# Part I: The Montana Community Benefit Guidebook

## MONTANA COMMUNITY BENEFIT GUIDEBOOK BOOTCAMP

January 25, 2023

© 2023 PYA, P.C.

WE ARE AN INDEPENDENT MEMBER OF HLB—THE GLOBAL ADVISORY AND ACCOUNTING NETWORK

# Introductions

Debbie Ernsberger
Principal
dernsberger@pyapc.com

Mark Brumbelow
Managing Principal of Tax
mbrumbelow@pyapc.com

pyapc.com
800.270.9629

# Agenda

- The Why — Why Is Schedule H Important?
- What Is Community Benefit?
- How to Get Started
- Purpose of Schedule H Reporting and Tracking Community Benefit
- FAP Definitions, Specifics, and Requirements
  - % of FPG for patient care to qualify for free care/discounted medical care
  - Detail asset test and criteria used
  - Medically Indigent Care
- Definitions and calculations
  - Financial Assistance at Cost
  - Medicaid
  - Costs of other means-tested government programs

# What is Community Benefit?

- Free and discounted care to those unable to pay
- Care to Medicaid beneficiaries and other indigent care programs
- Services to improve community health and improve access to health care services
- Programs to advance medical and/or health knowledge
- Initiatives to relieve/reduce the burdens of government agencies

# The History of Community Benefit:

## IRS Guidance

- Charity Care Standard
  - The initial standard for receiving tax-exemption for a hospital:
    - Provide charity care
    - Not deny care to patients unable to pay for it

# The History of Community Benefit:

## IRS Guidance

- Community Benefit Standard – Established in 1969
  - Charity care standard replaced with community benefit standard
  - IRS Rev. Rul. 69-545
  - Community benefit standard requires a hospital to demonstrate that it operates to promote the health of a class of persons that is broad enough to benefit the community

# The History of Community Benefit:

IRS Guidance

- Rev. Rul. 69-545 defines the following factors as demonstrating community benefit:
  - Operating an ER open to all, regardless of the ability to pay
  - Maintaining a board of directors drawn from the community
  - Maintaining an open medical staff policy
  - Providing hospital care for all patients able to pay, including those served through Medicaid and Medicare
  - Using surplus funds to improve facilities, equipment, and patient care
  - Using surplus funds to advance medical training, education, and research

# The History of Community Benefit:

IRS Guidance

- Affordable Care Act (ACA) – Enacted March 23, 2010
  - Established IRC Section 501(r) requirements for tax-exempt hospitals:
    - Conduct a Community Health Needs Assessment every three years
      - Provides for input from community members
    - Develop an Implementation Strategy
    - Require adoption and approval by board
    - Establish written financial assistance policy (FAP)
    - Widely publicize the FAP
    - Establish written emergency medical care policy

# The History of Community Benefit:

IRS Guidance

- Affordable Care Act (ACA) – Enacted March 23, 2010
  - Established IRC Section 501(r) requirements for tax-exempt hospitals:
    - Establish limitation on charges
    - Establish/define reasonable efforts for eligibility assistance under FAP before engaging in extraordinary collection efforts
    - Prepare/submit Schedule H, Hospitals, with Form 990
    - Attach Audited Financial Statements with Form 990 for hospitals only

# IRS Approach to Enforcement

- If fail to meet requirements of IRC Section 501(r), tax-exemption may be jeopardized
- Potential penalty excise taxes
- Continuous compliance checks by IRS agents by review of organization's website

# Community Benefit Reporting:

IRS Guidance

- Reported on Schedule H, Hospitals, as part of annual Form 990
- Current IRS regulations require no community benefit threshold to maintain tax-exempt status
- IRS instructions provide general guidance
- No bright line test as to what is or is not community benefit for purposes of reporting categories of Schedule H

# Community Benefit Reporting Challenges

- Staffing and technology resource constraints
- Gathering data across multiple departments/facilities
- Involvement of multiple departments with differing levels of knowledge
- Lack of uniformity
- Left to interpretation
- Inconsistency of accumulating/reporting data
- Size of hospitals (beds/revenues)
- Types of hospitals (critical access hospital, children's hospital, rehabilitation, psychiatric, acute inpatient, rural vs. urban, etc.)

