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Financial Assistance Policies of Charitable Hospitals

Industry Practices and Implications of Proposed Regulations

An HFMA White Paper

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The role that hospitals play in the communities they serve is both essential and evolving. Not too long ago, hospitals were places where only the sick went to be treated. Over time, the hospital's role has expanded to include educational and wellness services aimed at teaching community members how to live healthier lifestyles and preventing chronic conditions such as obesity, diabetes, and heart disease.

Through such initiatives as cancer screenings, health clinics, and educational classes, hospitals provide added benefits—often at little or no charge—that many community members would be unable to find anywhere else.

Still, a fundamental part of a not-for-profit hospital's benefit to its community continues to be its role as provider of care for those who are unable to pay for their healthcare costs. Indeed, according to the American Hospital Association, hospitals provided $39.3 billion in uncompensated care (including charity care and bad debt) in 2010.

Hospitals have an obligation to community members who for a variety of reasons cannot afford health care. However, it is not only patients who benefit from charity care: Not-for-profit hospitals are obligated to provide such care to maintain tax-exempt status under IRS regulations. Therefore, it is in the best interests of both the eligible patient to receive and the hospital to provide some amount of charity care.

Recently, the U.S. Department of the Treasury and the IRS have announced a number of proposed regulations related to the provision of charity care. The proposed regulations are designed to ensure that hospitals' financial assistance policies are both clear and fair and that financial assistance is accessible to those in need. Although the intentions of the proposed regulations are admirable, some hospitals are concerned about the potential unintended consequences that could result if these proposals were enacted. The fear is that some of the proposed regulations would not only increase a hospital organization's administrative costs, but also negatively affect a hospital's overall financial performance. Additionally, the extra work that the proposed regulations would require of hospitals may not provide the value that the Department of the Treasury is seeking, such as additional information for IRS purposes or an increase in the amount of charity care that hospitals provide.

This paper examines the potential unintended consequences of the proposed regulations related to the financial assistance hospitals provide—and offers several recommendations that could better support the goals that the proposed regulations were designed to achieve.

Background: Charity Care on the Rise

Hospitals have provided greater financial support to patients in need as the number of uninsured has grown, rising from 13.9 percent of Americans in 2002 to 15.7 percent in 2011, according to U.S.

Census figures. For hospitals, this financial support has ranged from providing charity care to writing off bad debt expense for patients who are unable to meet their financial obligations for care or service received. Hospitals recognize the need to provide this community benefit for both practical and ethical reasons.

For many hospitals and health systems, the proportion of charity care to bad debt that they provide has reversed in the past decade. In 2011, Adventist Health System, Altamonte Springs, Fla., wrote off $1.5 billion in unpaid debt; 81.2 percent was charity care, while the remainder was bad debt. In FY12, Rush University Medical Center, Chicago, wrote off three times as much charity care as bad debt, with charity care encompassing 7.4 percent of revenue and bad debt composing 2.4 percent. In FY10, the amount of charity care Rush provided was twice the amount of bad debt the health system had written off.

To be sure, the economy has played a role in the increased need for financial assistance as those without jobs or with lower-paying jobs cannot afford their healthcare costs. However, a portion of this increase in charity care can be attributed to the healthcare industry's improved communication about the availability of financial assistance at hospitals. Today, hospitals have become better at identifying patients who do not have the means to pay for care or service and categorizing these cases as charity care.

As such, hospitals have changed their practices in handling self-pay patients. It used to be that if patients did not seek financial assistance on their own, yet could not afford to meet financial obligations for care and services provided, their bill was more than likely to be considered a bad debt. Over the years, hospitals have come to realize that treating those who cannot afford the total cost of their care comes with responsibilities beyond providing testing, procedures, and bedside care. Hospitals are charged with identifying, educating, and assisting patients who do not have the means to pay for services provided.

Growth of Financial Assistance Policies at Hospitals

Hospitals have improved their practices in part by developing robust financial assistance policies that designate the criteria for a patient to be eligible for assistance. Hospitals recognize the importance of comprehensive, equitable, and effective policies and extend significant time and effort in both developing these policies and publicizing them to community members.

