

April 20, 2011

Sarah Hall Ingram  
Commissioner  
IRS Tax-Exempt & Government Entities Division  
Internal Revenue Service  
1111 Constitution Ave., NW  
Washington, DC 20224

Dear Commissioner Ingram:

On behalf of the American Hospital Association's (AHA) more than 5,000 member hospitals, health systems and other health care organizations, and its 40,000 individual members; the Healthcare Financial Management Association's (HFMA) more than 35,000 member health care financial executives; VHA Inc.'s 1,400 member hospitals and 23,000 non-acute health care organization members; and the state and metropolitan hospital associations that are signatories below, we are submitting these comments on the newly revised Schedule H and Instructions, and respectfully request a meeting to discuss our concerns, which can be summarized as follows:

- The new reporting requirements are onerous and redundant, and out of step with President Obama's call for "cutting down on the paperwork that saddles businesses with huge administrative costs."
- The revisions to Schedule H go beyond what the statute requires and are inconsistent with recommendations submitted to the IRS by AHA and other associations in September 2010.
- Key issues, such as the consequences of a facility's failure to meet the requirements, are not addressed.
- The IRS revised the Schedule H and Instructions rather than engaging in the promulgation of proposed regulations with proper notice and comment period. This is contrary to standard procedures and, in the context of a new federal tax exemption standard, denies hospitals the benefits and protections of a deliberative regulatory process that includes notice and opportunity for comment under the Administrative Procedure Act.

### **BACKGROUND**

On February 23, the Internal Revenue Service (IRS) released a revised Schedule H with Instructions, and announced a mandatory three-month extension for filing IRS Form 990 for certain filers. All filers with "hospital organizations" that have filing due dates before August 15, 2011 were directed **not** to file before July 1. In addition, Part V of Schedule H was amended to incorporate into Form 990 the requirements of the recently enacted Internal Revenue Code (IRC)

Sarah Hall Ingram

April 20, 2011

Page 2 of 7

Section 501(r), which sets forth new standards for exemption from federal income taxes for hospitals.

The new “H” vastly expands the paperwork required of hospitals beyond what is called for by the statute. Section V.B. requires responses to 21 questions which do not accurately reflect the requirements of 501(r), most of which have multiple sub-questions on behalf of **each** of the hospital’s licensed facilities. Any facility that does not meet the new standards will not be considered to be exempt. The IRS has not provided any guidance to hospitals in respect of the new standards or the consequences of a facility losing exempt status.

Part V.B. lines 1-7 notes that the seven questions regarding community needs assessment are “optional” for the 2010 filing. The Instructions explain that 501(r)(3) does not impose community health needs assessment requirements until tax years beginning after March 23, 2012. The rest of Part V.B. is not marked “optional”, but the questions are **NOT** applicable to hospitals whose 2010 fiscal year began **BEFORE** March 23, 2010. While the Instructions explain that these questions are optional for such hospitals, the form itself fails to make this clear, and thus will be a source of confusion for many hospitals.

The mandatory filing extension to August 15, 2011 will also be a source of confusion for many hospitals. We have heard from hospitals who are calendar year filers that they are now confused about how the mandatory extension affects their deadline, and the regular process of obtaining a six-month extension (e.g., to November 15, 2011 for calendar year hospitals). Guidance from IRS is needed regarding this issue.

### **INTERNAL REVENUE CODE SECTION 501(r)**

Section 501(r) was added to the IRC by the *Patient Protection and Affordable Care Act of 2010* (PPACA). It imposes four additional requirements on hospital organizations that either operate a facility “required by a State to be licensed, registered, or similarly recognized as a hospital” or that the “Secretary determines has the provision of hospital care as its principal function.” The requirements must be separately satisfied by each hospital facility operated by a hospital organization in order to maintain the hospital facility’s tax-exempt status under IRC Section 501(c)(3).

Three of the four requirements became effective for tax years that begin after March 23, 2010. The community health needs assessment requirement will be effective March 23, 2012. The four requirements are summarized briefly below.

Community health needs assessment. The assessment must be conducted every three years, and the hospital must adopt an implementation strategy to meet the community health needs identified by the assessment.

Financial assistance policy. A hospital must adopt a written financial assistance policy that details eligibility criteria for such assistance, the basis for calculating amounts charged, methods of application for assistance, and actions that may be taken in cases of nonpayment by organizations without separate billing and collections policies. Additionally, a hospital must provide care for emergency medical conditions, regardless of an individual's eligibility for financial assistance.

Limitation on charges. A hospital must limit charges for emergency or other medically necessary care provided to individuals eligible for financial assistance to amounts generally billed to individuals who have insurance covering such care. A hospital is prohibited from using gross charges to bill patients.

