Track

- How do communicate internally about what we are doing?

Community Benefit Planning Tool

NAME OF PROGRAM:

TYPE OF PROGRAM: To be completed by Community Benefits or Accounting Department.

- ☐ A. Community health improvement
- ☐ B. Health professions education
- ☐ C. Subsidized health services
- ☐ D. Research
- ☐ E. Financial contribution
- ☐ F. Community-building activities
- ☐ G. Community benefit operations

Describe program and purpose:

What is the community need for this program?

- ☐ Program developed in response to a community health needs assessment identified need
- ☐ Board or management considered need as a primary rationale for the program
- ☐ Program requested by community member/group and is related to documented need
- ☐ Research demonstrated need for service

Does the program meet one the criteria listed below? (At least one must be checked)

- ☐ generates a low or negative margin
- ☐ responds to public health needs
- ☐ involves education or research that improves community health (see next page also)
- ☐ responds to needs of special population (state population)_____
- ☐ supplies services or programs that would likely be discontinued if were made on a purely financial basis

Does the program reach out to persons who are poor or underserved?

- ☐ persons living in poverty
- ☐ persons who are underserved
- ☐ persons in the broader community

Are any of these types of populations served? (may be more than one checked)

- ☐ 1. Persons with disabilities
- ☐ 2. Racial, cultural and ethnic minorities
- ☐ 3. Uninsured/underinsured
- ☐ 4. Other (describe)

Does the program meet at least one of the following basic community benefit objectives listed below? (at least one must be checked to qualify)

- ☐ Improve access to health care services?
- ☐ Enhance the health of the community?
- ☐ Advance knowledge through professional education or research?
- ☐ Relieve the burden of government or other non-profit organization to provide?

Which age groups are targeted? (may be more than one)

- ☐ Infants
- ☐ Adults
- ☐ Children
- ☐ Seniors
- ☐ Teenage
- ☐ All Ages

Does program target a specific gender? ☐ Male ☐ Female ☐ Both

Is the program evidence-based (has it been proven to work in this or other communities)? ☐ Yes ☐ No

If so, provide explanation:

List anticipated outcomes and how these outcomes can be measured	
Anticipated outcome:	**Measure(s)** How will you determine if outcome was reached?
Anticipated outcome:	**Measure(s)** How will you determine if outcome was reached?

List specific action steps that your program will complete in order to complete the project. Also indicate a time frame for each action step.

Action step	Time frame
1.	
2.	
3.	
4.	

List the resources that will be needed to implement the program and action steps. Include staff, facility space, money, materials and volunteers.

1.
2.
3.

Will (or can) this program be a collaborative effort with others in the community? If so, who?

Provide contact person name, phone number and e-mail address:

Goals

- Goals are general statements about what changes your program hopes to achieve. They answer the question: What will be different in people's lives or the community as a result of the program?

Objectives

- Objectives are more precise statements of a goal that clearly state:
  - the name of the program,
  - the primary client or target population,
  - the behavior or condition that will be changed,
  - how it will be changed,
  - by how much and
  - the time frame for the change.
- Objectives can be short-term, intermediate, or long-term.

Objective example

- The _____ program will _____ (increase, decrease, add, create, modify) _____ (a condition or behavior) among (whom) through or by (how) _____ _____ % (how much) from a baseline of _____ by (specific date).

Indicators

- Indicators are a measure of whether an objective has been met. For each objective, ask:

How will I know if this objective has been accomplished?

The answer is your indicator.