Although hospitals' financial assistance policies are generally developed within the finance or revenue cycle realm, it is not uncommon for the final product to culminate from the review and approval of an interdisciplinary team, including representatives from the hospital's executive team (such as the CEO and CFO), along with physician leaders. The goal is not only to ensure that the policy adheres to IRS rules, but also to align with the hospital's mission. For example, at Mayo Clinic, Rochester, Minn., members of the executive team, including medical staff leaders, approve the organization's financial assistance policy. At Adventist, the organization's financial assistance policy is also approved by the system's board of directors, which includes church leaders—representatives who have a particular sensitivity to community obligation.

Financial assistance policies in various hospitals share some characteristics. Generally, patients are eligible for financial assistance if they meet federal poverty guidelines for adjusted household income. Hospital policies may differ in the level at which patients meet the criteria for assistance. For example, many hospitals have developed generous criteria that exceed the federal government's criteria, often allowing patients with income levels 200 to 300 percent above the guidelines to qualify for financial assistance. Some financial assistance policies also include a sliding scale beyond these percentages, so that a patient whose household income falls between 300 and 400 percent of the federal poverty guidelines may be eligible for a discount on the hospital bill.

When Adventist's initial financial assistance policy was drafted, patients with adjusted household income below 200 percent of the federal poverty guidelines would qualify for financial assistance. The policy was amended to grant discounts for patients at 200 to 400 percent of federal policy guidelines—resulting in a policy that many would consider generous. Under the amended policy, a self-pay patient earning $160,000 annually with a household of four would be eligible to receive a discount. The goal is to ensure the hospital is fulfilling a need and upholding its obligations to the community it serves.

Hospitals also review their policies on a regular basis to address both the needs within their communities and the dynamics of the changing healthcare environment. Hospitals may even have several versions of a financial assistance policy to meet varying state requirements for charity care practices, which often differ from federal requirements. Some policies may even be designed for extraordinary levels of care.

At Mayo Clinic, the majority of charity care adjustments relate to patients requiring highly complex tertiary care or quaternary care. Rush University Medical Center developed a catastrophic financial assistance policy based upon a multiple of a patient's earnings; the policy is designed to prevent patients from falling into financial ruin if a catastrophic health event were to deplete all of a person's financial resources.

Managing the Challenge of Providing Assistance

The steps to providing financial assistance are pretty straightforward. The often-overwhelming challenge lies in fulfilling the organization's obligations.

Over the years, hospitals have played a greater role in educating patients about their healthcare options, especially when it comes to covering their healthcare costs. Many hospitals use financial counselors to educate patients on their benefits if they have insurance coverage or on the type of financial assistance that is available if they do not. Hospitals do this not only to maintain their own financial health, but also because they view their educational role as a moral obligation. Patients have the right to know of their financial responsibility so they can make informed decisions about their health care, rather than relying upon someone else to make such critical decisions for them.

Part of providing a hospital's obligations in providing care is identifying those who are truly in need of assistance in paying for their care. But making an accurate determination of a patient's ability to pay is dependent upon the reliability of the information that the patient offers, whether in discussions with patient registration or financial services staff or in applications for financial assistance.

Generally, hospitals first try to determine whether patients qualify for Medicare or Medicaid; often, on-site counselors are available to help eligible patients complete applications to secure coverage. If the patient does not qualify for Medicare or Medicaid but does not have the financial means to pay for care or services in full or in part, the next step is getting the patient to complete a financial assistance application to receive free or discounted care. These processes also can be done in parallel.

Making patients aware of the financial assistance options available is an important initial step in a hospital's charity care practice. Throughout the care process, hospitals take many efforts to do so, such as:

> Informing patients of financial assistance options during the scheduling process
> Posting signage in registration and admitting areas detailing the hospital's financial assistance policy
> Using on-site financial counselors to explain the policy
> Including language in patient statements and other communication
> Posting the policy and application for assistance on their websites

Educating patients on their options is important because determining eligibility as early as possible in the care process benefits both the patient and the hospital. The sooner a hospital has that financial discussion with the patient, the better prepared the hospital will be to provide patients with options, such as using financing/installment plans to pay for their health care. Patients who are informed of their options are better able to make decisions about their health care and how they will meet their financial obligation.

Clearly, there are financial benefits for a hospital to determine eligibility early on as well. It is a well-known fact of business that the more an organization touches an account, the less likely that organization will be to actually collect on that account. Additionally, hospitals want to avoid spending resources on trying to collect from patients who are unable to pay.

