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Topics:

1. Only counting charity care when qualifying hospitals for federal tax exemption under 501(c)(3)
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Discussion:

1. Only counting charity care when qualifying hospitals for federal tax exemption under 501(c)(3)

The *Discussion Draft* proposes that hospitals must provide charity care of no less than five percent of total expenses or revenues, whichever is greater. Sanctions could include losing 501(c)(3) status or paying an excise tax based on the difference between five percent and the actual charity care percentage provided. It also suggests that a hospital that cannot meet the 501(c)(3) requirements may seek tax-exemption under 501(c)(4).

- This proposal would set a standard that some types of hospitals would not be able to meet, including independent children's hospitals. This is because most of the patients of children's hospitals have some form of insurance coverage through private or public sources. However, independent children's hospitals typically devote a disproportionately

large portion of their patient care to low-income children and medically needy families in their communities. These patients are Medicaid recipients. However, the proposals in the *Discussion Draft* would not count the Medicaid shortfalls that children's (and other types of) hospitals incur toward the five percent charity care standard that 501(c)(3) hospitals would be required to meet.

- The statistical basis for the five percent standard is not robust. The existing measures cited in the *Discussion Draft* as reference points are based on "uncompensated care," which includes bad debt. These measures also do not value charity care in the restrictive way proposed by the staff. Other measures, such as the five percent requirement that applies in Texas, include other community benefits (such as government-sponsored indigent health care) in addition to charity care. Texas also exempts hospitals, such as Medicaid disproportionate share hospitals, from its charity care requirement.

- The community benefit that hospitals and health systems provide includes more than "charity care." This reflects varying health care needs across the United States. Increasingly, tax-exempt hospitals are operating programs and services that improve access to care for vulnerable people, enhance population (public) health, advance knowledge by supporting health professions education and research, and relieve government of financial or programmatic burdens. Some of these programs specifically are targeted at root causes of disease, and thus at reducing the need for charity care.

The standard for qualifying for exemption under 501(c)(3) should consider all reasonably defined community benefits (including Medicaid losses), not just charity care. Were such an approach not taken, it would be important to exempt additional types of hospitals from the proposed standard as the proposal has exempted critical access hospitals.

2. Definition of charity care

The *Discussion Draft* proposes that tax-exempt hospitals should provide free, medically necessary care for uninsured consumers who have incomes equal to or less than 100 percent of the federal poverty level (FPL). Policymakers are advised to consider whether patients with higher levels of household income should qualify for charity care as well.

The *Discussion Draft* proposes that *charity care* consist only of the following:

- Medically necessary hospital services provided without expectation of [any] payment from or on behalf of the patient (free care)

- The value of medically necessary hospital services that have been discounted pursuant to a sliding-fee scale (e.g., FPL 100% to 300%), for the "underinsured" or for the "medically indigent"

- *Underinsured* patients have inadequate financial protection – e.g., anyone with annual out-of-pocket medical expenses that are 10% or more of income; low-income (incomes under 200% of FPL) patients with annual out-of-pocket medical expenses that are 5% or more of income; anyone with health plan deductibles that equal or exceed 5% of income

- *Medically indigent* patients are "patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and … their medical expense, in relationship to their income, would make them indigent if they were forced to pay full charges for their medical expenses"

- Discounted care would be valued based on a reduction of price from "(i) the lowest rate that would be paid by Medicare/Medicaid or (ii) the actual unreimbursed cost to the hospital"

- Charity care also would consist of medical care provided through free clinics, community medical clinics and other means of providing free medical care such as school-based programs and grants to other charities that provide free medical care

- Charity care would not include bad debt because "staff views it inappropriate for a hospital to seek payment from a patient by sending a bill, and when payment is not received to seek to recharacterize that debt as charity care"

My comments on these proposals follow:

- Increasingly, hospitals are considering <u>four</u> categories of uninsured and underinsured patients as eligible for financial assistance (charity care): financially indigent, medically indigent, government-sponsored indigent,

and presumed indigent. Financially indigent patients qualify for assistance due to limited means (as established through an application process or through information the hospital learns about patients independently), medically indigent patients qualify for discounts or if out-of-pocket *hospital* expenses exceed 20-30 percent of income, government-sponsored indigent patients (with Medicaid or SCHIP benefits) receive discounts on their co-pays or deductibles, and patients are "presumed indigent" if they are homeless, in the U.S. illegally, or if the hospital is unable to establish their identity.

