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Group Seeks Removal of New Community Benefit Reporting Rule.

Edward Goodman of VHA Inc. has expressed concerns about a policy change that was made by the IRS without adequate notice or public comment in the 2013 instructions to Schedule H (Form 990), "Hospitals," urging the IRS to remove a new rule treating restricted grants as "direct offsetting revenue" for community benefit reporting purposes.

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October 21, 2014

The Honorable John A. Koskinen
Commissioner
Internal Revenue Service
1111 Constitution Ave, N.W.
Washington, DC 20224

Dear Commissioner Koskinen:

On behalf of VHA Inc. ("VHA"), we are writing to express our concern about a policy change that was made by the IRS without adequate notice or public comment in the 2013 Instructions to Schedule H of the Form 990. As described in a recently-filed amicus curiae brief submitted by the American Hospital Association (AHA) to the United States Supreme Court,1 this ill-considered change appears likely to have serious tax consequences for a wide array of tax-exempt hospitals and represents a significant departure from longstanding IRS rulings that were recently reaffirmed by Congress when it enacted new Code section 501(r).

VHA is a national health care network that serves more than 1,500 not-for-profit hospitals nationwide. VHA is dedicated to the success of nonprofit community-based health care. VHA has participated for many years with the Catholic Health Association of the United States (CHA) in developing resources to help community hospitals fulfill their mission and maintain their tax-exempt status.

AHA's amicus brief, a copy of which is enclosed for ease of reference, recounts how the IRS first developed reporting rules for measuring community benefit in consultation with the hospital community, and then precipitously altered a significant aspect of the rules retroactively with only 10 days' notice and no meaningful opportunity for comment. The amicus brief also discusses the negative impact that the rule change is likely to have on the tax status of medical research hospitals.

VHA shares AHA's concerns about the flawed administrative process by which this key rule was changed (i.e., lack of public notice and comment) as well as its adverse impacts on academic medical centers. Further, VHA believes the following factors should be considered:

- The new IRS rule will likely have a negative impact not only on research hospitals, but also on

community hospitals (including critical access hospitals operating under significant financial constraints) to the extent that such hospitals' community benefit expenditures are funded in whole or part through designated grants and contributions.
- The new IRS rule is inconsistent with health care accounting principles and best practices developed by the Health Care Financial Management Association (HFMA) for the purpose of accurately measuring hospitals' provision of community benefits, including charity care.
- The new IRS rule is not only at odds with longstanding IRS revenue rulings, but also runs contrary to Congressional intent as expressed in the legislative history of new Code section 501(r).

In light of these significant procedural and substantive deficiencies, VHA urges the Commissioner to immediately withdraw the new rule and revert to the well-reasoned former rule, which excluded both restricted and unrestricted grants from the definition of "direct offsetting revenue."

The New Rule Announced in IRS Form Instructions

The new rule, imposed by a change in IRS Form Instructions first announced on December 9, 2013 and finalized on December 20, 2013, treats "restricted grants" as "direct offsetting revenue" for community benefit reporting purposes. As such, it would prevent tax-exempt hospitals that rely on grant funding to extend their reach into the communities they serve from being able to fully and accurately report their community benefit expenditures.

From the inception of the new Schedule H in 2008 through the first 11 months of 2013, the Instructions for Schedule H provided as follows:

"Direct offsetting revenue" means revenue from the activity during the year that offsets the total community benefit expense of that activity, as calculated on the worksheets for each line item. "Direct offsetting revenue" includes any revenue generated by the activity or program, such as payment or reimbursement for services provided to program patients. ***Direct offsetting revenue does not include restricted or unrestricted grants or contributions that the organization uses to provide a community benefit.***

However, in the final 2013 Instructions released on December 20, 2013, the IRS included a sentence that states the opposite, specifically that "[d]irect offsetting revenue also includes restricted grants or contributions that the organization uses to provide a community benefit, such as a restricted grant to provide financial assistance or fund research." The same sentence is included in the recently released 2014 Draft Schedule H Instructions along with a statement advising hospitals that "Organizations may describe any inconsistencies from reporting in prior years in Part VI."

Negative Impacts of IRS Rule Reversal

The new reporting regime imposed by the IRS form will artificially depress many hospitals' community benefit expenditure percentages — in particular, those community hospitals and academic medical centers that rely on foundation and government grants to help fund their community benefit expenditures (including research, community health improvement initiatives, and charity care).

VHA is particularly concerned about the new rule's adverse impact on financially struggling community hospitals that pro-actively extend their community benefit reach by partnering with community organizations and foundations. While the IRS in its new community health needs assessment rules encourages hospitals to partner with other hospitals, community health organizations and local, state and federal health agencies, the new Schedule H reporting rule will unfairly penalize hospitals funding community benefit expenditures with grant funds derived from

most charitable or government grants. Although the reporting rule would allow full credit for expenditures made with "unrestricted" grants, the reality of institutional grant-making is that the majority of grants made to hospitals (whether for research or community health programs) are "restricted" grants.

