American Hospital Association

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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*:

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[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]

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[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.

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,

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