WHITE PAPER:

For what it's worth: The proactive approach to maintaining nonprofit status as a charitable entity

Author: Steve Levin, Chief Strategy Officer, Waystar

WAYSTAR

A new day dawning for nonprofit hospitals

In June 2015, a New Jersey tax court ruled that Morristown Medical Center failed to meet the legal test for nonprofit status and owed property taxes on their facility.

Following the Morristown Medical Center ruling, thirty-five other New Jersey municipalities filed tax appeals against thirty-five nonprofit hospitals. In Washington State, a class action against Northwest Hospital & Medical Center claims the hospital "fails to properly screen poor patients eligible for charity care" and sent their debts to collection instead. Not only were those actions outside the Affordable Care Act requirements, the lawsuit claims, they were also in violation of the state's Charity Care Act.

Jim Flynn, head of the healthcare practice group at Bricker and Eckler, said hospitals should be on guard when it comes to their tax-exempt statuses because of their excessive debt collection activities and inability to sufficiently identify charity care patients. Flynn made this comment in regard to the New Jersey tax court ruling against Morristown Medical Center, in large part because of their overly aggressive debt collection from poor patients.

"The facts they have here are not unique at all to Morristown," said Michael Meissner, a tax partner at Squire Patton Boggs. "If this standard were applied across the board or across the country, you would have a lot of hospitals that would have some serious concerns."

"Such cases may be on the rise," Flynn said, as local and state governments look for ways to increase their property-tax revenue to deal with tight budgets.

"Illinois has already passed a law that essentially states that not-for-profit hospitals must provide an amount of no-cost charity care equal to what they are otherwise saving through property-tax exemptions," said Don Stuart, a partner at Waller Lansden Dortch & Davis, who also leads the American Health Lawyers Association's tax and finance practice group. If local or state governments start flagging noncompliant hospitals, the IRS can be involved rather quickly.

It's something even the judge in the Morristown case alluded to in his opinion. "If it is true that all non-profit hospitals operate like the Hospital in this case, as was the testimony here, then for purposes of the property-tax.

What is a nonprofit hospital, yesterday and today?

On emotions alone, most people would support any company choosing to work "not for profit" and for a greater good to be allowed that opportunity. The reality, however, is that conferring nonprofit status carries with it significant economic benefits—notably exemption from state and federal taxes.

In 1954, the federal government defined nonprofit status, also called 501(c)(3), for organizations that operated solely for charitable purposes. Those qualified became exempt from federal income tax. To qualify, hospitals had to commit to provide free or reduced-cost care to patients unable to pay for it. In 1969, nonprofit hospital requirements were relaxed further to include activities that "benefited communities," which meant any money and in-kind resources spent promoting community health could also be included in the tally. As to what activities were considered to "benefit communities," the guidelines were loose and open to interpretation.

The Patient Protection and Affordable Care Act (PPACA or ACA) shepherded in a new era for nonprofits. Expanded government funding for individual healthcare both through sponsoring Medicaid expansion and direct consumer premium subsidy came with higher expectations. The IRS added a new section to their Form 990, Schedule H, specifically for nonprofit hospitals and their community benefit efforts. Stakes were further raised when IRS section 501(r) was officially rolled out in 2014, adding substantial details to the boundaries and expectations around consumer collection practices in healthcare settings.

All rights reserved © 2019 Waystar Health

With PPACA:

1. Each “hospital facility” must conduct a “community health needs assessment” at least once every three years;
2. Each hospital facility is required to adopt both a written financial assistance policy and a written emergency medical care policy that comply with certain statutory criteria;
3. Hospital facilities may not charge patients eligible for financial assistance more than “amounts generally billed” to insured patients and are prohibited from using “gross charges” for patients eligible for financial assistance; and
4. Hospital facilities may not commence certain “extraordinary collection actions” before making “reasonable efforts” to determine if the patient involved is eligible for financial assistance under the financial assistance policy.

These principles need to be documented and submitted annually to the IRS under detailed questions regarding

1. Unreimbursed costs of providing free or discounted services to qualifying patients

2. Participation in Medicaid

3. Education for health professions provided

4. Health services research

5. Subsidized health services

6. Community health improvement activities

7. Cash or in-kind contributions to other nonprofit groups (such as hosting a blood drive)

8. Clear delineation between charity care and bad debt

With new regulations also came changes to what was considered community benefit. Hospitals used to be able to consider patient revenue that becomes bad debt as a community benefit. Now, patient bad debt is not accepted. This places premium importance on separating patients who would go to bad debt but are in fact qualified for charity classification according to charity guidelines. This approach aligns with the mandate to be proactive in evaluating patients for financial assistance under ACA.

