



30 WINTER STREET
SUITE 1010
BOSTON, MA 02108
TEL 617.338.6035
FAX 617.451.5838
WWW.COMMUNITYCATALYST.ORG

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VIA ELECTRONIC MAIL AND FIRST-CLASS MAIL

IRS
Draft 2008 Form 990 Instructions, SE:T:EO
1111 Constitution Ave., NW.
Washington, DC 20224

Re: 2008 Schedule H (Form 990) Instructions

Dear Sir/Madam:

Thank you for the opportunity to offer comments on the draft set of instructions to the recently revised IRS Tax Form 990 (hereinafter “the Instructions”).

The undersigned organizations represent local, state and national consumer organizations that are working to improve access to health care services for uninsured and underinsured patients across the country. We have worked to promote improved financial assistance and community benefit programs at individual hospitals as well as to create standards for these programs at the local, state and federal levels. Because of our focus on health care issues, we are limiting our comments to the Instructions pertaining to Schedule H and its related worksheets.

We applaud the Service for its efforts to increase transparency among tax-exempt hospitals. For too long, regulatory standards for nonprofit hospital community benefit and financial assistance performance have been vague. Although significant numbers of hospitals do provide meaningful amounts of financial assistance to their patients and implement community benefit policies sensitive to community needs, too many hospitals fail to do so. We believe Schedule H will provide important information that will promote an improved dialogue between tax-exempt hospitals and consumers in order to better address the health care needs of the communities served by the hospitals.

First, we support and applaud the Service’s repeated and unequivocal prohibition against including bad debt in any community benefit calculation. We believe that this will rightly encourage hospitals to improve their “front-end” operations, i.e. those that seek to qualify patients for public programs or the hospital’s own financial assistance programs. Second, we agree with the Service’s requirement that certain activities reported in

Schedule H must be “*responsive to an identified community need.*” Third, we concur with the general requirement that reported activities must “*promote the health of the community the organization serves.*” These three approaches go a long way toward increasing transparency and promoting greater clarity and uniformity in reporting. We believe, however, that the modifications recommended in this letter will greatly help to further these goals.

Definition of Charity Care (Instructions, p. 5)

As drafted, the Instructions define charity care as “free or discounted health services provided to persons who meet the organization’s criteria for financial assistance and are thereby deemed unable to pay for all or a portion of the services.” Allowing hospitals to report charity care based on their own criteria allows for wide variation among reporting hospitals. With such a wide range of approaches, the problem identified in the IRS Hospital Compliance Interim Report, which found that hospitals have an enormous variety of approaches in defining uncompensated care, only continues. A preferable approach would be to set a standard for charity care that a) establishes the types of charity care a nonprofit hospital must offer and b) includes a process for determining eligibility that is uniform, fair and transparent.

Patient Education of Eligibility for Assistance (Instructions, p. 15)

Question 3 of Part VI requires that each organization describe how they inform and educate patients about their eligibility for assistance under various government programs or under the organization’s charity care policy. The Instructions with respect to this reporting requirement provide a number of “examples” of ways in which this education can occur. All of these five examples are critical components of a tax-exempt hospital’s financial assistance program and are necessary to ensure that eligible patients don’t fall through the cracks. Thus, rather than include them as “examples,” we would urge the IRS require organizations to report affirmatively or negatively on each method.

Permission to Use Other Costing Methodologies (Instructions, pp. 1, 7)

We applaud the Service’s decision to require charity care and other community benefits to be valued at cost. This provides a far more accurate view of the value of services the hospital organization provides and promotes consistency in reporting. However, we question that the draft Instructions permit organizations to select their own methodologies when computing these costs in Worksheets 1 and 2, which are not filed with Form 990. To avoid introducing an element of variation in reporting, we recommend that the IRS require hospitals to use one costing methodology for the purpose of determining the value of the services they provide. We believe the most uniform and least burdensome method is the cost-to-charge ratio, by service, as calculated by hospitals in preparing their Medicare Cost Reports.

Treatment of Unrestricted or Restricted Grants (Instructions, pp. 1, 7)

We believe community benefits are the *unreimbursed* goods, services and resources provided by health care institutions that address community identified health needs and concerns, particularly of those who are uninsured or underserved. As drafted, the Instructions do not require that hospitals count “grants restricted for community benefit activities” as direct offsetting revenue when determining their net community benefit expenses. This provision is troubling as it appears to be contrary to the very foundational definition of community benefits. We strongly recommend that grants received for community benefit activities should be treated as offsetting revenue for the purposes of determining net community benefit expenses. We note that revenue from these grants may be offset by the costs associated with seeking the grants—costs that may be reportable in the community benefit operations section.

Revenue from Uncompensated Care Pools (Instructions, p. 16)

Worksheets 1 and 3 require that organizations report “revenue from uncompensated care pools or programs, meaning payments received from a state, including Medicaid DSH funds...” We recommend that the IRS amend this statement to also include payments received from counties or other municipal authorities.

