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strategies for accurate community benefit reporting

As tax-exempt hospitals prepare to complete Schedule H of the revised IRS Form 990, there are seven actions they should take to ensure they receive full credit for the community benefit they provide.

AT A GLANCE

Steps a hospital can take to ensure it receives full credit for the community benefit it provides include:

- > Ensuring that community benefit spending is reported as expense on the books of the organization that operates the hospital
- > Verifying that the ratio of net community benefit expense divided by total expense accurately depicts the organization's charitable activities
- > Reviewing all contracts and arrangements between the hospital and other entities to assess whether documentation supports that community benefit is being provided
- > Ensuring that "what counts" criteria are met

Schedule H of the new IRS Form 990 requires detailed reporting of the community benefit hospitals provide. There are several strategic approaches hospitals can take in completing Schedule H to ensure they receive full credit for the community benefit they provide.

Issues to Consider When Completing Schedule H

Community benefit activities and programs are designed to address identified community health-related needs as well as to improve access to health services, enhance public health, advance knowledge through education and research that provide public benefit, and relieve government burden (instructions for Schedule H, IRS Form 990). To achieve these objectives, a strategic approach to needs assessment, program development, and program management is important.

The accounting framework that underlies community benefit reporting on Schedule H is cost-based. The framework requires hospitals to report both total (gross) expense and net expense (total expense minus "direct offsetting revenue") and focuses on actual, auditable financial costs rather than opportunity costs (e.g., charges that could have been collected if charity had not been granted).

Direct offsetting revenue includes net patient revenue and other resources that should be matched to each program (because the revenue would not exist without the program, or vice versa). The one exception to this matching principle is restricted grant revenue. The IRS decided not to include any grant funds in direct offsetting revenue, whether or not the funds are restricted to a specified community benefit purpose.

Although a cost-based approach to community benefit reporting now is generally accepted, the accounting framework as implemented by IRS can yield comparative disadvantages for some types of organizations. Organizations should be particularly diligent in their approaches to community benefit accounting if they:

- > Are highly efficient or low-cost organizations
- > Lack good cost accounting information
- > Lack experience with grant funds
- > Operate multientity corporate structure(s) where portions of the organization's community benefit spending are not recorded on the books of the entity that files Schedule H

Community benefit includes Medicaid losses (net revenue minus cost), the shortfalls associated with “subsidized health services” (clinical programs that are operated at a loss because their communities need access to those programs), and losses incurred in operating health professions education programs. A highly efficient or low-cost hospital is likely to report lower losses for these programs. (Interestingly, low-cost hospitals may also report higher margins and may not only report lower community benefit, but also enjoy higher “tax benefits”—the amount of tax that would be paid if the organization were not tax-exempt—than high-cost hospitals.)

Organizations that lack good cost accounting information have fewer options for assigning costs to community benefit programs. The IRS accepted the principle that hospitals may use their *most accurate* cost accounting methods (including cost accounting systems) rather than requiring a standardized approach based on a “ratio of cost to charges” or on Medicaid cost reports. Organizations without cost accounting systems may also find it difficult to identify clinical programs that qualify as “subsidized health services.”

Some organizations have well-developed infrastructures in place to apply for and manage grant funds (e.g., National Institutes of Health research grants and charitable donations), while others have no experience with identifying and accessing these resources. Because the IRS decided not to include grant funds as direct offsetting revenue, those without grant experience also may be at a comparative disadvantage.

Corporate structures vary across health systems. For example, some hospitals include the function

For accurate reporting on Schedule H, hospitals should verify that the ratio of net community benefit expense divided by total expense accurately depicts the organization's charitable activities.

that donates or grants resources to community groups as a hospital department. For them, qualifying donations made to community groups can be reported as a *hospital* community benefit. Others have established foundations or corporate parents with their own, separate employer identification numbers (EINs). Donations made by such nonhospital entities would not be reported as a hospital community benefit (but could be discussed in Part VI of Schedule H). Significant variation also exists in how academic medical centers account for research and education spending. These costs could be “on the books” of the affiliated medical school(s), in a separately incorporated research or education institute, or within the hospital's accounts.

