



**American Hospital
Association**

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

By Overnight Mail and Email

May 17, 2010

Sarah Hall Ingram
Commissioner
IRS Tax-Exempt & Government Entities Division
Internal Revenue Service
1750 Pennsylvania Ave., NW, Rm. 684
Washington, DC 20016

Dear Commissioner Ingram:

We would like to thank you and the Department of the Treasury and the Internal Revenue Service team you assembled to meet with us on May 7, 2010 for an open discussion on improvements to Schedule H. Our team, including representatives from the American Hospital Association (“AHA”), large hospital systems and a researcher with the Urban Institute among others, was pleased with the opportunity to raise a number of important issues regarding Schedule H at such a well attended meeting. As you know, in recent years, we have worked closely with you in developing Schedule H and we appreciate the opportunity to continue to work with the Service to achieve our common goals regarding accurate and complete information reporting by tax-exempt hospitals.

Our feedback to you and your colleagues from the meeting can be summarized as follows:

We do not see *any* conflict between the new tax-exemption and disclosure provisions applicable to tax-exempt hospitals contained in *The Patient Protection and Affordable Care Act of 2010* (PPACA) and improving the Schedule H form to allow hospital systems the option of reporting on a consolidated basis, rather than in the current disjointed manner. We have shown through extensive research (see attachment) the current reporting method undervalues system contributions to the communities they serve. Moreover, reporting as a system is entirely consistent with the delivery system reforms at the heart of PPACA.



We believe that the new requirements in PPACA can be accomplished with relatively straight-forward changes to Schedule H that encourage the provision of community benefit. Consequently, we again urge you to act with dispatch to improve Schedule H to allow hospital systems to report community benefit on a unified basis at the same time you update the form to comply with PPACA. We similarly urge you to modify the form in a manner that is mindful of the administrative burdens already present in a new and untested reporting form.

NEW HOSPITAL EXEMPTION AND DISCLOSURE REQUIREMENTS

At the meeting, you raised as a principal concern how PPACA provisions that added Internal Revenue Code (IRC) § 501(r) intersect with the tax-exemption requirements under § 501(c)(3) and information reporting requirements on Schedule H. As you are aware, Schedule H currently does not permit a filing organization that is a hospital system to report information from related corporations. **Thus, the only way to be assured of getting reliable data for nearly 60 percent of nonprofit hospitals that are part of a multi-hospital system is to allow systems to file Schedule H on a consolidated hospital basis.** The consolidated H could include a listing of all EINs included in the hospital system.¹

Consolidated hospital system reporting is consistent with the new requirements for exemption. In fact, PPACA explicitly states that consolidated audited financial statements must be attached to the Form 990, if an organization is included in a consolidated financial statement with other organizations. A consolidated Schedule H would allow more accurate reporting of the community benefit activities undertaken by the system *and* its constituent hospitals. Filing organizations already will have the opportunity to report detailed narrative and financial information on the Core Form 990; therefore, a consolidated Schedule H would allow all of the aspects of community benefit to be reported as well.

PPACA imposes four requirements on hospitals seeking to qualify for and maintain tax-exempt status under § 501(c)(3). Although the community health needs assessment requirement is effective for tax years beginning after March 23, 2012, the remaining three requirements are effective immediately. The four requirements are as follows:

- **Community Health Needs Assessment.** Hospitals must conduct a community health needs assessment at least every three years, which must be made widely available to the public and must take into account input from persons who represent the broad interests of the community served by the hospital facility. In addition, hospitals must adopt an

¹ The term “hospital system” refers to affiliated hospitals and other entities, exemptions for which are covered under more than one Employer Identification Number (EIN).

implementation strategy for the community health needs identified through such an assessment.

- **Financial Assistance Policy.** Hospitals must establish a written financial assistance policy that includes: (i) eligibility criteria, and whether such assistance includes free or discounted care; (ii) the basis for calculating amounts charged to patients; (iii) the method for applying for financial assistance; (iv) if no separate billing and collections policy, the actions the organization may take in the event of non-payment; and (v) measures to publicize the policy within the community. Hospitals must have a written emergency medical care policy that requires the organization to provide, without discrimination, care for emergency medical conditions.
- **Limitation on Charges.** Hospitals must limit the amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy described above to not more than the amounts generally billed to individuals who have insurance covering such care. Hospitals also must prohibit the use of gross charges, i.e., “chargemaster” rates, when billing individuals who are eligible for financial assistance. Amounts billed to those who are eligible for financial assistance may be based on either the best – or an average of the three best – negotiated commercial rates, or Medicare rates. (*Technical Explanation of the Revenue Provisions of the “Reconciliation Act of 2010” As Amended, in Combination with the “Patient Protection and Affordable Care Act”* Joint Committee on Taxation Report, March 21, 2010 at 82).
- **Billing and Collection.** Hospitals must not engage in extraordinary collection actions before making reasonable efforts to determine whether the individual is eligible for assistance under its financial assistance policy.

