

Coronavirus Pandemic and Community Benefit Reporting

By Keith Hearle, Verité Healthcare Consulting, LLC¹

The coronavirus pandemic is having **very significant** impacts on communities, patients, and the hospitals that serve them. Hospital finances (revenues, expenses, cash flows, and bond ratings) have been severely affected.

Questions have arisen regarding how pandemic-related expenses (and offsetting revenues) should be reported as community benefit. This document was prepared to help and to complement and supplement the instructions to Schedule H and other emerging community benefit reporting guidelines relating to the pandemic. The document:

- **Summarizes early information regarding how the pandemic is affecting hospital finances.** Many types of expenses being incurred by hospital organizations are reportable as community benefit on IRS Form 990, Schedule H. However, there are some emerging revenue sources intended to offset COVID-19 related expenses.
- **Highlights some important community benefit reporting and hospital accounting principles.** It's always important to base community benefit reporting on the instructions to Schedule H. It's also important to align the reporting of expenses and revenues with Generally Accepted Accounting Principles that apply to hospital organizations (unless overridden by the Schedule H instructions).

Assuring accurate reporting of pandemic-related revenues (e.g., funds flowing through FEMA and the U.S. Department of Health and Human Services), in-kind donations received (e.g., ventilators), supplies expenses and amounts in inventory, and other amounts will require active involvement of accounting and finance professionals.

- **Provides a series of “process recommendations,”** including setting up tracking accounts (cost centers, general ledger accounts) and named community benefit programs (including COVID-19 product lines or “subsidized health services”), reviewing current community health programs for expansion opportunities, assuring alignment between community benefit reporting and FEMA claims, and others.
- **Provides reporting recommendations within each category of community benefit.**² A framework is proposed for capturing “facility-wide” and “department or product-line specific” expenses and revenues.

A discussion of emerging revenue sources is included in **Appendix 1**. Suggestions for possible adjustments to Financial Assistance Policies due to the pandemic are provided in **Appendix 2**.

¹ If any portion of this work is quoted or copied into other documents, citations as to the source would be appreciated.

² See Part I, Line 7 in Schedule H, at: <https://www.irs.gov/pub/irs-pdf/f990sh.pdf>

Appendices 3 and 4 provide definitions for community benefit categories and discuss *why* pandemic-related expenses are reportable as community benefit.

How the Pandemic is Affecting Hospital Finances

The pandemic is having a major impact on hospital financial performance. The combined effects of reductions in hospital revenues and increases in operating expenses (and cash outlays) are contributing to significant reductions in short-term margins and cash flows.

1. Impacts on Hospital Revenues

Hospital revenues are being significantly reduced, due to the following:

- **Postponed elective procedures.** At the request of the Centers for Disease Control and Prevention, government officials, and other public health entities, hospitals (and their medical staffs) are postponing elective surgeries and other procedures so that capacity is available to treat patients with COVID-19.³ These difficult decisions are reducing anticipated, budgeted net patient revenues. When the pandemic subsides, patients whose procedures have been delayed are likely to present with more acute problems.
- **Unemployment and fewer commercially insured people.** The pandemic has led to increased unemployment. Job losses are leading to greater numbers of uninsured individuals and to growth in Medicaid enrollment.⁴ Revenues also will be affected by a changing payer mix.
- **Adjustments to collections actions.** Many hospitals are adjusting their billing and collections policies and procedures and are not enforcing certain collections actions for patient deductibles and co-payments, if allowed by health insurers.
- **Credit downgrades.** Moody's Investors Services recently adjusted its outlook for not-for-profit hospitals from stable to negative.⁵ In addition to the above factors, Moody's cited hospital investment losses and higher staffing and supplies costs.

Reflecting these concerns, share prices for several publicly-traded hospital companies (e.g., HCA and Tenet Healthcare) fell over 50 percent in March 2020 – much greater declines than U.S. equities as a whole.

Several newly appropriated funds are becoming available to help hospitals address revenue losses and new COVID-19 expenses (See **Appendix 1**). These include:

- **Federal CARES Act appropriations.** The CARES Act provides appropriations intended to reimburse hospitals for COVID-19 expenses, including: “building or construction of temporary structures, leasing of properties, medical supplies and

³ <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/guidance-hcf.html>

⁴ <https://www.medicaid.gov/sites/default/files/2020-03/covid-19-faqs.pdf>

⁵ <https://www.modernhealthcare.com/providers/covid-19-poses-long-term-impact-not-profit-hospitals>

equipment including personal protective equipment and testing supplies, increased workforce and trainings, emergency operation centers, retrofitting facilities, and surge capacity.” Claims for expenses and revenue losses are being processed through FEMA.⁶