# MHA Project Approach

- Develop a guidebook specific to the hospitals served within Montana to define, document, and explain categories as reported on Schedule H, Hospitals, to:
  - Define and calculate community benefit expenses
  - Develop a process for gathering data
  - Develop a consistent measure of community benefit items
  - Provide opportunities for improvement and identification of items for inclusion

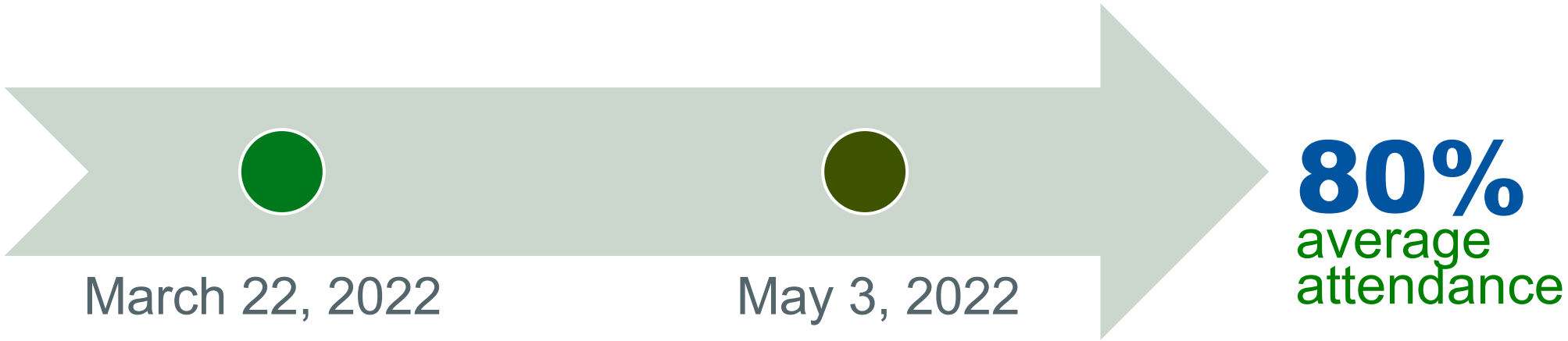
# Task Force Members

- Montana hospital representatives:
  - **April Keippel,** *Mission and Community Benefit Program Manager*
    *SCL Health MT – St. Vincent Healthcare*
  - **Brad Ludford,** *CFO*
    *Bozeman Health*
  - **Brian Hall,** *System Director of Finance*
    *Logan Health*
  - **Brigid Burke**, *CFO*
    *Cabinet Peaks Medical Center*
  - **Burt Keltner**, *CEO/Administrator*
    *Prairie Community Hospital*
  - **Carla Neiman**, *CFO*
    *Clark Fork Valley Hospital*
  - **Christie Delaney**, *Finance Project Analyst*
    *Sidney Health Center*
  - **Christina Andes**, *Director of Revenue Cycle*
    *Mountainview Medical Center*
  - **Denise Juneau**, *Chief Government and Community Affairs Officer*
    *Bozeman Health*
  - **Emily Isaacson**, *Controller*
    *Shodair Children's Hospital*
  - **Jenny Taylor**, *Controller*
    *St. Peter's Health*
  - **Jon Griffin, MD**, *Chief Medical Innovation Officer*
    *St. Peter's Health*
  - **Kaci Husted**, *Vice President of Communications & Business Development*
    *Benefis Health System*

# Task Force Members

- Montana hospital representatives:
  - **Kim Lucke**, *VP Finance*
    *Northern Montana Hospital*
  - **Linda Harris**, *Director of Foundation & Finance*
    *Beartooth Billings Clinic*
  - **Marjorie Losing**, *CFO*
    *Fallon Medical Complex*
  - **Merry Hutton**, *Regional Director Community Health Investment, Washington/Montana Region*
    *Providence St. Patrick Hospital & Providence St. Joseph Medical Center*
  - **Mindy Price**, *CEO*
    *Rosebud Health Care Center*
  - **Pam Palagi**, *VP of Finance Montana Region*
    *SCL Health MT – St. James Healthcare*
  - **Paul Keenan**, *Tax Director*
    *SCL Health System*
  - **Priscilla Needham**, *CFO*
    *Billings Clinic*
  - **Shari Hagengruber**, *Community Relations Coordinator*
    *St. Peter's Health*
  - **Tina Giem**, *CFO*
    *Barrett Hospital & Healthcare*

