



Show Me the Money: The Implications of Schedule H

ISSUE BRIEF
NO. 831

EILEEN SALINSKY, *Consultant*

APRIL 21, 2009

OVERVIEW — Responding to policymakers' concerns, the Internal Revenue Service (IRS) implemented significant new hospital community benefit reporting under Schedule H of its revised Form 990, the return used by tax-exempt organizations. This issue brief considers the policy implications of the quantitative and qualitative information that hospitals are now mandated to report through Schedule H, including the costs associated with charity care, bad debt, and the unreimbursed costs of Medicaid and Medicare. The paper examines unresolved issues related to the new reporting requirements, such as controversies regarding the scope of Schedule H, and considers the potential for these reports to influence IRS oversight activities, legislative action, and hospital policies and practices.

National Health Policy Forum

2131 K Street, NW
Suite 500
Washington, DC 20037

T 202/872-1390
F 202/862-9837
E nhpf@gwu.edu
www.nhpf.org

Judith Miller Jones
Director

Sally Coberly, PhD
Deputy Director

Monique Martineau
Publications Director

Since the passage of Medicare and Medicaid in 1965, policymakers have periodically raised concerns regarding the extent to which not-for-profit hospitals merit the tax-exempt status afforded them under state and federal laws. These policy debates often coincide with significant expansions in public funding for health services or austere budget cycles. A number of states and localities have imposed specific requirements for hospital tax exemption, and some have mandated payment in lieu of taxes to recoup the costs of public services. Although less definitive action on hospital tax exemption has transpired at the federal level, Congress has addressed the issue repeatedly through its oversight activities.

Senator Grassley (R-IA) has been particularly vocal in calling for greater accountability from not-for-profit hospitals and more stringent standards for conferring federal tax exemption. In commenting on a recent Internal Revenue Service (IRS) report on hospital compliance Sen. Grassley stated, "The tremendous advantage of tax-exempt status, and the ability to raise capital through tax-deductible contributions and tax-exempt bonds, puts non-profit hospitals in a position to provide health care to people who otherwise can't afford it. In fact it's that public good that justifies the tax-exempt status. Neither the IRS nor Congress has done a very good job when it comes to establishing the criteria for enjoying this tax status since the IRS scrapped charity care for its community benefit standard in 1969."¹

Private, not-for-profit hospitals have historically qualified for tax exemption as charitable organizations that engage in activities deemed consistent with the exempt purposes described in section 501(c)3 of the Internal Revenue Code, although hospitals are not specifically identified in statute.² The regulatory parameters for defining a hospital's charitable purpose have changed little since the issuance of the community benefit standard in 1969 which sets out a rather flexible framework for gauging the charitable performance of hospitals.

In what is arguably the most significant development in federal oversight of tax-exempt hospitals since the establishment of the

The National Health Policy Forum is a nonpartisan research and public policy organization at The George Washington University. All of its publications since 1998 are available online at www.nhpf.org.

community benefit standard, the IRS has implemented specific, uniform reporting requirements regarding hospital community benefit activities. In December 2007, the Internal Revenue Service (IRS) released the redesigned Form 990 for tax year 2008 (to be filed in 2009). Form 990 is the return filed by charities and other tax-exempt organizations and is the primary mechanism used to monitor exempt organizations' financial status and compliance with federal tax law. Included

in the redesigned Form 990 is Schedule H which requires private, tax-exempt hospitals to report on their community benefit activities. Transition relief was provided for Schedule H, delaying filing of most parts of the Schedule until 2010 (for the 2009 tax year). Once filed, these reports will furnish the IRS with the most complete, consistent identification and enumeration of the community benefit activities conducted by not-for-profit hospitals across the country.