- Regarding standards for the "medically indigent", it is important to recognize that hospitals only have information on the expenses associated with *hospital* services. Basing the above definitions on *medical expenses* would present significant administrative barriers. Hospitals do not always have access to information on physician office expenses, pharmacy expenses and the cost of other services unless those services are provided and billed directly by the hospital. Thus, there are substantial barriers to determining the amount of *medical expenses* in relation to household income.

- Valuing discounted care based on a reduction of price from the lower of Medicaid/Medicare or unreimbursed cost would present additional administrative barriers. Both Medicare and Medicaid payment systems are complex. Medicare payments are based on the assignment of hospital discharges to Diagnosis Related Groups (DRGs) and hospital outpatient encounters to Ambulatory Payment Classification Groups (APCs). Hospitals currently do not assign services for uninsured patients to these groups. The 50 states have 50 significantly different Medicaid reimbursement policies and rate structures. The Catholic Health Association (CHA) accounting framework for community benefit values charity care on the basis of unreimbursed cost. That framework is more appropriate both for administrative reasons and because it values charity care on the basis of the net cost that hospitals incur when providing charity care.

- The view that charity care only can apply to patients who were *never* billed by the hospital is not aligned with current or with reasonable business practice. In many cases and even with best efforts, hospitals learn important information about patient financial circumstances only after the patients receive a bill. This often is the case with emergency

room patients who do not provide sufficient information for hospitals to determine ability to pay, either at all or until well after services have been rendered. The accounts in question are classified as "self-pay" until hospitals have sufficient information to classify them reliably as either bad debt or charity. That information frequently is obtained after bills have been sent to the patients. The Heathcare Financial Management Association (HFMA) Principles and Practices Board Statement 15, which allows granting charity care at any time during the revenue cycle if facts support providing discounted or free care to patients, reflects the realities of trying to establish which patients should qualify for financial assistance.

- The staff proposal indicates that charity care shall be for *medically necessary* services and indicates that "the staff also is considering whether a 501(c)(3) hospital should be taxed on any non-medically necessary services (such as cosmetic surgery)" that are performed through a joint venture. The *Discussion Draft* is silent regarding who will determine which services are medically necessary and which are not.

3. Should "community building" be counted as community benefit?

A generally accepted definition of *Community Building* is "activities carried out or supported to improve social factors found to be key determinants of health in communities: housing, education, environment, and economic prosperity.[1]"

In recent years, many hospitals and health systems have been developing very worthwhile community benefit programs. These programs focus on identifying health care needs, enhancing charity care policies and how they are administered, and developing programs targeted at improving community (public) health. In my view, the most effective hospital community benefit programs are those that adopt public health perspectives. Public health entities focus on improving community health status rather than solely on medical treatment.

Earlier in my career, I served as a Finance Officer in one of the nation's largest county public health departments. Community Building programs provided by hospitals clearly supplemented the supportive housing, environmental health, prevention, and public health education programs we offered as a health department. Community Building services provided by hospitals thus clearly

[1] Catholic Health Association.

leveraged the programs we provided – demonstrating that this category of hospital activity meets one criterion for inclusion as community benefit – the relief of government burden.

It is not uncommon for hospital-sponsored needs assessments to identify problems with housing, education, the environment, or economic conditions – and to highlight the morbidity (and mortality) caused by these problems. Any hospital discharge planner can describe the health care problems patients experience post-discharge if they lack housing, are poorly educated, or lack the means to continue receiving the care they need (e.g., pharmaceuticals or physician care that generally is out of the control of the hospital). When these problems come to light, hospitals respond by developing or supporting Community Building activities.