We understand PPACA provides that a hospital *organization* that operates more than one hospital facility must meet the above four requirements separately with respect to each facility. In addition, a hospital organization would not be treated as described under § 501(c)(3) for any facility that does not separately meet any of the four requirements.² **Requiring compliance with these new requirements on a hospital facility basis is consistent with permitting a hospital system to file a consolidated Schedule H.** Moreover, separate hospital facility compliance with the new requirements could easily be added to the Schedule H form. For example, questions about the new community health needs assessment requirement, similar to those below, could be completed by a hospital system *on behalf of hospitals in the system*:

² We note that the issue of how the income from a facility that might fail to meet these four requirements and the impact on the filing organization for reporting purposes is something that needs to be clarified.

- Has each organization conducted, or collaborated with a public health agency or another non-profit organization that conducted, a community health-needs assessment in the applicable taxable year or in either of the two taxable years immediately preceding such taxable year?
- Does each organization make the community health needs assessment available to the public?
- Does the community health needs assessment conducted by each organization take into account input from persons who represent the broad interests of the community served by each hospital facility, including those with special knowledge of or expertise in public health?
- Has each organization adopted an implementation strategy for meeting the community health needs indentified in the assessment?
 - Describe how each organization is addressing the needs identified in the community health needs assessment and any such needs that are not being addressed together with the reasons why such needs are not being addressed.
- If the answer to any of the above questions is “no,” provide the name and EIN of the hospital and an explanation.

Congress has directed Treasury to review the community benefit activities of each hospital organization to which these provisions apply at least once every three years. Just as new Schedule H was intended to capture the information regarding how nonprofit hospitals provide community benefit, Schedule H can effectively capture the information regarding compliance.

PPACA requirements originated with Senate Finance Committee Chairman Max Baucus’s Mark of the *America’s Health Future Act of 2009*. The Chairman’s Mark provided that “the IRS would be required to review information about a hospital’s community benefit activities (currently reported on Form 990, Schedule H) at least once every three years” and that a “hospital must disclose in its annual information report to the IRS (i.e., Form 990 and related schedules) how it is addressing the needs identified in the [community needs] assessment and, if all identified needs are not addressed, the reasons why.” Consequently, it is our view that these PPACA provisions originated with an understanding that Schedule H would be modified to include information reporting regarding compliance with these new requirements.³

³ We also understand that you have a preference to rely on information that already is filed. We are not aware of any filings with the Department of Health and Human Services that are responsive to the four requirements.

CONSISTENCY WITH OTHER PROVISIONS IN THE PPACA

At the meeting, you also asked whether the current approach you described to completing Schedule H solely by EINs would be consistent with other provisions in PPACA. Our view is that the approaches are *not* consistent.

As described by Senator Max Baucus and nine freshman senators (T. Udall, Warner, Bennet, M. Udall, Burris, Gillibrand, Kirk, Hagan and Franken), health reform legislation “includes a robust set of delivery system reforms aimed at incentivizing physicians, hospitals, and other providers to modernize the delivery of health care by pursuing collaborative care models and different cooperative arrangements to promote high quality, patient-centered care.” (Letter to U.S. Government Accountability Office, December 23, 2009.) The reforms the senators refer to are intended to move the hospital field toward greater integration and alignment using expedients such as a national pilot program on payment bundling, a Medicaid global payment system demonstration, accountable care organizations pilot programs, health homes for Medicaid patients with chronic conditions and a Center for Medicare and Medicaid Innovation that is charged with testing innovative payment and service delivery models to reduce program expenditures while preserving or enhancing quality. All of these efforts are designed to improve quality and care coordination, reward effective and efficient care, promote innovation and control costs – in other words, to spur and support efforts by providers, like hospitals, to function more as a system of care rather than individual care silos.

Many hospitals already pursue these goals as part of a system, and more are expected to do so as health reform is implemented. **Currently nearly 60 percent of nonprofit hospitals are part of multi-hospital systems. Hospital system growth is expected to continue, particularly as the value of being able to coordinate care, improve quality, lower costs and provide a comprehensive data reporting system to support those objectives (among others) meld with implementation of PPACA.** Consequently, an approach to reporting on community benefit activities that fails to recognize the value and contributions of a hospital system in providing health care and related services to a variety of communities on a system-wide and coordinated basis is not consistent with the letter or spirit of PPACA.