Schedule H collects quantitative information on the costs hospitals incur in providing community benefit services. Activities that can be included in calculations of community benefit costs under Schedule H include:

- Charity care (that is, free or discounted health services provided to persons who meet the hospital's criteria for financial assistance and are thereby deemed unable to pay for all or a portion of the services)
- Unreimbursed costs of providing care to recipients of means-tested government insurance programs (such as Medicaid)
- Community health improvement efforts
- Health professions education
- Subsidized health services
- Research
- Charitable donations

THE COMMUNITY BENEFIT STANDARD

IRS Revenue Ruling 69-545* states that a hospital fulfills its charitable purpose by promoting the health of a class of persons broad enough to benefit the community as whole. Prior to 1969, hospitals were explicitly required to provide charity care to the extent of their financial ability to do so.** The community benefit standard established that the provision of free and discounted services to the poor is one of multiple ways that hospitals can promote community health and fulfill their community benefit obligations. Notably, the 1969 revenue ruling does not define "community" in any way nor does it require hospitals to explicitly identify the community or communities they serve.

* IRS Revenue Ruling 69-545 available at www.irs.gov/pub/irs-tege/rr69-545.pdf

** IRS Revenue Ruling 56-185 available at www.irs.gov/pub/irs-tege/rr56-185.pdf

Schedule H also collects information on the costs associated with community building, bad debt (uncollectable charges), and the unreimbursed costs of providing care to Medicare patients. Although these activities are not classified as community benefit costs under Schedule H, the IRS has invited filing organizations to provide a rationale for including these expenses in calculations of community benefit costs.

In addition to these quantitative data, Schedule H also captures a limited amount of qualitative information related to organizational structure and facility descriptions, charity care eligibility thresholds, debt collection practices, publicly available community benefit reports, needs assessments, a description of the community served, and descriptions of cost accounting methods used to allocate indirect patient care costs.³

The new Schedule H reporting requirements do not change the requirements that hospitals must fulfill to retain their federal tax exemption. However, the breadth and depth of these reporting requirements—and the increased consistency and transparency these reports promise—shine a light on the various dimensions of the community benefit standard and may portend policy changes in the future. The nature and extent of potential changes remain unclear, but speculation and concern have centered on the following issues: Does Schedule H narrow the definition of community benefit? Is Schedule H reporting likely to change IRS compliance oversight activities? Could Schedule H trigger federal statutory changes to the community benefit standard? Are hospitals likely to change their charity care and debt collection practices?

THE DEFINITION OF COMMUNITY BENEFIT

The IRS is considering whether any part of bad debt, Medicare shortfall, or community building should be included in a calculation of community benefit expenses. In the past, hospitals were not required to enumerate or report their community benefit activities, and individual hospitals had a fair degree of discretion in determining what activities constituted community benefit. A clear consensus regarding the treatment of community building, bad debt, and Medicare shortfall does not currently exist.

Recognizing bad debt and unreimbursed Medicare costs in a definition of community benefit is particularly controversial. Community

benefit reporting guidelines previously developed by the Catholic Health Association exclude bad debt and Medicare shortfall from community benefit expenses (but include community building). In contrast, the American Hospital Association (AHA) has argued that these costs should be reflected in community benefit accounts. Reflecting this lack of consensus, the IRS received many comments arguing for and against the inclusion of these items in Schedule H.

Pro-inclusion arguments generally focus on pragmatic concerns, while anti-inclusion arguments typically stress the charitable principles that distinguish not-for-profit hospitals. Those opposed stress that for-profit hospitals also incur bad debt and Medicare shortfall, therefore these costs do not differentiate not-for-profit institutions in a meaningful way. Also, the magnitude of these costs can be profoundly influenced by inappropriate hospital management decisions. Bad debt may be significantly increased by restrictive eligibility criteria for charity care, passive charity determination practices, failure to screen patients for public insurance programs, and inappropriate debt collection activities. Similarly, Medicare shortfalls may reflect an excessive cost structure resulting from provider inefficiency, rather than underpayment.

Proponents of including bad debt and Medicare shortfall often emphasize the practical realities confronting hospitals. The rationale for including bad debt often centers on the administrative challenges of verifying income and assets to determine charity care eligibility, as well as evidence that low-income patients account for the majority of bad debt expenses. Arguments for including Medicare shortfall often highlight that serving Medicare patients is a requirement of the current community benefit standard, and the AHA contends that Medicare underpayment is widespread.

