Starting with fiscal years that begin in 2009, all U.S. tax-exempt hospitals must complete and submit the entire IRS Form 990 Schedule H. Organized into six parts, Schedule H requires hospitals to:

- Summarize their charity care policies
- Document their community benefits and community building programs
- Identify how they meet community healthcare needs
- Describe other activities or characteristics that the IRS associates with tax-exempt status and/or believes important to disclose to the public

Schedule H also requires that hospitals clearly distinguish between charity care (for patients the hospital determines are financially unable to pay all or portions of their bills based on the hospital’s financial assistance policy) and bad debt (for patients the hospital determines to have ability to pay but have not).

Much of Schedule H can be completed in a relatively straightforward fashion—by following the instructions, completing accounting worksheets that have been available in various forms for about 20 years, and preparing cogent responses to the open-ended questions in Part VI.

However, the second page of the schedule includes a question that is proving particularly challenging for hospitals to answer. Part III, Section A, Line 3 states: “Enter the estimated amount of the organization’s bad-debt expense (at cost) attributable to patients eligible under the organization’s charity care policy.”

AT A GLANCE

- IRS Form 990 Schedule H requires hospitals to estimate the amount of bad debt expense attributable to patients eligible for charity under the hospital’s charity care policy.
- Responses to Schedule H, Part III.A.3 open up the entire patient collection process to examination by the IRS, state officials, and the public.
- Using predictive analytics can help hospitals efficiently identify charity-eligible patients when answering Part III.A.3.

For a description of elements to look for when evaluating predictive analytics, go to www.hfma.org/hfm.
Part III.A.3 emerged from a policy debate about whether bad debt should be counted (in whole or in part) as a community benefit (i.e., in Part I of Schedule H). The question is challenging from multiple perspectives:

> The answers will have policy significance in terms of future community benefit reporting and exemption standards for hospitals.
> Different stakeholders may reach different conclusions regarding the answers.
> The value requested never has been required as a part of routine financial reporting or patient accounting.
> Hospitals will not all use the same method to develop answers.
> No generally accepted methodology has yet been developed.

**High-Stakes Issue**

Answers to this and other questions on Schedule H may open up the entire patient collection process (including outsourced elements) to examination by the IRS, state officials, and the public. This scrutiny will be occurring amid continued concern regarding how patients are treated by some hospitals during the billing and collection process. For example:

> Provisions in proposed federal health reform legislation would require that hospitals make reasonable attempts to qualify patients for financial assistance before taking certain extraordinary collection actions.
> Several states—including California, Connecticut, Illinois, Maryland, and Massachusetts—are regulating collection practices for uninsured and/or charity-eligible patients.
> A new Consumer Financial Protection Agency has been proposed in response to the financial crisis, creating another entity that may regulate how medical debts are collected from consumers.

Interestingly, several of the recent and emerging governmental initiatives are making it clear that all business partners, including those who undertake patient collections on behalf of hospitals, are equally accountable for identifying patients who are potentially eligible for charity care programs and for complying with hospital policy.

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**Hospitals are simplifying and streamlining documentation requirements associated with the charity care eligibility process.**

**Answer Using Any Reasonable Method**

The Schedule H Part III.A.3 instructions clarify that hospitals are to value bad debt (at cost) for patients “for whom sufficient information was not obtained to make a determination of their eligibility” for charity care—using any reasonable method.

The question thus focuses on patient balances where hospitals (and/or third-party agents) do not have enough information to grant financial assistance based on the charity care policy, or to reclassify balances from bad debt to charity care. These accounts can be referred to as the “unknowns.” Accordingly, Part III.A.3 could be restated as follows: What is the value of the bad debt (at cost) for patients who would have qualified for financial assistance (pursuant to the hospital’s charity care policies) if documentation required by the hospital had been available?

Organizations should ensure that any amount reported for Part III.A.3 is not also reported as charity care in Part I of Schedule H. The Schedule H instructions are quite clear that no amounts reported in Part III should be double counted in Part I.

The instructions further state that hospitals can answer the question using any reasonable methodology, including “record reviews, assessment of charity care applications that were denied due to incomplete documentation, or other analytical methods.”

