Recommendations for Reporting Community Benefit Related to Coronavirus

As America’s hospitals respond to the unprecedented needs of their communities because of the coronavirus/COVID-19 pandemic, community benefit leaders have raised questions of how to identify and track reportable community benefits. Following are preliminary suggestions for reporting community benefit expenses using the categories from Part I of the Internal Revenue Service (IRS) Form 990 Schedule H and the Catholic Health Association (CHA) Guide for Planning and Reporting Community Benefit.

These are early recommendations from community benefit leaders based on their current experience. They are not exhaustive. They do not represent tax or legal advice.

As you assess what expenses may be reported as community benefit, consider existing guidance from CHA and the IRS:

- Guidance on reporting community benefit in CHA’s Guide to Planning and Reporting Community Benefit, Chapter 2

This guidance is also included in an Appendix to this document.

Reporting Categories of Community Benefit Services

Category 1: Financial Assistance
Free or discounted care provided to persons who cannot afford to pay and who meet the eligibility criteria of the hospital’s financial assistance policy. Hospitals may want to review their financial assistance policies and consider whether to make changes based on the current environment.

Category 2: Government-Sponsored Means-Tested Health Care
Medicaid and other unpaid costs of public programs for low-income persons. Hospitals should monitor any federal, state or local policy changes related to eligibility for these programs during the crisis. They should also track any additional public payments that offset losses.

Category 3: Community Benefit Services (sub-categories A-G)
Programs that respond to an identified community health need and are designed to accomplish one or more community benefit objectives (improve access to health care services, enhance public health, advance medical knowledge, or relieve the burden of government to improve health). These examples are not intended to be an exhaustive list.
A. **Community Health Improvement Services**

These activities are carried out to improve community health. They do not generate inpatient or outpatient bills, although they may involve a minimal fee. In all cases, be sure to identify and subtract from total expenses any restricted offsetting revenue.

- **Community Health Education**: Participation in awareness and education activities for the community and first responders, including production, translation and distribution of educational material, coordinating media response, public service announcements, and telephone hotlines for answering questions.
- **Community-based Clinical Services** including free or nominal cost services or screening for coronavirus, flu immunizations, mobile units and offsite testing costs for the virus not included in Category 1 or 2 or Subsidized Health Services.
- **Health Care Support Services**, including
  - Executive and other employee time spent planning for and recovering from the public health emergency
  - Information and referral services
  - Community mental health services including support of self-care programs and crisis intervention.
- **Social and Environmental Improvement Activities**
  - Activities related to responding to social needs in the community, including food and housing insecurity
  - Disaster readiness and response over and above state and federal licensure requirements. (See [https://www.chausa.org/communitybenefit/what-counts-q-a-listing/community-building-activities/disaster-preparedness](https://www.chausa.org/communitybenefit/what-counts-q-a-listing/community-building-activities/disaster-preparedness)). This may include participation in planning for community disaster preparedness, the establishment of command centers and regular huddles that are specific to disaster readiness and over and above licensure requirements and participation in community-wide assessments of community disaster preparedness and resilience.

B. **Health Professions Education**

- Costs associated with educating health professionals related to treating/responding to coronavirus when education meets criteria for required degree, certificate or training. Education for health professionals that does not meet the criteria can be reported as Community Health Improvement Services, Community Health Education.

C. **Subsidized Health Services**

- This would include a program, clinical department or service line that as a whole were to lose money at the end of the fiscal year and was continued despite the loss because it met a need in the community (i.e. an emergency department, ICUs) and would otherwise not have been available or adequately available in the community. Report when the loss remains after removing losses associated with financial assistance,
Medicaid, other means-tested government programs, and bad debt. Be careful not to double count with other community benefit expenses. Offset with any payments for this purpose.

D. Research
- Research conducted on COVID-19, including screening, treatment and the impact on the health and welfare of communities, which will be shared across professional disciplines and organizations.