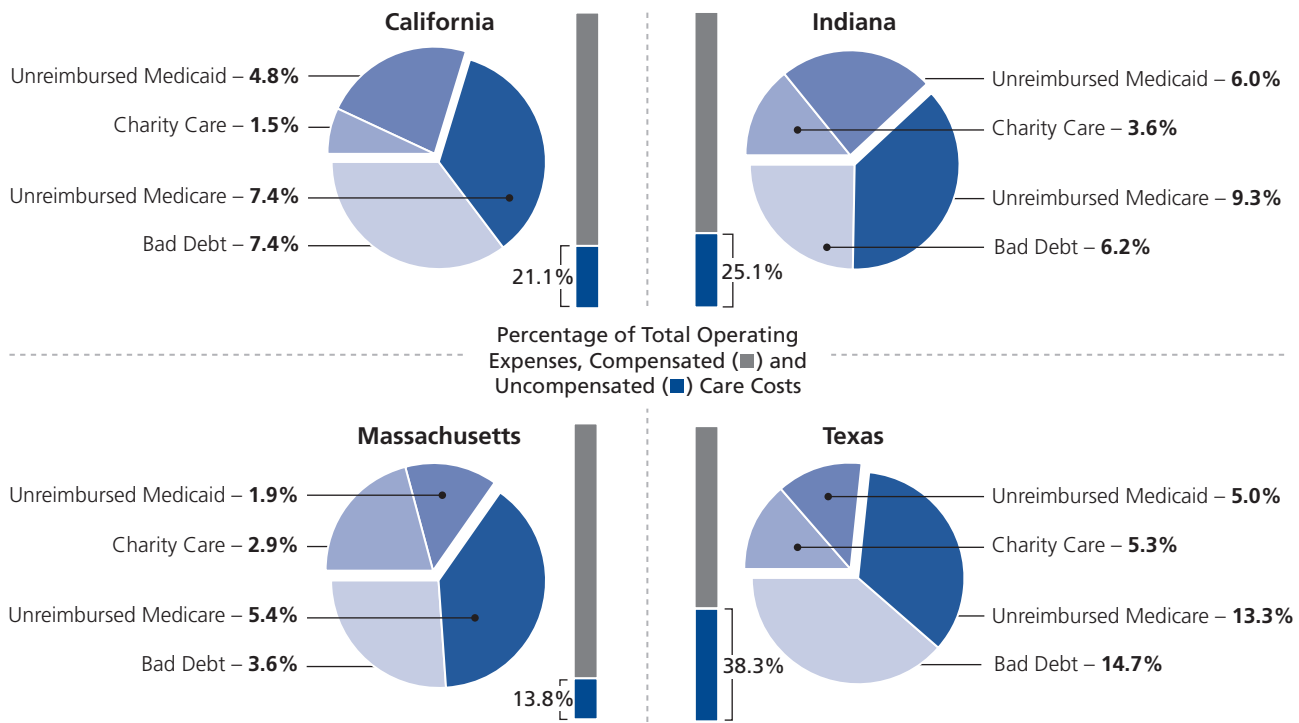
Current practices regarding the treatment of bad debt and Medicare shortfall have not been fully documented. A questionnaire fielded by the IRS in 2007 revealed that approximately 44 percent of responding hospitals included bad debt in uncompensated care totals, 51 percent included Medicaid shortfall, and 20 percent included shortfalls from Medicare or private insurance.⁴ However, this questionnaire did not directly probe whether hospitals considered these components of uncompensated care community benefit contributions.

The decision to incorporate bad debt and Medicare shortfalls in a definition of community benefit would likely have considerable consequences for the magnitude and distribution of hospital community benefit costs.