Primary Purpose Test (Instructions, pp. 2-3, 16; Worksheets 1 and 3)

We support the Service’s use of the “primary purpose requirement” in its treatment of Medicaid and provider taxes and revenue from uncompensated care pools as costs and revenues associated with charity care. We believe that using this test will best promote transparency while also accommodating the differences among states’ allocation of uncompensated care pools, including DSH payments.

Treatment of Medicare in Reporting Charity Care and Other Community Benefits (Instructions, p. 2; Worksheets B, 5, and 6)

The draft Instructions allow hospitals to report Medicare revenues and expenses in Part I’s Table of charity care and community benefits costs “only to the extent that [they] are related either to... subsidized health services...or to Medicare GME that is reportable as health professions education.” All other Medicare costs and revenues must be reported in Part III of Schedule H.

We appreciate that the Service limits the inclusion of health professions education as community benefits to situations in which, by the Service’s definition, such education provides a greater boon to the community than to the reporting organization. We would advise the Service, however, to incorporate an even more targeted approach. Health care service providers should be required to demonstrate the link between their educational activities and the identified health care needs of the targeted community. Only those health professions educational activities that can be linked in this way should be reported as community benefits. Therefore, we urge the IRS to amend the language in the

Instructions to Worksheet 5 so that it matches that of Worksheet 6: “In order to qualify as a reportable health professions education activity or program, the organization must provide the activity or program *because it meets an identified community need.*”

Medicare Shortfall (Instructions, p. 10)

While the Instructions expressly prohibit hospitals from claiming Medicare shortfalls as community benefits, they do allow organizations to describe in Part VI the extent to which the Medicare shortfall they claim should be *treated* as a community benefit. The Instructions require that the rationale for such inclusion must have a “reasonable basis”; however, they fail to provide additional guidance or definition about what is “reasonable.” Without sufficient guidance on the definition of “reasonable,” this becomes a potentially troubling loophole. Generally speaking, the Medicare Payment Advisory Commission (MedPAC) views Medicare payment rates as adequate.¹ While MedPAC acknowledges that hospitals may differ, it strongly suggests that hospitals are responsible for controlling costs rather than simply claiming payment inadequacy. Therefore, we recommend the following guidance for organizations wishing to treat their Medicare shortfall as a community benefit: Organizations must provide a narrative that demonstrates that their facilities are efficient. Efficiency may be demonstrated in a number of ways, including by providing data on their case-mix-adjusted-cost per discharge, compared to their peers.

Foreign Hospitals (Instructions, p. 3)

We generally agree with the Service’s approach to the inclusion of data from foreign hospitals, with one small modification. If organizations choose to include data from foreign hospitals in Parts I, II, III or V, they *must* be required to provide detail about this component of their community benefits report in Part VI.

Subsidized Health Services (Instructions, pp. 3, 22)

We applaud the Service for specifying that “in order to qualify as a subsidized health service, the organization must provide the service because it meets an identified community need.” We believe that organizations may include the portion of costs to conduct a physician clinic or skilled nursing facility only if those costs are related to services for patients in the community that are typically underserved. Organizations should not be permitted to include costs associated with services that are otherwise reimbursable.

“Certain Other Community Benefits” and “Community-Building Activities” (Instructions, pp. 6, 8-9, 14)

Part I, lines 7e – 7i of Schedule H requires organizations to report “certain other community benefits” at cost. These benefits include: community health improvement

¹ See, e.g., Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, Section 2A, Hospital Inpatient and Outpatient Services, March 2008.

services and community benefit operations, health professions education, subsidized health services, research and cash and in-kind contributions to community groups. Each of activities listed within these categories may be rightfully claimed as “certain other community benefits,” but we strongly urge that the Service require the activities within these categories be listed in Part VI, and not just on unfiled worksheets. Also, in reporting “certain other community benefits,” nonprofit hospital organizations should also be required to describe in Part VI – as the Service already requires for “community-building activities – how they “provide community benefit and promote the health of the communities [they] serve.” Finally, the Service should require reporting organizations to demonstrate that all activities reported as “community benefit” are “responsive to an identified community need,” as established through a needs assessment process.² We recommend that the needs assessment process include both an analysis of the most recent public health data and a mechanism for engaging — at regular intervals — members of the community served.

Examples of Community Benefits (Instructions, pp. 3, 9)

We applaud the Service for its efforts to provide a number of good examples of activities that hospital may claim as community benefits. As noted above, each of the examples provided may indeed be considered a valid community benefit *provided that* they can be connected to an identified need within the community the hospital serves.

We note, however, that the list of community-building activities includes “leadership development and training of community members” and that the examples provided include leadership and training with regard to “medical interpreter skills for community residents.” We strongly urge the Service to exclude this example because medical interpreter services must be provided in order to ensure patients have “meaningful access” to health care services. While they are to be commended for training community members in this way, nonprofit hospital organizations should not be allowed to claim as “community benefit” a service so closely related to what they are already required to provide and for which they are typically reimbursed.³

Augmenting Organizational Filings with Individual Documentation

While the Service has already decided to allow nonprofit hospitals to report on an EIN, or organizational, basis, there are certain instances in which requiring hospital systems to attach individual, hospital-specific documentation would capture the level of information necessary to achieve the Service’s objectives of accuracy and transparency in reporting.