- **Medicare sequestration suspension.** The annual two percent Medicare payment sequester (reduction) has been suspended through the end of 2020.
- **Medicare payment increase for Inpatient Prospective Payment System (IPPS) COVID-19 cases.** The 20 percent increase is likely to apply to eight specific Diagnosis Related Groups (DRGs) – see Appendix 1. However, a study recently was published that concludes that the 20 percent add-on is unlikely to be enough to avoid significant losses on IPPS cases.⁷
- **Medicaid DSH cuts delay.** Reductions in Medicaid DSH planned fiscal year 2020 and 2021 have been deferred to future years.
- **Medicare payment reduction for clinical laboratory and durable medical equipment delay.** The CARES Act also delays Medicare payment cuts to these services.
- **Expanded Medicare Accelerated Payments Program.** Accelerated payment options should provide cash flow benefits for hospitals experiencing financial challenges due to payment delays for services provided to Medicare patients.
- **Mandatory health plan coverage for COVID-19 testing and preventive services.** Commercial payers are required to cover these services without patient cost sharing.
- **Expanded Medicare telehealth flexibility.** New flexibility helps to assure reimbursement for this increasingly important care modality.
- **Reimbursement for hospital care provided to uninsured COVID-19 patients.** Recent news reports indicate that funds will be available to reimburse hospitals at Medicare rates for uninsured patients with COVID-19.

There also are indications that states are adjusting Medicaid eligibility, benefits, and reimbursement levels – to help support people and providers affected by the pandemic.

Despite these resources, many hospitals are anticipating that the pandemic will lead to significant financial losses. Hospitals that are small, located in rural areas, with below-average reserves, and/or unaffiliated with multi-hospital systems are most at risk.

2. Impacts on Hospital Expenses

Hospitals also are incurring extraordinary, unbudgeted expenses to (for example):⁸

- **Convert and open bed capacity.** Hospitals are converting current bed capacity to increase the number of intensive care (and other) beds/units that are equipped and staffed

⁶ <https://www.gnyha.org/news/covid-19-fema-grants-for-hospitals-upcoming-webinar-request-for-contacts/>

⁷ <https://www.stratadecision.com/blog/report-hospitals-face-massive-losses-on-covid-19-cases-even-with-proposed-increase-in-federal-reimbursement/>

⁸ Note: this list was constructed by consulting with several hospital organizations and reviewing available press accounts.

to treat and isolate patients with COVID-19. They also are opening previously shuttered patient units, wings, and/or whole hospitals.

- **Establish telehealth services.** Hospitals and their medical staffs are establishing and/or enhancing telehealth services.
- **Support patients at home.** Hospitals are supporting discharged patients at home rather than discharging them to post-acute settings to minimize exposure to coronavirus. They also are offering services to homebound individuals who haven't yet been hospitalized.
- **Provide food and other basic necessities.** Hospitals are providing resources to assure that patients have access to food and other basic necessities, many of which have become scarce or difficult to access thanks to the pandemic. Hospitals also are supporting food banks and other social services agencies by providing cash and in-kind contributions.
- **Retain patients rather than transferring to post-acute settings.** Hospitals are keeping patients who otherwise would be transferred to post-acute care settings, because those providers are at capacity or are unable to take care of COVID-19 patients.⁹
- **Provide community health education.** Hospitals are providing community health education about available testing, treatment, and prevention resources and regarding how COVID-19 symptoms can be managed at home until hospital care is needed.
- **Provide testing services.** Hospitals are enhancing clinical laboratory services, establishing and operating testing centers (including drive-through centers), and opening new clinics.
- **Coordinate with public health agencies and other providers.** Hospitals are devoting staff and are establishing or deploying command centers to help coordinate responses to the pandemic with public health agencies, other hospitals, community health centers, and others.
- **Enhance cleaning and sterilization efforts.** Hospitals are devoting additional resources to sterilize and clean facilities, equipment, clothing/masks for reuse, and other materials.
- **Increase staffing.** Hospitals are hiring additional staff, including contract labor – both to respond to increased patient care needs and to backfill for staff who themselves have been exposed to the coronavirus and/or become ill with COVID-19.
- **Increase staff training.** Hospitals are training or retraining staff (including retirees who have rejoined the healthcare workforce) who have been assigned to treating COVID-19 patients – and others who need to take greater precautions given the pandemic.
- **Purchase and store essential and increasingly expensive supplies and equipment.** Hospitals are incurring significant, additional expenses for: Personal Protective Equipment, ventilators, and COVID-19 testing supplies and equipment – unless donated on a permanent or temporary basis.
- **Conduct research.** Hospitals are participating in clinical trials for COVID-19 vaccines and therapies and are publishing research studies regarding effective approaches to treating and preventing the disease.

⁹ CMS addresses the reimbursement implications of patients that need continued hospitalization if post-acute facilities are not available in: <https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>

- **Provide in-kind support to other providers.** Hospitals are sharing expertise, supplies, and equipment with public health agencies, community health centers, physician offices, new field hospitals, and others as possible.
- **Oversee accounting and reporting requirements.** Hospitals are devoting and expending an unanticipated amount of resources to account for these expenses and revenues, preparing requests for reimbursement, and for related needs.