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*a. Internal Revenue Service, Instructions for IRS Form 990, Schedule H, Tax Year 2008.*
How Readers May Interpret Results
Regardless of the methodology that the hospital selects, readers will form their own conclusions based on the results.

On one end of the spectrum, a high value in Part III.A.3 (in dollar or percentage terms) unfortunately could be interpreted as suggesting that the hospital has any of the following:
> Comparatively restrictive charity care policies
> An inefficient, ineffective, or under-resourced self-pay revenue cycle process
> A weak, inaccessible financial counseling process
> Large numbers of patients who do not cooperate with the charity eligibility process
> Third-party agents that are not helping the hospital document charity care eligibility
> Large numbers of charity-eligible patients subjected to collection actions
> No policy for making patients aware of the availability of financial assistance so applications are not being initiated
> Requirements of patients to submit too much, hard-to-understand documentation to qualify for financial assistance

On the other end of the spectrum, a low or zero value for Part III.A.3 could be interpreted as implying that the hospital has:
> A highly effective financial counseling and self-pay revenue cycle process that appropriately and accurately grants charity care to all qualifying patients
> Effective communication to all patients regarding the availability of financial assistance
> A charity care application process that facilitates completion of the financial application in all cases
> A solid, fact-based methodology (supportable under GAAP) for reclassifying bad-debt accounts into charity
> A solid process for third-party collection agencies to identify all patients who could be charity-eligible

Reporting $0 as the answer to Part III.A.3 has its risks, because the hospital can be viewed as asserting that all patients who could be eligible for charity received appropriate discounts through the hospital financial assistance program.

State of Hospital Charity Processes
Most hospitals are somewhere in the middle of this continuum. They make strong efforts to qualify eligible patients for financial assistance, but some still slip through the cracks. Illiteracy, language barriers, embarrassment, cultural issues, fear, pride, and many other elements contribute to patients slipping through. Revenue cycle processes have gaps—and often a patient’s ultimate out-of-pocket payment responsibility is determined long after the service has been provided.

Many hospitals are revamping their charity care policies and are publicizing them more widely. Charity care policies increasingly are allowing hospitals to grant free care based on “presumptive eligibility” criteria. Under these criteria, if a

POTENTIAL REACTIONS TO HIGH AND LOW PERCENTAGE OF CHARITY CARE DOCUMENTED IN SCHEDULE H PART III.A.3

0% “There is no charity in my bad debt.”
> “Perfect” financial counseling and self-pay revenue cycle process.
> All unknown patients who are charity eligible are identified through methods approved in the charity care policy, and reclassified from bad debt to charity.
> All patients are knowledgeable of the availability of charity care and apply for it.

100% “All my bad debt is from charity patients.”
> Self-pay process does not separate those who can pay from those who cannot.
> Patients without the ability to pay are subjected to collection actions.
> All patients who have ability to pay do so during active A/R.
> Third-party agents are unsupervised.
> All bad debt is from nonresponsive low-income patients.
> The charity application process is too complicated for patients.
> Availability of charity care has not been well communicated.

b. See HFMA’s P&P Board Sample Hospital Charity Care Policy and Procedures (www.hfma.org/library/accounting/reporting/400647.htm).
patient is found to be homeless or already qualifies for a means-tested government program, he or she can be classified as presumptive charity as soon as this information is known.

Hospitals also are simplifying and streamlining documentation requirements associated with the charity care eligibility process. They are investing in more financial counselors and other resources to help patients through the eligibility process and to support appropriate account classification early in the revenue cycle. They are requiring third-party agencies to assist in identification of charity-eligible patients and to follow hospital policy.

**Answering Part III.A.3**

While these efforts are under way, hospitals still must provide the value requested in Part III.A.3. Hospitals may use either a manual process or predictive analytics to determine this estimate.

**Manual process.** Hospitals using manual procedures can provide a yield analysis of their financial counseling efforts. Hospitals can research registration, financial counseling, or other financial records to determine a percentage of accounts that have a potential for charity care classification, but for which required documentation was not obtained and therefore ended up in bad debt.