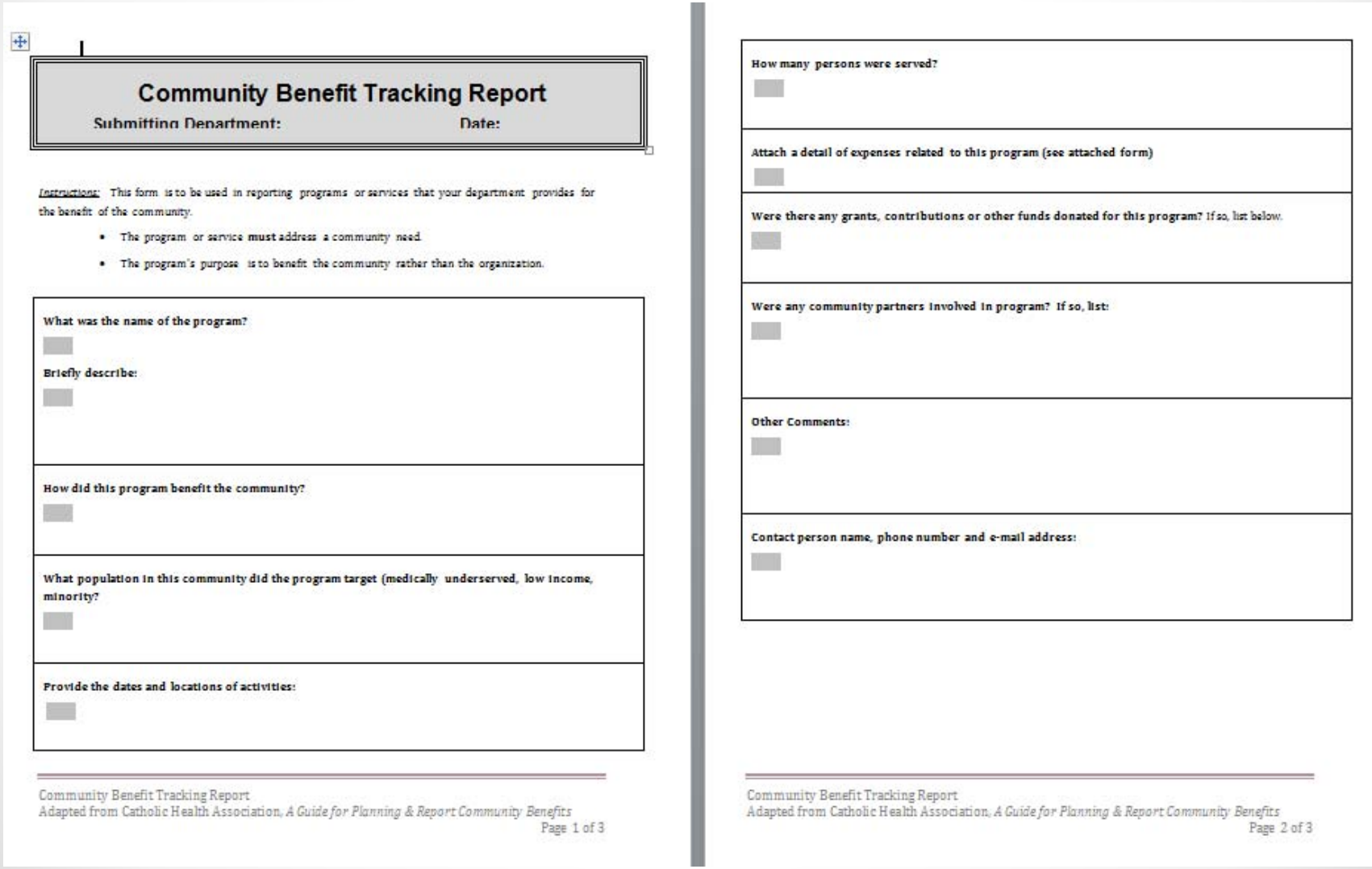
Solutions

- When dealing with problems without clear solutions,
  look for evidence-based programs, that is, approaches that have been tried and proven successful. Sources for evidence-based programs include the Centers for Disease
  Control and Prevention, public health literature and other published articles about successful programs.

Measurable outcomes

- Outcomes describe the type and amount of items the program will
  - o Produce
  - o Provide
  - o Generate or
  - o Number of persons who will be served or who participated.

Community Benefit Tracking Report



Community Benefit Tracking Report

Submitting Department: Date:

Instructions: This form is to be used in reporting programs or services that your department provides for the benefit of the community.

- The program or service must address a community need.
- The program's purpose is to benefit the community rather than the organization.

What was the name of the program?

Briefly describe:

How did this program benefit the community?

What population in this community did the program target (medically underserved, low income, minority?

Provide the dates and locations of activities:

Community Benefit Tracking Report
Adapted from Catholic Health Association, *A Guide for Planning & Report Community Benefits*
Page 1 of 3

How many persons were served?

Attach a detail of expenses related to this program (see attached form)

Were there any grants, contributions or other funds donated for this program? If so, list below.

Were any community partners involved in program? If so, list:

Other Comments:

Contact person name, phone number and e-mail address:

Community Benefit Tracking Report
Adapted from Catholic Health Association, *A Guide for Planning & Report Community Benefits*
Page 2 of 3

Community Benefit Activity Costs

(file one report for each activity occurrence)

Submit report to Accounting Office

Project		Project Coordinator	
# Persons served	# Handouts	Code	
Activity Date:		Activity Location:	

NOTE: The dollar value of time spent by salaried employees can be included if the employee is participating during "paid work time" AND if participation is clearly part of the individual's job responsibilities.

Complete only non-shaded areas below.

Personnel:					
Name	Dept.	Hours	Direct cost	Indirect costs	
Materials: attach support					
Description			Direct cost	Indirect costs	
Other expenses: attach support					
Description			Direct cost	Indirect costs	
			Direct	Indirect	Total
		Total Costs			

Page 3 of the report will be used to gather information for use in quantifying the cost of the project.