Many of these expenses are reportable as community benefit, because they align with definitions and instructions in IRS Form 990, Schedule H and with other generally accepted guidelines regarding “what counts” as community benefit.

Reporting Pandemic-Related Activities and Programs: Accounting and Reporting Principles

Community benefits are accounted for by quantifying the actual total expense, the direct offsetting revenue, and the resultant net expense borne by the hospital organization for:

- Financial Assistance,¹⁰
- Medicaid,
- Other Means-tested Government Programs (e.g., county indigent care programs for which individuals qualify based on their household income and assets),
- Community Health Improvement Services,
- Community Benefit Operations,
- Health Professions Education,
- Subsidized Health Services,
- Research funded by government and other tax-exempt sources, and
- Cash and In-kind Contributions for Community Benefit.

On Schedule H, hospitals also account for community building activities (in Part II), Medicare (amounts not elsewhere reported as community benefits), and bad debts (in Part III).

Community benefit reporting is grounded in accounting principles. Given the magnitude of expenses (and possible revenues) associated with responding to the pandemic, it’s important to assure that community benefit reporting remains aligned with these principles, including the following.

- 1. Only report actual expense for community benefits, not “opportunity costs” (including revenue losses) or capital expenditures.**

Community benefits are valued based on actual expense. For hospital organizations that file IRS Form 990, this means any amounts reported as expense on Schedule H should also be included

¹⁰ Before the Affordable Care Act this generally was known as “charity care.”

as expense on IRS Form 990 in Part IX, the Statement of Functional Expenses.¹¹

Note that because community benefit reporting follows instructions to Schedule H and also Generally Accepted Accounting Principles (GAAP) that apply to not-for-profit hospital organizations, there will be differences between “cash outlays” for COVID-19 related expenditures and “expense” for purposes of reporting on Schedule H, IRS Form 990, and hospital financial statements.

As a result of these different accounting treatments, reimbursement requests or claims submitted to FEMA, the U.S. Department of Health and Human Services, and others (which generally will be based on cash outlays) will have different values than those reported as expense on Schedule H and hospital financial statements.

Examples of these differences can include:

- Supplies expense, because if amounts purchased are significant, they first are accounted for as assets (inventory, supplies on hand) until they are used – at which time they are charged to expense;
- Equipment, including ventilators, if they have a “useful life” that extends beyond one year – because the cost of these items is expensed over time as depreciation expense;
- Facilities renovations, the cost of which also is spread over multiple years as depreciation expense; and
- In-kind donations (of supplies, equipment, and other resources) received by hospitals to help them respond to the pandemic.

When in-kind donations are received, both revenues and expenses are recognized based on the fair market value of the resources received.

Similarly, financial appropriations and revenues received by hospitals to help them respond to the pandemic should be recorded as revenue based on “accruals” rather than on amounts received.

- Under GAAP for not-for-profit hospitals, revenues are recognized when certain “performance obligations” have been satisfied.
- On Schedule H, whatever “direct offsetting revenue” applies to community benefit expenses should align with how these revenues are reported in hospital financial statements.

It’s always been important that community benefit and accounting/finance staff communicate effectively and be “on the same page” when reporting expenses and revenues.

¹¹ Schedule H calculates the percentage of expenses reported by the organization in Form 990, Part IX (after certain offsetting revenues are subtracted) that are for community benefits. In other words, if amounts are not reported as expense in Part IX of Form 990, they should not be reported as community benefit on Schedule H.

Given the magnitude of COVID-19 related expenses and offsetting revenues, that collaboration has become even more vital.

2. Use “most accurate” cost accounting methods to quantify eligible expenses and offsetting revenues.

Community benefit accounting largely is an exercise in cost accounting. Longstanding guidelines and Schedule H instructions encourage organizations to rely on their most accurate cost accounting methods, such as the Ratio of Patient Care Cost to Charges, cost accounting systems, Medicare or Medicaid cost reports, and others – whichever is considered most accurate. Revenues that support eligible expenses should be included based on the same principles that apply to the organization’s financial statements.

If revenues are appropriated to (or received by) a hospital for COVID-19 related revenue losses or expenditures, the hospital may need to allocate amounts received to various purposes so that community benefit reports are accurate. The following example is provided to illustrate an allocation:

- A hospital submits claims to FEMA for COVID-19 related revenue losses and expenditures that total \$50 million. The claims include amounts for care provided to uninsured COVID-19 patients, supplies, facilities renovation expenditures, in-service staff training, and an array of other allowable expenses.
- FEMA awards \$40 million with or without details regarding which requested amounts have and have not been approved.
- Due to some uncertainties, the hospital accrues \$30 million of the amounts awarded as revenue in its financial statements for the year ending June 30, 2020.
- The hospital should use a reasonable methodology to allocate the \$30 million in revenue to each category of requested amounts, including:
 - A portion to revenue losses (which would not be reportable as community benefit),
 - Offsets to Financial Assistance expenses (Medicare reimbursement for uninsured COVID-19 patients, if included in the amount awarded),
 - A portion to expenditures/expenses that are not reportable as community benefit, and
 - Another portion to categories of expenses that are reportable as community benefit.