Using the manual process, a hospital first should identify whether any patients can qualify for free care on a presumptive basis. Those accounts can be reclassified as charity and reported in Part I of Schedule H if the hospital’s charity care policy permits. For those accounts, collections activity should cease and any adverse credit reporting should be reversed.

After presumptive eligibility has been assessed, the hospital still will have self-pay accounts with bad debt that represent “unknowns” (the hospital does not have sufficient information to qualify patients for charity). These accounts can include patients who did not initiate or complete the application process. For hospitals relying on a manual process, the answer to Part III.A.3 can be calculated as follows:

1. Determine the value of bad debt for the “unknown” accounts
2. Calculate a ratio of the dollar value of charity care approvals (including presumptive patients) to the total dollar value of all approved and denied accounts assessed (the approval rate)
3. Apply the approval rate to the value of bad debt for “unknown” accounts
4. Convert the resultant charges to cost, pursuant to the Schedule H instructions

The exhibit on page V illustrates the calculation.

### COMPARISON OF METHODS USED TO ANSWER FORM 990 SCHEDULE H PART III.A.3

<table>
<thead>
<tr>
<th>Method</th>
<th>Approach</th>
<th>Benefits / Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial counseling audit</td>
<td>Ratio analysis of accounts processed through financial counseling or qualifying as presumptively eligible</td>
<td>&gt; Highly manual&lt;br&gt; &gt; Fails to overcome any skewing between nonresponsive and responsive accounts&lt;br&gt; &gt; Inaccurate if financial counselors do not interact with all patients and offer them charity review&lt;br&gt; &gt; Requires a process to address patients believed to have third-party coverage at registration but who later are determined to be self-pay&lt;br&gt; &gt; Likely underestimates true value</td>
</tr>
<tr>
<td>Predictive analytics on unknown accounts</td>
<td>Predictive assessment of charity care versus bad-debt accounts</td>
<td>&gt; Automated approach&lt;br&gt; &gt; Comprehensive, consistent, and repeatable&lt;br&gt; &gt; Not dependent on financial counseling process performance&lt;br&gt; &gt; Overcomes patient engagement issues&lt;br&gt; &gt; Can be measure of ongoing efficacy&lt;br&gt; &gt; Cost of model may be reportable as community benefit</td>
</tr>
</tbody>
</table>

**USE HFMA RESOURCES**
The **PATIENT FRIENDLY BILLING** project provides resources on charity care identification and best-practice organizations. www.patientfriendlybilling.org
The manual approach usually requires substantial staff effort and time to gather the source information. It also does not account for patients who do not enter the financial counseling process at all or who present claiming third-party sponsorship that later is lost.

Moreover, because patients may avoid or be missed by the financial counseling efforts for any number of reasons, the “unknown” population can be expected to have a disproportionate share of charity-eligible patients. As a result, the manual approach can significantly underestimate the amount of bad debt attributable to potentially charity-eligible patients.

**Predictive analytics.** The use of predictive analytics is less labor-intensive and provides solid logic and supporting data for the reported value.

Effective predictive analytics considers demographic information provided at registration and accesses third-party information to estimate ability to pay. Individual models incorporate different third-party information to determine household income levels. Model results can be correlated to the federal poverty guidelines and the hospital’s charity care policy, allowing charity to be granted even if all required documentation is not available.

Predictive analytics offer several benefits. The analytic models can consistently and repeatedly assess whether an unknown account would have qualified for financial assistance based on a hospital’s charity care policy, if required documentation were available. Every patient balance can be assessed, even if patients were unable to interact with financial counselors or if eligibility for third-party coverage is not finalized until late in the revenue cycle.

Better predictive analytics can be calibrated to a hospital’s specific charity policy and sliding fee discounts for patients who could qualify for partial charity discounts. Hence, they are not simply yes/no flags. Robust, calibrated analytics can provide a solid, auditable basis for amounts reported on Schedule H.

Over time, predictive analytics can help assess the effectiveness of a hospital’s financial counseling process. A downward trend in the volume and value of self-pay accounts being identified by the model as charity at bad-debt assignment could indicate systematic improvement.