Cost measurement

- The cost of a community benefit project must be reported to the Internal Revenue Service.
- The project costs will include two components:
  - Direct costs
  - Indirect costs

Direct Costs

Costs that can be directly identified with the services

- Staff costs
- Materials
- Handouts
- Brochures
- Supplies

Personnel:			
Name	Dept.	Hours	Direct cost
Materials: attach support			
Description			Direct cost
Other expenses: attach support			
Description			Direst cost

Indirect costs

Personnel:				
Name	Dept.	Hours	Direct cost	Indirect costs
Materials: attach support				
Description			Direct cost	Indirect costs
Other expenses: attach support				
Description			Direst cost	Indirect costs

Indirect costs are allocated to projects by accounting

- o Fringe benefits
- o Purchasing
- o Finance/accounting
- o Utilities
- o Depreciation

If benefit cannot be quantified

Report these services in a narrative form.

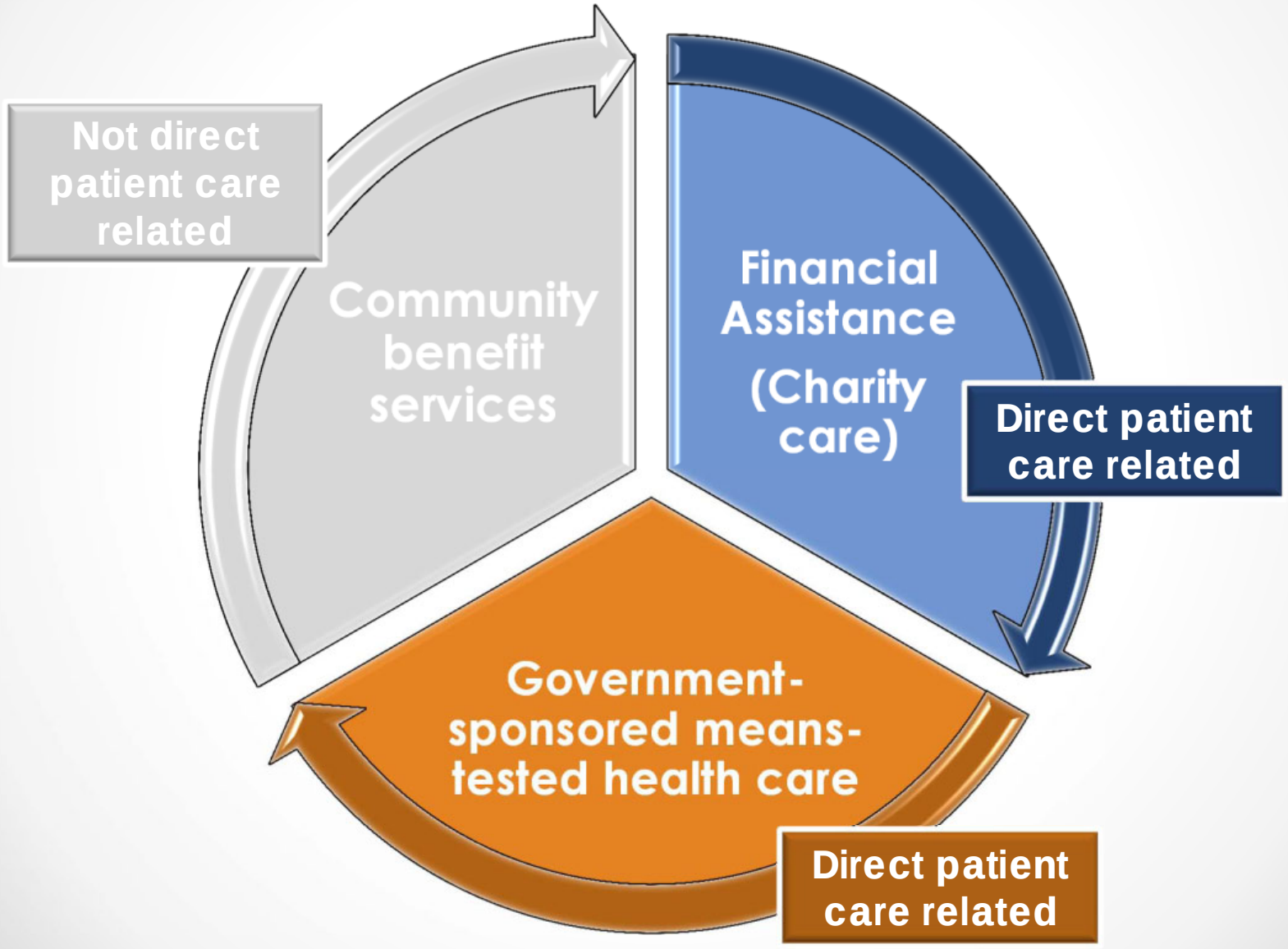
- Significant community benefit, but break even or involve minimal cost.
- Better described in terms of benefit provided rather than dollars spent (including low cost or grant supported programs).
- Are provided entirely **by volunteers** or involve staff donating their own time to the program.

Report

"Standardized accounting of community benefit allows policy makers, regulators and the public to compare hospital community benefit efforts accurately and improves the acceptance of reported information."