As explained above, we believe hospital systems should be able to report on community benefit activities and the new exemption requirements for all the hospitals in the system. Schedule H can be revised to reflect the new exemption requirements, but current reporting limitations (by EIN) do not accurately reflect a hospital system’s community benefit activities, and are not in sync with the future direction of health care delivery as reflected in PPACA.

Commissioner Sarah Hall Ingram

May 17, 2010

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We would be pleased to continue to work closely with you and your colleagues to improve the Schedule H by making it a more accurate and valuable tool that is in sync with the hospital field's efforts to successfully implement PPACA reforms. For more information, please don't hesitate to contact me at mhatton@aha.org or (202) 626-2336.

Sincerely,

A handwritten signature in black ink, appearing to read "Melinda Reid Hatton". The signature is stylized with a large initial "M" and "R" and a long horizontal stroke at the end.

Melinda Reid Hatton

Senior Vice President and General Counsel

Attachment: Bradford H. Gray and Ashley Palmer, *Does It All Add Up? Trustee*, March 2010.

cc: IRS Commissioner Douglas Shulman

Does It All Add Up?

Flaws in **Schedule H** community benefit reporting will affect nonprofit multihospital systems

Beginning in 2010 for tax year 2009, organizations that operate nonprofit hospitals will be required to report community benefit activities and expenditures on a new Schedule H Form 990, the “Return of Organization Exempt from Income Tax.” Many concerns have been raised about the Internal Revenue Service decision, one of which is how such a requirement will work for health care systems that operate multiple hospitals. Almost 60 percent of nonprofit hospitals are part of systems that have multiple hospitals.

At the American Hospital Association’s request, we studied the role of nonprofit multihospital systems regarding community benefit.

Three questions were at the core of our research:

- Do system-level policies and practices influence community benefit performance and reporting at the individual hospital level?
- Do systems engage in activities that convey public benefit that are not expected to generate an economic return, whether or not these are reportable as community benefit?
- What reporting issues are associated with community benefit activities in systems?

To answer these questions, we first visited 12 large hospital systems between March and May 2009 to interview senior executives, tax professionals and staff responsible for community benefit programming and reporting. We used a structured interview protocol developed with the advice of AHA staff and an advisory committee. Then, to gain a broader perspective, an Internet survey was conducted of the 210 systems with three or more nonprofit hospitals, receiving 76 responses (a 36 percent response rate). Survey responses were consistent with interview responses and enhanced our understanding of the frequency of issues we learned about in the site visits.

What we found raises questions about the usefulness of Schedule H, particularly with regard to systems. The reporting requirements will result in some systems reporting on a single Schedule H form and other systems reporting on multiple seemingly unconnected Schedule H forms. Cross-subsidies among hospitals within systems will not necessarily be captured on the form, resulting in a distorted picture of community benefit spending. The requirement that expenses for entities other than hospitals be included in the schedule will probably skew downward the amounts of reported community benefit, again leading to a less than accurate picture, particularly for systems. While these flaws can and should be corrected, it is likely that the initial Schedule H filings will be disappointing to those hoping for a reliable tool to accurately capture and compare community benefit among different hospitals and the systems to which many belong.

System-Level Community Benefit Activities

Most types of community benefit activities in systems occur at the hospital level but are affected by system-level policies and activities. We learned in our site visits that:

- Systems may convey expectations to hospitals regarding community benefit and standardize important aspects, such as charity care policies, planning or budgeting community benefit activities, and data collection and reporting.
- Systems may create a “community benefit culture” by raising visibility of the issue through activities such as awards programs and by establishing mechanisms for sharing ideas such as working groups involving staff from multiple hospitals.
- Systems provide technical expertise for hospitals regarding such matters as legal requirements, needs assessments, planning, evaluations and reporting.

BY BRADFORD H. GRAY AND ASHLEY PALMER

The survey data in the table on Page 25 shows the system policies and activities that affect community benefit at the hospital level. It is common for systems to standardize charity care policies, provide education and training, prepare hospitals' community benefit reports and provide financial support for community benefit activities. In a few systems, hospital executive compensation includes incentives related to community benefit.

Systems also assist their hospitals in important ways that are only indirectly related to community benefit but may be very important to the communities in which the hospitals are located. These include providing economies of scale, which can reduce hospitals' operating costs and in some cases help enable the survival of financially precarious hospitals. They may also facilitate access to capital that supports the full range of hospitals' activities, including community benefit.