In my experience, if a hospital devotes resources to Community Building programs, this does not "crowd out" the hospital's ability to provide charity care. Community Building programs help address some of the root causes of disease, which over time can free up resources to meet other priorities, such as additional charity care. In my community benefit work with hospital chief financial officers, I never have encountered a situation where one has said: "if we spend more on this Community Building program, we have to cut back on charity care." Instead, Community Building programs are viewed in the context of a total commitment to charitable activities that taken as a whole are designed to improve community health and demonstrate charitable purpose.

4. Should Medicare losses be counted?

In its comments to the IRS on the draft form 990, CHA has submitted several arguments as to why Medicare losses should not be counted as community benefit. Of these arguments, I would emphasize the following points:

- The CHA community benefit framework certainly allows programs that serve the Medicare population to be counted. If hospitals operate programs for patients with Medicare benefits that respond to identified community needs, generate losses for the hospital, and that meet other criteria, these programs can be included in the CHA framework as "subsidized health services." I believe that a programmatic approach to documenting community benefits provided for Medicare beneficiaries is the most appropriate methodology, in large part because there are categories of Medicare patients that historically have been the subject of intense competition by hospitals of all kinds. There are other Medicare

patients with chronic health care needs and who generate substantive losses.

- Serving Medicare patients is not a differentiating feature of tax-exempt healthcare organizations. There are for-profit specialty hospitals that specifically have focused on attracting patients with Medicare coverage, e.g., specialty cardiac and orthopedic facilities.

- Significant effort and resources are devoted to assuring that hospitals are reimbursed appropriately by the Medicare program. The Medicare Payment Assessment Commission (MedPAC) carefully studies Medicare payment and the access to care that Medicare beneficiaries receive. MedPAC recommends payment adjustments to Congress accordingly. In contrast, hospital Medicaid reimbursements generally do not receive this level of attention, which is one of the reasons why Medicaid losses almost always exceed those generated by Medicare patients. Medicaid payment is largely driven by what states can afford to pay – and the varying emphases that states have between putting their Medicaid resources into expanding eligibility versus increasing provider reimbursement rates.

5. Should bad debts incurred by hospitals be considered community benefit?

Regarding Bad Debt, I would emphasize the following points:

- If the IRS asks hospitals to report "uncompensated care" (which is the sum of bad debt and charity care) rather than just charity care, then hospitals with more generous charity care policies will not be differentiated from those with less generous policies. Consider two hospitals, both with $5 million for the cost of "uncompensated care" and with $100 million in total operating revenue. Hospital A could have $4 million in bad debt and $1 million in charity care. Hospital B could have $2 million in bad debt and $3 million in charity care. If the 990 requests only "uncompensated care", the two hospitals would appear to have the same level of commitment to charity care.

- In recent years, many hospitals have been updating and revising their charity care policies. These hospitals frequently see a shift in their uncompensated care as a result: a decrease in bad debt and a commensurate increase in reported charity care. A continued shift of this nature should be anticipated (particularly if the final 990 requests charity

care cost statistics) – thus reducing the "need" to include bad debt as a reportable community benefit.

- One of the reasons why many hospitals and hospital associations are suggesting that bad debt should be included as community benefit is that there are a number of uninsured or underinsured patients who do not provide information needed to grant them charity care. The amount these patients owe thus is written off to bad debt, because the application for charity care is incomplete or not filled out. This category of patient accounts can be referred to as the "unknowns".

  I often respond to this concern by indicating first that HFMA Principles and Practices Board Statement 15 allows hospitals to classify patient accounts as charity care even if the information about certain patients is incomplete. On this basis, there are some hospitals that will "deem" some types of patients (e.g., homeless, …) as qualifying for charity care even if they don't complete charity care applications. One specific example of how a hospital has adjusted its charity care policy to recognize these types of patients is as follows:

The categories of patients who qualify for charity care are defined as:

- Financial indigents
- Medical indigents
- Governmental sponsored indigents/patient portion
- Presumed indigents

Presumed Indigents:

1. Persons who do not provide the detailed documentation necessary to be classified as financially or medically indigent but who, to the best of [the hospital's] knowledge, would be eligible for charity under the program guidelines had the person completed the documentation
2. This patient population would include, but is not limited to:
   a. Illegal aliens
   b. Deceased with no estate or known family
   c. Transient, homeless persons
   d. Persons estranged from family and who have no effective support group or are socially dysfunctional
   e. Persons whose identity cannot be established

In addition, technology solutions are emerging that help hospitals qualify patients for financial assistance even if there is incomplete information. One example technology is offered by HTP, Inc. HTP offers a suite of software products that establish (1) whether a patient presenting for care is eligible for Medicaid or any other form of third-party coverage, (2) the uninsured or underinsured patient's ability to pay their out-of-pocket financial liability, (3) probable patient income, and (4) availability of other resources that are relevant to qualifying a patient for financial assistance. This technology thus can significantly reduce the number of "unknowns" that otherwise would be classified as bad debt. As this type of technology is implemented in U.S. hospitals, the amount of bad debt reported should decline, and bad debt will not include amounts for patients truly unable to pay their bills.

- Bad debt is higher at hospitals whose business office functions are inefficient. Hospitals that make mistakes in billing insurance companies (e.g., billing the wrong insurer) and that do not emphasize timely collections of patient out-of-pocket payments will have higher bad debt expense.

It would not make sense to reward those hospitals with less efficient business offices or with less generous charity care policies by allowing the full amount of hospital bad debt to be counted as community benefit.

6. Converting hospitals to 501(c)(4)

The staff suggests that Congress should legislate special rules for hospitals seeking exemption under 501(c)(3) and 501(c)(4), with more stringent requirements under 501(c)(3) because these organizations receive greater tax benefits – tax-exempt financing and deductible charitable contributions. These benefits would be lost under 501(c)(4).

My comments regarding this proposal are as follows:

- The 501(c)(4) structure is unproven. No hospitals are now tax-exempt under 501(c)(4). It is not known whether non-profit hospitals can operate successfully within that structure. Not-for-profit hospitals will not be able to provide as much community benefit if they no longer could issue tax-exempt debt or receive deductible contributions. Children's hospitals

would be disproportionately affected by the loss of deductible contributions and tax-exempt financing.

- It would be helpful to research what the conversion process from 501(c)(3) to 501(c)(4) status would involve. The disposition of non-profit assets comes under the jurisdiction of many state governments in addition to the federal government. The conversion to 501(c)(4) status would be likely to trigger the need to refinance or refund existing long term debt and make it challenging to raise new capital in the future. The conversion process would be expensive, time consuming, disruptive and challenging – leaving hospitals with little choice but to seek to remain tax-exempt under 501(c)(3) and face the risks associated with the proposed sanctions if they did not comply with 501(c)(3) requirements.

The *Discussion Draft* recognizes that conversion rules will have to be created for converting 501(c)(3) hospitals to 501(c)(4) tax-exempt status; however, the *Discussion Draft* includes no draft rules for comment. No legislation to reform non-profit hospital federal tax-exemption should be implemented without providing hospitals the opportunity to comment on these rules.

7. Involving MedPAC in the discussions

According to the MedPAC website:

> The Medicare Payment Advisory Commission (MedPAC) is an independent federal body established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program. The Commission's statutory mandate is quite broad: In addition to advising the Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.[2]

MedPAC staff is very knowledgeable about Medicare payment and can help Congress determine whether Medicare losses should be considered a community benefit provided by tax exempt hospitals.

MedPAC also has been working with the Centers for Medicare and Medicaid Services (CMS) on one schedule included within the Medicare Cost Report. The intent of Schedule "S-10" has been to collect hospital charity care (and Medicaid)

[2] http://www.medpac.gov/about.cfm

information. However, many have viewed the current schedule to be problematic. MedPAC is advising CMS on changes that should be incorporated into the S-10, and thus also is considering how charity care should be defined. It would be logical for federal agencies addressing charity care information (IRS and CMS with MedPAC input) to consult with one another so that reporting inconsistencies are not created.