Source: Catholic Health Association, "A Guide for Planning and Reporting Community Benefit", Chapter 5

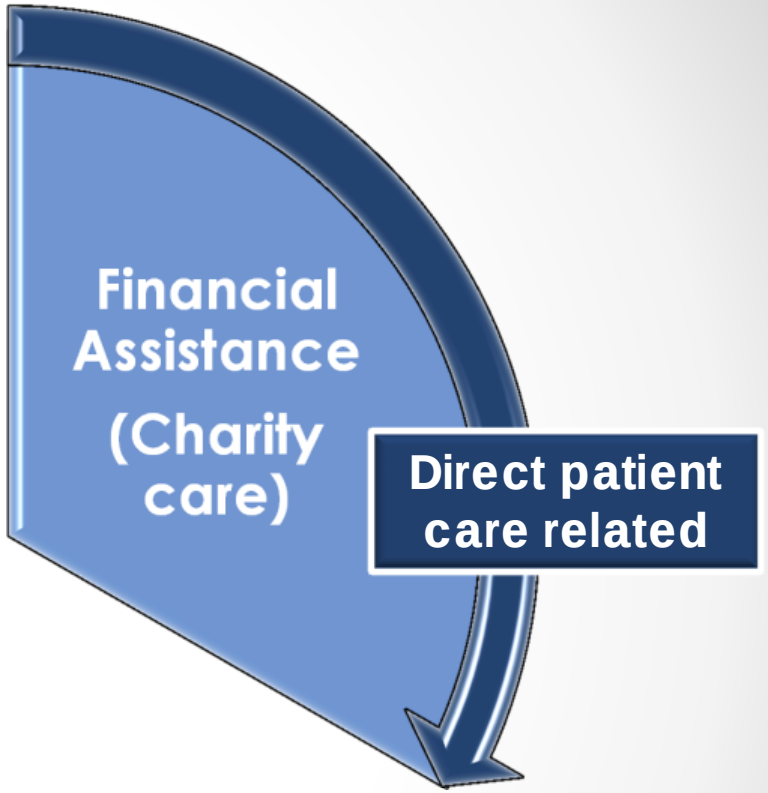
Community Benefit Categories



Financial assistance

Financial assistance is one of the most significant community benefits provided by tax-exempt organizations.

Therefore it is critical that charity care be identified and quantified when reporting community benefits.



Financial assistance

- Financial assistance is an important indicator of the organization's fulfillment of its tax-exempt purpose.
- Identification is critical to State and Federal reporting on charity care and community benefits.

Financial assistance reporting

- Includes free and partially discounted care provided to persons who meet organization's financial assistance policy. (Report to IRS "cost", not gross charges)
- Includes "medically" indigent

  Persons whom the organization has determined are unable to pay some or all of their medical bills because their medical bills exceed a certain percentage of income or assets, even though they have income or assets that otherwise exceed the general eligibility requirements for free or discounted care under the financial assistance policy.

Financial assistance reporting

- Includes the expenses of the charity care program.
- Includes provider taxes, assessments or fees if Medicaid DSH funds in your state are used in whole or in part no offset the cost of charity care.

Financial assistance reporting

- DO NOT COUNT:
  - Discounts provided to self-pay (uninsured) patients who do not qualify for financial assistance
  - Contractual allowances or quick-pay discounts
  - Medicare and Medicaid short-falls (reported elsewhere)
  - Bad debt

Bad debts or charity?

Bad debt

- A person has the financial capacity to pay, but is unwilling to settle the claim.
  - May be total charges billed
  - May be a portion of charges billed

Charity

- A patient has a demonstrated inability to pay.
  - May be total charges billed
  - May be a portion of charges billed

Criteria for financial assistance

- Each organization establishes its own financial assistance policies.
- Policies should be clearly documented and approved by organization's governing body.
- Section 9007 of the Affordable Care Act provides governmental requirements for items to be included in policies.

Affordable Care Act Section 9007

Financial Assistance Policy

(Charity Care)

Financial assistance policies

`(4) FINANCIAL ASSISTANCE POLICY- An organization meets the requirements of this paragraph if the organization establishes the following policies:

`(A) FINANCIAL ASSISTANCE POLICY- A written financial assistance policy which includes--

`(i) eligibility criteria for financial assistance, and whether such assistance includes free or discounted care,