Allocating appropriated funds to individual community benefit programs may prove challenging. A reasonable amount for, say, the entire “community health improvement services” category can be entered as a lump sum on Schedule H or in community benefit tracking software.

3. Include indirect (overhead) costs for every category.

Schedule H instructions state the following:

“Total community benefit expense” includes both “direct costs” and “indirect costs.” “Direct costs” means salaries and benefits, supplies, and other expenses directly related to the actual

conduct of each activity or program. “Indirect costs” means costs that are shared by multiple activities or programs, such as facilities and administration costs related to the organization’s infrastructure (space, utilities, custodial services, security, information systems, administration, materials management, and others).

After identifying direct expenses for COVID-19 related community benefits, hospitals shouldn’t ignore including reasonable indirect expenses as well. Given the extent to which responding to the pandemic is affecting hospital finances, “indirect cost factors” and allocations established for community benefit reporting purposes should be reassessed.

4. Include direct offsetting revenue generated by each category of community benefit.

Schedule H instructions state the following:

“Direct offsetting revenue” includes any revenue generated by the activity or program, such as reimbursement for services provided to program patients. “Direct offsetting revenue” also includes restricted grants or contributions that the organization uses to provide a community benefit, such as a restricted grant to provide financial assistance or fund research. “Direct offsetting revenue” does not include unrestricted grants or contributions that the organization uses to provide a community benefit.

As previously stated, to the extent that hospitals receive appropriations, grants, and other revenues specifically intended to offset COVID-19 expenses that have been reported as community benefit, those amounts should be reported as “direct offsetting revenue.” Appropriations or grants that offset COVID-19 related revenue losses should not be included in offsets. Hospitals may need to split any funding or revenue received between these purposes.

5. If in doubt, follow generally accepted accounting principles and align with financial statements (GAAP).

Questions sometimes arise regarding how certain expenses or revenues should be valued. Hospitals are encouraged to use the same accounting principles that apply to their audited financial statements and to IRS Form 990, so that community benefit accounting aligns as much as possible with those principles.

Process Recommendations

Identifying and tracking COVID-19 expenses (and offsetting revenues) would be facilitated if hospitals implemented certain procedures as soon as possible, so that amounts are captured in

real time rather than retroactively. Procedures that hospitals may want to consider include the following:

- **Establish tracking accounts** (cost centers and/or general ledger accounts) to which expenses, such as salaries and supplies, can be assigned. Confirm that COVID-19 related expenses are being captured accurately and consistently within these cost centers.
- **Create named COVID-19 community benefit programs** – including several focused-on community health and outreach – and also one or more named COVID-19 clinical product lines (groupings of inpatient DRGs and/or outpatient cases/APCs for patients with COVID-19 diagnosis codes).
- **Review current community health programs**, and “double down” on those likely to help respond to the pandemic. Developing effective community health-related programs takes time and effort, and some programs (e.g., those focused on food and housing insecurity) can be expanded.
- **Estimate financial impacts of the pandemic** by conducting variance analyses, such as comparing actual financial statements and reports for March and April 2020 with monthly budgets and with statements from the prior year. Variance analyses may help to estimate the magnitude of COVID-19 related impacts on overall revenues and expenses (budget versus actual) and can support identifying why they are occurring.
- **Focus first on direct expenses** and then account for indirect expenses and assign or allocate offsetting revenues at a later date.
- **Assure active involvement of both community benefit and accounting/finance staff in the reporting process**, so that amounts reported align with accounting principles (and Schedule H instructions), and so that community benefit staff are “in the loop” when applications or claims are developed for submission to government agencies for reimbursement.

Reporting Recommendations

Hospitals are encouraged to report as community benefit expenses and offsetting revenues for COVID-19 related activities and programs that:

1. **Are incremental and temporary** in that they would not have been incurred or received but for the pandemic;
2. **Align with the general requirements that apply to all types of community benefits** (see **Appendix 3** for definitions for each category of community benefit and **Appendix 4** for characteristics of activities or programs that can and cannot be reported);

Note also that expenses relating to COVID-19 generally fall into the following categories:

- Expenses (and offsetting revenues) that have been **directly assigned** to community benefits, because they qualify to be reported in one of the allowed categories.
- **Facility-wide, direct** expenses due to COVID-19 that haven’t been directly assigned. Note that these expenses are includable in the numerator of the “ratio of patient care cost

to charges” and thus a portion will be counted in expenses for Financial Assistance, Medicaid, and possibly Subsidized Health Services (wherever the ratio is applied).