These and other types of organizations should work to avoid appearing like outliers when IRS and the public review and assess Schedule H filings. The strategies below can help achieve that objective.

Action Steps for Hospitals

Several strategies can be considered for achieving accurate, full community benefit reporting on Schedule H.

Ensure that community benefit spending is reported as expense on the books of the organization that operates the hospital(s). Many healthcare organizations operate in multicorporate structures (e.g., foundations, research institutes, education divisions, community clinics, or other areas of activity in corporations separate from the hospital). Community benefit reporting rarely, if ever,

was a significant criterion that influenced how these structures were developed. Two health systems can provide the same amount of community benefit, but the amounts they report on their Schedule H filings can vary simply due to differences in corporate structure.

As a result, finance staffs can consider several ways to account for existing community benefit programs on the books of the organization that operates the hospital(s):

- > Reintegrate education and research institutes or other functions with a substantive community benefit role back into hospital entities.
- > Make sure that any subsidization of the organization's education, research, or other community benefit activities occurs through donations made by the hospital, rather than other related entities (e.g., a system office or related foundation).
- > Shift responsibility for donations made to community groups to the hospital. For example, if a foundation or system office now makes these types of donations, have that entity make an unrestricted grant to the EIN that operates the hospital so it can donate the funds and report them as a hospital community benefit.
- > Allocate any system-office costs for community benefit operations (the costs of community benefit administrative staff, needs assessments, software) explicitly to hospital(s) so those costs can be reported on Schedule H.

Verify that the ratio of net community benefit expense divided by total expense accurately depicts the organization's charitable activities. The federal government has not established a quantitative threshold for the amount of community benefit that tax-exempt organizations with hospitals should provide. Nevertheless, Schedule H contains a metric likely to receive significant attention: net community benefit divided by total expense. The numerator and the denominator of this ratio thus become important.

Some organizations include activities such as home health, physician groups, pharmacy, laboratory, fitness centers within the corporate entity that also contains the hospital. Compared with

other core hospital programs, these activities may contribute more to the denominator than to the numerator of the ratio. Two similarly situated hospitals thus could appear to have different levels of commitment to community benefit simply due to where these activities are housed. Therefore, another strategy is to spin these activities out into a separate, nonhospital entity that would not file a Schedule H. That entity, however, will need to demonstrate that it deserves tax-exempt status on its own merits.

Review all contracts and arrangements between the hospital and other entities to assess whether documentation supports that community benefit is being provided. 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 possibly also subsidies for indigent care), contracts with hospital-based and other physicians (to help finance charity care and/or Medicaid services they are providing), and joint venture agreements. If community benefit is being provided through these arrangements, contracts should segregate and specify such activities, improving the "audit trail" for amounts reported in Schedule H.

Be sure that certain "what counts" criteria are met, so that spending can be reported on Schedule H.

The instructions to Schedule H include several criteria that must be met before community benefit activities and programs can be reported. The following six initiatives can help satisfy those criteria.

First, donations made by the Schedule H-filing organization should be restricted to a community benefit purpose. Schedule H instructions indicate that unless the organization formally restricts recipient use of donations to a specific hospital community benefit purpose (e.g., charity care, Medicaid services, health professions education, or public health oriented screenings), the amounts are not to be reported on Schedule H.

Second, community need should be established for each reportable program. Need can be established in at least three ways:

- > Showing that needs assessment was conducted or accessed by the organization
- > Documenting that the program originated from a request by a community group
- > Demonstrating that the program is operated in collaboration with government (e.g., a local health department) or an unrelated tax-exempt healthcare organization

In addition, community need for some programs can be established by showing that the public health problems they seek to address are generally accepted and/or well documented in the literature.

Third, the organization's clinical programs should be examined to discern which programs may qualify to be counted as "subsidized health services"—programs that require subsidization and for which community need clearly has been established, including programs with significant amounts of Medicare funding. This is one of the most underreported areas of community benefit.

