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New IRS Hospital Reporting Requirements Create New Opportunities for Improving Access to Care

In August 2008, the Internal Revenue Service (“IRS”) released the final building block in its redesign of **Form 990**, the annual tax return filed by nonprofit institutions. Among the redesigned form’s innovations is Schedule H, the new filing requirement for organizations that operate nonprofit hospitals. For the first time, Schedule H requires nonprofit hospitals (which comprise nearly **sixty percent** of all hospitals) to report **quantifiable data on the amount of charity care and other community benefits that they provide in exchange for federal tax exemptions**.

The arrival of Schedule H is well-timed. As state budgets groan under increasing economic burdens, as Washington wrestles with how to prepare Medicare for an aging America, and as candidates for the next presidency drive stakes into the ground on health care reform, the American public is voicing increasing concern that too many people lack adequate access to and coverage for health care in times of need.¹ By shining a spotlight on nonprofit hospitals, Schedule H promises to capture information of interest to lawmakers and the public alike: how do our nonprofit hospitals, key players in our healthcare system, compare when it comes to meeting their communities’ needs?

Schedule H is not a panacea for what ails our healthcare system. It is, however, an important new tool that consumer advocates can use to gauge nonprofit hospitals’ performance in carrying out a significant part of their missions: helping to meet the unmet needs of their communities. What follows is a brief summary of Schedule H’s *key provisions and their shortcomings*, along with a list of *opportunities* it presents for consumer advocates seeking to engage state and local stakeholders -- including hospitals -- to develop solutions to health care access problems.

Background

According to a 2002 report by the Joint Committee on Taxation, nonprofit hospitals receive an estimated **\$12.6 billion per year** in local, state, and federal tax exemptions. **To justify this transfer of tax revenues from federal taxpayers, nonprofit hospitals are expected to provide some benefit to their communities, including free care** (care given without expectation of payment). Although Form 990 has long been the primary means by which the IRS and the general public could hold nonprofit hospitals accountable for their use of these monies, the old Form’s limited reporting requirements made it impossible for either the IRS or the general public to determine whether nonprofit hospitals were meeting these obligations. The IRS introduced the revised Form 990 and Schedule H last year to combat this lack of transparency and promote tax compliance while keeping the filing burdens hospitals will face to a minimum.

¹ In 2007, almost two thirds of American adults reported difficulty paying medical bills as a result of high cost and inadequate coverage. See Collins, S.; Kriss, J.; Doty, M.; and Rustgi, S. [“Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families.”](#) *The Commonwealth Fund Report*, Volume 99 (August 20, 2008). Also see Doty, M.; Edwards, J.; and Holmgren, A. [“Seeing Red: Americans into Debt by Medical Bills.”](#) *The Commonwealth Fund Report*, Volume 10 (August 10, 2005).

Key Provisions: Improvements

Any nonprofit organization that operates a hospital that is licensed, registered, or otherwise recognized as such under state law will be required to file Schedule H. These organizations will be required to report the following:

1. **General narrative information regarding community benefits.** Schedule H will require a hospital system to provide general narrative information related to its provision of “community benefits,” as follows:
 - **Charity care.** The hospital system must report whether it has a charity care policy; whether the policy exists in writing; whether the policy includes the medically indigent (e.g., the underinsured); and a description of the eligibility requirements the hospital system uses to determine eligibility for free or discounted care.
 - **Community benefit report.** The hospital system must report whether it produces an annual community benefit report and, if so, whether it makes this report available to the public.
 - **Debt collection policies and procedures.** The hospital system must report whether it has a written debt collection policy and, if so, whether the policy outlines procedures for patients known to qualify for charity care or financial assistance.
 - **Patient education.** The hospital system must describe how it informs and educates patients about their rights under its own charity care policies and their eligibility for assistance under government programs.
 - **Community needs assessments.** The hospital system must describe the demographics of the community it serves, how it assesses the health care needs of that community, and how its activities promote the health of that community.
2. **Financial information on how the hospital system determines the cost of the “community benefits” it provides.** This includes information about billing and debt collection policies.
 - **Net community benefit expenses.** The hospital system must provide financial information regarding the cost of its charity care and means-tested programs (e.g. Medicaid); other benefits it provides (e.g. community health improvement services and educational research); and “community building activities” (e.g. physical and environmental improvements, coalition building, and workforce development). The hospital system has the *option* of reporting the number of activities and programs it offers, along with the *option* of reporting the number of people these programs serve, but this is not required.
 - **Bad debt reporting.** The hospital system must state whether it reports bad debt expense in accordance with Healthcare Financial Management Association standards. In addition, the hospital system must list the total amount of its bad debt expense, at cost; and the methodology used to determine these amounts. The hospital system must also describe how it accounts for patient payments and discounts when reporting bad debt expense, as well as how it determines what amount of bad debt might be attributed to patients who would likely have qualified for charity care.
 - **Uniform reporting of Medicare revenues.** The hospital system must report only the aggregate reimbursements and costs for Medicare programs included in its annual Medicare Cost Reports, including Disproportionate Share (“DSH”) and indirect medical education (“IME”) payments. Hospital systems must describe the costing methodology they use to determine this amount in Part VI of the Schedule.