Billing and collection. A hospital must refrain from extraordinary collection actions before making reasonable efforts to determine an individual's eligibility for financial assistance.

## ISSUES

### **I. Facilities**

Part V, titled "Facility Information," requires the hospital organization to complete a separate Section V.B. for each facility licensed, registered or similarly recognized as a hospital. Section V.B. is **optional** for hospital organizations reporting tax years beginning on or before March 23, 2010. Schedule H does not, however, indicate that Section V.B. is optional, which will result in confusion and reporting by hospitals before they have fully complied with 501(r).

Instructions to Schedule H require a hospital organization to first list and classify each facility operated during the tax year in Section V.A. Then, for each facility identified in Section V.A., the organization must answer a series of questions in Section V.B., aimed at monitoring compliance with the four requirements of Section 501(r). A new Section V.C. requires the hospital to list all non-hospital health care facilities operated during the year, but exempts the organization from completing Section V.B. for such facilities.

The Instructions also direct a hospital organization to submit a copy of its audited financial statements to the IRS. If a hospital files a consolidated financial statement with other organizations, the consolidated financial statement must be attached to Form 990.

**In addition to the onerous reporting obligations imposed on hospital organizations by Section V.B., Section V.C. requires disclosure not contemplated by Section 501(r). The provisions of Section 501(r) apply only to licensed or similarly recognized hospitals or facilities providing "hospital care." Section V.C., on the other hand, mandates disclosure of all non-hospital health care facilities that an organization operates, including "rehabilitation and outpatient clinics, diagnostic centers, long-term acute care facilities,**

**and skilled nursing facilities.” Such disclosures contravene the explicit provisions of Section 501(r); they reach beyond the scope of Section 501(r); and they should be eliminated.**

## **II. Community Health Needs Assessment**

Lines 1 through 7 of Section V.B. evaluate a hospital’s compliance with the community health needs assessment requirement. Section 501(r)(3)(B) requires that a community health needs assessment be conducted every three years and it should be conducted so that it:

- (i) takes into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and
- (ii) is made widely available to the public.

The 28 detailed questions inquire at the facility level whether and when a “needs assessment” was conducted, what the needs assessment described, how the assessment was publicized, and how the needs identified in the assessment were addressed. The questions regarding needs addressed are confusing, shifting the focus from an implementation strategy to other types of plans that appear to go beyond the statutory requirements and create new standards for compliance. Also, there is no question that allows a hospital to respond that the community health needs assessment is conducted jointly on behalf of all facilities. In fact, this section does the opposite. After completing each of the 28 questions for **each** facility, Question 4 requires that each facility list each of the **other** facilities that participated in the community health needs assessment. **Neither the question nor the instructions allow a hospital to respond that all facilities participated, or to list which facilities participated. Rather the question and instructions require redundancy in the required responses, and supplemental information called for in Part VI.**

## **III. Financial Assistance Policy**

The financial assistance policy requirements in Section 501(r)(4) are reflected in Lines 8 through 13 of section V.B. Section 501(r)(4)(A) mandates a hospital to adopt a financial assistance policy that includes:

- (i) eligibility criteria for financial assistance 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) in the case of an organization which does not have a separate billing and collections policy, the actions the organization may take in the event of non-payment including collections action and reporting to credit agencies, and

(v) measures to widely publicize the policy within the community to be served by the organization.

As part of the financial assistance requirement, a hospital must have a written policy requiring the organization to provide, without discrimination, care for emergency medical conditions to individuals, regardless of their eligibility under the financial assistance policy.

Further, Lines 8 through 13 replicate many of the inquiries contained in other sections of Schedule H. For example, Line 8 asks whether a policy explains eligibility criteria for financial assistance and Line 13 requires hospitals to indicate how the financial criteria were publicized. **Such questions, however, are covered in other parts of Schedule H.** Part I, Line 1(a) already asks whether an organization has a financial assistance policy and Part VI, Line 3 requires a facility to describe its efforts to publicize various financial assistance programs. These Parts could have been modified to reflect new Section 501(r)(4) so as to avoid duplication. Instead redundancy of responses was the approach adopted by the IRS.

