

The IRS currently is developing Instructions for the new 990, including Schedule H (released December 19, 2007). The Instructions should be available for public comment in March 2008 and will clarify many important questions. Even before the Instructions are available, there are 12 initiatives that hospitals can consider implementing to help get ready.

1. Senior management and Board should review the new 990, including Schedule H, and become educated on the new requirements.

The 990 has been transformed from a document with few hospital-specific requirements to one that will provide the IRS and the public much more transparency into charity care policies, community benefit, needs assessment, and other practices increasingly expected of tax-exempt organizations. Boards should study the new requirements, take an active role as part of their compliance and fiduciary responsibilities, and understand how the public will interpret the hospital's results.

2. The finance office should study the CHA community benefit accounting framework, because this framework is the foundation for the financial disclosures required in Schedule H.

The Catholic Health Association published *A Guide for Planning and Reporting Community Benefit* in May 2006¹. Chapter 4 discusses recommended accounting principles and approaches for community benefit, and the *Guide* includes worksheets based on those principles. Key components of Schedule H are based on those worksheets and accounting methods. While changes to that framework are forthcoming², understanding its underlying principles will help hospitals get ready.

¹ <http://www.chausa.org/Pub/MainNav/ourcommitments/CommunityBenefits/Resources/TheGuide/>

² Changes to the CHA Accounting Framework are forthcoming, due to input from the Association of American Medical Colleges (education and research), an effort to align charity care accounting with Statement 15, and to align the framework with Schedule H requirements.

3. The finance office should study HFMA Principles and Practices Board Statement 15, which discusses accounting and policies for charity care and bad debt.

Statement 15 clarifies that charity care represents revenue forgone by policy, while bad debt is created when revenue was expected (reasonably assured) but not collected. The Statement also discusses when decisions should be made, and documentation needed to grant financial assistance.

It indicates that revenue should not be accrued unless there is reasonable assurance of payment, and states “AICPA ... believes healthcare providers inappropriately classify some items as bad debts that were never revenue in the first place.³”

Schedule H asks whether the hospital reports bad debt expense in accordance with Statement 15. Hospitals should consider adopting Statement 15, so the response in 990 H can be “yes” (or if “no”, an explanation can be provided in Part VI of the form).

4. The hospital should review financial assistance policies (including discount levels) and charity care accounting methods against community standards and best practices.

Many hospitals recently have updated their financial assistance policies. Many policies grant free care for patients with household income between 0 and 200 percent of Federal Poverty Guidelines (“FPG”), and discounts are provided for patients up to 400+ percent of FPG, for medically indigent consumers, and to “underinsured patients” who receive assistance with co-pays and deductibles. Schedule H will allow simple comparisons between each hospital’s policies with those of others in the community, the state, and the U.S. Each hospital should know how they compare.

There remains great variation in charity care accounting methods. For now, Schedule H will value charity care based on the amount of charges forgiven pursuant to financial assistance policies, converted to cost.

³ HFMA Principles & Practices Board, Statement 15.

However, Schedule H may provide hospitals the option to report charity care based on Statement 15. Statement 15 values charity care as: the *total cost* of care for patients who received assistance minus *any revenue* anticipated from the patient and any third-party payers. This means only those accounts where costs are greater than revenue are considered charity. Thus, if a hospital grants a 50 percent discount, but cost is lower – (i.e., the ratio of cost to charges is .50 or lower), under Statement 15 charity is not being provided.

5. The hospital should develop a preliminary methodology to answer specific questions such as, "how much bad debt expense was attributable to patients eligible under the organization's charity care policy?"

The CHA community benefit framework never has considered bad debt to be community benefit. Some hospitals advocated to include bad debt in part because they indicated that portions of bad debt expense result from numerous low-income consumers who have not provided documentation (or applications) needed to qualify them for financial assistance (or government health benefits). In response, the IRS included the above question. This is one of the most difficult and riskiest questions to answer. For the first time, hospitals will need a methodology to place a dollar value on the subset of bad debt they incur for low-income patients. Hospitals with material amounts of bad debt for patients who could (or should) have received financial assistance may want to consider adjusting their policies (to relax documentation requirements, allow patients to qualify as “presumed indigents”, and/or integrate findings from technology solutions).