Determining eligibility is often a time-consuming and expensive endeavor. Adventist Health System is a faith-based, not-for-profit hospital organization whose sheer growth and geographic spread—55,000 employees span 43 campuses in 10 states, including Adventist's flagship Florida Hospital—made conditions ripe for inconsistent billing practices and disparate systems across its multiple billing offices. Adventist spends more than $500,000 annually obtaining credit score information, with the patient's consent, to determine the patient's ability and propensity to pay a bill.

The central issue for many organizations is distinguishing between those who are unable to pay and those who are unwilling to pay. As hospital organizations grant more charity care, they may hire additional financial counselors to interview and educate patients and process paperwork. Patients may initially fill out a brief questionnaire asking for basic information, such as household size, household income, homeownership, assets, and credit obligations. Or a financial counselor may explain the hospital's financial assistance policy and help a patient gather the necessary financial information, such as income tax returns, required in an application.

Ideally, hospitals have the financial discussion with patients before care or service is provided. In reality, many patients who are unable to pay receive care in urgent and emergency situations. The challenge of determining eligibility for these patients is especially daunting. Some patients simply do not want to divulge such personal information. Hospitals have to be especially careful in working with patients who may once have had an ability to pay, but because of the loss of job or other hardships, are no longer able to meet their financial obligations for care or service provided. These patients may be too embarrassed to discuss their financial data, so hospitals must look to other means for obtaining such information.

Use of Eligibility Tools to Predict the Need for Assistance

The tools currently available to verify a patient's ability to pay can be useful, but also have limitations. A credit score, for example, is not always indicative of a person's ability to pay. A person with good credit may pay bills on time, but still may not have the resources to cover costly medical expenses. Conversely, a person who procrastinates on paying bills may still have the funds, but a low credit score would seem to indicate otherwise. And hospitals must use alternative methods of verifying patients' ability to pay in instances where patients do not have credit scores.

Hospitals also determine eligibility by obtaining verification of a patient's adjusted gross income from the IRS; this can be done by phone or by faxing a form to the IRS. Although this process is helpful in determining a patient's ability to pay for care or service, it also can be cumbersome and time-consuming.

Such tools are useless if a patient does not consent to release such information. Also, neither the credit score nor the income verification method is foolproof. It is not unreasonable to conclude that some patients with the means to pay neglect to do

so and are successful at masking their true income level and assets. The result: Hospitals sometimes grant financial assistance to those who do have the means to pay for their healthcare costs.

Fortunately, as the need for financial assistance grows, hospitals are finding ways to determine eligibility that are proving to offer improved accuracy.

One method hospitals have begun to use more and more is a presumptive charity score—a derived figure that estimates the likelihood a patient will be eligible for charity or has the means and propensity to pay. The score is calculated using various socioeconomic data, such as household income and size and asset ownership. This data is then compared to group data obtained from various sources of public records, such as U.S. Census data, court records, and asset ownership files, to predict the likelihood that a particular patient will qualify for financial assistance under the hospital's specific criteria.

Some hospitals calculate such a score internally; others use outside services. Hospitals implement the presumptive charity score at differing points in the care process. For example, hospitals within the Catholic Health East system in Newtown Square, Penn., determine a patient's score after the patient has been billed but has neither responded to the bill nor sent payment.

The benefits of the presumptive charity score are twofold: A hospital can reduce the time spent trying to obtain payment from patients who do not have the money, and more significant, the need for the patient's involvement is eliminated. Patients do not have to complete an application for financial assistance, nor do they even have to request the assistance. The presumptive score is expected to help hospitals classify more cases as charity care rather than bad debt.

Concerns with Proposed Regulations

Although hospitals have become more successful at increasing the amount of charity care and financial assistance they provide, the need to develop standards to ensure hospitals are fulfilling such obligations is understandable. Hospitals know full well the benefits of reducing variation and improving outcomes through standardization, so applying a set of standards to the way in which hospitals determine whether a patient qualifies for financial assistance is overall a worthwhile undertaking. The key to successful standardization in any arena, however, is improving outcomes without placing unnecessary burdens on those that are subject to such rules.