E. Cash and In-kind Donation
- Cash or in-kind contributions provided to community groups within and outside the local community that are restricted, in writing, to be used for one of the community benefit activities described herein, in response to the pandemic. Be sure to retain a restriction letter that the receiving organization must use the funds to support a community benefit activity.
- Assisting other hospitals and health care facilities not having the resources, capacity or expertise to meet COVID-19 response needs.
- Assisting other community organizations responding to the pandemic including support for mental health and substance abuse programs.
- In-kind contribution examples include donating medical, surgical and pharmaceutical supplies and providing staff to other organizations to conduct training or provide services.

G. Community Benefit Operations
- Report cost of community benefit operations (e.g., community benefit program administration, fundraising or grant writing for coronavirus-related community health improvement service) related to the coronavirus and not included above.
- Revisions to or updates of community health needs assessments (CHNAs) and implementation strategies necessitated by the pandemic.

Do not count:
- Loss of revenue due to canceled appointments, surgeries, procedures, etc. CHA community benefit guidelines recommend not counting as community benefit “opportunity costs” – the amount of revenue that could have been collected. However, loss of revenue may contribute to the need to subsidize needed programs or services (see above, Subsidized Health Services).
- Time spent by employees on their own time and the time of volunteers.
Additional Considerations

We recognize that hospitals are experiencing significant unanticipated costs associated with their response to the coronavirus pandemic.

To the extent the costs are incurred for services that are not billed for inpatient or outpatient services, they may be reportable as community health improvement, such as community-based clinical services.

To the extent they are incurred for services that generate inpatient or outpatient revenue, such as most clinical services, they should not be reported as community health improvement. Rather, they could be collected in a separate account or incorporated into the expenses reported in Categories 1 or 2 or Subsidized Health Services. This will probably apply to most unreimbursed costs related to surge capacity.

Here are examples of costs hospitals are experiencing related to COVID-19. Some of these costs could be included in financial assistance, Medicaid or other means-tested programs, subsidized services or community health improvement means services (see above). Some may be deemed a cost of doing business.

- Costs of medications, supplies and equipment, including purchase and rental of ventilators (not billed to individual patients)
- Costs associated with establishment of alternative work locations
- IT infrastructure enhancements including additional capacity for employees working remotely
- Childcare services provided to employees (although this may be a cost of doing business)
- Facility enhancements or modifications including construction costs for temporary or mobile medical units
- Costs for redeployed, contracted or quarantined employees
- Increase in wrapped plastic utensils and to-go containers in the dietary department
- Increase in environmental services cleaning agents
- Other unreimbursed costs related to surge capacity

June 2020 Update – The above examples were deleted because many of these COVID-related expenses are likely to be covered by federal payments and many are costs that are incurred in the process of providing billed services to patients and therefore not eligible to be reported as community health improvement. We recommend working with finance staff to determine whether costs and payments are for community benefit activities and if any funds should be reported as off-setting revenue. We also recommend monitoring payment and financing developments through the Healthcare Financial Management Association
https://www.hfma.org/topics/coronavirus.html
July 17, 2020 Update - Questions and Answers from May 19, 2020 What Counts Webinar

**Are coronavirus screenings considered community benefit?**

If screening for coronavirus is a billed service, it could be reported as community benefit when it is provided to someone under the hospital’s financial assistance policy. If the patient is a Medicaid beneficiary, the cost could be reported under Medicaid. If the screening is not a billed service but offered either free or at a nominal fee, it can be reported as Community Health Improvement, Community-based /Services, A2. Be sure to include fees collected as off-setting revenue.

Setting up mobile units for screening that is billed would not be reported as community benefit.

**Can mindfulness, meditation and support sessions offered to employees count under A3. Health Care Support Services due to COVID? I know we normally don’t count activities for just employees but is there an exception to things now put in place for the mental/physical/emotional well-being of staff during this time.**

This is a wonderful support service for your employees. However, activities exclusively for staff members should not be reported on the IRS Form 990H.