Whatever methodology is adopted will need to be explained in Part VI.

6. Immediately begin an inventory of activities and programs that satisfy "what counts" criteria.

Hospitals that have been reporting community benefit for some time should review their programs to assure they represent true community benefit. Schedule H instructions are likely to include examples and principles to guide this process. CHA has a growing array of tools and materials available on its website to help hospitals sort out “what counts” as community benefit.

Hospitals that never have reported community benefit are advised to start developing an inventory of programs that can be counted and documented on Schedule H: community health improvement, community benefit operations, education, research, subsidized health services, fund raising activities, and others. While conducting the inventory, also obtain information on the resources going into each (e.g., staff hours and supplies), how many persons are served, and documentation about why the program should count as community benefit.

7. Assess available software tools, both to help qualify patients for Medicaid and/or financial assistance and to capture and report community benefit information.

Software tools, such as the Community Benefit Inventory for Social Accountability (CBISA)⁴, are available to help document and report community benefit. The time is right to assess these tools, which will be updated to provide documentation needed for Schedule H.

Other tools are available to help determine patient ability to pay, to identify available sources of third-party payment, and to streamline the revenue cycle for uninsured and underinsured patients. These tools can help establish patient ability to pay, and minimize uncompensated care – particularly bad debt for patients eligible for charity care.

8. Review all contracts and arrangements between the hospital and other entities, to assess whether documentation supports that community benefit is being provided.

From experience, many hospitals provide community benefit through contracts with other entities. Examples include: affiliation agreements with medical schools (which include education costs, research support, explicit medical school support, and frequently also payments for indigent care), contracts with hospital-based and other physicians (to support charity care they are providing), and joint venture agreements. If community benefit is being provided through these

⁴ CBISA was developed by Lyon Software in partnership with CHA and VHA Inc.

arrangements, contracts should segregate and specify such activities, improving the “audit trail” for amounts reported in Schedule H.

9. Identify questions for which the hospital may not have satisfactory answers (e.g., how do you assess community needs) and develop plans for these areas.

While reviewing Schedule H, if your response to any question is “I don’t know”, then planning that would lead to specific answers is warranted.

For example, one question asks how the hospital assesses community health care needs. Hospitals that have conducted or participated in needs assessments can answer this question readily. Others can obtain needs information from local health departments. Those that never have assessed community health care needs (or whose assessments are outdated) can access resources that have been organized by the Association for Community Health Improvement (ACHI) on a newly published website and/or initiate the assessment process.

10. Develop an overall work plan that is ready to "execute" upon issuance of draft Instructions.

Once the Instructions are issued, several open questions will be addressed. For example, how community benefit provided by joint ventures should be included in Schedule H. Having a work plan that indicates the role to be played by key staff (e.g., legal, finance, compliance, community benefit, and executive staff) and Board members will be helpful. Watch for guidance from the newly-formed 990 Coalition for Hospitals, the Catholic Health Association, and others for tasks and elements to include in work plans.

11. Consider on a preliminary basis whether to complete the full Schedule H for Tax Year 2008, to use 2008 as an internal "Dry Run", or to wait for the Tax Year 2009 filing.

Most Schedule H requirements are optional for Tax Year 2008. Only two are optional thereafter. Hospitals can fill out Schedule H for 2008 and then decide later to submit all or only portions of requested information. The 2008 Tax Year thus can serve as a “dry run”.

12. Organize and if necessary obtain outside resources to help with the new requirements.

Consulting, law, tax, and accounting firms are studying the new requirements and are building expertise to help with needs assessment, accounting, charity care policies, and related matters. Watch for guidance from these firms, state and national associations, and the IRS in working to comply with the new requirements.

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The new 990 and Schedule H provide hospitals with an opportunity to document how they serve their communities, advance knowledge, and demonstrate charitable purpose. Planning can begin now, even before the Instructions are available for comment and review.