Lines 9 and 10 are particularly superfluous. In combination, they inquire about a hospital's use of federal poverty guidelines (FPG) to determine eligibility for providing either free or discounted care to low-income individuals and instruct a hospital to indicate the FPG family limit for free or discounted care. By referring to FPGs, the IRS implies that the guidelines should be used as eligibility criteria for financial assistance. However, Section 501(r)(4)(A)(i) only requires a description of criteria for eligibility under a hospital's financial assistance policy. The section does not prescribe that the FPG are the only means to meet the criteria. Part I Lines 3(a) and 3(b) request identical information from a hospital on a hospital-wide basis, but due to the facility by facility exemption standard in 501(r) Part V.B. Lines 9 and 10 must be completed for each facility, and the hospital still must respond to Part I. **Again a policy of redundancy has been implemented instead of elimination of questions that require duplication of information submitted.**

#### **IV. Billing and Collection**

Section 501(r)(6) prohibits a hospital from engaging in "extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for financial assistance under the assistance policy. . ." Part V.B., Lines 14 through 17, inquire about a facility's billing and collections policies. Line 15 asks whether collection actions such as lawsuits, reporting to credit agencies, liens on residences or body attachments were permitted during the tax year. Congress did not include reporting to credit agencies as an extraordinary action and the customary action of reporting nonpayment of bills does not belong in that category. Including "body attachments" on the form is needlessly provocative and based on outdated and unrepresentative press accounts. **Presumably this list of collection actions constitutes "extraordinary collection" efforts, but the IRS has yet to provide a general definition of the term and the Instructions fail to indicate whether such activities constitute**

**“extraordinary collection actions.”** Likewise, on Line 17 the IRS lists actions that presumably represent “reasonable efforts” used to determine a patient’s eligibility for financial assistance, again without defining the term. **However, it is unclear whether taking only one or some of the listed actions would suffice as a “reasonable effort.”**

## V. Limitation on Charges

Section 501(r)(5)(A) limits the amounts charged for emergency or other medically necessary care by providing that:

(5) LIMITATION ON CHARGES.—An organization meets the requirements of this paragraph if the organization—

- (A) limits amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy described in paragraph (4)(A) to not more than the amounts generally billed to individuals who have insurance covering such care, and
- (B) prohibits the use of gross charges.

Part V.B., lines 19 through 21 address the limitation-on-charges requirement of Section 501(r)(5). Line 19 asks how amounts billed to individuals who do not have insurance are determined. Line 20 asks if those eligible for assistance were charged more than those who had insurance. Line 21 asks if the hospital charged any patient using gross charges. Both lines 19 and 21 go beyond the reach of 501(r) and more is needed to make an informed answer to line 20.

The statute is clear that the limitation on amounts billed only applies to individuals eligible for financial assistance (See 501(r)(5)(A)). And while the literal language of the prohibition on the use of gross charges in 501(r)(5)(B) is general, the legislative history makes clear that Congressional intent was to place limitations only on charges to those patients who qualified or could qualify for financial assistance. If a hospital facility used gross charges to bill a wealthy patient from abroad, for example, the answer to Question 21 would be “yes”. As a result of this answer, the facility would improperly be viewed as violating Section 501(r)(5)(B) and at risk of losing its tax-exempt status. **The IRS must issue guidance to address this discrepancy, because Congress could not have intended that a hospital facility can lose its tax-exemption for charging gross charges to a wealthy patient from abroad.** In fact, failure to charge gross charges to a wealthy patient could constitute private benefit, which could jeopardize a hospital’s tax-exempt status. Similarly, the IRS should clarify that Question 19 only applies to individuals qualified or who could qualify for financial assistance. Lastly, because the Instructions fail to explain how a facility should calculate an “amount that is generally billed,” there is no way for an informed answer to be provided to Question 20.

**RECOMMENDATION**

Rather than revising substantially Part V of Schedule H, the IRS could have streamlined incorporation of 501(r) requirements into Schedule H by revising the instructions to other questions on the existing form. In a letter to Commissioner Shulman on July 22, 2010, AHA and other associations made specific recommendations for changes to those instructions. To further assist the IRS in understanding the recommendations that have been made previously, attached to this letter are revised instructions to Schedule H. (See attachment A.)

**SUMMARY**

The final Schedule H is burdensome, carelessly redundant, and was developed outside of the normal IRS process for implementing new statutory requirements for tax exemption. By failing to promptly initiate a meaningful notice and comment opportunity in connection with the new 501(r), the IRS has produced a reporting tool that will be more difficult for hospitals and less useful to communities than we hoped or expected. We hope the IRS will act with dispatch to withdraw and reissue the form, improve the Instructions and issue clear and usable guidance. Throughout the process of implementing Section 501(r) the hospital community has offered its assistance to the IRS repeatedly. We stand ready to continue our assistance and work with you to achieve clear and usable guidance.

Sincerely,

Melinda Reid Hatton  
Senior Vice President &  
General Counsel  
AHA

Richard L. Gundling  
Vice President Healthcare Financial  
Practices,  
HFMA

Edward N. Goodman  
Vice President, Public Policy  
VHA Inc.