`(ii) the basis for calculating amounts charged to patients,

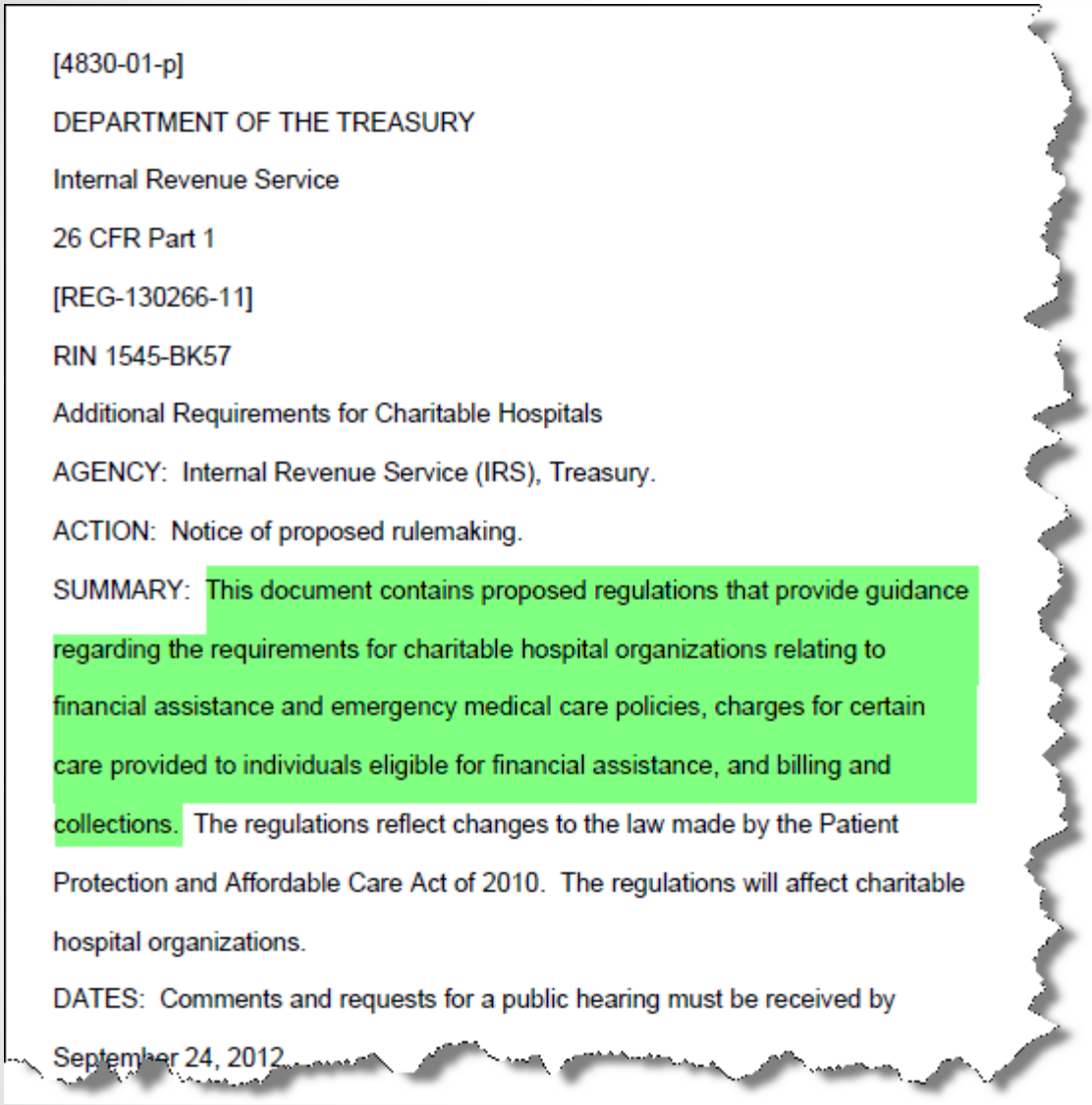
`(iii) the method for applying for financial assistance,

`(iv) in the case of an organization which does not have a separate billing and collections policy, the actions the organization may take in the event of non-payment, including collections action and reporting to credit agencies, and

`(v) measures to widely publicize the policy within the community to be served by the organization.

Emergency care policies

`(B) POLICY RELATING TO EMERGENCY MEDICAL CARE- A written policy requiring the organization to provide, without discrimination, care for emergency medical conditions (within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd)) to individuals regardless of their eligibility under the financial assistance policy described in subparagraph (A).



[4830-01-p]

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[REG-130266-11]

RIN 1545-BK57

Additional Requirements for Charitable Hospitals

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking.

SUMMARY: This document contains proposed regulations that provide guidance regarding the requirements for charitable hospital organizations relating to financial assistance and emergency medical care policies, charges for certain care provided to individuals eligible for financial assistance, and billing and collections. The regulations reflect changes to the law made by the Patient Protection and Affordable Care Act of 2010. The regulations will affect charitable hospital organizations.

DATES: Comments and requests for a public hearing must be received by September 24, 2012.

On June 22, 2012, the Internal Revenue Service finally released proposed regulations providing guidance on the remainder of the PPACA 501(r) provisions.

