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I am Keith Hearle, President of Verité Healthcare Consulting, LLC. 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've continued to work with CHA in recent years, by updating its community benefit accounting framework and the original Worksheets, and serving as a resource to help respond to the challenging question of "What should count as community benefit?" With a few changes, the IRS used the accounting Worksheets in its draft form 990.

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

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

Colleges—develop their responses to your *Draft* and to the draft IRS 990. Today, however, I am speaking as an independent policy analyst.

I would like to comment briefly on two overall issues raised by the *Draft*.

- First, the need for legislation to change requirements for federal income tax exemption, and
- Second, what should be counted when qualifying hospitals for 501(c)(3).

The Need for Legislation

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

- 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 special voice to community and population health perspectives in decision making and strategy. Educational sessions sponsored by CHA, state hospital associations, and other organizations on community benefit now are sold out.
- Data received by the IRS in response to the new 990 will improve the fact base regarding the need for future legislative efforts. It will take time to analyze that data.

- 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, requirements in their state, and other metrics.

- Without a careful but appropriate definition of what should be counted towards qualifying for exemption, there may be unintended consequences for some types of organizations, like children's hospitals that unique depend on philanthropy that would be lost if they no longer qualify under 501(c)(3). Because of federally-supported coverage expansions under Medicaid and SCHIP, children's hospitals typically report little charity care. However most provide: substantial services for children who are Medicaid recipients, health professions education and research, and prevention programs.

If momentum behind voluntary 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:

- Should community benefits beyond charity care count in qualifying for 501(c)(3) status?

- If yes, should "community building", Medicare losses and bad debt costs be considered community benefit?

In my work around the U.S., I've been advising that to count as community benefit, a service or program should accomplish one of three objectives. It should:

1. Explicitly address a documented community need or health status Problem[1], such as
    A. Improving access to health services for vulnerable people (with demonstrated or well known difficulty getting access to care)
    B. Enhancing population (public or community) health
2. Advance knowledge (through educating health professionals or supporting research that benefits the public); or
3. Otherwise demonstrate charitable purpose, by (for example) being more prominent in tax-exempt hospitals than their taxable counterparts.

All of these objectives are public policy priorities that receive federal support: improving access, enhancing public health, advancing knowledge, and leveraging activity of government.

Similarly, programs that should not be counted as community benefit have the following characteristics:

[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

1. The program has a marketing focus, for example designed to generate referrals principally to the hospital versus community-wide resources; or
2. The program is not broadly available to all who need it, e.g., Continuing Medical Education program only for the hospital's medical staff rather than all licensed physicians in the area; or
3. The activity represents a normal "cost of doing business" or is associated with the current standard of care.

When I apply this framework, I conclude that:

- More than charity care should count towards qualifying hospitals for exemption under 501(c)(3).
- "Community building" programs should be counted.
- And the answers for Medicare and bad debt are "not yet" and "no".

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