# Task Force Members




**80%**
average attendance

# Montana Community Benefit Survey

**46**
survey results received

**75%**
response rate

Survey questions related to:

- Charity care and financial assistance thresholds and criteria
- Procedures for tracking community benefit expenses
- Summary of activities reported within community benefit categories

# MHA Project Overview

- Review the following areas of Schedule H:
  1. FPG% specific to providing free care
  2. FPG% specific to providing discounted care
  3. Asset tests
  4. Discounts for the “medically indigent”
- Recommendations related to each area as best practices for Montana Hospitals
- Considerations related to the importance of capturing community benefit items
- Review of Community Benefit Guidebook

# Schedule H, Line 3a

**3** Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.

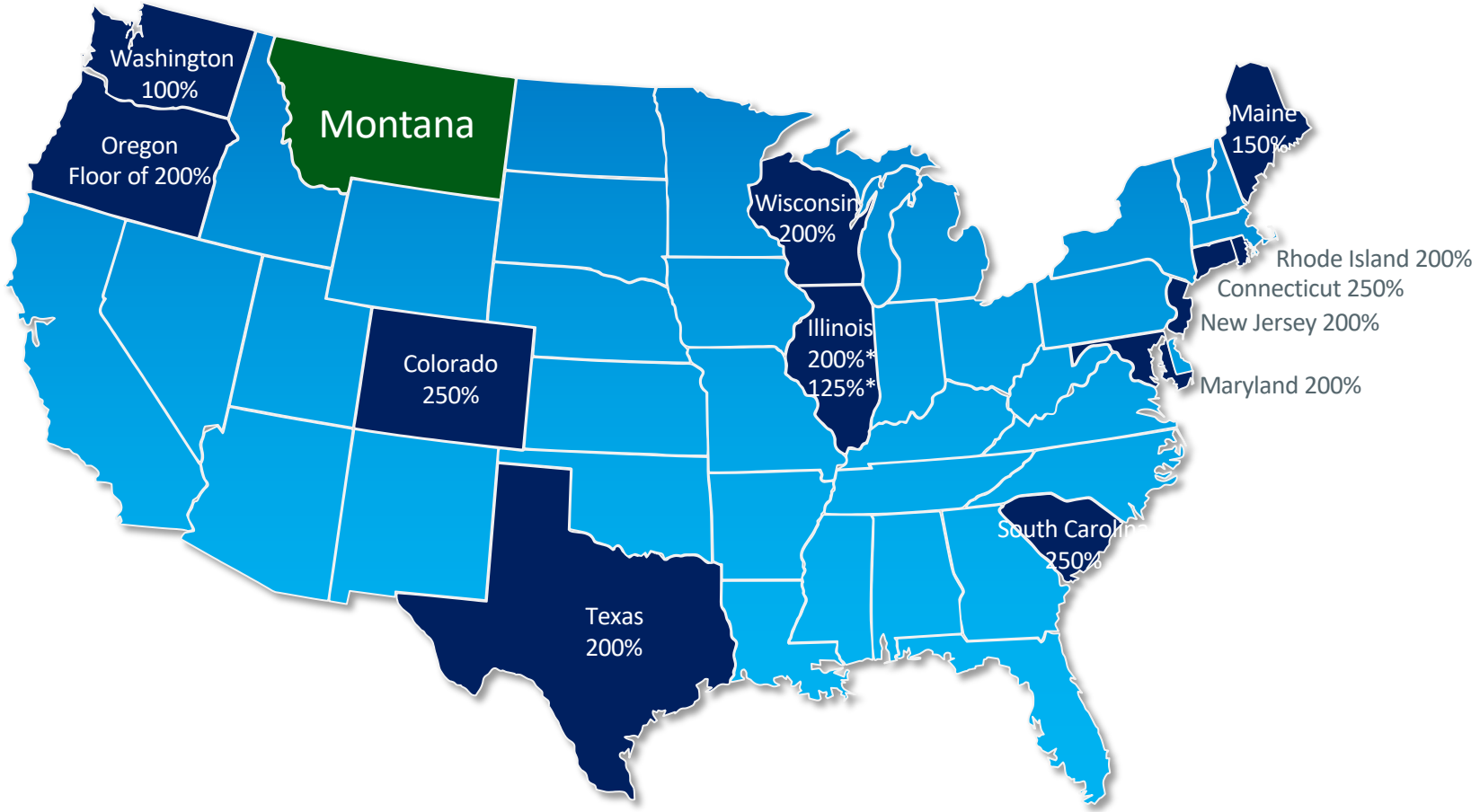
**a** Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care:

☐ 100% ☐ 150% ☐ 200% ☐ Other _____ %

| | | | |
|---|---|---|---|
| | | | |
| **3a** | | | |
| | | | |

# Free Care - Other Considerations

American Hospital Association – 200% of FPL




Colorado 250%
Connecticut 250%
Illinois 200%
**(other than rural and CAH)*
Illinois 125%
**(for rural and CAH)*
Maine 150%
Maryland 200%
New Jersey 200%
Oregon – floor of 200%
Rhode Island 200%
South Carolina 250%
Texas 200%
Washington 100%
Wisconsin 200%

# Free Care – Task Force Recommendations

- Hospitals consider a floor of 200% of FPL for free care.
- Hospitals that are above 200% maintain current standard.
- Increased focus on patient education and education of employees in patient registration.
  - Charity vs. bad debt

# Schedule H, Line 3b

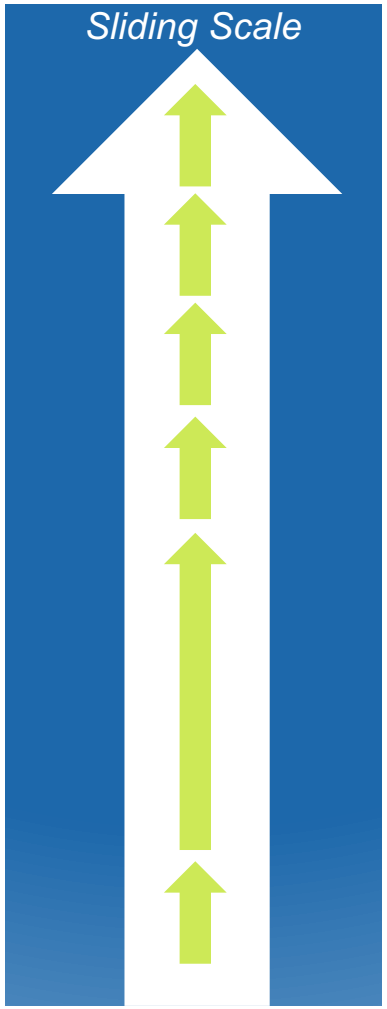
**b** Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: . . . . .

☐ 200% ☐ 250% ☐ 300% ☐ 350% ☐ 400% ☐ Other _____ %

| | | |
|---|---|---|
| | | |
| **3b** | | |
| | | |

# Discounted Care – Other Considerations

| | |
|---|---|
| Illinois | up to 600% |
| Maryland | up to 500% |
| Oregon | up to 400% |
| California | up to 350% |
| Rhode Island | up to 300% |
| New Jersey | up to 300% |
| New York | up to 300% |
| Washington | up to 200% |



# Discounted Care – Task Force Recommendations

**Up to 400%**
Sliding Scale

**$**
value thresholds to be determined by hospitals individually

# Discounted Care – Montana (Example Only)

2022 Federal Poverty Guidelines (FPG)

| Family or Household Size | 100% FPG | 200% FPG | 250% FPG | 300% FPG | 350% FPG | 400% FPG |
|---|---|---|---|---|---|---|
| | *Free Care* | *Free Care* | *80% Discount* | *70% Discount* | *60% Discount* | *56% Discount* |
| 1 | $13,590 | $27,180 | $33,975 | $40,770 | $47,565 | $54,360 |
| 2 | $18,310 | $36,620 | $45,775 | $54,930 | $64,085 | $73,240 |
| 3 | $23,030 | $46,060 | $57,575 | $69,090 | $80,605 | $92,120 |
| 4 | $27,750 | $55,500 | $69,375 | $83,250 | $97,125 | $111,000 |
| 5 | $32,470 | $64,940 | $81,175 | $97,410 | $113,645 | $129,880 |
| 6 | $37,190 | $74,380 | $92,975 | $111,570 | $130,165 | $148,760 |
| 7 | $41,910 | $83,820 | $104,775 | $125,730 | $146,685 | $167,640 |
| 8 | $46,630 | $93,260 | $116,575 | $139,890 | $163,205 | $186,520 |