Interestingly, the cost of the predictive analytics itself also can be considered a reportable community benefit expense, if charity care is being granted based on the model’s results.

For a description of elements created by the authors to look for when evaluating predictive analytics, go to www.hfma.org/hfm.

### Example of Manual Calculation for Part III.A.3

<table>
<thead>
<tr>
<th>1. Determine % of patients qualified for charity</th>
<th>Sample Amount</th>
<th>Formula</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value (at cost) of accounts successfully qualified for charity (including presumptive approvals)</td>
<td>$7 million</td>
<td>A</td>
</tr>
<tr>
<td>Value (at cost) of accounts denied charity in financial counseling process</td>
<td>$3 million</td>
<td>B</td>
</tr>
<tr>
<td>Approval rate of financial counseling</td>
<td>70%</td>
<td>C = A/(A + B)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Apply % to “unknowns”</th>
<th>Sample Amount</th>
<th>Formula</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value (at cost) of accounts that did not complete financial counseling and assigned to bad debt, “unknowns”</td>
<td>$5 million</td>
<td>D</td>
</tr>
<tr>
<td>Approval rate of financial counseling</td>
<td>70%</td>
<td>E = C × D</td>
</tr>
<tr>
<td>Estimated charity (at cost) in bad debt</td>
<td>$3.5 million</td>
<td></td>
</tr>
</tbody>
</table>

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Example of Applying Predictive Analytics to Schedule H

The following example demonstrates the application of predictive analytics to Schedule H Part III.A.3.

First, the hospital should ensure that the accounts of patients who are bankrupt, deceased, or could qualify as presumptively eligible for charity are identified and appropriately classified before running the model.

Assume that a hospital, after granting charity on a presumptive basis (pursuant to hospital policy), has $10 million in bad-debt expense (at charges) and runs predictive analytics on all of these accounts. Predictive analytics indicates that 25 percent of the $10 million in bad debt is for patients who can be presumed to qualify for charity. The hospital then can use the 25 percent factor in one of the following two ways, depending on whether the charity care policy allows reclassification of accounts based on predictive analytics results:

> Reclassify $2.5 million in bad debt to charity (25 percent of $10 million) and report that amount as charity (before converting to cost) in Part I of Schedule H.

Then, under both approaches, apply the 25 percent factor to the value of “unknown” accounts—those that could not be assessed by the model—and include the resultant amount in Part III.A.3 before converting to cost.

Then, again under both approaches, add an amount in Part III.A.3 that reflects the model’s estimated error rate. The model used in this article’s example has a known error rate of 20 percent. This error could be in either direction (i.e., overestimating or underestimating); however, the most conservative approach is to assume that the tool is underestimating the amount of charity care in bad debt.

The exhibit below summarizes the example calculations.

A hospital should not adopt the first approach unless its charity care policies explicitly allow account reclassification using predictive

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**Example of Predictive Modeling Applications for Schedule H Part III.A.3**

