Submitted December 26, 2013
Via the IRS Comment on Tax Forms and Publications web page
http://www.irs.gov/uac/Comment-on-Tax-Forms-and-Publications

On behalf of the Healthcare Financial Management Association (HFMA) and its 40,000 individual members and the American Hospital Association (AHA) and its more than 5,000 member hospitals, health systems and other health care organizations, we are writing to raise concerns regarding certain changes to the draft 2013 version of the Form 990 Schedule H (Hospital) instructions recently posted on the IRS website. Our concerns are two-fold: failure to provide public notice and an opportunity for comment under the Administrative Procedure Act; and two significant changes to the instructions that are contrary to sound public policy.

We are very troubled that, once again, policy is being developed through the issuance of "forms" and outside any formal notification to those subject to the policy, in this case hospitals, and without an opportunity to have their input formally considered. The two changes at issue: 1) under what circumstances grant-funded activities count as community benefit to the community, and 2) what policies control interactions with patients in the emergency department, are more than direction on ministerial matters, e.g., how to complete a form, they have significant consequences for a hospital's compliance with its tax-exempt obligations. The change regarding emergency department policies is an effort to impose by instruction what the IRS has otherwise *proposed* in a notice and comment rulemaking that is still in process. These two changes should be removed from the 2013 instructions.

On the merits, the two changes are bad public policy that should not be imposed by "form" or by regulation.

To net 'direct offsetting revenue' as the draft instructions indicate is not appropriate and does not provide the users of this information an accurate reporting of the community benefit being provided. A major attribute of tax-exempt healthcare providers is the mission to provide community benefit. Specifically, these providers reduce government burden to fully meet these community health needs. The government's cost to provide these healthcare services would increase dramatically or many needs would go unmet. Generally, healthcare providers account for any additional funding that is used to offset the general cost of community benefits as 'other revenue' and is also disclosed in the footnotes of the financial statements.

To net the revenue and the expense obfuscates the activity that the healthcare provider has undertaken. For example, a foundation's support to both expand a successful youth development and mentorship program in one community, along with additional funding for the hospital to work with members of another community to replicate the program. Grant funding by a

foundation, corporation, or other source is indicative of broad support for that community benefit activity performed by the healthcare provider and should not be offset in the reporting. Additionally, netting direct offsetting revenue and comparing them to gross expenses distorts the amount and percentage of community benefits provided. To provide an accurate representation of the amount of benefit delivered, as a comparison to total expenses, direct offsetting revenue should not be netted.

Regarding financial interactions with patients in the emergency department, the IRS should defer to the federal *Emergency Medical Treatment and Labor Act* (EMTALA) and the Department of Health and Human Service 's (HHS) comprehensive regulations and guidance implementing the statute. They address a hospital's duty to provide care as well as control registration processes and discussions regarding a patient's ability to pay in the emergency department. Hospital policies and procedures for the emergency department are based on EMTALA. HHS has years of experience and expertise overseeing a hospital's implementation of EMTALA. The IRS should not attempt to supersede or interject needless confusion and inconsistency into requirements for the operation of an emergency department. Compliance with this provision should simply state:

- The hospital facility may check "Yes" if it had a written policy that required compliance with Subchapter G of Chapter IV of Title 42 of the Code of Federal Regulations, the subchapter regarding the Centers for Medicare and Medicaid Services' standards and certification and including the regulations under the Emergency Medical Treatment and Active Labor Act (EMTALA).

- If "No," indicate the reasons why the hospital facility did not have a written nondiscriminatory policy relating to emergency medical care by checking all applicable boxes. If the reason the hospital facility did not have a written nondiscriminatory policy relating to emergency medical care is not listed in lines 19a through 19c, check line 19d, "Other," and describe the reason(s) in Part V, Section C.

We stand ready to continue to provide our assistance and work with you to improve the Instructions.

Sincerely,

/S/
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