- **Facility-wide, indirect (overhead)** expenses due to COVID-19 that also haven’t been directly assigned to one or more community benefit activities or programs. These expenses also will be counted in part, because hospital indirect expenses generally are to be included in every category of community benefit.¹²

The following recommendations are made for reporting community benefits associated with the pandemic, by category.

1. Financial Assistance

Financial Assistance expenses are likely to rise given greater numbers of uninsured and underinsured patients, and because higher operating costs will affect the “ratio of patient care cost to charges” applied to Financial Assistance charges.

This is a good time for hospitals to consider introducing or adjusting certain Financial Assistance Policy (FAP) provisions. See **Appendix 2**.

This would help assure that patient out-of-pocket liabilities that never would be collected would be reportable as charity care rather than bad debt.

If or when reimbursement is provided (at Medicare rates) for uninsured patients who also qualify for Financial Assistance, expenses would be reported in this category based on the following formula:

$$\begin{aligned} & \text{(Total Charges for Uninsured COVID-19 Patients } \textit{minus} \text{ Medicare Reimbursement)} \\ & \qquad \qquad \qquad \times \\ & \qquad \qquad \text{Ratio of Patient Care Cost to Charges.} \end{aligned}$$

Pursuant to current Schedule H instructions, the Medicare reimbursement itself would not be reported in “direct offsetting revenue.”

2. Medicaid and Other Means-Tested Government Programs.

Given the impacts of the pandemic, hospitals may want to renew efforts to help uninsured individuals sign up for Medicaid and for other means-tested government programs. Consensus has been reached that expenses incurred in helping patients apply for these programs is reportable under community health improvement services (health care support services).

¹² See instructions to Schedule H.

3. Community Health Improvement Services (and Community Benefit Operations Expenses)

A wide array of activities and programs established or expanded due to the pandemic are reportable in this category as community benefit.¹³ Hospitals should consider reporting expenses (and direct offsetting revenues) for the following activities and programs. Direct offsetting revenues would include any program-specific fees charged to program clients as well as a reasonable allocation of funds recognized as revenue and provided through the CARES Act and comparable government programs.

- Providing community health education, newsletters, and information designed to keep communities informed about the pandemic and how to access available community resources.
- Providing unbilled “ask-a-nurse” type services established in response to the pandemic, and self-help programs for individuals recuperating at home.
- Providing telemedicine services, if unbilled by the organization (note that if these services are billed then they should be reported within the “subsidized health services” category).
- Sponsoring support groups for patients and families affected by the pandemic.
- Supporting discharged patients at home rather than in post-acute facilities, if this has been done explicitly to mitigate coronavirus exposure risks (if this is a billed, home health type service, then these services should be reported within the “subsidized health services” category).
- Providing mobile, drive-through, and free clinic testing and treatment services specifically associated with the pandemic (if not generating patient bills).
- Providing discharged patients with food and other basic necessities made scarce due to the pandemic.
- Operating or participating in the work of disaster response (or incident response) centers.
- Coordinating activities and programs with public health agencies, other hospitals, and others in response to the pandemic.
- Coordinating the work of volunteers who are responding to hospital staffing needs.
- Costs to recruit staff specifically needed to meet patient care and other demands due to the pandemic.
- In-service training (for new, reassigned, and other staff) conducted expressly in response to the pandemic.
- Incremental expenses associated with sterilization, cleaning, clothing/masks, and other supplies that have not been allocated or directly assigned to “subsidized health services” that have been reported.
- Activities and programs to enroll individuals into Medicaid and other means-tested insurance programs.

¹³ This category is reported on Schedule H, in Part 1, Line 7e.

- Transportation services provided at the expense of the hospital that otherwise would be unaffordable or unsafe for affected individuals.
- Any other activities and programs (that don't generate patient bills) established in response to the pandemic that are focused on addressing public health objectives and social determinants of health, and that otherwise meet the definitions that apply to community benefits and community health improvement services.

Please note that if COVID-19 expenses are assigned (or assignable) to patient care departments that generate patient bills (gross charges), those expenses should not be reported in this category. Instead, they should be accounted within the “subsidized health services” category.

4. Health Professions Education

Some hospitals are encouraging health professions education students to help them meet staffing shortages. For others, affiliated health professions schools may be seeking to minimize time spent by medical, nursing, and other allied health students in hospital settings. Expenses incurred by hospitals in providing education that counts towards degrees, certificates, licensure, or certifications needed by health professionals to practice in their professions are reportable as community benefit.

Continuing medical education (CME) programs sponsored by hospital organizations also are reportable if they are open to all community physicians rather than only to members of the organization's own medical staff. Expenses incurred by such CME programs established in response to the pandemic would be reportable in this category of community benefit.

If the hospital has requested governmental appropriations to offset Health Professions Education expenses that are reportable as community benefit, then a reasonable proportion of amounts recognized as revenue should be included in “direct offsetting revenue.”