Systems do commonly make donations and in-kind contributions at the system level, focusing generally on the geographic area in which the corporate offices are located. While amounts are generally quite modest (compared with the amount of community benefit expense at the hospital level), about one-third of systems have made more substantial contributions by creating departments, centers or foundations at the system level aimed at improving community health, often in conjunction with hospitals and other community organizations. This may involve significant investments related to community benefit. Systems that serve a single metropolitan area or state seem most likely to take on this type of endeavor.

Reporting Issues

It became apparent on our site visits that the ways systems are organized and operated affects the amount and value of the activities that are reportable on Schedule H, as well as the comparability of Schedule H information. These effects can be independent of the amount of community benefit they provide.

The first page of Schedule H ends with a calculation of total community benefit expenses as a percentage of total expenses. This percentage, along with the cost of charity care as a percentage of total expenses, will likely be the most widely discussed figures on Schedule H. These percentages are also likely to vary widely across Schedule H reports, and they will be affected—probably dramatically—by how systems are organized. Comparability will be compromised.

This bears explanation. The requirement to include a Schedule H with a nonprofit's 990 filing is triggered if it operates one or more nonprofit hospitals. Unfortunately, like the rest of the 990, the information reported on Schedule H applies to the whole filing organization, as defined by its tax ID number (employer identification number, or EIN). The problem arises because of organizational differences among systems.

Hospitals in some systems have separate EINs, so each will be covered by a separate Schedule H. However, some or all hospitals in some systems are covered under a single EIN. If all of a system's hospitals are covered by a single EIN, it will file only one Schedule H. Most systems surveyed will be affected by this requirement: although 41 percent of the systems said that each of their hospitals will be in a separate Schedule H, 24 percent said that all or most of their hospitals would be in a single Schedule H and 30 percent have a mix, with some hospitals reporting together and some individually. Because the number of hospitals covered by Schedule H will vary from system to system, comparisons across systems will be problematic at best.

A second organizational factor that will affect the calculation of community benefit is what entities other than hospitals exist under the EIN of the filing organization. This issue is not limited to multihospital systems since they commonly operate a wide

variety of ambulatory and long-term care services, foundations, and other entities. Schedule H is commonly described as a filing requirement for hospitals, but the expenses of nonhospital components in the same EIN as the hospital will be included in Schedule H calculations.

The inclusion of expenses of these nonhospital components will obviously affect the calculation of community benefit expenses as a percent of total expenses. This percentage is

most likely to be lower—perhaps substantially lower—than calculations based only on hospitals' expenditures for two reasons.

First, many—perhaps most—of these components are not themselves subject to community benefit expectations so that the percent of their expenses that go to community benefit is likely to be lower than in hospitals. Second, collecting community benefit expenditure information is challenging, and many organizations that file Schedule H may not capture it for their nonhospital components.

The inclusion of expense information from nonhospital components of filing organizations will also affect the cross-organizational comparability of Schedule H information. Not only do systems vary with regard to the number, types and size of their nonhospital components, but they also vary by whether these components are covered by the same EINs as are their hospitals.

In our survey, 34 percent of systems or their hospitals reported that their Schedule H would not include some expenditures that convey a public benefit and were not undertaken for economic gain. About 20 percent had expenditures at the system level that would not be in a Schedule H because it was not in the same EIN as a hospital. Twenty-four percent said that they had such expenditures elsewhere in the system that were not in an EIN with a hospital. Only 8 percent said that they had expenditures that didn't fit the categories in Schedule H; this low number may reflect a lack of experience with the form.

The inclusion in Schedule H of multiple hospitals and of non-hospital components seems likely to lead to much disappointment

BEFORE SCHEDULE H

Prior to the introduction of Schedule H, most of the systems surveyed had experience with some type of community benefit reporting: 75 percent said that all of their hospitals had prepared community benefit reports in the past; only 13 percent said that none had done so. About half said they had produced such reports to meet state or local government requirements, but many indicated that reporting was done because of systems' own policy decisions. Almost all systems make their community benefit reports public.

FORMS OF SYSTEM INVOLVEMENT IN THEIR HOSPITALS' COMMUNITY BENEFIT ACTIVITIES

(percentage of systems reporting)



Source: AHA/Urban Institute 2009 Survey of Multihospital Systems

among people who are interested in what Schedule H will tell us about hospitals' charitable activities.

Other Reporting Issues

The ability to cross-subsidize among hospitals may be one of the most important benefits that systems offer to their constituent hospitals. Internal cross-subsidies support charitable activities in many systems. Our survey of systems showed that about half do this: 27 percent said they routinely use revenues from some hospitals to support other hospitals, and 25 percent said this happens occasionally.