Another key change in what constitutes community benefit was made with Medicaid and Medicare. Historically, reimbursement shortfall (the difference between what care actually costs and what the government reimbursed for that care) was considered community benefit. However, federal regulations no longer recognize those amounts as community benefit expenses.

Reason for alarm?

Healthcare is the largest expense after housing for the average American family. According to the US Bureau of Labor Statistics, healthcare costs average 8% of a family’s expenditures for all income ranges.

Despite the Affordable Care Act’s intentions to help more Americans become covered by health insurance, 28.5 million people (9%) remain uninsured, and in 2015, 46% of uninsured adults said that they tried to get coverage but did not because it was too expensive.

Among those insured, many high-deductible plans are sideswiping families with greater out of-pocket costs. A Kaiser Family Foundation study found employee deductibles on average increased 67% from 2010 to 2015. As of February 2016, nearly 25% of employees are enrolled in a high-deductible plan, up from 4% in 2006.

The Consumer Financial Protection Bureau reported that 43 million Americans have overdue medical debt on their credit reports. Medical debt is the number-one source of consumer bankruptcy, as a recent Harvard

All rights reserved © 2019 Waystar Health

University study showed that medical expenses account for approximately 62% of personal bankruptcies.

Statistics also suggest that among patient accounts declared bad debt, upward of 30% of them are actually patients who are qualified for financial assistance under hospital policies. Providers have financial incentive to identify these people early in the process because there is often reimbursement available, if documented.

As a result, providers make strong efforts to engage patients and have them document their situation. Unfortunately, many still slip through the cracks. Illiteracy, language barriers, embarrassment, cultural issues, fear, pride, and many other elements contribute to patients slipping through. According to the Department of Education, one in five consumers is financially illiterate and cannot complete an application. 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.

How can nonprofit hospitals continue to claim "charitable" status while Americans are going bankrupt from medical bills?

What is the value of nonprofit status for hospitals?

Depending on the local and state definitions, nonprofit hospitals with taxexempt status are exempt from paying certain payroll, property, or federal taxes. In addition, they can obtain tax exempt financing and can accept tax-deductible charitable contributions. If a hospital loses its tax-exempt status, it will also lose its Medicare and Medicaid subsidies that accompany a hospital's status as a nonprofit.

In 2013, Pittsburgh filed a suit challenging the University of Pittsburgh Medical Center's tax-exempt status, saying that the medical center should pay some payroll taxes and more property taxes, estimated to total about $20 million annually. In the Morristown case, the property taxes were estimated to be $2.5 to $3 million annually. According to the American Hospital Association, in 2014 23.3% of all community hospitals were operating on negative total margins, defined as total net revenue less total expenses divided by total net revenue. Adding a new cash line item—taxes—to tight budgets would certainly push more institutions into financial straits.

How are hospitals responding to the heightened expectations?

Alignment is more than simply publishing new policies. In fact, the policy changes are the easy part. Adherence that stands up to public review really requires significant adjustments to patient interactions before, during, and long after treatment.

In an effort to simplify and streamline the financial assistance documentation requirements, hospitals need to invest in trained financial counselors and other resources to help patients through the eligibility process. These associates need to be knowledgeable in the intricacies of the various means tested programs and legal documentation requirements as well as bilingual or trilingual. Ideally, they are engaging patients prearrival but, at a minimum, onsite around treatment events. This is really a 7x24 challenge. Many organizations are hiring thirdparty agencies to assist in this effort due to the complexity.

A related priority for most hospitals is incorporating specialized advanced predictive analytics in their tool kits. With good analytics, the highly specialized eligibility resources can better target their efforts. With good analytics, accounts can be scrubbed prior to bad debt assignment to maximize their reported community benefit and avoid inappropriate assignment to more aggressive collection efforts.

All rights reserved © 2019 Waystar Health

With good analytics, annual reporting and documentation is more robust and definitive when put under public scrutiny.

Standard consumer finance scores are not appropriate. Credit scores used by banks, auto dealers or retailers are not appropriate. First, upward of one in four households fails to have a credit score. Second, these scores measure ability to repay a loan and not income relative to guidelines. The obvious example of the difference is a high-income household that buys an expensive home leading to financial distress. This individual has a poor credit score but is not necessarily qualified for poverty treatment according to PPACA. Propensity-to-pay scores, also commonly used to stratify patient collections in healthcare, are similarly inappropriate. These analytics don't actually evaluate income or qualification, merely willingness to pay. Analysis shows that many high-income individuals will fail to pay their bills for one reason or another.

Standard income estimates are also insufficient. The regulations and charity policies are quite specific in terms of household assets and income that qualify for assistance with the bands being relatively narrow—a couple thousand dollars of annual income one way or the other can totally change the answer. The precision makes traditional income estimates that are useful for marketing purposes too blunt an instrument.

