COMMUNITY CATALYST

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

September 13, 2007

VIA ELECTRONIC MAIL
Mr. Ronald J. Schultz
Senior Technical Advisor
Tax Exempt and Government Entities Division
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224

Re: Comments on the Proposed Redesigned Form 990 and New Schedule H

Dear Mr. Schultz:

Thank you very much for providing us with this opportunity to comment on the proposed redesigned Form 990 and the new Schedule H. Our comments in this letter will be focused primarily on Schedule H.

We represent health care consumer organizations from across the United States that are working to ensure that all stakeholders in the health care system -- including federal, state, and local governments; hospitals; and health insurers – assume their fair share of the obligation to provide quality, affordable health care for all.

First, we want to express our appreciation for your efforts to redesign Form 990. As you know, the public often looks first to Form 990 for information on how nonprofit institutions are performing and on how they measure up against each other in serving their communities. Because the proposed new Form 990 would increase transparency, and promote greater clarity and uniformity in reporting, your office's efforts represent a valuable public service.

Second, we want to make it clear that, beyond the redesign of these forms, there is still much more to be done. Although the new Form 990 and Schedule H will give both your office and the public a much better picture of whether nonprofit hospitals are living up to their obligations as tax-exempt institutions, there will still be a need to raise and clarify the standards under which hospitals earn this exemption. As your office has recently found,[1] and as the office of Senator Chuck Grassley has also noted,[2] too many tax-exempt hospitals are falling short in the provision of charity care and community benefits without consequence to their tax-exempt status. It is our hope that the introduction of Schedule H will help all sides in promoting a debate on establishing firm, meaningful standards on charity care and community benefits.

[1] Internal Revenue Service, Hospital Compliance Report, Interim Report. (http://www.irs.gov/pub/irs-tege/eo_interim_hospital_report_072007.pdf)
[2] Office of Senator Chuck Grassley, Ranking Member of the Senate Committee on Finance, "Tax Exempt Hospitals: Discussion Draft", posted on July 18, 2007. (http://finance.senate.gov/press/Gpress/2007/prg071907a.pdf) [hereinafter "Discussion Draft"]

The Crisis in Charity Care and Community Benefits

Charity care is often the only option for uninsured and underinsured persons or families in the United States.[3] And yet, many hospitals have failed to develop and implement an adequate charity care policy. The two recently issued reports noted above powerfully state that far too many of these tax-exempt, charitable institutions are not providing their fair share of charity care and community benefits to the communities they are meant to serve. The report issued by your office shows that more than 20% of tax-exempt hospitals provide less than 1% of the value of their revenues in uncompensated care.[4] The report issued by the office of Senator Grassley states that a significant number of nonprofit hospitals have been failing to provide sufficient levels of charity care, and suggests that all tax-exempt hospitals be required to provide annual charity care with a minimum value of 5% of the hospital's gross revenues or patient operating expenses, whichever is greater.[5]

This problem is compounded by the tendency of some hospitals to not sufficiently and appropriately publicize the existence of their charity care policies. In some cases, tax-exempt hospitals have denied that they provide any charity care.[6] Fearing high medical bills, many who might qualify for full or partial charity care instead refuse to seek treatment, usually resulting in greater illness and higher medical costs later on.[7] When people do seek treatment, some hospitals, without adequately attempting to determine whether a patient is eligible for charity care, engage in aggressive debt collection practices, which can destroy the financial security of the uninsured or underinsured patient.[8]

The Importance of Transparency

We recognize that there are many issues of great debate on the role of tax-exempt hospitals in our communities and in our nation's health care system. But the public cannot fully participate in these debates without access to the vital, and vitally relevant, data sought in Schedule H. With the modifications that we suggest in this letter, Schedule H will become a valuable tool for the public, policymakers, hospitals, and other health system stakeholders as we attempt to debate the best way to resolve the crisis in charity care and community benefits.

---

[3] Community Catalyst, "Not There When You Need It: The Search for Free Hospital Care," October 2003, p. 29. (http://www.communitycatalyst.org/doc_store/publications/not_there_when_you_need_it_the_search_for_free_hospital_care_oct03.pdf)

[4] Internal Revenue Service, Hospital Compliance Report, Interim Report, p. 24.