**Would any education about COVID-19 such as mask fitting or infection control education for staff count under Health Professions Education or Community Education?**

Infection control education cannot be reported under Health Professions Education. The IRS 990 Schedule H instructions for reporting Health Professional Education is limited to education that results in a degree, certificate or training that is necessary to be licensed to practice as a health professional or continuing education that is necessary to retain state license or certification.

Training related to providing care to billed patients should not be reported as community health improvement. However, such trainings could be reported as community benefit to the extent they are incurred for a community health improvement service, like the community-based clinical services (such as non-billed, free or nominal cost screening).

**Should we count employee and visitor screening and testing at hospital locations?**

Costs related to employee and visitor screening and testing would be considered part of the hospital’s infection control efforts that are a cost of doing business, required of all providers, and not community benefit.
We originally had not planned on reporting surge capacity activities (e.g. staff time planning for surge) as community benefit but realize we probably should. Would you recommend reporting 100% of incident command time as community benefit? It seems that there is also a business need for these activities.

IRS instructions for Form 990 Schedule H indicate that community disaster preparedness and response activities can be reported as community benefit. Here is an excerpt from the Instructions:

*Community benefit activities or programs 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 ...... Strengthen community health resilience by improving the ability of a community to withstand and recover from public health emergencies.*

We interpret this to mean that administrative and clinical staff working with public health and community partners to prepare the community for disasters, including the COVID pandemic, could be reported as community benefit. Planning for patient care related activities and operations would not be included as community benefit.

**Our hospital had a COVID-19 war room setup. I assume all of that time would count?**

See above. If the “war room” is engaged in helping the community prepare for and recover from the pandemic, it could be reported as community benefit. If it is dealing with hospital functions it would not.

**If we are redeploying staff (salaried and hourly) to support required patient and associate screenings (such as temperature and symptom checks) would this count?**

Redeploying staff to other community organizations could be reported in E. Cash and In-Kind Contributions. Reassigning staff to address patient and staff screening would not be reported as community benefit unless the staff are engaged in activities that qualify as community benefit. **Can we count programs that have a loss due to COVID due to lower census--could that be counted as a subsidized service?**

No, costs related to lower census, cancelled appointments and surgeries would be considered what finance people call “opportunity costs” and should not be reported as community benefit expense. However, these losses may be a factor in calculating the expense of subsidizing services.

**What type of COVID advocacy efforts should be reported?**

Advocacy related to a community health need can be reported. This would include coverage for low-income persons and issues related to the social determinants of health. Advocacy related to hospital reimbursement should not be reported as community benefit.
Can we count the cost for updating our infrastructure such as the cost associated with developing negative air pressure rooms or adding isolation rooms?

We would not recommend counting the cost of the negative air pressure room or adding isolation rooms as community benefit. Facility enhancements are incurred to enable employees to provide clinical services that generate inpatient or outpatient revenue and would not be considered community benefit for IRS 990H purposes.

Do clinical trials of a vaccination or medication count as community benefit?

If the clinical trials and vaccine research is being funded by the hospital, the government or another not-for-profit and the research will be shared (published in papers/journals, presented at conferences, etc.) we would recommend counting the cost as Category D. Research. Remember to offset the cost with any grant funding (or other revenue received, such as license fees and royalties or COVID-19 reimbursement for research).

We have an COVID-19 associate support program which provides emergency financial support for groceries, rent/mortgage, utilities, etc. for our associates and families who have been impacted directly by COVID-19. Normally we would not consider counting this, but had been under the impression it would count due to some of the special exceptions for COVID-19 response?

Since this program is for employees only, we would not recommend counting the costs as community benefit. However, we would recommend that you talk about this program in Part VI of the IRS 990H and any narrative report to the community.