The decision to incorporate bad debt and Medicare shortfalls in a definition of community benefit would likely have considerable consequences for the magnitude and distribution of hospital community benefit costs. A recent study by the Government Accountability Office (GAO) examined these various types of uncompensated care in select states.⁵ Some variation across states was observed, but bad debt and unreimbursed Medicare costs account for the majority of total uncompensated care costs in all of the states studied, as shown in Figure 1. In contrast, charity care and the unreimbursed costs of Medicaid represented only one-quarter to one-third of total uncompensated care costs. It is uncertain whether these select states are representative of the national experience.

**FIGURE 1:
Uncompensated Care
Costs, Selected States**

Although proportions vary across states, the GAO found that bad debt and unreimbursed Medicare costs (Medicare shortfalls) account for two-thirds to three quarters of uncompensated care costs. Incorporating these costs into community benefit estimations would greatly impact the amount organizations could claim as community benefit contributions.



Source: Government Accountability Office, "Nonprofit Hospitals: Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements," GAO-08-880, September 2008; available at www.gao.gov/new.items/d08880.pdf.

The GAO found that data were unavailable to assess how the inclusion of community building expenses—those undertaken to strengthen a community’s infrastructure—might affect community benefit valuations. Based on limited anecdotal information, community building costs do not appear to be substantial in aggregate, yet may be significant for particular institutions. Future Schedule H reporting will help the IRS determine whether community building should be treated as community benefit, but it is likely that the overall contribution of community building activities to total community benefit expenses is relatively small.

Some have cited the potential for gaming and abuse as an argument against the broad inclusion of community building activities in community benefit reporting. Reports of hospitals investing in lucrative real estate development projects and counting these efforts as community benefit efforts have raised serious questions about the best way to identify and recognize community building efforts that are likely to have a meaningful effect on population health. Some advocates have suggested that documented need (which is required for the community benefit activities that fall in the “certain other” category reported in Part I of Schedule H) should be established to justify any community building activities reported as community benefit. The contested nature of community building may also reflect limited visibility of legitimate community building investments by hospitals. To the extent that such investments are occurring, hospitals and community leaders may not be differentiating these efforts from other community health improvement activities.

The IRS has indicated that the status of bad debt, Medicare shortfall, and community building is under consideration, pending review of initial Schedule H reports. Because the IRS does not have an empirically defined “bright line” test for assessing the adequacy of community benefit contributions, the significance of excluding these contested items as community benefit activities is uncertain. Schedule H was designed to better inform IRS officials, policymakers, and other decision makers, rather than provide a litmus test for establishing charitable purpose. However, a more inclusive definition of community benefit would clearly cast more hospitals in a favorable light.

Although evidence is limited, it appears that many hospitals may be unable to demonstrate significant levels of quantifiable community benefits, particularly if bad debt and Medicare shortfall are excluded. The IRS Exempt Organizations Hospital Compliance Project

The IRS Exempt Organizations Hospital Compliance Project found that the majority of aggregate community benefit spending—60 percent—was contributed by just 9 percent of all hospitals surveyed.

Final Report⁶ found wide variation in both total community benefit expenditures and uncompensated care costs across the national sample of hospitals surveyed. For respondent hospitals, average and median percentages of total revenues spent on community benefit activities were 9 percent and 6 percent, respectively. However, community benefit contributions were unevenly distributed and concentrated in a relatively small group of respondents.

The majority of aggregate community benefit spending (60 percent) was contributed by just 9 percent of all respondents. Twenty-one percent of the hospitals reported aggregate community benefit expenditures equal to or less than 2 percent of total revenues, and 47 percent reported aggregate community benefit expenditures equal to 5 percent or less of revenues. Similarly, 82 percent of aggregate uncompensated care costs were borne by 26 percent of respondents. Most responding hospitals (58 percent) reported uncompensated care costs equal to 5 percent or less of total revenues. The IRS report notes that “an attempt to draw bright lines could have disproportionate impacts on hospitals depending upon their size, where they are located, their community benefit mix, and other hospital and community demographics.”