5. Subsidized Health Services

Subsidized Health Services have been under-reported by many hospitals. The coronavirus pandemic provides an important opportunity to identify and report qualifying services.

Hospitals are encouraged to establish named COVID-19 inpatient and/or outpatient product lines. These can be comprised of groups of DRGs or APCs for COVID-19 patients (diagnosis code U07.1, COVID-19 – see **Appendix 1**). It is highly likely that given the resources and lengths of stay needed to treat these patients that these services will qualify to be reported as “subsidized health services.”

Postponing elective procedures and otherwise assuring that capacity for COVID-19 patients is present is likely to affect the financial performance of many other product lines (e.g., orthopedics, behavioral health, emergency services, and others). Clinical services that didn't qualify to be reported as Subsidized Health Services at pre-pandemic volumes and payer mix

now may. Hospitals also are encouraged to assess all product lines to see if they now qualify to be reported during relevant fiscal/tax years.

6. Research

Several important clinical trials have been initiated to test the safety and efficacy of coronavirus vaccines and therapies. Hospitals also are publishing COVID-19 related research papers. If the hospital organization has incurred expenses for these investigations and if they have been funded by a tax-exempt or governmental entity (including the organization itself), then they are reportable as community benefit.

Hospitals also may be publishing information on their achievements in treating COVID-19 patients and in community-wide responses to the pandemic. If these insights are made available to the public and can be considered “research,” then expenses incurred by the hospital in documenting and sharing this generalizable knowledge also are reportable in this category.

7. Cash and In-Kind Contributions for Community Benefit

Cash contributions made that are restricted, in writing, to a community benefit purpose – e.g., to helping other organizations (including FQHCs, physician practices, new field hospitals, and others) respond to the coronavirus public health emergency are reportable in this category.

In-kind contributions for community benefits also are reportable. To the extent that hospitals donate Personal Protective Equipment, supplies, pharmaceuticals, staff expertise and time (while on the hospital payroll), to other organizations (including other providers) and community response efforts, reasonable values for these in-kind expenses also are reportable as in-kind contributions.

APPENDIX 1: Pandemic-Related Appropriations and Revenues

This Appendix identifies and briefly discusses appropriations and revenues intended to support hospital COVID-19 related expenses and revenue losses.

1. The CARES Act (Coronavirus Aid, Relief, and Economic Security Act) and other initiatives will be providing some funding intended to offset the impacts of pandemic-related revenue losses and expenses. Portions of these resources should be included in “direct offsetting revenue” to the extent that they have been provided to support expenses that have been reported as community benefit.
2. The Act increases funding (by \$100 billion) to the Public Health and Social Services Emergency Fund to reimburse hospitals and other “eligible providers” for COVID-19 expenses. Providers need to submit an application to HHS “justifying the need of the provider for the payment.” The Act isn’t clear regarding how or when funds will be disbursed.¹⁴ Expenses for “building or construction of temporary structures, leasing of properties, medical supplies and equipment including personal protective equipment and testing supplies, increased workforce and trainings, emergency operation centers, retrofitting facilities, and surge capacity” are eligible for reimbursement.
3. The Act (and emerging regulations and pronouncements) also:
 - Suspends the annual two percent sequester that applies to Medicare payments through the remainder of 2020.
 - Adds 20 percent to Medicare inpatient prospective payment system reimbursement (IPPS) for COVID-19 patients. CMS has not established a new DRG (diagnosis related group) specifically for COVID-19 patients. Note that cases with a new COVID-19 diagnosis code are likely to be grouped into the following DRGs:¹⁵

Assignment of new ICD-10-CM diagnosis code U07.1, COVID-19, is as follows:

Diagnosis Code	Description	CC	MDC	MS-DRG
U07.1	COVID-19	MCC	04	177,178,179
			15	791,793
			25	974,975,976

¹⁴ There are numerous summaries of the CARES Act available, including: https://www.chapman.com/insights-publications-CARES_Act_Health_Care_Businesses.html

¹⁵ <https://edit.cms.gov/files/document/icd-10-ms-drgs-version-371-r1-effective-april-1-2020-updated-march-23-2020.pdf>

[Note that A study recently was published that concludes that the 20 percent add-on is unlikely to be enough to avoid significant losses on Medicare IPPS cases.^{16]}

- Delays fiscal year 2020 and 2021 cuts to Medicaid Disproportionate Share Hospital payments.
- Delays cuts to Medicare payments for clinical laboratory services and durable medical equipment.
- Expands the Medicare Accelerated Payments Program for hospitals experiencing financial challenges due to payment delays for services provided to Medicare patients.
- Provides flexibility for hospitals to transfer patients to post-acute care settings (e.g., long term acute care hospitals and inpatient rehabilitation facilities) under certain conditions.
- Requires health plans to cover COVID-19 testing and preventive services, without patient cost sharing.
- Increases Medicare telehealth flexibility – allowing Medicare beneficiaries to receive telehealth services from a broader range of providers.
- Limits liability for volunteer health care professionals during the COVID-19 emergency response period.
- FEMA also will be awarding funds to “eligible private nonprofits” in response to applications for COVID-19 related assistance.¹⁷
- In addition, recent news reports indicate that resources will be made available to hospitals to pay for hospital care provided for uninsured COVID-19 patients.