Fourth, steps should be taken to ensure that community benefit is the primary purpose of education programs and that the programs are opened up to unaffiliated persons (e.g., inviting physicians who are not on the medical staff to participate in continuing medical education programs). Education programs that are restricted only to the organization's own employees or medical staff should not be reported, although an exception is made for interns and medical residents who typically are employees of the teaching hospital.

Fifth, establish the public benefit provided by research studies reported on Schedule H. The instructions indicate that only research funded by tax-exempt or government resources is to be reported in Part I of Schedule H. Publishing research results helps to validate public benefit. Industry-sponsored research studies can be described in Part VI of Schedule H filings if they provide public benefit in this manner.

Sixth, *programs* should be defined with due care. Consistent with Catholic Health Association guidelines, the instructions for Schedule H clarify that organizations should not report programs that are designed primarily to provide organizational benefit (e.g., marketing). This restriction raises questions about how organizations should define a program. For example, a broad, public-health-oriented diabetes health education program would be counted on Schedule H even if it has a small marketing component. Separating the marketing side of this service as a distinct program would disqualify it from being reported.

Include all reasonable indirect and direct costs on the organization's cost accounting for community benefit.

Community benefit measurement largely is an exercise in accurate cost accounting. The ratio of cost to charges included in the Schedule H instructions is designed to avoid double-counting various costs (e.g., health professions education in Medicaid services, and research costs in charity care). Several points should be kept in mind.

First, if the organization has a well-maintained cost accounting system, that system generally should be used, as it will include all costs rather than Medicare or Medicaid allowable cost, will incorporate a more accurate allocation of overhead, and will address double counting concerns more reliably. Second, rather than using "other operating revenue" in the ratio of patient care cost-to-charges (as a proxy for the cost of nonpatient care activities), effort should go to costing out the services that generate that revenue. Most likely, doing so will increase the ratio while also improving its accuracy. And third, both direct and indirect (overhead) costs should be included throughout the accounting. Indirect cost rates should be built up that can be applied reliably and accurately to programs located on the hospital campus and also off-site.

The "most accurate" community benefit accounting methods are not necessarily those that produce the highest costs, but those that are most defensible in the event of an examination (audit)

and that avoid some of the “double counting” challenges embedded in community benefit accounting.

Make sure your organization is identifying all reportable charity care. Four separate initiatives can help organizations accomplish this objective. One of these initiatives should focus on ensuring that charity care policies accurately and fairly consider the patient’s ability to pay. Increasingly, organizations are granting financial assistance to patients who are “medically indigent” because their out-of-pocket medical expenses exceed a specified amount of household income during the prior 12 months. Organizations also are granting assistance to patients who are “pre-sumed indigent” because they are homeless, qualify for another type of means-tested government program (e.g., supported housing), or have other characteristics indicative of inability to pay. They also are becoming more thoughtful about discounts offered to uninsured consumers, calibrating them to cost or to private or public payer reimbursement levels.

Another initiative should seek to verify that the accounting process properly recognizes revenue, bad debt expense, and charity care. HFMA’s Principles and Practices Board Statement 15: *Valuation and Financial Statement Presentation of Charity Care and Bad Debt by Institutional Healthcare Providers*, suggests that bad debt is overstated because “healthcare providers inappropriately classify some items as bad debts that were never revenue in the first place.” This occurs because these items were never truly collectible and thus should not have been recognized as revenue.

The goal of a third initiative should be to build a “patient friendly, well-managed, and efficient operational revenue cycle infrastructure that implements policy consistently.

Finally, a fourth initiative should consider the application of technologies that can help find eligibility for Medicaid and other third-party coverage, reduce charity care documentation requirements by researching medical credit score information, support reclassifying bad debt into charity care (if consistent with the organization’s charity care policy), and support the accounting and revenue recognition process.

A Thoughtful Approach Is the Best Strategy

Because only Part V of Schedule H must be completed for tax years beginning in 2008, organizations have time to consider a range of strategies for community benefit reporting. They also have time to further develop community benefit programs that make a difference. Organizations with effective community benefit programs and thoughtful reporting will be in the best position to get full credit for the community benefit programs they provide on Schedule H. ●

About the author



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