The IRS acknowledges that the Compliance Project survey results are limited by reporting inconsistencies, which compromise the utility of results for comparative purposes. Some respondents may have overstated community benefit by including bad debt and Medicare shortfall, whereas others may have understated community benefit values by omitting Medicaid shortfall and subsidized services. Also, some hospitals reported values based on charges (rather than costs), and the sample of the 489 hospital organizations that responded to the survey may not be representative of the not-for-profit sector as a whole.

IRS COMPLIANCE OVERSIGHT

The Hospital Compliance Project Final Report notes that in the future IRS inquiries will focus on (i) the accuracy of the costing methodologies hospitals use to measure community benefit, (ii) medical research funded by for-profit organizations or not made widely available, (iii) amounts reported as bad debt attributable to charity care, (iv) treatment of portions of Medicare shortfall or community building as community benefit, and (v) review of the non-quantifiable

aspects of community benefit. These next steps suggest that the IRS is focused on improving the information it routinely collects to assess hospital compliance and may signal future changes in Schedule H reporting requirements.

The extent to which the improved information gathered through Schedule H results in increased regulatory intervention remains to be seen. Better information on normative practices and variation from those norms will more clearly identify outlier organizations. Theoretically, such information could be used to trigger audits and examinations to monitor compliance with current policies. During the five-year period 2001 to 2006, IRS audits of not-for-profit hospitals did not examine community benefit activities.⁷ The IRS has not announced any plans to increase the frequency of community-benefit related audits, and observers are unsure whether Schedule H reporting will lead to an increase in compliance checks by IRS regulators.

Officials at the state and local level may also use Schedule H data to increase their own regulatory efforts. In general, state and local officials have been more active than federal regulators in stipulating requirements for hospital tax exemption and enforcing compliance with those requirements. While a number of states have established their own community benefit reporting requirements, these mandates vary significantly across states.⁸ Schedule H will enable a new level of state-to-state comparison, and findings may encourage state and local officials to exercise their regulatory powers even further.

Whether possible enhancements in oversight will lead to future revocations of hospitals' tax-exempt status at the federal level remains highly speculative. The IRS has never revoked a hospital's tax-exempt status based on failure to meet the community benefit standard. Such revocation is the only regulatory penalty that can be imposed, as intermediate sanctions (such as fines or excise taxes) cannot be applied in cases where a hospital fails to demonstrate that it is operating in a manner that furthers its charitable purpose.

Some wonder whether Schedule H reporting will force the IRS to make more fundamental changes to the community benefit standard. Individual audits and examinations have the potential to result in future revenue rulings regarding community benefit expectations. It is important to remember that the flexible community benefit standard currently in force resulted from an administrative policy change undertaken by the IRS. Prior to 1969, the provision of charity care was a

clear test for demonstrating whether tax-exempt hospitals were operating in a manner consistent with their charitable purpose. Returning to a standard for hospital tax exemption more explicitly based on charity care could potentially be achieved through a future revenue ruling without legislative mandate.

IRS officials have raised thoughtful questions regarding the role the agency should play in revising the community benefit standard. In remarks made before the Office of the Attorney General of Texas on January 12, 2009, Steven Miller, IRS Commissioner for Tax Exempt and Government Entities, suggested that refinements to the community benefit standard may need to be considered, but questioned whether the IRS was the right organization to make those refinements.⁹ “[I]s the IRS in the best position to decide whether and how to change the current exemption standard? Do we have the requisite expertise? Do we have sufficient perspective to foresee how our changes might promote—or inadvertently frustrate—much broader health policy goals and changes that will soon be the subject of vigorous debate?”

THE COMMUNITY BENEFIT STANDARD AND FEDERAL STATUTE

Sen. Grassley has indicated his intent to introduce legislation early in 2009 to create a more specific, stringent standard for hospital tax exemption. Based on a staff discussion draft document released by the Senate Finance Committee in July 2007,¹⁰ Sen. Grassley is considering reforms that would create a “bright line test” for hospital tax exemption. The policy options outlined in this discussion draft include requiring all 501(c)3 hospitals to adopt a clear charity care policy, establishing a minimum charity care eligibility threshold at 100 percent of federal poverty level, and mandating that hospitals devote at least 5 percent of their operating revenues or expenses (whichever is greater) to charity care.