There also are indications that states are adjusting Medicaid eligibility, benefits, and reimbursement levels – to help support people and providers affected by the pandemic.

Despite these resources, many hospitals are anticipating that the pandemic will lead to significant financial losses. Hospitals that are small, located in rural areas, with below-average reserves, and/or unaffiliated with multi-hospital systems are most at risk.

¹⁶ <https://www.stratadecision.com/blog/report-hospitals-face-massive-losses-on-covid-19-cases-even-with-proposed-increase-in-federal-reimbursement/>

¹⁷ <https://www.fema.gov/news-release/2020/03/23/coronavirus-covid-19-pandemic-public-assistance-simplified-application>

APPENDIX 2: Financial Assistance Policy Recommendations

Financial Assistance expenses are likely to rise given greater numbers of uninsured and underinsured patients, and because higher operating costs will affect the “ratio of patient care cost to charges” applied to Financial Assistance charges.

This is a good time for hospitals to consider introducing or adjusting certain Financial Assistance Policy (FAP) provisions. This would help assure that patient out-of-pocket liabilities that never would be collected would be reportable as charity care rather than bad debt.

1. Many hospitals include “catastrophic coverage” in their FAPs, such that patient out-of-pocket liabilities (for hospital and non-hospital medical care) greater than 15-30 percent of annual household income would be written off to charity care.
2. Many hospitals include presumptive eligibility provisions – allowing charity care to be granted to patients who don’t complete Financial Assistance applications or who have characteristics indicating limited incomes/resources (e.g., deceased with no estate, children in household eligible for free or reduced cost lunch, eligible for other means-tested government programs). The pandemic likely is creating challenges regarding the application process, particularly for families impacted by the virus.
3. Hospitals can include provisions specific to patients with COVID-19, including waiving co-payments, co-insurance, and deductibles for households up to a specified level of income (if permitted under health insurance contracts). These provisions can include amounts not covered by reimbursements (at Medicare rates) to be provided for uninsured patients with COVID-19.
4. Hospitals can clarify that financial support they receive via the CARES Act will not be considered income for purposes of the Financial Assistance eligibility determination process.
5. Hospitals can extend Financial Assistance to telemedicine services, if not already covered or if offered by a non-hospital affiliate.
6. Hospitals may not want to reduce partial discounts that are tied to Medicare rates (given the 20 percent increase in Medicare IPPS payments).
7. Many hospitals provide Financial Assistance eligibility for a defined number of months, so that patients need not reapply whenever services are provided or sought. Given that financial circumstances are in flux for many people, policies should assure that applications can be considered at any time, upon request.
8. Hospitals also should assure there is clarity regarding the ability to apply for Financial Assistance for 240 days from the date of the first billing statement. Revised FAP eligibility provisions may be in effect for a few months. FAPs can state that patients with a date of

service during that period can apply for Financial Assistance based on provisions in effect during dates of service, rather than those in effect when they apply.

9. Some hospitals are suspending certain collections actions, particularly for COVID-19 and newly unemployed patients – and are assuring rigid adherence to the requirement that reasonable efforts be undertaken prior to any Extraordinary Collections Actions (providing 30-day notice prior to any ECAs and information about the FAP).

Patients with existing payment plans also should be allowed to apply or reapply for assistance if their circumstances have changed. Hospitals can provide charity care write-offs for remaining balances on payment plans if patient financial circumstances change.

APPENDIX 3: Community Benefit Categories

This appendix provides definitions for each category of community benefit, as described in the instructions to IRS Form 990, Schedule H.

Category	Definition and Description
Financial Assistance ¹⁸	<p>Free or discounted health services provided to persons who meet the organization’s criteria for financial assistance (as specified in a Financial Assistance Policy) and are thereby deemed unable to pay for all or a portion of the services. Financial assistance does not include self-pay discounts, prompt pay discounts, contractual allowances, and bad debt.</p> <p>Financial assistance is reported based on cost – not the amount of gross patient charges forgiven.</p>
Medicaid	<p>The United States health program for individuals and families with low incomes and resources.</p> <p>Medicaid (Medi-Cal) community benefits are reported as the difference between the cost of care and reimbursement. Net community benefits thus are the loss incurred by the hospital organization in providing access to care for Medi-Cal recipients.</p>
Other Means-tested Government Programs	<p>Government sponsored health programs where eligibility for benefits or coverage is determined by income and/or assets (e.g., county indigent care programs).</p>
Community Health Improvement Services	<p>Activities or programs carried out or supported for the express purpose of improving public health that are subsidized by the health care organization.</p> <p>Examples include:</p> <ul style="list-style-type: none"> • Community health education, including classes and education campaigns, support groups and self-help groups; • Community-based clinical services, such as screenings, annual flu vaccine clinics and mobile units; • Health care support services for lower-income persons, such as transportation, case management, Medicaid enrollment assistance, services to help homeless persons upon discharge; and, • Social and environmental activities known to improve health, such as violence prevention, improving access to healthy foods, removal of asbestos and lead in public housing, and housing support for low-income and homeless populations.