[5] Discussion Draft, p. 7. The Discussion Draft also proposes several other reforms that would heighten both transparency and accountability in the nonprofit hospital sector. (http://finance.senate.gov/press/Gpress/2007/prg071907a.pdf) [hereinafter "Discussion Draft"]

[6] "Not There When You Need It," pp. 17-18. This section describes the discouraging results when community monitors contacted hospitals from around the country and attempted to learn if charity care were available.

[7] Id. at 29.

[8] Gerard F. Anderson, "From 'Soak the Rich' To 'Soak the Poor': Recent Trends in Hospital Pricing, Health Affairs May/June 2007, Vol. 26, No. 3, pp. 784-5; citing D.U. Himmelstein et al, "Illness and Injuries as Contributors to Bankruptcy," Health Affairs Vol. 24 (2005).

Schedule H, Part I: Community Benefit Report

We support your office's use of the Catholic Health Association's (CHA's) reporting guidelines as a model for reporting community benefits. This model affirms what many other health system stakeholders, including many tax-exempt hospitals, have recognized: that a meaningful charity care and community benefits program is an absolutely essential part of a nonprofit hospital's mission. The Community Benefit information that the new Schedule H requires will shine a powerful light on those hospitals that excel in serving their communities -- and those that are falling short.

Column (a): "Number of activities or programs" and Column (b): "Persons served"

Although the data sought in columns (a) and (b) might not be essential in seeking information on "Other Benefits" (lines 5-9), we hope that that your office will retain the requirement that hospitals report not only the dollar amount of charity care provided,[9] but also the number of persons served by the hospital's charity care program. Reporting the number of persons served will provide the public with a much fuller picture of whether tax-exempt hospitals are doing enough to publicize and make available charity care to those who might be eligible for such care.

Lines 5-9: Definition of "Other Benefits"

There is a great debate about what constitutes a "true" community benefit. In many cases, programs and activities that fit within the categories of "Other Benefits" described in lines 5 through 9 of Part I would fall under the definition of community benefit. However, we believe that some activities that might fit within these categories, such as research activities that are so broad that they will provide no direct benefit to the hospital's targeted community, should not be considered a community benefit.[10] Some other community activities conducted by hospitals, which would not fall within the categories listed on lines 5-9, such as sponsoring a section of a local highway, while laudable, would also not have a sufficient connection to a hospital's charitable health mission to be considered a community benefit. On the other hand, we also believe that there are instances when programs and activities not accounted for in lines 5-9 could still be considered a community benefit.

We believe that in order to report programs and activities as "other benefits," a hospital must demonstrate that such programs or activities 1) stem from a properly conducted community health needs assessment, and 2) target the underserved and medically vulnerable in the community.[11] We would therefore recommend that an additional line be included in the "Other

[9] We agree with the CHA that dollar amounts of charity care and community benefits should be measured and reported using a standardized cost-to-charge ratio.

[10] Community Catalyst, "Commentary to the Health Care Institution Responsibility Act," p. 7. (http://www.communitycatalyst.org/doc_store/publications/commentary_to_the_health_care_institution_responsibility_model_act_1999.pdf)

[11] See Community Catalyst's "Health Care Institution Responsibility Model Act" for a more detailed discussion of the definition of a community benefit, including a list of examples. (http://www.communitycatalyst.org/doc_store/publications/the_health_care_instititution_responsibility_model_act_1999.pdf)

Benefits" portion of the chart that would enable hospitals to report all other community benefit programs and activities that meet these strict standards.

Line 13b: Description of the hospital's charity care policy

We welcome the requirement that hospitals provide a detailed description of their charity care policies. But we are concerned that this reporting requirement, as currently worded, will not elicit information important to assessing the performance of a hospital, or to comparing hospitals. We would therefore recommend that your office add a question that requires hospitals to describe in detail the specific criteria they use to determine patient eligibility for charity care.

We also recommend that your office require hospitals to state which services are included, or excluded, under their charity care policies. For instance, are only emergency services covered? Or do hospitals include non-emergency services, and if so, which services?