Proposed Regulatory Guidance

Financial Assistance

Emergency Care Policy

Limitation on Charges

Billing and Collections

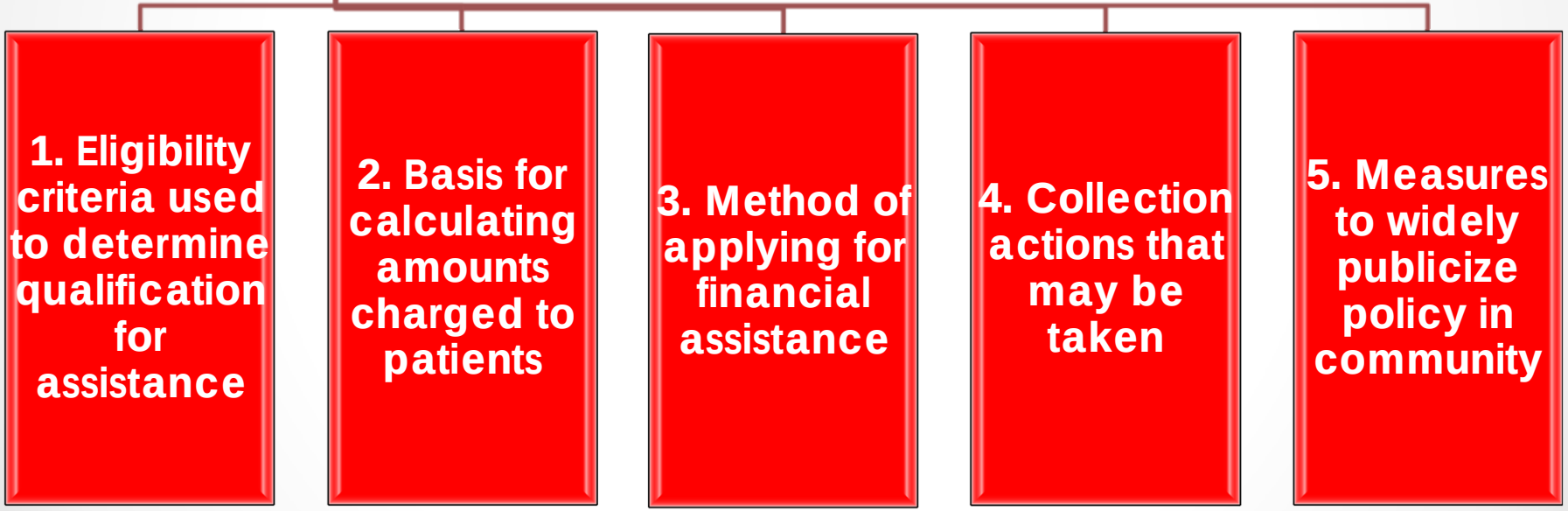
Financial Assistance

Proposed Regulation 1.501(r)-4:

- Requires a written FAP and a written emergency care policy.
- Requires the FAP to apply, at a minimum, to all emergency and medically necessary care provided by the hospital.
- Does not mandate any specific FAP eligibility criteria.
- Treasury is seeking comments on a potential link between the FAP and the needs identified in the CHNA.

Financial Assistance (FAP)

Section 501(r)(4) requires a hospital facility to establish a written financial assistance policy that must include the following:



1. Eligibility criteria used to determine qualification for assistance

- Specify **all of the eligibility criteria** an individual must satisfy for each type of assistance offered.
- Describe **all** of the assistance available, including discounts and free care, or other assistance. If discounts are provided, the policy must specify the amounts to which the discounts will apply.

2. Basis for calculating amounts charged to patients

- Once FAP eligibility is determined, **limit the amounts charged such individuals to not more than the amounts generally billed to insured individuals** for emergency and medically necessary care.
- Describe how the amounts generally billed insured patients are determined.

3. Method of applying for financial assistance

Methods for applying for financial assistance

- Describe how to apply.
- Describe the **specific information** and documentation required as part of the application process.
- Provide contact information for assistance with the FAP process.

4. Collection actions that may be taken

Actions available for nonpayment of a bill must be described either as part of the FAP or in a separate billing and collections policy.

- Actions any authorized party may take to obtain payment,
- The process and time frames the facility or authorized party uses in taking such actions
- The reasonable efforts made to determine FAP eligibility before engaging in any extraordinary collection actions
- The office or department with final authority for determining whether reasonable efforts to determine FAP eligibility have been made.

5. Measures to widely publicize policy in community

A. Make the FAP, FAP application form, and a ***plain language summary*** of the FAP widely available on a website,

B. Make paper copies of the FAP, FAP application form, and ***plain language summary*** of the FAP available upon request and without charge, both in public locations in the hospital facility and by mail, **in English and in the primary language of any populations with limited proficiency in English that constitute more than 10 percent of the residents of the community** served by the hospital facility;

All measures must be used.

5. Measures to widely publicize policy in community

C. Inform and notify visitors to the hospital facility about the FAP through **conspicuous** public displays;

D. Inform and notify residents of the community served by the hospital facility about the FAP in a manner reasonably calculated to reach those members of the community who are most likely to require financial assistance.

All measures must be used.