The draft also proposes creating a more flexible alternative tax-exempt status for hospitals under 501(c)(4) of the Internal Revenue Code that would be broadly analogous to the current community benefit standard and would require that 5 percent of operating revenues or expenses be devoted to community benefit activities. Hospitals exempt under 501(c)4 would be exempt from federal income tax, but would not be eligible for tax-exempt bond financing, and

financial contributions to these organizations would not be tax-deductible for donors. The draft also proposes establishing special rules for joint ventures with non-exempt partners, including specific charity care policies for joint venture services.

Securing broad support for these plans in Congress may be challenging, and Sen. Grassley has acknowledged that some modifications to his proposal may be warranted.¹¹ Although a number of state governments have enacted or are considering stricter, charity-care based standards for property tax exemption, historically federal policymakers have been reluctant to create a legislatively defined standard for hospital tax exemption. Current economic conditions and related health reform proposals might overcome, or harden, this reticence.

Sens. Grassley and Bingaman (D-NM) unsuccessfully proposed amendments to the economic stimulus bill to improve monitoring of hospitals' charity care. One amendment would have required the Centers for Medicare & Medicaid Services (CMS) to coordinate with the IRS and the Medicare Payment Advisory Commission to develop uniform definitions of charity care and uncompensated care. The other would have required the IRS to study differences in operation between for-profit and not-for-profit hospitals. The Hospital Compliance Project Final Report suggests that the IRS concurs with the need to learn more about the charity care and uncompensated care activities of for-profit hospitals, but does not provide detailed plans for such study.

While legislative activity related to hospital community benefit could precede the release of reports on Schedule H data, some policymakers may advocate for deferring major policy change until the data can be analyzed. The magnitude of hospitals' community benefit expenses, particularly for those activities clearly labeled as such under Part I of Schedule H, could significantly influence the prospects for legislative activity on the hospital community benefit standard. High normative community benefit costs with a narrow distribution around the median might obviate the perceived need for congressional intervention. Conversely, if the field as a whole exhibits an anemic community benefit contribution—or if wide deviations are seen across institutions—policymakers may feel compelled to establish a more exacting standard for bestowing tax exemption to hospitals.

Historically, federal policymakers have been reluctant to create a legislatively defined standard for hospital tax exemption.

The availability and utility of Schedule H data for health policymakers remains unclear. Complete data is not expected until late 2010 because hospitals can file based on the close of their fiscal year 2009, rather than the calendar year. It may take even longer for data to be aggregated for broader analytic purposes. Furthermore, methodological concerns surrounding differences in provider types, variations in cost accounting methods, and offsetting revenue exemptions¹² could obscure meaningful variation across filing organizations and may make the data sub-optimal for health policy decision making. Skeptics are concerned about data quality, particularly in the early years of Schedule H reporting.

HOSPITAL CHARITY CARE AND DEBT COLLECTION PRACTICES

Some observers speculate that hospitals may seek to preempt federal statutory or regulatory actions to tighten hospital community benefit requirements by proactively implementing more generous charity care and debt collection practices. The clear distinction between bad debt and charity care under Schedule H reporting may prompt some hospitals to either be more rigorous in implementing their current charity care policies or to adopt more inclusive eligibility standards for charity care.

Although the IRS has not taken a firm position on whether bad debt will be treated as a community benefit, hospitals' reliance on bad debt as a contribution toward community benefit may prove risky. Schedule H invites hospitals to make a case for such inclusion and explicitly asks hospitals to estimate what proportion of their bad debt should be considered community benefit and to provide a rationale for this estimate. However, in reporting reasons why portions of bad debt should be considered community benefit, hospitals will likely raise questions regarding the exclusiveness of, and documentation burdens associated with, their charity care eligibility policies. If large portions of bad debt are attributable to low-income populations, regulators may ask why the hospital has not instituted more generous eligibility criteria or less onerous determination procedures. These questions are particularly likely if the filing organization has low charity care expenses (measured as a percentage of total operating cost) relative to other hospitals.