We would also suggest that your office add a separate but similar set of questions in this section regarding partial charity care. A tax-exempt hospital's approach to partial charity care is often one of the most important issues facing the underinsured.

Part II: Billing and Collections

This new section is an important and useful addition to the Form 990 process. For the first time, the public will be able to access hard, uniform data showing how hospitals serve all classes of patients – from those who are privately insured, to those who receive Medicare, Medicaid, and other government programs, to the uninsured. We would add that we do not believe that collecting and reporting this information would be unduly burdensome to a hospital. It is our understanding that many tax-exempt hospitals already collect this information for their own purposes.

Medicare Shortfall

We recognize that there is great debate regarding how a hospital's Medicare shortfall should be reported. As you know, the CHA does not consider the Medicare shortfall to be a community benefit. Whether it is considered a community benefit or not, we think that this information is an important part of the debate and should be required to be reported.[12] It is worth adding that, in the event that a hospital ended a particular year with a Medicare surplus, as opposed to a shortfall, a Medicare-specific reporting requirement would also capture this fact.

Bad Debt and Collection Practices

The CHA model is also useful because it makes clear that which must not be considered a community benefit. "Bad debt" has been widely recognized not to represent a true community benefit. We understand that there are cases when a hospital might have difficulty ascertaining a patient's eligibility for charity care upon admission. Unfortunately, however, too many hospitals

[12] The size of all shortfalls should be measured using an appropriate methodology, such as by using an actual reimbursement-to-charge ratio.

have adopted a "bill first, ask questions later (if at all)" policy that wreaks havoc on the financial and emotional wellbeing of the medically vulnerable and their families. The quality and humaneness of a hospital's debt collection policy and practices, particularly as they relate to a hospital's determination of charity care, are a key factor in determining whether a hospital is fulfilling its obligations as a community benefit provider.

We also recommend that, should your office require the reporting of bad debt anywhere on Schedule H, there should also be a requirement that the hospital report emergency room- and non-emergency room-related bad debt separately. This information is often very useful in determining the effectiveness of a hospital's overall charity care policy.

Part III: Management Companies and Joint Ventures

We applaud your office's focus, both within the proposed redesigned Form 990 generally, and within Schedule H, on the potentially harmful effects of joint ventures between tax-exempt hospitals and for-profit entities. In the past, some joint ventures between nonprofit and for-profit institutions have resulted in a *de facto* conversion of charitable assets to non-charitable use. It is our hope that Part III, as currently formulated, will call attention to any hospital that attempts in the future to divert its charitable resources for private, profit-making purposes.[13]

Part IV: General Information

Each of the four lines in Part IV seeks important information about a hospital's record of service to the community. For example, the development of a community health needs assessment, and the manner in which it is developed, are important aspects of a community benefits program. Line 1 will enable the public and policymakers to compare the community assessment processes of different nonprofit hospitals, discover best practices among hospitals, and work to establish higher standards in this area for all hospitals.[14]

Line 2 requires hospitals to address another key issue. As we noted earlier, some tax-exempt hospitals are not doing enough to publicize their charity care policies, and to educate patients about their eligibility for charity care or other medical assistance.[15] There no longer is an obligation under the Hill-Burton Act requiring hospitals to publicize their charity care policies.[16]

---

[13] The office of Senator Grassley makes some useful suggestions regarding ways in which charitable assets and a nonprofit's charitable mission might be preserved following a joint venture. See Discussion Draft, pp. 10-12. See also, Community Catalyst, "A Conversion Model Act," particularly Section 15 on joint ventures. (http://www.communitycatalyst.org/doc_store/publications/a_conversion_model_act_oct03.pdf)

[14] Such an assessment should take into account existing data from other community health or public agencies, attempt to identify institutional or systemic reasons for a community's poor health status, target the medically underserved, and should re-assess existing community benefit programs and activities conducted by the hospital. Community Catalyst, "Commentary to the Health Care Responsibility Model Act", pp. 8-9. See, e.g., Baystate Medical Center FY 2006 Community Benefits Report, pp. 2-4, for a description of that hospital's effective community health needs assessment process. (http://baystatehealth.com/forms/pdf/FY_2006_BMC_Community_Benefits_Report.pdf)

[15] See generally "Not There When You Need It." For a positive example, see the webpage of the North Shore-Long Island Jewish Health Care Access Center, (http://www.northshorelij.com/body.cfm?id=565&oTopID=565&PLinkID=1360.)