The proposed regulations from the U.S. Department of the Treasury and the IRS in regard to hospitals' financial assistance policies, emergency medical care policies, and billing and collection practices related to charity care practices are designed to work toward this goal. Indeed, as described earlier, the financial assistance policies of many hospitals already include many of the practices called for in the proposals. What is of concern to the community of hospitals that provide charity care is the ways in which complying with some of the proposed regulations could add to the costs of providing assistance without measurably changing the amount of charity care and other financial assistance that many hospitals currently provide.

Here are some of the concerns hospitals have and the potential negative consequences that could result if the proposed requirements were enacted as they are currently written.

The extended notification period provided for in the proposed regulations could result in additional work, increased cost, and higher levels of bad debt. The proposed regulations call for two successive periods of 120 days in which a patient who has received service can consider applying for financial assistance and then actually turn in an application. Allowing patients 90 to 120 days to consider and complete an application for financial assistance is a reasonable practice. Patients often require time to recuperate from a procedure before handling financial matters. However, patients also have a responsibility to not only provide accurate

personal information, but also act in a timely manner in meeting their financial obligations. Granting an additional period of 120 days if the patient has not completed his application for assistance seems excessive and arbitrary. It means that hospitals potentially would have to wait as long as 240 days before taking what the Department of the Treasury deems "extraordinary collection activity" on an account. This is simply too long.

Extending the application period puts additional burden on financial counseling staff to check the status of applications. Experience within the industry suggests that the longer a patient has to return payment, the less likely a hospital is to collect on that account. Requiring hospitals to complete additional work that will most likely not result in additional payment will just add to a hospital's administrative expenses and is, in fact, contrary to the goals of the Affordable Care Act in reducing healthcare costs.

The additional days an account spends in receivables negatively affects revenue cycle/financial performance statistics, measures that may ultimately have an impact on the hospital's ability to secure capital for investment in improving equipment and buildings. The length of time an account spends in receivables also affects its collectability—the older an account, the less value it has. Lengthening the time frame in which a hospital can take action on an account decreases the overall value of receivables. At the same time, the extra 120 days increases the likelihood that the account will be treated as a bad debt because patients who would have otherwise paid their hospital bill may choose not to if they are given more time. The longer patients are given to pay the bill, the less likely they are to pay it.

In addition, the use of presumptive charity scoring enables a hospital to make an informed, data-based judgment on a patient's ability and propensity to pay. If a hospital determines that a patient does not require financial assistance, but has the means to pay, it seems senseless to restrict that hospital for an unusually long period of time from pursuing reasonable and fair collection activity.

Averaging Medicare rates in amounts generally billed will lead to distorted hospital charges. The proposals call for the amounts generally billed (the charges applied to a patients case under a hospital's financial assistance policy) to be based upon an average of the claims paid to a hospital facility by both Medicare and private/commercial insurance. However, including Medicare rates would only distort the average. Medicare rates are not market based. The Medicare population also is very different from the charity care population, which would presumably carry insurance if it held the means. It seems reasonable, therefore, to base amounts generally billed on a hospital's private/commercial insurance rates, not Medicare rates, which do not fully cover costs and would only lower a hospital's rate of charges.

Additional notification steps will lead to additional costs. According to the proposed regulations, if a hospital sends a patient an application for financial assistance and receives no reply from a patient after 120 days, the hospital must then send another notice saying it is going to pursue further action. That additional letter represents an additional cost. At this point, up to 240 days may have passed from the point of service—time spent simply waiting for a response from the patient. At the end of the day, the additional letter will most likely not provoke a response from the patient; rather, it simply represents an additional cost for the hospital. The more often a hospital's patient financial services department handles an account, the more money it costs.

In addition, the proposed regulations call for including a plain-language summary of the financial assistance policy with all (and at least three) billing statements during the 120-day notification period. Sending a plain language summary with successive statements would add cost unnecessarily since hospitals already take specific steps to notify patients of their financial assistance policies. The policies at Adventist Health System,

for example, vary between two and three pages, depending upon the hospital. It would cost an extra 45 cents for each patient statement, or about $160,000, to send the additional paperwork, a more than 50 percent increase from the $300,000 Adventist currently spends on sending statements. Sending the financial assistance policy electronically, such as through email or via mobile phones, after it is included in the first statement would be much more efficient.

