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I am Keith Hearle, President of Verité Healthcare Consulting. Thank you for inviting me to participate in this Round Table.

In 1989, I designed the accounting framework for the Catholic Health Association's *Social Accountability Budget*, which provided the first comprehensive guidance for hospitals to help them plan and account for their Community Benefits.

I recently helped CHA update the accounting framework and the original Worksheets, and continue serving as a resource to help respond to the challenging question: "What should count as community benefit?" With a few changes, the IRS used the CHA accounting Worksheets in its draft form 990.

I also have worked with the HFMA Patient Friendly Billing Project to develop resources to help hospitals update their charity care policies, and currently assist several leading tax-exempt health care systems with community benefit reporting and planning, and to assess their strengths and weaknesses from a community perspective.

I helped several national hospital associations—CHA, the National Association of Children's Hospitals, and the Association of American Medical Colleges—develop their

responses both to your *Discussion Draft* and to the draft IRS 990. But today I'm here as an independent policy analyst.

I'll provide my views on two issues:

- First, the need for federal legislation at this time and
- Second, what should be counted when qualifying hospitals for exemption under 501(c)(3).

For several reasons I think the time is not right for federal legislation.

1. Many hospitals and health systems are implementing voluntary efforts to enhance their charity care policies and the benefits they provide communities. It's not uncommon for there now to be a Senior Director or Senior Vice President of Community Benefit at health systems, giving more voice to community and population health perspectives in decision making and strategy. Educational sessions sponsored by CHA, state hospital associations, and others now are almost always sold out.
2. Data received by the IRS in response to the new 990 will improve the fact base regarding need for legislation. It will take time to analyze that data.
3. Hospitals and health systems themselves are establishing quantitative thresholds for community benefit: based on the value of the tax benefits they receive as exempt organizations or requirements in their state.

4. The proposals in the Discussion Draft may create unintended consequences for some types of organizations, like children’s hospitals that depend on philanthropy that would be lost if they no longer qualify under 501(c)(3). Because of federally-supported coverage expansions, children’s hospitals typically report comparatively low amounts of charity care. However most provide: substantial services for children who are low-income Medicaid recipients, and significant health professions education, research and prevention programs – that under one proposal would not count towards exemption under 501(c)(3).
5. Lastly, states are moving to implement charity care, billing and collection, and community benefit requirements that reflect state and local health care markets and needs. I would point to California AB 774 as a good example of this trend.

If momentum behind these efforts stalls, then federal legislation may be warranted.

What Should be Counted

A number of questions have been raised regarding which hospital programs and services should be counted when considering exemption. For example:

- Should anything beyond charity care count in qualifying for 501(c)(3) status?
- If yes, should that include “community building”, Medicare losses and bad debt costs?

I've been advising that to count as community benefit, a service or program should accomplish at least one of three objectives. It should:

1. Explicitly address a documented community need or health status Problem¹,

such as

- A. Improving access to health services for vulnerable people (with demonstrated or well known difficulty getting access to care) or
 - B. Enhancing population (public or community) health
2. It should advance knowledge (through educating health professionals or supporting research that benefits the public); or
 3. It should otherwise demonstrate charitable purpose, by being more evident in tax-exempt hospitals than in their taxable counterparts.

Note that these objectives also are policy priorities that receive federal support: improving access, enhancing public health, and advancing knowledge.

Programs that should not be counted as community benefit are those that primarily:

1. have a marketing focus designed to generate referrals; or
2. are not broadly available to all who need them; or
3. represent a normal "cost of doing business"; or

¹ This is one of the main reasons why hospitals should have access to a community needs assessment prepared within the last 3-4 years

4. are associated with the current standard of care.

When I apply this framework, I conclude that:

- Community benefit is more than charity care
- “Community building” programs should be counted
- And the answers for counting Medicare and bad debt are: “not yet” and “no”.

When it comes to Medicare, I strongly advise that Congress ask for input from the Medicare Payment Assessment Commission as well.

My written supplement provides more details regarding these conclusions. I look forward to participating in the question and answer session. Thank you.