¹⁸ Before the Affordable Care Act this generally was known as “charity care.”

Category	Definition and Description
Health Professions Education	<p>Educational programs that result in a degree, certificate, or training that is necessary to be licensed to practice as a health professional, as required by state law; or continuing education that is necessary to retain state license or certification by a board in the individual’s health profession specialty.</p> <p>Expenses incurred by the UC Medical Centers in educating interns and residents, medical students, and allied health professionals are reported in this category.</p>
Subsidized Health Services	<p>Clinical services provided despite a financial loss to the organization because they are needed to assure access to care for members of the community.</p> <p>The financial loss is measured net of any financial assistance and Medicaid losses to avoid double counting.</p>
Research	<p>Any study or investigation that receives funding from a tax-exempt or governmental entity of which the goal is to generate generalizable knowledge that is made available to the public.</p> <p>Research (e.g., clinical trials) funded by for-profit entities is not reportable as community benefit on Schedule H.</p>
Cash and In-kind Contributions for Community Benefit	<p>Contributions made by the organization to support community benefits provided by other organizations.</p>

APPENDIX 4: Why Pandemic Related Expenses (and Offsetting Revenues) Are Reportable as Community Benefit

The Schedule H instructions and long-standing community benefit reporting principles provide a solid basis for reporting many or most COVID-19 related expenses (and relevant offsetting revenue) as community benefit. Key excerpts from the Schedule H instructions are copied below. Principles most aligned with reporting COVID-19 related expenses are highlighted in bold.

1. General Characteristics of Reportable Activities and Programs

Community benefit activities or programs also seek to achieve a community benefit objective, including **improving access to health services, enhancing public health**, advancing increased general knowledge, **and relief of a government burden to improve health**. This includes activities or programs that do the following.

- **Are available broadly to the public and serve low-income consumers.**
- **Reduce geographic, financial, or cultural barriers to accessing health services**, and if they ceased would result in access problems (for example, longer wait times or increased travel distances).
- **Address federal, state, or local public health priorities** such as eliminating disparities in access to health care services or disparities in health status among different populations.
- **Leverage or enhance public health department activities** such as childhood immunization efforts.
- **Strengthen community health resilience by improving the ability of a community to withstand and recover from public health emergencies.**
- **Otherwise would become the responsibility of government or another tax-exempt organization.**
- **Advance increased general knowledge through education or research that benefits the public.**

To be reported, community need for the activity or program must be established. Community need can be demonstrated through the following.

- A CHNA conducted or accessed by the organization.
- **Documentation that demonstrated that community need or a request from a public health agency¹⁹ or community group was the basis for initiating or continuing the activity or program.**

¹⁹ E.g., the CDC that asked hospitals to postpone elective procedures.

- **The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the activity or program** carried out for the express purpose of improving community health.

2. Characteristics of Activities or Programs that Cannot Be Reported as Community Benefit

Activities or programs cannot be reported if they are provided primarily for marketing purposes or if they are more beneficial to the organization than to the community. For example, the activity or program may not be reported if it is designed primarily to increase referrals of patients with third-party coverage, required for licensure or accreditation, or restricted to individuals affiliated with the organization (employees and physicians of the organization).

About the Author

Keith Hearle, MBA, is President of Verité Healthcare Consulting. Prior to establishing Verité in 2006, Keith led the Hospitals and Health Systems practice for The Lewin Group, Inc., served as CFO of the San Francisco Department of Public Health (Public Health Division), as a Manager at KPMG Peat Marwick, and as a Senior Equities Analyst (Healthcare) for a California-based money manager.

In 1989, he developed for the Catholic Health Association and Vizient (CHA/Vizient) the first accounting framework for hospital community benefits and co-authored the CHA/Vizient Social Accountability Budget. He also authored the accounting chapters (and worksheets and other materials) in the May 2006 and December 2008 CHA/Vizient *Guide to Planning and Reporting Community Benefit* and in all subsequent editions. He developed a framework for determining “What Counts as Community Benefit,” adopted by CHA/Vizient in 2007. In 2008, he was asked by IRS officials to draft major sections of the Instructions to IRS Form 990, Schedule H. He worked with IRS staff thereafter on refinements to the Instructions. The firm works with hospital organizations and policy makers on all aspects of community benefits.

Keith.Hearle@veriteconsulting.com
www.veriteconsulting.com