# Schedule H, Line 3c

| | | |
|---|---|---|
| c | If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care. | |

# Asset Test –
## Proposed Task Force Recommendations

- For those hospitals with no asset test, recommend no changes are necessary.
- For those hospitals with an asset test, recommend that the policy specifically only consider assets easily convertible to cash, and unnecessary for the patients daily living.
- Do not allow the asset test to prevent an otherwise qualifying individual from receiving the appropriate charity care. This will generally lead to an increase in bad debts.

# Schedule H, Line 4

| | | |
|---|---|---|
| 4 | Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? . . . . . | 4 |

# “Medically Indigent” –

## Proposed Task Force Recommendations

Currently a vast majority of Montana Hospitals have a policy covering the “medically indigent”. Recommendation that all Montana Hospital’s adopt such a policy.

# “Medically Indigent” - Considerations

- Catastrophic costs or conditions occur when there is a loss of employment, death of a primary wage earner, excessive medical expenses or other unfortunate events.
- Medical indigence/catastrophic circumstances will be evaluated on a case-by-case basis that includes a review of the patient’s income, expenses, and assets.

# MHA Project Overview

- Considerations related to the importance of capturing community benefit items
- Development of Community Benefit Guidebook as a resource to Montana Hospitals to identify and inventory community benefits and provide for a standardization of accounting and reporting the information to the IRS and the public

# Community Benefit

- Why is reporting community benefit important?

# Community Benefit - In the News

- Community benefit in the news and analyzed:
  - Kaiser Health News
  - Oregon
  - North Carolina
  - Lown Institute

# Schedule H Reporting

**Table 2. Hospitals' total benefit to the community** (Percent of expense)

| Hospital Category | Financial Assistance And Certain Other Community Benefits | Community Building Activity | Medicare Shortfall* | Bad Debt Expense Attributable To Financial Assistance | Total Benefits To The Community |
|---|---|---|---|---|---|
| **All Filed Schedule Hs** (2,907 hospitals) | 10.5% | 0.1% | 3.1% | 0.3% | 13.9% |
| **DEMOGRAPHIC COMPARISONS** (1,931 individual hospitals) | | | | | |
| **Size** | | | | | |
| Small | 8.9% | 0.1% | 1.7% | 0.7% | 11.4% |
| Medium | 9.1% | 0.1% | 3.0% | 0.5% | 12.6% |
| Large | 10.9% | 0.1% | 2.8% | 0.3% | 14.1% |
| **Location** | | | | | |
| Rural | 7.9% | 0.1% | 1.5% | 0.6% | 10.1% |
| Urban/Suburban | 10.5% | 0.1% | 2.8% | 0.4% | 13.7% |
| **Type**** | | | | | |
| General Medical | 10.1% | 0.1% | 2.9% | 0.4% | 13.5% |
| Children's | 14.4% | 0.1% | 0.2% | 0.1% | 14.8% |
| Teaching Hospital | 10.7% | 0.1% | 2.6% | 0.3% | 13.7% |
| Critical Access Hospital Status | 9.0% | 0.1% | 1.0% | 0.6% | 10.7% |
| **System-Affiliation** | | | | | |
| Affiliated | 9.9% | 0.0% | 2.9% | 0.3% | 13.2% |

**Note:** Percentages may not sum to total percent due to rounding.

* Net shortfall (gross shortfall less surplus)

** A single hospital can be in more than one TYPE category

# Schedule H Reporting

- Per the American Hospital Association, total community benefit expenses of 13.9% were provided in 2019.
- Per the American Hospital Association, total community benefit expenses of 13.9% were provided in 2018.
- Per the American Hospital Association, total community benefit expenses of 13.8% were provided in 2017.