5. Measures to widely publicize policy in community

Plain language summary

- Written;
- Brief description of eligibility requirements and assistance offered;
- Direct website address and physical location(s) where individual can obtain copies of FAP and FAP application;
- Instructions on how to obtain a free copy of FAP and FAP application by mail;
- Contact information of staff who can provide information about FAP and FAP application process;
- Availability of translations of FAP, application and summary;
- Statement that no FAP-eligible individual will be charge more for emergency or other medically necessary care than AGB.

Emergency Care Policy

- Requires a hospital facility to provide care for emergency medical conditions without discrimination to all individuals **regardless of whether they are FAP eligible**; and

- **Prohibits debt collection activities** from occurring that may interfere with emergency medical treatment.

Limitation on Charges

- Limit the amount charged **for any emergency or other medically necessary care provided to a FAP-eligible individual** to not more than the **amounts generally billed** to individuals with insurance covering that care (**AGB**).

- Limit the amount charged for any other medical care provided to a FAP-eligible individual to less than the gross charges for that care.

Limitation on Charges

Methods to determine Amounts Generally Billed (AGB)

Look Back

- Based on actual fee for service claims.
- May be Medicare only
- May be Medicare only OR Medicare plus private health insurers

Prospective

- Based on Medicare claims only

Look Back

Calculated annually
Based on a prior 12-month period
Includes payments for deductibles and co-payments.

$$AGB\% = \frac{\text{Sum of } \textbf{all} \text{ claims payments for ER and other } \textbf{medically necessary} \text{ care } \textbf{PAID IN FULL*}}{\text{Gross charges related to claims}}$$

***1) Medicare primary only OR 2) Medicare plus private insurers**

May have more than one AGB% - allowed to compute for different categories of care

Look Back

Example 1 – Combined

On January 15 of year 1, Y, a hospital facility, generates data on all claims paid to it in full for emergency or other medically necessary care by all private health insurers and Medicare fee-for-service as primary payers over the immediately preceding calendar year.

Y determines that it received a total of $360 million on these claims from the private health insurers and Medicare and another $40 million from their insured patients and Medicare beneficiaries in the form of deductibles, co-insurance, and co-payments.

Y's gross charges for these claims totaled $800 million.

Example 1 – Combined

Y calculates that its AGB percentage is 50 percent of gross charges ($400 million/$800 million x 100).

Y determines AGB for any emergency or other medically necessary care it provides to a FAP-eligible individual between February 1 of year 1 *(less than 45 days after the end of the 12-month claim period)* and January 31 of year 2 by multiplying the gross charges for the care provided to the individual by 50%.

Look Back

Example 2 – Medicare Only

On September 20 of year 1, X, a hospital facility, generates data on all claims paid to it in full for emergency or other medically necessary care by Medicare fee-for-service as the primary payer over the 12 months ending on August 31 of year 1.

X determines that, of these claims for inpatient services, it received a total of $80 million from Medicare and another $20 million from Medicare beneficiaries in the form of co-insurance or deductibles. X's gross charges for these inpatient claims totaled $250 million.

X calculates that its AGB percentage for inpatient services is 40 percent of gross charges ($100 million/$250 million x 100).

Look Back

Example 2 – Medicare Only

Of the claims for outpatient services, X received a total of $100 million from Medicare and another $25 million from Medicare beneficiaries.

X's gross charges for these outpatient claims totaled $200 million. Its AGB percentage for outpatient services is 62.5 percent of gross charges ($125 million/$200 million x 100).

Look Back

Example 2 – Medicare Only

Between October 15 of year 1 *(45 days after the end of the 12-month claim period)* and October 14 of year 2, X determines AGB for any emergency or other medically necessary inpatient care it provides to a FAP eligible individual by multiplying the gross charges for the inpatient care it provides to the individual by 40%.

The AGB for any emergency or other medically necessary outpatient care it provides to a FAP-eligible individual is determined by multiplying the gross charges for the outpatient care it provides to the individual by 62.5%

Prospective

Bill patients using the same billing and coding methodology as used for Medicare.

Example:

Z is a hospital facility. Whenever Z provides emergency or other medically necessary care to a FAP-eligible individual, Z determines the AGB for the care by using the billing and coding process it would use if the individual were a Medicare fee-for-service beneficiary and setting AGB for the care at the amount it determines Medicare and the Medicare beneficiary together would be expected to pay for the care.

Billing and Collections

Billing statement may state the gross charges as the starting point to which contractual allowance, discounts, or deductions are applied AS LONG AS the individual is expected to pay less than gross charges.