In response to a question about sources of support for hospitals' community benefit activities, we learned that although hospitals' own operating revenues are by far the most important source of funding for community benefit activity, approximately half of the systems who responded to our survey used combined revenues from multiple hospitals. Variability among systems regarding cross-subsidization will again affect comparability across systems, but the more serious problem is that Schedule H is not configured to capture cross-subsidies within systems.

Cross-subsidies within systems will not be visible on Schedule H. Where cross-subsidies occur among organizations within the same EIN, the subsidized expenditure will at least be included in the Schedule H that covers the subsidizing hospital. However, if a system uses revenues from a hospital covered by one EIN to subsidize the charitable activities of hospitals covered in other EINs, the contribution of the subsidizing hospital won't be captured in its Schedule H, making it appear less charitable than it is. Including it in both Schedule H forms would amount to double counting, but not including it results in an inaccurate picture of the subsidizing hospital and fails to capture the nature of systems themselves as charitable organizations.

Another issue regarding Schedule H is that the calculation on its first page of community benefit expenses as a percent of total expenses does not include several items that many hospital officials believe should be counted. Two of these—bad debt expense and Medicare shortfalls—are controversial and have been widely discussed. The form requests this information and invites explanation of why they should be considered a community

benefit. More puzzling is the IRS' decision to put community building expenditures—for physical improvements in the neighborhood, economic development, workforce development and the like—on the second page of Schedule H. The IRS' decision regarding community building has a doubly negative effect: not only is it not counted in the numerator of the calculation of community benefit expense as a percent of total expenses, but its inclusion in the denominator means that engaging in community development activities, as many systems do, will actually have the effect of reducing the percent of their expenses that are reported for community benefit.

In addition to the problems we have already discussed, it should be expected that the quality of the information in Schedule H will be uneven for several years, as systems become accustomed to the new reporting requirements. Organizations need specialized internal reporting systems to capture most of the information to be reported in Schedule H. For many hospitals and systems, this will be an altogether new and quite challenging task, since reportable activities can occur in virtually all departments of a hospital or system. Some organizations will undoubtedly be more successful than others at collecting this information. Moreover, variations in interpretation of what should be included are certain to occur. All of this will affect comparability across organizations, but such problems are inherent in the development of a new reporting requirement and should diminish as experience grows and the reporting requirement is improved.

Not the Whole Story

Schedule H is the most important change in the accountability of nonprofit organizations since the Form 990 itself was implemented almost 70 years ago. It will generate a great deal of public information about a wide array of community benefit activities. However, though most hospitals are part of multihospital systems, the role of systems will not be visible in Schedule H. Organizational differences among systems will affect both reports of the percent of total expenditures devoted community benefit and cross-organizational comparability. Systems in which all components are covered by the same EIN will be reporting as a whole. Other systems may want to generate their own system-level reports for

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public dissemination, even if their reports to the IRS are in separate components.

A final point concerns the use of expense information to measure community benefit. A metric that permits comparison has obvious advantages, made less so in this case by the noncomparability of the reporting entities, as discussed in this article. But expenditures are a very crude measure of community benefit. Consider the wisdom of using expenditures to assess programs to reduce teenage pregnancy or hospitalizations for childhood asthma. Is the value of sustaining a money-losing program that provides needed services best measured by the amount of subsidy it requires? What about a system that helps a struggling sole community hospital to survive? Eighty percent of the systems surveyed reported engaging in activities to reduce the use of the emergency department. Similarly, 68 percent of respondents engaged in activities to reduce hospital admissions, and 64 percent said they had engaged in activities to reduce the use of other hospital services. Clearly, dollars expended is a poor measure of the benefit of reducing the need for hospital services.

The importance of "telling the story" came up repeatedly in our site visits, but Schedule H is not designed for that purpose. Most systems already do community benefit reports. With the advent of Schedule H, public understanding can be further enhanced if hospitals and systems use such reports to tell a story, particularly about activities that have produced measureable improvements in such matters as emergency department use and preventable hospitalizations.

More thought should be given to developing new metrics to measure community benefit, measuring community benefit in multihospital systems, and separating out the expenses of nonhospital components of organizations that operate nonprofit hospitals. Schedule H will provide a more accessible picture of the charitable activities of nonprofit hospitals, but its shortcomings need to be addressed if it is to become a truly useful tool for the communities that hospitals serve. **T**

BRADFORD H. GRAY, PH.D. (bgray@urban.org), is senior fellow and ASHLEY PALMER, MPP (apalmer@urban.org), is research associate at the Urban Institute in Washington, D.C.