Inconsistency of New Rule with HFMA Charity Care Valuation Principles

According to guidelines developed by the HFMA on calculating charity care and community benefit, the concept of subtracting out **"direct offsetting revenue"** was intended to make sure that hospitals did not inflate the value of charity care by including "any patient-related revenue" in the amount counted as charity care. The subtraction of "direct offsetting revenue" was not intended to create disincentives for charitable hospitals to use grants to fund community benefit initiatives. For that reason, Statement 15 of the HFMA Principles & Practices (P&P) Board Statement on Valuation of Charity Care by Health Care Providers (" Statement 15 ") (issued Dec. 2006) only stipulates that health care providers subtract out patient-related revenue in determining the net cost of charity care. Further, Section 7.1 of Statement 15 explains the accounting principle as follows: "The goal of charity care disclosure is to identify the net cost related to charity care, as determined by the total cost of charity care services **less any patient-related revenue** due to sliding scale payments or other patient-specific sources." HFMA recognized that charity care is frequently funded by external sources (such as grants, contributions and special taxes) as well as by hospital surplus revenues.

The IRS's rule reversal deviates from these common-sense principles. It would allow hospitals funding charity care or other community benefit with their own surplus operating revenues to fully report such community benefit expenditures, while discounting the community benefit expenditures of those financially struggling or low-margin hospitals that solicit and receive grants to help fully fund their programs. Consequently, the IRS's proposed treatment of most hospital grants as "Direct Offsetting Revenue" will result in reporting distortions and the creation of perverse incentives.

Inconsistency of the New Rule with IRS Rulings Recently Affirmed By Congress

When it passed the Affordable Care Act (ACA), Congress imposed new requirements on tax-exempt hospitals, including the following:

- Section 9007(a) of the ACA added new statutory requirements that must be met by all hospitals seeking exemption from federal income tax and other tax benefits as 501(c)(3) organizations. These provisions, now contained in new Internal Revenue Code ("Code") Section 501(r), require hospitals to — prepare a community health needs assessment (CHNA) every three years, — adopt a financial assistance policy to provide charity care and emergency medical services, — abide by a limitation on charges for medical care provided to needy patients, and — refrain from engaging in certain types of collection efforts
- Section 9007(b) added a new penalty excise tax (new Code section 4959) to help enforce the new CHNA requirements.
- Section 9007(c) mandates IRS review of each 501(c)(3) hospital and its community benefit activities at least once every three years.
- Section 9007(d) imposes new reporting and disclosure requirements on 501(c)(3) hospitals filing the annual information return known as the IRS Form 990.

The new ACA requirements are entitled, "Additional Requirements for Section 501(c)(3) Hospitals," and the legislative history of the ACA makes it clear that the new requirements are in addition to, and not in lieu of, the requirements otherwise applicable to 501(c)(3) organizations.2 In fact, the legislative history of the ACA describes in great detail the prevailing IRS standard for tax-exemption as follows:

Since 1969, the IRS has applied a “community benefit” standard for determining whether a hospital is charitable. According to Revenue Ruling 69-545, community benefit can include, for example: maintaining an emergency room open to all persons regardless of ability to pay; having an independent board of trustees composed of representatives of the community; operating with an open medical staff policy, with privileges available to all qualifying physicians; providing charity care; and utilizing surplus funds to improve the quality of patient care, expand facilities, and advance medical training, education and research.3

As emphasized by the AHA amicus brief, this longstanding IRS community standard has never required hospitals to discount their community benefit expenditures by the amount of restricted grants they receive.

Conclusion

In 2008, the IRS, in consultation with the Treasury Department and the hospital community, promulgated a definitional rule that made sense. In 2013, the IRS unilaterally and retroactively replaced the rule with one that is inconsistent with recognized accounting practices, published revenue rulings and the intent of Congress. In view of these inconsistencies and the negative impact of the rule on both research and community hospitals, the IRS should immediately withdraw the new rule and replace it with the former rule.

If you have any questions about VHA’s comments or have further questions, please contact VHA’s Senior Director, Governmental Relations, Cidette Perrin at (202) 354-2608 or at cperrin@vha.com.

Sincerely,

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cc:
Chairman Dave Camp and Ranking Member Sander S. Levin,
Committee on Ways and Means, United States House of Representatives

Assistant Secretary (Tax Policy) Mark J. Mazur,
United States Treasury Department

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FOOTNOTES

1 The amicus brief was filed in Perez v. Mortgage Bankers Association, Nos. 13-1041, 13-1052. See Brief for the American Hospital Association, Association of American Medical Colleges, and Healthcare Financial Management Association as Amici Curiae Supporting Respondent, 2014 WL 5299417 (2014).

2 See S. Rep. No. 111-89, at 346-348 (2009). See also Staff of the Joint Committee on Taxation, 111th Cong., Technical Explanation of the Revenue Provisions of the “Reconciliation Act of 2010,” as amended, in combination with the “Patient Protection and Affordable Care Act” (“Technical

Explanation), at 78 (J. Comm. Print. 2010) (citing Rev. Rul. 69-545, 1969-2 C.B. 117).

3 S. Rep. No. 111-89 at 346.