# Reporting Categories of Community Benefit

- Financial Assistance
- Medicaid
- Costs of Other Means-tested Government Programs
- Community Health Improvement Services
- Health Professions Education
- Subsidized Health Services
- Research
- Cash and In-Kind Contributions
- Community Building Activities

# Reporting Categories of Community Benefit

- Sources utilized:
  - 2021 IRS Form 990
  - 2021 IRS Form 990 Instructions
  - CHA, A Guide for Planning & Reporting Community Benefit, 2020 Edition
  - Community Benefit Reporting Form Instructions, State of Oregon v. 1/31/2022
  - PYA research and experience

# Schedule H, Line 7a

| 7 Financial Assistance and Certain Other Community Benefits at Cost | | | | | | |
|---|---|---|---|---|---|---|
| **Financial Assistance and Means-Tested Government Programs** | **(a)** Number of activities or programs (optional) | **(b)** Persons served (optional) | **(c)** Total community benefit expense | **(d)** Direct offsetting revenue | **(e)** Net community benefit expense | **(f)** Percent of total expense |
| **a** Financial Assistance at cost (from Worksheet 1) . . . . . | | | | | | |

# Schedule H, Line 7a

## Key items to include within this category:

- Financial assistance reported as costs, not charges.
- Costs of free care based on the organization's FAP.
- Costs of partially discounted care based on the organization's FAP.
- Provider taxes, assessments, fees associated with Medicaid DSH funds used entirely or partially to offset the cost of financial assistance.
- Taxes paid into a state high-risk pool (to obtain medical insurance coverage) to benefit the community in improved access to care.
- Costs associated with out-of-pocket amounts related to copayments and deductibles for those with Medicaid and other low-income patients. Organization's FAP should specifically provide for these costs as grants to assist underinsured patients.

# Schedule H, Line 7a

## Key items to exclude within this category:

- Bad debts.
- Uncollectible charges.
- Bad debts and/or uncollectible charges recorded as revenue and subsequently written off due to patient's failure to pay.
- Medicaid losses (reported elsewhere).
- Medicare losses (reported elsewhere).

# Schedule H, Line 7a

## Key items to exclude within this category:

- Discounts not described in the organization's FAP.
- Discounts provided to self-pay patients.
- Discounts provided to prompt pay patients.
- Discounts provided for services ineligible for financial assistance.
- Contractual adjustments with any third-party payers.

# Schedule H, Line 7a

- Direct offsetting revenue.
  - Generally, this amount will be zero.
  - Include any amounts received that are restricted for financial assistance use.

# Schedule H, Line 7b

# Schedule H, Line 7b

**Consider the following to include within the calculation:**

- Medicaid.
- Medicaid (fee for service).
- Medicaid, including managed care plans.
- Medicaid denied claims if patient was eligible and services are “medically necessary.”
- Uncollected Medicaid co-pays written off by the organization if in accordance with the FAP.
- Include from all states, not just from the organization’s home state.

# Schedule H, Line 7b

- Direct offsetting revenue.
  - Include all Medicaid net patient revenue, including fee-for-service and managed care from all states.
  - Medicaid Disproportionate Share Hospital payments.
  - Medicaid Delivery System Reform Incentive Payment.
  - Medicaid Indirect Medical Education reimbursement.
  - HUF Supplemental revenue  - matching of expenses and only associated revenue

# Schedule H, Line 7c

| | | | | | | |
|---|---|---|---|---|---|---|
| c | Costs of other means-tested government programs (from Worksheet 3, column b) . . . . | | | | | |

# Schedule H, Line 7c

**Consider the following to include within the calculation:**

- State Children's Health Insurance Program (SCHIP).
- Children's Health Insurance Program (CHIP).
- Other federal, state, or local health care programs.
- State or local programs intended for those qualifying based on income and/or assets.
- State and local indigent care programs for those individuals ineligible for Medicaid.
- Include revenues/expenses from all states, not just from the state in which is considered the home state.

# Schedule H, Line 7c

**Exclude from the calculation:**

- Medicare losses.
- Medicare shortfalls.
- CHAMPUS associated losses since not a means-tested public program.
- Veterans Administration since not a means-tested public program.
- Indian Health Service since not a means-tested public program.
- Any other government health care programs that are not means-tested.

# Schedule H, Line 7c

- Direct offsetting revenue.
  - State Children's Health Insurance Program (SCHIP), county indigent care programs and other government health insurance programs with eligibility based on household means.
  - Does not include Medicare, VA health benefits, TRICARE or other items for which eligibility is not on a means-tested basis.

# How Can We HELP?


A national healthcare advisory services firm providing consulting, audit, and tax services