The estimated burden of complying with the regulations will potentially result in more than 1,000 hours of additional work for hospitals annually. The proposed regulations estimate that it will take a hospital 11.5 hours annually to collect the additional information required under Section 501(r). However, HFMA estimates that hospitals would have to expend between 120 to 2,700 hours annually to comply with the Section 501(r) requirements. This would include such tasks as widely publicizing a hospital's financial assistance policy to community members, translating the financial assistance policy into languages of minority populations that constitute more than 10 percent of the community served by the hospital, and creating, revising, or otherwise establishing regulations-compliant billing and collection policies, to name just a few. Adventist Health System estimates that it would take 600 hours annually just to publicize its financial assistance policy. The health system's total annual estimate of the number of hours required to comply with the proposed regulations: 2,785 hours.

Recommendations

To better meet the common goals that hospitals, the U.S. Department of the Treasury, and the IRS have in ensuring that patients in need of financial assistance receive such assistance, the authors recommend the following action steps.

Enable hospitals to verify adjusted gross income online. Perhaps the greatest challenge a hospital faces in granting financial assistance for patients is in determining eligibility, which can be achieved by verifying a patient's adjusted gross income with the IRS. The more quickly a hospital obtains this verification, the more quickly the hospital can either take steps to pursue payment or grant financial assistance rather than invest resources on collection activities unnecessarily. Currently, hospitals can obtain such data from the IRS via telephone or fax—which is a convenient, but time-consuming method of verification. Instead, obtaining adjusted gross income data through an automated, online process, such as an EDI 270/271 transaction, would streamline the process and minimize the resources used to determine eligibility. Hospitals would pay a fee to cover the cost of implementing such an automated system.

Clarify the proposed regulations' emergency medical care policy. The proposed regulations, which stipulate that a financial assistance policy prohibit a hospital from "engaging in actions that discourage individuals from seeking treatment," appear to contradict the Emergency Medical Treatment and Labor Act, which does not allow providers to collect in the emergency department (ED) until the patient has been screened and it has been determined that no serious illness is present. The proposed regulations are not clear as to where and under what conditions pursuing payment in the ED would be permitted. Not educating patients about their financial obligations and availability of financial assistance puts the patient at a disadvantage in terms of making informed healthcare decisions.

Allow pursuit of extraordinary collection actions after first refusal of financial assistance. The proposed regulations call for granting patients extra time to reconsider financial assistance once it has been refused. Once a patient has signed a statement refusing financial assistance and does not provide personal financial data, the hospital should be free to pursuit extraordinary collection activities. Hospitals know the negative consequences of abusing extraordinary collection activities. Patients are members of the communities that hospitals serve, so taking extraordinary steps, such as placing liens on property or seizing a bank account, may not be productive. State laws often prevent hospitals from taking such actions in

the first place. Hospitals, of course, have a right to pursue action when an asset check uncovers bank accounts, cars, and other property demonstrating a person's ability to pay. But common sense says that employing harsh tactics against patients with limited means is not a good use of resources. If a patient reconsiders financial assistance, a hospital can stop collection activities and follow its financial assistance policy in determining eligibility.

Remove credit reporting from the category of extraordinary collection activities. The proposed regulations include reporting adverse information to consumer credit reporting agencies or credit bureaus as an extraordinary collection activity, the use of which is restricted until reasonable efforts have been made to determine financial assistance eligibility. Healthcare institutions have an obligation to the banking/lending community to ensure awareness of consumer's ability to fulfill financial obligations and should not be restricted in reporting adverse information.

Clarify medical necessity. The proposed regulations require that a hospital have written financial assistance policies that apply, at a minimum, to all emergency and other medically necessary care. A formal definition of what constitutes "medically necessary care" would greatly benefit hospitals in complying with this regulation.

Working Together Toward a Common Goal

Hospitals whose charity care represents a greater proportion of unpaid debt versus bad debt are already demonstrating the effectiveness of their financial assistance policies. Adding to a hospital organization's costs without providing any additional value for patients, providers, or regulators does not seem reasonable. One possibility might be to consider those hospitals whose charity care levels are a certain percentage greater than bad debt (e.g., 50 percent) as already being in compliance with the proposed regulations.

Fundamentally, hospitals want to be fair in meeting their obligations to the communities they serve. Providing charity care is viewed as a moral and financial duty, and assisting patients in their overall healthcare decisions is part of this duty. Hospitals should be held accountable for their obligation to provide charity care—but they should not be hindered in trying to meet it.

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