare a system-wide or hospital-specific community benefit report on behalf of the hospital.
14. The facility chart requires that the programs be described for each facility. This information could amount to multiple pages for many hospitals. The chart should be

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streamlined to ask only for the name and address of the facility in column A and for the “type” of facility in column B.

We appreciate the opportunity to submit our comments, and we especially appreciate the IRS’ efforts to reach out to the hospital community and better understand its concerns. We welcome the opportunity to help the IRS improve draft Schedule H. If you have any further questions, please contact me at (202) 626-2336 or [mhatton@aha.org](mailto:mhatton@aha.org).

Sincerely,

Melinda Reid Hatton  
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