Hospitals may wish to avoid such a situation by proactively revising their charity care policies in advance of Schedule H reporting. Anecdotal evidence suggests that some hospitals are reviewing their charity care eligibility criteria and determination processes to determine the extent to which they conform to peers and appropriately reflect their own financial resources. Others have already undertaken careful review of these policies, and still others are only just beginning to explore the implications of Schedule H reporting.

Reporting requirements at the state level may already have triggered such changes for some providers. State community benefit reporting laws appear to increase the level of uncompensated care provided by tax-exempt hospitals.¹³ This effect appears most pronounced in states that have established minimum charity care or uncompensated care requirements, rather than merely requiring hospitals to disclose the levels of charity or uncompensated care provided.

Although much attention has been given to the monetary valuation of charity care and the income criteria hospitals use to establish eligibility for such care, Schedule H reporting is also likely to create a renewed focus on debt collection practices, particularly as they relate to low-income persons who are potentially eligible for charity care. Hospitals have faced criticism in recent years regarding the prices charged uninsured patients and the aggressive collection practices used to pursue the high levels of debt incurred. Patient advocacy groups, such as Families USA, the Hospital Debt Justice Project, and Community Catalyst, have been vocal in raising concerns that these practices conflict with the community benefit obligations of not-for-profit hospitals, and several states have passed legislation or taken regulatory action to ensure fair billing and collection practices. Congressional staff have also considered proposals to limit what tax-exempt hospitals can charge uninsured or underinsured low-income patients, pegging such charges to Medicare or prevailing private insurance rates.

A desire to minimize challenges may prompt hospitals to revise their debt collection policies and practices before this information is reported to the IRS. Schedule H reporting covers only limited information regarding debt collection practices, but responses may leave hospitals vulnerable to regulatory action, negative media coverage, or public backlash if they appear “uncharitable” relative to industry

State community benefit reporting laws appear to increase the level of uncompensated care provided by tax-exempt hospitals.

Increased transparency may prompt some hospitals to be more generous in their charity care policies, it could also influence others to voluntarily relinquish their tax-exempt status and convert to for-profit organizations

norms. Schedule H seeks only yes/no responses regarding compliance with guidance provided by the Healthcare Financial Management Association (HFMA) on record keeping, valuation, and disclosure of charity care and bad debts—and asks for descriptive information regarding special collection provisions applied to patients potentially eligible for charity care. Hospital representatives submitting comments to draft versions of Schedule H sought clarification that failure to adopt HFMA recommendations (known as “Statement 15”) would not result in an increased audit risk. The IRS did not include such language in the final form, but did specify that compliance with HFMA recommendations was not obligatory.

Schedule H reporting will allow for an unprecedented ability to compare hospitals’ charity care policies and community benefit contributions relative to one another and promises to put “outlier” organizations in a position that may be difficult to defend. While this increased transparency may prompt some hospitals to be more generous in their charity care policies, it could also influence others to voluntarily relinquish their tax-exempt status and convert to for-profit organizations. Currently, there is no evidence that hospital conversions are increasing in advance of the new reporting requirements. Schedule H is unlikely to be the sole driver behind future conversions, but some observers speculate that reporting pressures could be a decisive factor for institutions that might be considering conversion for other reasons.

CONCLUSION

How much community benefit is enough? Future regulatory and legislative activity on hospital community benefit will ultimately be driven by assessments of whether the contributions reported through Schedule H are adequate. Although Schedule H does not fully resolve the “in” or “out” classification of contested activities, the reporting it requires will provide a much clearer picture of not-for-profit hospitals’ financial commitment to community benefit activities. However, Schedule H was not designed to determine what level of commitment *should be* exhibited or even if a monetary standard is appropriate.

These questions remain the purview of regulators and policymakers. Historically, these issues have been resolved implicitly, in the absence of measurable norms or benchmarks.