California Hospital Association  
Florida Hospital Association  
Greater New York Hospital Association  
Illinois Hospital Association  
Massachusetts Hospital Association  
Ohio Hospital Association  
South Dakota Association of Healthcare Organizations  
Virginia Hospital & Healthcare Association  
West Virginia Hospital Association  
Wisconsin Hospital Association

## PROPOSED REVISIONS TO SCHEDULE H AND INSTRUCTIONS

### I. PART V.A. FACILITY INFORMATION

See attached additions to the hospital facilities chart on p. 3 of Schedule H. If any facility is not in compliance with the requirements for the following policies, provide explanations as instructed in Part VI.

#### INSTRUCTIONS

“CHNA”—Check this box only if the facility listed was included in a Community Health Needs Assessment (“CHNA”) as defined in Instructions for Part VI, line 2 within the last three years.

“Financial Assistance Policy”—Check this box only if the facility listed complies with the hospital’s Financial Assistance Policy described in Instructions for Part VI, line 1, referencing Part I, line 3.

“Charges”—Check this box only if the facility listed complies with the hospital’s Limitations on Charges Policy described in Part VI, line 8 and Instructions.

“Collections”—Check this box only if the facility listed complies with the hospital’s Billing and Collections Policy described in Instructions for Part III, line 9(b).

### II. COMMUNITY HEALTH NEEDS ASSESSMENT

#### INSTRUCTIONS

Part VI, Line 2

A “community health needs assessment” (CHNA) is a written document developed by a hospital (alone or in conjunction with others) that includes the following: a description of the process used to conduct the assessment, how the organization took into account input from community members and public health experts, a description of the community served, including geographic and demographic data, a description of the health needs identified through the assessment process, a description of which needs the organization intends to address and the reasons those needs were selected, and a summary of the implementation strategy the

organization will undertake to address selected needs. Indicate the tax year in which the hospital last conducted a CHNA, or state that it has not yet conducted a CHNA. State whether all facilities listed in Part V.A. participated in the CHNA, and if not, why not for each facility that did not participate. State whether any other hospitals or other organizations participated, and describe the nature of the input. If a state report comparable to a CHNA was required to be filed, indicate the name of the state. Describe how the CHNA is made available to the public, such as through the web site, available upon request, or any other means.

### **III. FINANCIAL ASSISTANCE POLICY**

#### **INSTRUCTIONS**

Part 1, Line 3c.

Describe in Part VI, line 1, the financial assistance policy, including

(1) the basis for calculating amounts charged to patients; (2) the method for applying for financial assistance under the policy; (3) if the organization does not have a separate billing and collections policy, whether the financial assistance policy describes the actions the organization may take in the event of nonpayment; (4) how the organization makes the financial assistance policy available to the community it serves; and (5) whether the organization has a written emergency medical care policy that requires the organization to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the financial assistance policy.

Part VI, Line 1. Provide the following supplemental information:

Part I, Line 3(c). Describe the financial assistance policy, including

(1) the basis for calculating amounts charged to patients; (2) the method for applying for financial assistance under the policy; (3) if the organization does not have a separate billing and collections policy, whether the financial assistance policy describes the actions the organization may take in the event of nonpayment; (4) how the organization makes the financial assistance policy available to the community it serves; and (5) whether the organization has a written emergency medical care policy that requires the organization to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the financial assistance policy.

#### **IV. LIMITATION ON CHARGES**

##### **NEW QUESTION**

Part VI, Question 8

Describe how the hospital determined the amounts billed to individuals for emergency or other medically necessary care who qualified for financial assistance. .

##### **INSTRUCTIONS**

Include in this description whether the hospital billed any of its patients eligible for assistance under the hospital's financial assistance policy more than the amounts generally billed to patients with insurance. Indicate whether the hospital billed "gross charges" to any patient eligible for financial assistance. Indicate whether all facilities adhered to this policy, and if any did not, indicate for each facility why not.

#### **V. BILLING AND COLLECTIONS**

##### **INSTRUCTIONS**

Part III, Line 9(b)

Describe in Part VI, Line 1 whether the written collection policy requires the hospital to make reasonable efforts to determine whether the individual is eligible for assistance under the hospital's charity care policy. If any facility did not make reasonable efforts, indicate why not.

**Part V Facility Information**

**Section A. Hospital Facilities**

(list in order of size, measured by total revenue per facility, from largest to smallest)

How many hospital facilities did the organization operate during the tax year? \_\_\_\_\_

Name and address

	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	CHNA	Assistance	Financial	Charges	Collections
<b>1</b>													
<b>2</b>													
<b>3</b>													
<b>4</b>													
<b>5</b>													
<b>6</b>													
<b>7</b>													
<b>8</b>													
<b>9</b>													
<b>10</b>													
<b>11</b>													
<b>12</b>													
<b>13</b>													
<b>14</b>													
<b>15</b>													
<b>16</b>													