These include the following:

² This standard is articulated in the draft Instructions as pertaining only to the sections related to subsidized health services; and community health improvement services and community benefit operations.

³ See U.S. Department of Health and Human Services, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient (LEP) Persons*. Available at <http://www.hhs.gov/ocr/lep>.

- An organization that lacks written charity care policies should at least be required to provide a description of the unwritten policies practiced in each of its hospitals in Part VI (Instructions p. 5).
- An organization or any of its component parts that prepare budgets for charity care should be required to attach them to the organization's Schedule H submission (Instructions p. 6).
- Reporting organizations should attach any annual written reports that describe hospital programs that serve the community, community benefit reports, descriptions of their hospitals' communities, and needs assessments conducted by individual hospitals (Instructions p. 6).
- Organizations should be required to attach written debt collection policies for each of its hospitals (Instructions pp. 12, 14).

Use These Reporting Requirements as the Basis for Standards

Finally, the revision of Form 990 and the inclusion of Schedule H underscore the need to develop clearer standards for community benefits. The community benefit standard has not been updated since 1969. In the near 40 years since its enactment, much has changed in our health care environment. Today, more than ever, tax-exempt hospitals have an important role to play in helping to address the health care needs of the communities they serve. It is time to clarify the obligations of tax-exempt hospitals and establish firm standards for what is required of them in exchange for the valuable tax-exemptions they receive. The information required in the new Schedule H could serve as the basis for these standards, and we urge the Service to take up this important task in the coming year.

We welcome the opportunity to work with your office as you finalize the Instructions to this very important Schedule.

Sincerely,



Renée Markus Hodin
Project Director
Community Catalyst



Jessica L. Curtis
Staff Attorney
Community Catalyst

ALSO ON BEHALF OF:

ACORN – Association of Community
Organizations for Reform NOW
New Orleans, Louisiana

Arkansas ACORN
Little Rock, Arkansas

Center for Disability Issues and the
Health
Professions
Western University of Health Sciences
Pomona, California

Coalition of Wisconsin Aging Groups
Madison, Wisconsin

Colorado Consumer Health Initiative
Denver, Colorado

Community Legal Services, Inc.
Philadelphia, Pennsylvania

Congress of California Seniors
Sacramento, California

Connecticut Citizen Action Group
Hartford, Connecticut

Consumers for Affordable Health Care
Augusta, Maine

Disability Health Coalition
Sacramento, California

Empire Justice Center
Rochester, New York

Florida CHAIN
Hollywood, Florida

Florida PIRG
Tallahassee, Florida

Health Care For All
Boston, Massachusetts

Health Law Advocates
Boston, Massachusetts

Health Rights Hotline
Sacramento, California

Human Services Coalition
Miami, FL

Independent Living Resource Center San
Francisco (ILRCSF)
San Francisco, California

Kentucky Task Force on Hunger
Lexington, Kentucky

Local 49, Service Employees
International Union (SEIU)
Portland, Oregon

Maine People's Alliance
Portland, Maine

The Maryland Citizens' Health Initiative
Baltimore, Maryland

Maternity Care Coalition
Philadelphia, Pennsylvania

Mississippi ACORN
Jackson, Mississippi

Mississippi Center for Justice
Jackson, Mississippi

Naugatuck Valley Project
Waterbury, Connecticut

Nebraska Appleseed Center for Law in
the Public Interest
Lincoln, Nebraska

Neighborhood Family Practice
Cleveland, Ohio

New Jersey Appleseed
Newark, New Jersey

New Jersey Citizen Action
Newark, New Jersey

North Carolina Fair Share
Raleigh, North Carolina

North Carolina Justice Center
Raleigh, North Carolina

Northwest Federation of Community
Organizations
Seattle, Washington

Oregon Health Action Campaign
Salem, Oregon

Oregonians for Health Security
Portland, Oregon

Pennsylvania ACORN
Philadelphia, Pennsylvania

Philadelphia Unemployment Project
Philadelphia, Pennsylvania

SEIU Nevada
Las Vegas, Nevada

St. Louis Area Business Health Coalition
St. Louis, Missouri

Tennessee Health Care Campaign
Nashville, Tennessee

Tennessee Justice Center
Nashville, Tennessee

Texas ACORN
San Antonio, Texas

Texas Impact
Austin, Texas

Texas PIRG
Austin, Texas

The Access Project
Boston, Massachusetts

UHCAN Ohio
Columbus, Ohio

Utah Health Policy Project
Salt Lake City, Utah

Virginia Poverty Law Center
Richmond, Virginia

Western Center for Law and Poverty
Los Angeles, CA