(Unfortunately, Schedule H appears to give hospital systems ample opportunity to write off Medicare shortfalls as “community benefit.”)

3. **General identifying information for the hospital system as a whole.** The organization filing Schedule H must provide basic identifying information—name, address, and type of facility—for each hospital and health care facility operating under its EIN. This is the only reporting requirement that will be mandatory for tax year 2008.

Key Provisions: Shortcomings

Despite the vast improvements Schedule H makes in hospital reporting standards, it does contain a number of shortcomings of which advocates should be aware. The following list illustrates what Schedule H does *not* do with regard to increasing hospital accountability. Advocates may want to view these items as points of departure from which to engage state, local, and even federal stakeholders.

1. **Does not mandate reporting until tax year 2009 (reported in 2010).** The IRS has made reporting, with the exception of general identifying information, *optional* until tax year 2009. Unless the hospital system voluntarily completes the entire Schedule H, this information will not be made public for another two years.
2. **Does not establish firm standards.** Requiring nonprofit hospitals to report their current policies and practices is a vital step towards increasing hospital accountability. There is a difference, however, between reporting requirements that call for *descriptions* of hospital policies and *standards* that set substantive requirements for those policies. In particular, Schedule H falls short by failing to articulate *firm standards* in the following areas:
 - What constitutes a “**community benefit**.”
 - What **eligibility standards** should be used in determining whether a patient qualifies for charity care.
 - What obligations nonprofit hospitals hold with regard to **publishing information and educating the communities** they serve around issues of financial assistance and charity care.
 - What standards and procedures should be in place with regard to **debt collection policies**, particularly as they apply to patients who are eligible to receive charity care.
 - What hospitals must do to show a **demonstrable link** between the services they provide and the needs of their outlying communities.
3. **Does not capture vital information about local hospitals’ practices.** While Schedule H may be instrumental in gathering information about the hospital system’s overall policies, it prohibits public access to information about *specific hospital practices* in the following key ways.
 - **Mandates that the hospital system report on an EIN, rather than facility-by-facility, basis.** Because the system has to report on its single employer identification number (its “EIN”) rather than on a hospital-by-hospital basis, Schedule H will capture only what is generally true of the system’s policies and practices. It will not illuminate differences in practices and policies as they occur in local hospitals. This may paint a false picture, negative or positive, of the degree to which a local hospital facility is truly providing a “community benefit.”
 - **Mandates that the hospital system report only the criteria used to determine charity care eligibility for the largest number of its patients.** As a result of this

limitation, the hospital system has no obligation to provide eligibility information relevant to *all* classes of patients.

- **Does not mandate that the hospital system report specific information about the number of programs offered and people served by its “community benefit” endeavors.** Because such reporting is optional, the hospital system will be able to claim expenses for these activities without providing data about the extent of its outreach to the community or the number of people who are actually impacted by these campaigns.
4. **Does not prohibit the hospital system from mischaracterizing bad debt and Medicare shortfalls as “community benefit.”** The hospital system is given multiple opportunities throughout Schedule H (Parts III and VI) to provide rationales in narrative form for including bad debt and Medicare shortfalls in its demonstration of providing “community benefit.”

Opportunities for Advocates

For state consumer advocates working to increase transparency in hospitals’ financial assistance policies, **this reform at the federal level presents an opportunity to engage state and local stakeholders in a timely and effective fashion.** State advocates can use the introduction of Schedule H as an opportunity to do the following:

1. **Engage hospitals.** Advocates can use Schedule H as a reference point in their work with local hospitals as follows:
 - **Encourage local hospitals to “take the option.”** Encourage local hospitals to *voluntarily* 1) file the complete Schedule H for tax year 2008; 2) report numerical data related to their community benefits programs and participation; and 3) provide eligibility criteria applicable to *all* patients, not just the largest subset. This can easily be incorporated into Part VI of Schedule H, “Supplemental Information.”
 - **Work with hospitals to improve and strengthen their community benefit programs** before they need to file Schedule H. Hospitals may welcome the opportunity to work with advocates to not only demonstrate their commitment to the community but also to better direct their community benefit resources to meet agreed-upon priorities. For example, Schedule H will require hospitals to describe how they assess the needs of their communities. It will also require hospitals to describe the processes they use to inform patients about the existence of public programs and charity care. Consumer advocates can be helpful here, both by connecting local hospitals directly to their communities so they can identify real needs and by pointing out areas where current charity care notification policies or practices create barriers for consumers seeking needed care.
2. **Engage state officials.** Advocates can use Schedule H’s new federal reporting standards to move state attorneys general and other regulators towards setting higher state requirements. Additionally, the new federal focus on hospital accountability may be used to sharpen state lawmakers’ interest in other issues implicitly related to charity care policies (e.g. preventing medical debt, setting similar requirements for state tax benefits to nonprofit hospitals, regalanizing expansion efforts).
3. **Engage your Congressional delegation.** Advocates can use the new Schedule H as an opportunity to educate federal lawmakers on the importance of setting firm federal standards for community benefits. These federal standards, however, should not preempt states’ ability to enact more stringent requirements.