<table>
<thead>
<tr>
<th>Example Calculations</th>
<th>If Reclassify</th>
<th>Formulas</th>
<th>If Don’t Reclassify</th>
<th>Formulas</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Value before analytics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total charity care (charges)</td>
<td>$8 million</td>
<td>A</td>
<td>$8 million</td>
<td>A</td>
</tr>
<tr>
<td>Total bad debt expense (charges)</td>
<td>$10 million</td>
<td>B</td>
<td>$10 million</td>
<td>B</td>
</tr>
<tr>
<td><strong>Predictive modeling results</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of sample proving to be charity eligible</td>
<td>25%</td>
<td>C</td>
<td>25%</td>
<td>C</td>
</tr>
<tr>
<td>% of sample not able to be evaluated</td>
<td>10%</td>
<td>D</td>
<td>10%</td>
<td>D</td>
</tr>
<tr>
<td>Error estimation (provided by modeling resource)</td>
<td>20%</td>
<td>E</td>
<td>20%</td>
<td>E</td>
</tr>
<tr>
<td><strong>Bad debt implications</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bad debt that is likely charity</td>
<td>$2.5 million</td>
<td>F = B × C</td>
<td>$2.5 million</td>
<td>F = B × C</td>
</tr>
<tr>
<td>Bad debt of which was not evaluated</td>
<td>$7.5 million</td>
<td>G = B − F</td>
<td>$7.5 million</td>
<td>G = B − F</td>
</tr>
<tr>
<td></td>
<td>$1 million</td>
<td>H = D × B</td>
<td>$1 million</td>
<td>H = D × B</td>
</tr>
<tr>
<td><strong>Charity missed by model</strong></td>
<td></td>
<td>I = F × E</td>
<td></td>
<td>I = F × E</td>
</tr>
<tr>
<td>Bad debt that may be charity due to model error</td>
<td>$0.5 million</td>
<td>J = H × C</td>
<td>$0.5 million</td>
<td>J = H × C</td>
</tr>
<tr>
<td>Bad debt that may be charity due to unable to evaluate</td>
<td>$0.25 million</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Schedule H values (before applying RCC)</strong></td>
<td></td>
<td>K = A + F</td>
<td>$8 million</td>
<td>A</td>
</tr>
<tr>
<td>Charity care (at charges) - Part I</td>
<td>$10.5 million</td>
<td>L = B − F</td>
<td>$10 million</td>
<td>B</td>
</tr>
<tr>
<td>Bad debt expense - Part III</td>
<td>$7.5 million</td>
<td>M = I + J</td>
<td>$3.25 million</td>
<td>M = F + I + J</td>
</tr>
<tr>
<td>Answer to Part III A.3 (at charges)</td>
<td>$0.75 million</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
analytics. The hospital’s auditors likely will need to sign off on the process as well.

The above examples demonstrate the benefit of being able to grant charity care on a presumptive basis using the results of predictive analytics. Hospitals should consider modifying their policies and procedures accordingly.

**Action Plan: What to Do and How Fast?**

Every hospital needs to consider the best method to use to determine its response to Schedule H Part III.A.3.

Hospitals should consider whether predictive analytics is part of the solution, either on a one-time basis or as part of routine revenue cycle operations. One-time bad-debt inventory reclassifications can be a fast and effective approach to cleaning up historic accounts. This activity enables a hospital to reverse inappropriate bad-debt placements, increase presumptive charity care reportable amounts, and establish an error rate percentage for answering Schedule H Part III.A.3.

On a routine basis, in the self-pay revenue cycle process, predictive analytics can be an efficient, repeatable, and reliable solution to identify charity-eligible patients. If the model is applied before bad-debt assignment, identified charity-eligible accounts can be removed and classified as charity. This will help fully capture community benefit activity and help collection agencies focus their efforts on the accounts with ability to pay. Predictive analytics can also be used to prioritize financial counseling effort earlier in the revenue cycle.

In terms of ongoing efforts to improve capture of charity-eligible patients, hospitals can engage in several equally important activities to help ensure compliance, maximize efficiency, and fully capture a hospital’s reportable charity care:

> Conduct a review of their charity operations to ensure that they have a simple, patient-friendly, and streamlined financial assistance process.

> Identify barriers that might preclude patients from participating in their financial assistance application process, such as cultural, literacy, and language.

> Ensure that the availability of financial assistance is publicized and that staff are knowledgeable of the availability of financial assistance.

> Conduct reclassifications of self-pay accounts before bad-debt placements and periodically when the account is in bad-debt status.

> Take advantage of the improvements and availability of analytics to predict charity care at several different times in the revenue cycle process.

Hospitals should carefully consider their approaches to answering Part III, Section A. Line 3 of Schedule H. Using analytics can provide a sound basis to justify their answer to Part III.A.3 while increasing the reportable value of Part I.

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**About the authors**

Shari Bailey  
is vice president, Verité Healthcare Consulting, LLC, Washington, D.C.  
(shari.bailey@veriteconsulting.com)

David Franklin  
is chief development officer, Connance, Inc., Waltham, Mass.  
(dfranklin@connance.com).

Keith Hearle  
is president, Verité Healthcare Consulting, LLC, Washington, D.C.  
(keith.hearle@veriteconsulting.com).

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