Schedule H promises to shift the policy debate in a more concrete, quantifiable direction. Should community benefit obligations reflect normative policies or financial commitments across the not-for-profit hospital sector? Should these norms be tied to national, regional, state, or local experiences? To what extent should the uncompensated care burdens of for-profit and public hospitals that will not file Schedule H be considered? Are annual operating revenues or expenses the appropriate base against which community benefit investments should be weighed, or are organizational assets a better basis for gauging the adequacy of community benefit? Should community benefit expectations be tied to an empiric valuation of the financial advantages enjoyed by tax-exempt hospitals rather than normative experience? Alternatively, are monetary measures the best way to gauge charitable intent?

Schedule H may prompt change in the approach hospitals, regulators, and policymakers take to considering community benefit, but the time horizon for such a shift is highly uncertain. Schedule H promises to provide a significantly enhanced evidence base for decision-making, increase the visibility of those decisions, and may create incentives for greater collaboration among providers. While the information gleaned from Schedule H will be revealing, Schedule H reporting is unlikely to provide a definitive resolution to the debate surrounding hospital community benefit expectations. As negotiations around broader national health reform unfold, Congress will likely continue to grapple with the role tax-exempt hospitals should take in providing health care services to the poor.

ENDNOTES

1. Sen. Chuck Grassley, "IRS Report on Tax Exempt Hospitals," memorandum to reporters and editors, February 12, 2009; available at <http://finance.senate.gov/press/Gpress/2009/prg021209a.pdf>.
2. The National Health Policy Forum publication, "What Have You Done for Me Lately? Assessing Hospital Community Benefit" (Issue Brief No. 821, April 19, 2007; available at www.nhpf.org/library/details.cfm/2560) provides a more detailed summary of the federal and state policies guiding hospital tax exemption and how these policies have evolved since the passage of Medicare and Medicaid in 1965.

3. The National Health Policy Forum publication "Schedule H: New Community Benefit Reporting Requirements for Hospitals" (Background Paper No. 67, April 21, 2009) provides a detailed summary of the information to be collected through Schedule H and highlights key methodological guidance provided by the IRS in instructions to filers.
4. Internal Revenue Service (IRS), IRS Exempt Organizations (TE/GE), Hospital Compliance Project, Final Report, February 2009, p. 98; www.irs.gov/pub/irs-tege/frephosproj.pdf.
5. Government Accountability Office, "Nonprofit Hospitals: Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements," GAO-08-880, September 2008; available at www.gao.gov/new.items/d08880.pdf.
6. IRS, IRS Exempt Organizations (TE/GE) Hospital Compliance Project Final Report.
7. Sen. Chuck Grassley, "GAO on non-profit hospitals," memorandum to reporters and editors, October 14, 2008; available at <http://finance.senate.gov/press/Gpress/2008/prg101408.pdf>.
8. See table 1 in "Schedule H: New Community Benefit Reporting Requirements for Hospitals," p. 16.
9. Steven T. Miller, "Charitable Hospitals: Modern Trends, Obligations and Challenges," remarks before the Office of the Attorney General of Texas, January 12, 2009; available at www.irs.gov/pub/irs-tege/miller_speech_011209.pdf.
10. Senate Finance Committee, Minority Staff, "Tax-exempt Hospitals: Discussion Draft," staff document; available at <http://finance.senate.gov/press/Gpress/2007/prg071907a.pdf>.
11. Sen. Chuck Grassley, "Prepared Remarks On Charities and Governance," delivered at Buchanan Ingersoll & Rooney, Washington, DC, March 10, 2009; available at <http://finance.senate.gov/press/Gpress/2009/prg031009a.pdf>.
12. See the "Methodological Concerns" section of "Schedule H: New Community Benefit Reporting Requirements for Hospitals," p. 21.
13. Fred Joseph Hellinger, "Tax-Exempt Hospitals and Community Benefits: A Review of State Reporting Requirements," *Journal of Health Politics, Policy and Law*, 34, no. 1 (February 2009): pp. 37–61; available by subscription at <http://jhppl.dukejournals.org/cgi/reprint/34/1/37>.