Billing and Collections

Safe Harbor

May charge more than AGB **IF**

1. The FAP-eligible individual has not submitted a **complete** FAP application as of time of charge; and
2. Hospital is making reasonable efforts to determine if individual is FAP-eligible during applicable time periods

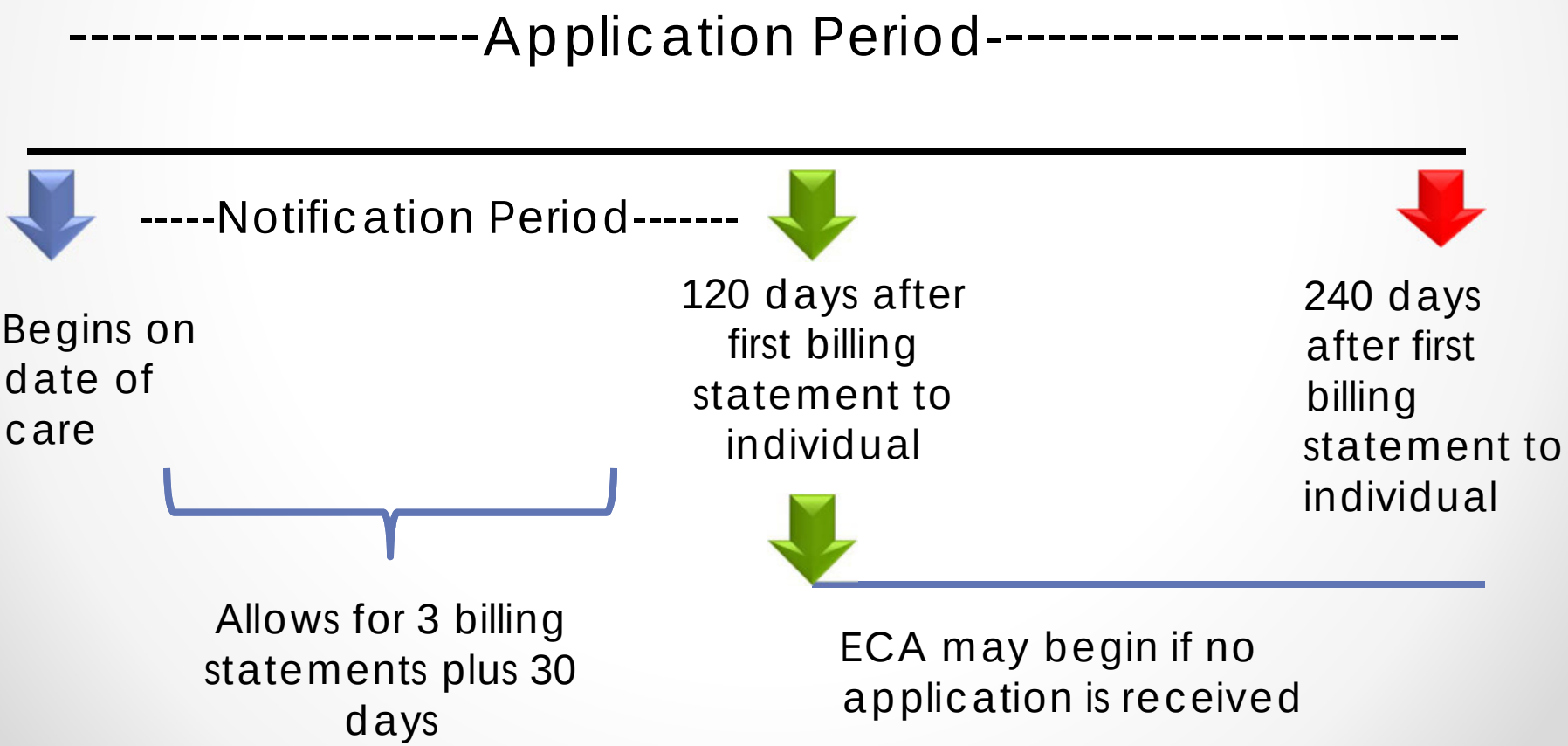
Billing and Collections

MUST forego extraordinary collection actions before the hospital has made **reasonable efforts** to determine whether the individual is eligible for financial assistance.

To have made a reasonable effort, a hospital facility should:

- Notify the individual about its FAP during the notification period;
- Follow up with regard to incomplete applications in a prescribed manner;

Reasonable efforts to determine eligibility for financial assistance



Extraordinary collection efforts

ECAs that require a legal or judicial process include, but are not limited to, actions to—

- Place a lien on an individual's property;
- Foreclose on an individual's real property;
- Attach or seize an individual's bank account or any other personal property;
- Commence a civil action against an individual;
- Cause an individual's arrest;
- Cause an individual to be subject to a writ of body attachment; and
- Garnish an individual's wages.

Extraordinary collection efforts

Reporting to credit agencies is an ECA? **YES**

Is sale of an individual's debt an ECA? **YES**

Referral to collection agency

- Debts may be referred to third parties to assist with collection actions at any time, including the initial 120-day notification period.

Extraordinary collection efforts

Do Not Include:

- Deferring or denying non-emergency care based on a pattern of nonpayment,
- Requiring deposits before providing non-emergency care, or
- Charging interest for non-emergency care.

Governing board approval is not required before engaging in ECAs.

Effective dates

- Proposed to apply for taxable years beginning ***on or after the date*** these rules are ***published in the Federal Register*** as final or temporary regulations.