[16] Anderson, "From 'Soak the Rich' To 'Soak the Poor'," p. 784.

It is our hope that, by requiring hospitals to answer Line 2, hospitals that are not doing enough to educate patients in need will begin to improve this aspect of their service to the community.

Overall, the answers to these questions will do more than educate the public. It is our hope that being required to provide this information will challenge all tax-exempt hospitals to raise their standards in these important areas.

Additional Issues

Filing by Institution versus Filing by Group of Institutions

One objection that we have to the proposed Form 990 is that is appears to allow a hospital system to report as one unit. We are concerned that this would prevent the public from getting an accurate picture of how hospitals in their particular communities are performing. It is not unusual for health care systems to control hospitals in urban, suburban, and rural areas, with different patient mixes and different levels of commitment to charity care and community benefits. Furthermore, we do not believe that requiring hospitals to report individually would be unduly burdensome. It is our understanding that hospital systems already collect this information on an institution-by-institution basis for their own uses. We would therefore strongly urge your office to require hospital systems or other entities that control more than one exempt hospital to submit a separate Schedule H for each hospital in the system.

Schedule H Rollout and Implementation

We recognize that the revised Form 990 and the range of new and revised Schedules that your office is proposing will require some retooling of the record keeping and reporting practices of nonprofit organizations. However, we feel strongly that Schedule H, at a minimum, should be rolled out in time for calendar year 2008, for filing during 2009. Most, if not all, of the data required to complete Schedule H, such as levels of charity care and other community benefits, should already be compiled by hospitals, or should at least be relatively straightforward to compile.

The Importance of the New Schedule H

As your office clearly recognizes, Form 990 is meant for everyone. It is not merely meant for accountants, lawyers, and health care professionals. Especially in the Internet (and GuideStar) age, it cannot be overemphasized that the public depends upon Form 990 to provide important information about the nonprofit institutions that serve their communities. Schedule H, with its basic questions about hospital practices, and clear categories for reporting community benefits and billing, will allow people to assess how well their hospitals are serving their communities, and to engage in the great debate on how to enhance access to quality, affordable health care. Again, we hope that these positive developments on the reporting front will also lead to the creation of more meaningful standards for tax-exempt hospitals' charity care and community benefits policies.

We look forward to working with your office as the redesign process continues.

Thank you,

Frank McLoughlin
Staff Attorney
Community Catalyst

Renée Markus Hodin
Project Director
Community Catalyst

Also on behalf of:

TakeAction Minnesota
St. Paul. Minnesota

TexPIRG
Austin, Texas

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

Coalition for Citizens with
Disabilities of Mississippi
Jackson, Mississippi

Healing the Children FL-GA
Palm Coast, Florida

Maternity Care Coalition
Philadelphia, Pennsylvania

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

Subcommittee on Free Care Monitoring
Project – Galveston Co. Cancer Coalition
Galveston, Texas

Progressive States Network
New York, New York

The Artists Foundation
Boston, Massachusetts

Oregon Health Action Campaign
Salem, Oregon

Consumers for Affordable Health Care
Augusta, Maine

Universal Health Care Action Network of Ohio
Columbus, Ohio

Virginia Poverty Law Center
Richmond, Virginia

Independent Living Resource
Concord, California

Florida CHAIN
Plantation, Florida

Maine Equal Justice
Augusta, Maine

Community Service Society
New York, New York

The Access Project
Boston, Massachusetts

Families USA
Washington, District of Columbia

cc: Senator Max Baucus, Chairman, Senate Committee on Finance
Senator Chuck Grassley, Ranking Member, Senate Committee on Finance
Secretary Henry M. Paulson, Jr., Department of the Treasury