

needs to be complete, accurate and timely. The IRS will continue to use more and more of the submitted information to analyze both governance and operations of nonprofit organizations over time. Therefore, organizations need to be sure they have the proper process in place to accurately report the organization's information.

Clear, effective direction will help ensure that everyone understands the Form 990 review process. Communicate with governance in advance about what information they can expect management to provide, what actions governance is expected to take — and give them ample time to review documents.

As noted above, at least one organization has asked if they should post their Form 990 on their website. To date, that isn't required, but Form 990 is to be made available to the general public.

Posting it on a website gives easier access, if so desired.

STAY CURRENT

As the IRS receives information gathered via Form 990, they are likely to re-focus their attention on certain a

reas they are more interested in further pursuing. That means changes are likely. Keep management informed about current developments, and look to the IRS, CHA and other organizations such as the Healthcare Financial Management Association to see if they offer webinars and other helpful information about Form 990 updates.

JEFF LADENBURGER is chief audit executive with CHAN Healthcare Auditors, Cincinnati.

IRS Form 990, Schedule H

A DEEP DIVE: READY, SET, GO

BY JULIE TROCCHIO, M.S.

The Patient Protection and Affordable Care Act became law in March 2010, and it contained new requirements for tax-exempt hospitals. These included requirements for conducting community health needs assessments every three tax years and adopting implementation strategies for addressing community health needs identified in the assessments. It also added requirements for adopting and publicizing hospital financial assistance and billing policies, including when certain collection efforts can be used and how much patients can be charged.

Reflecting the new law, the Internal Revenue Service (IRS) has issued a revised Form 990 Schedule H for tax year 2010 and has extended the filing deadline for organizations that file those forms. In granting an automatic three-month extension, the IRS asked organizations filing Form 990 with Schedule H attached not to do so before July 1, 2011.

The Form 990, including Schedule H, filed by

a tax-exempt organization, is based on its Employer Identification number (EIN). Some EINs contain more than one hospital.

The Affordable Care Act provisions for tax-exempt hospitals apply to individual hospitals. The 2010 Schedule H instructs the filing organization to complete Part V for each hospital within its EIN. Part V asks questions related to the law's new requirements.

The form asks hospitals if their financial assistance policy explains the method for applying for financial assistance and specifies measures for publicizing the policy.

Reporting on community health needs assessment (Part V, lines 1-7) is optional for tax year 2010, but all other information must be reported

Hospitals must meet the assessment and implementation strategy requirements by 2012. The other requirements were effective in March 2010 when the law was enacted.

COMMUNITY HEALTH NEEDS ASSESSMENT

Schedule H asks, "During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment?" If the answer is yes, hospitals must answer a series of questions:

Did the needs assessment describe:

- A definition of the community served by the hospital?

- Demographics of the community?

- Existing health care facilities and resources within the community available to address health needs?

- The health needs of the community?

- Primary and chronic disease needs and other health issues of uninsured, low-income persons and minority groups?

- How data was obtained and the process used for identifying and prioritizing community health needs?

- The process used for consulting persons representing the community's interests?

- Information gaps that limit the hospital's ability to assess all of the community's needs? The Schedule H Instructions define information gaps as areas where additional information is needed to assess whether a particular health need exists.

In what tax year did the hospital last conduct a needs assessment?

Did the hospital take into account input from persons who represent the community served by the hospital?

If yes, hospitals are asked to describe in Part

VI of the form how the hospital did this and to identify the persons consulted.

Did the hospital conduct its needs assessment with one or more other hospitals? If the answer is yes, the other hospital facility or facilities should be listed in Part VI.

Is the needs assessment widely available to the public?

How — through the hospital's website, upon request or in other ways (which the hospital is asked to describe)?

If the hospital addressed needs identified in the needs assessment, how did it do so?

- By adopting and executing and implementation strategy?

- By participating in the development and execution of a community-wide plan? Hospitals are told to answer "yes" if they collaborated with others in the community to develop a written plan and carry it out.

- By including a community benefit section in operational plans and adopting a budget to provide service to address needs?

Did the hospital prioritize health needs in the community and prioritize services it will undertake to meet needs?

Did the hospital facility address all of the needs identified in its most recently conducted needs assessment?

If the answer is no, hospitals are asked to explain in Part VI which needs are not addressed and the reasons why the hospital has not addressed such needs. According to the instructions, an example could be that the facility had limited resources.

FINANCIAL ASSISTANCE POLICY

The new Schedule H asks hospitals if they have in place a written financial assistance policy and whether it includes:

- Eligibility criteria for financial assistance and if assistance includes free or discounted care.

- The use of federal poverty guidelines (FPG) and if so, the FPG family income limit (percentage) used for eligibility for free care and discounted care.

- The basis for calculating the amounts charged to patients. Does this include income

level, asset level, medical indigency, insurance status, uninsured discounts, Medicare/Medicaid, state regulations, or other factors (which need to be described in Part VI)? The Schedule H instructions say that other factors could include the amount budgeted for financial assistance.

The form asks hospitals if their financial assistance policy explains the method for applying for financial assistance and specifies measures for publicizing the policy. Options given for publicizing the policy include posting on the hospital's website; attaching with billing invoices; posting in emergency rooms, waiting rooms or admission offices; providing the policy in writing to patients upon admission to the facility, upon request, or other ways (which should be described).

BILLING AND COLLECTIONS

Schedule H asks hospitals if they had in place a separate billing and collections policy or written financial assistance policy that explained the actions they may take upon non-payment. Another question asks which of the following such actions

Hospitals are asked to indicate how they determined the amounts billed to patients who did not have insurance covering emergency or other medically necessary care.

are permitted under the hospital's policy: reporting to a credit agency, lawsuits, liens on residences, body attachments, other action (which should be described in Part VI).

Hospitals are then asked if they took any of the above actions during the tax year.

Another question asks about actions the hospital took (or authorized others to take) before initiating collection. Did it notify patients of the financial assistance policy on admission, prior to discharge or in communications (in person, tele-

phone, or invoice)? Did the hospital document its determination of whether a patient who applied for financial assistance was qualified for financial assistance?

EMERGENCY MEDICAL CARE

The form asks hospitals if they "have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?"

If the answer is no, hospitals are asked if this is because they do not provide emergency care, do not have a policy or whether they limit who is eligible to receive emergency care.

CHARGES

Hospitals are asked to indicate how they determined the amounts billed to patients who did not have insurance covering emergency or other medically necessary care. Options given include the lowest negotiated commercial rate for those services, the average of the three lowest negotiated commercial rates, the Medicare rate or other means, which should be described in Part VI.

The form asks:

- Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care?

- Did the hospital facility charge any of its patients an amount equal to the gross charge for any service provided to that patient?

If the answer is yes to either question, hospitals are to explain in Part VI.

JULIE TROCCHIO is CHA's senior director, community benefit and continuing care ministries, Washington, D.C. Write to her at jtrocchio@chausa.org

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