Accounting Question

This question was referred to Keith Hearle, President Verite Healthcare Consulting

Hospitals often use cost-to-charge ratios to estimate the costs of financial assistance and Medicaid services. Cost-to-charge ratios have been impacted by the interruption in services provided and costs incurred. Are there recommendations on how to handle the impact of this to the cost-to-charge ratios used to estimate cost? Should adjustments be made to normalize the impact to the ratios or should we simply use the ratios as calculated?

It’s important to calculate the ratio of patient care cost to charges (the ratio) as required by instructions to IRS Form 990, Schedule H. Worksheet 2 (and its accompanying instructions) describe the expenses (and adjustments) that apply to the numerator of the ratio for the tax year being reported. All expenses for the tax/fiscal year should be included (along with the adjustments specified in the Worksheet) – just like all allowable expenses for the year will be included in Medicare and Medicaid cost reports. All charges for the tax year also should be included.
Note that many hospital organizations use Other Operating Revenue as a proxy for the expense associated with “Nonpatient care activities” (see Line 2 in Worksheet 2 in the Schedule H instructions). Because many organizations also are reporting Provider Relief Fund payments in Other Operating Revenue, care should be taken not to include that revenue in Line 2 of the worksheet. As stated in the instructions, organizations are instructed to include the actual cost of nonpatient care activities in that line. Relying on Other Operating Revenue as a proxy value is allowed if the organization is “unable to establish the cost associated with nonpatient care activities.” Organizations generally find that including the actual cost of these activities is most accurate.

Adjustments to normalize the impact of service interruptions and extraordinary expenses should not be made.

Please Take Note: The information provided above does not constitute legal or tax advice. The information is provided for informational/educational purposes only. Please consult with counsel regarding your organization’s particular circumstances.
APPENDIX

Existing CHA and IRS Guidance on What Counts as Community Benefit

From CHA What Counts Q&A Website

DISASTER PREPAREDNESS

Question: What costs related to emergency/disaster preparedness can be counted as community benefit?

Recommendation: Costs for disaster readiness of your organization over and above accreditation, licensure requirements and standard practice may be reported as community building. Be careful not to double-count with in-kind donations and be certain that these expenses are not already captured in indirect costs.

Costs for community disaster readiness can be reported as community benefit.

The IRS instructions include as community health improvement, activities and programs that "strengthen the community health resilience by improving the ability of a community to withstand and recover from public health emergencies."

Report costs associated with:

- Participation in community-wide **assessments** of community disaster preparedness and resilience (not facility assessments).
  - Report under Category G. Community Benefit Operations when done as part of the organization's broader community health needs assessment.
  - Report under A 4 Social and Environmental Improvement Activities when done as a separate assessment for community disaster preparedness.

- Participation in **planning** for preparing the community for disaster preparedness.
  - Report under G. Community Benefit Operations when done as part of the organization's implementation strategy
  - Report under A 4 Social and Environmental Improvement Activities when done as a separate plan for community disaster preparedness

- Participation in **implementing** plans associated with preparing the community for disaster preparedness (such as mental health resource costs associated with training, community partnerships, and outreach planning).
  - Report under A 4 Social and Environmental Improvement Activities

- Assisting other hospitals and health care facilities not having the resources, capacity or expertise to meet their own preparedness needs. Examples of assistance include stockpiling medical,
surgical, and pharmaceutical supplies for other health care organizations or providing staff and community member training and drills.

- Report in category F3. Community Support. If contributions are financial, be sure to retain documentation from receiving organization that funds will be used to support a community benefit activity.

- Other costs for activities over and above accreditation, licensure requirements and standard practice.
  - Report under F3. Community Support

Note: The instructions for IRS Form 990 Schedule H state that organizations can report as community health improvement programs or activities that "strengthen community health resilience by improving the ability of a community to withstand and recover from public health emergencies."

(Updated April 2015; Updated November 2015)
CHA’s *A Guide for Planning and Reporting Community Benefit* – Chapter 2: What Counts as Community Benefit
IRS 990 Schedule H Instructions

Double click on image below to open document.