For all these reasons, leading hospitals are utilizing purpose-built predictive analytics that utilize the basic demographic information provided at registration combined with external data about the individual and their community to predict qualification to the institution's specific charity policies. Because these analytics are targeted specifically at the question of poverty as defined by hospital guidelines, the models are tuned to consistently and repeatedly assess whether an unknown account would have qualified for financial assistance had documentation been available.

And, as a bonus, 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.

Just as there are a lot of different credit analytics in the market, there are multiple charity analytics. Key differences to consider include these:

- **Data inputs and coverage.** Some models will utilize regulated credit data; others will not. Accessing credit data as part of a scoring process is visible to that person, which can be perceived as invasive. Additionally, many patients—especially those living in poverty—lack credit files, and hence this input will be unavailable for that portion.
- **Calibration.** Does the model calibrate to the specific hospital guidelines and local market conditions? What income constitutes poverty in Idaho is different than in NYC.
- **Multiple checks.** Accurately predicting income is very difficult. For that reason, better solutions will tend to utilize multiple, separate checks in their evaluation process. They will consider socio-demographic models plus asset reviews with an estimated income range to confer final acceptance.
- **Deployment flexibility.** Ideally, the same analytic is used throughout the process to ensure consistency. Not every model is available for real-time applications on site as well as in batch mode for bulk processing.
- **Operational support.** Many vendors will offer supporting information for Form 990 submissions as well as best practices for process deployment.

All rights reserved © 2019 Waystar Health

Staying ahead of the charity compliance game

The recent legislation and reporting changes have changed the game for regulators and nonprofit hospitals alike. The wave of legal battles and court rulings has increased the stakes.

As hospitals face this new world, there is a lot to get done and a lot to align. In the appendix, Waystar, a predictive analytics technology solutions provider, shares their 501(r) Compliance Checklist to assist hospitals in measuring their alignment to the 501(r) requirements. Tools like these and predictive analytics can help nonprofit hospitals to avoid penalties while meeting the needs of their charitable patients and complying with regulations.

Most certainly, change will continue to occur, and expectations will rise. However, as in most things, failure to stay up-to-date will make later efforts harder and more expensive. Falling behind now, which is arguably like the first innings of a baseball game, will most certainly make tomorrow harder when government investment is larger, when state budgets are tighter, and when precedents for nonadherence are set.

Resources

Aleccia, J. (2016, Jun 21). Suit claims Northwest hospital fails to screen for charity care. Seattle Times. Retrieved November 9, 2016, from: http://www.seattletimes. com/seattle-news/health/suit-claims-northwest-hospital-fails-to-screen-for-charitycare/

Bailey, S., Franklin, D., & Hearle, K. (2010). A Form 990 Schedule H conundrum: how much of your bad debt might be charity? Healthcare Finance Management, 64(4), 86–92.Retrieved October 11, 2016, from: http://www.connance.com/wpcontent/uploads/61-ConnanceArticle_a_Form_990_Schedule_H_conundrum_hfm_April_2010.pdf

Dolan, Rachel (2016, Feb 4).Robert Wood Johnson Foundation, Health Policy Brief: High-deductible health plans. Retrieved November 1, 2016, from: http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_152.pdf

Ellison, A. (2016, Aug 22). 35 NJ hospitals sued over tax-exempt status. Becker's Hospital CFO. Retrieved November 9, 2016, from: http://www.beckershospitalreview.com/finance/35-nj-hospitals-sued-over-tax-exempt-status.html

Johnson, J. (2016, Feb 25). Robert Wood Johnson Foundation, Health Policy Brief: Nonprofit hospitals' community benefit requirements. Under the Affordable Care Act, many nonprofit hospitals must meet new requirements to retain their tax-exempt status. Retrieved October 11, 2016, from: http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_153.pdf

Jones Day (2015, March). Commentary: Protecting your hospital's tax-exempt status: Compliance with the Affordable Care Act and final IRS Section 501(r) regulations. Retrieved October 11, 2016, from: http://www.aha.org/content/15/150317-ahacommentary.pdf

Rosenthal, E. (2013, Dec 16). Benefits questioned in tax breaks for nonprofit hospitals. New York Times. Retrieved October 11, 2016, from: http://www.nytimes.com/2013/12/17/us/benefits-questioned-in-tax-breaks-for-nonprofit-hospitals.html?_r=0

Schencker, L. (2015, Jul 8). Not-for-profit hospital's tax exemption case could signal trouble for others. Modern Healthcare. Retrieved October 11, 2016, from: http://www.modernhealthcare.com/article/20150708/NEWS/150709925

All rights reserved © 2019 Waystar Health

APPENDIX: Section 501r Requirements	Yes	No
Written financial assistance policy The policy, summary, and application must be written in plain language.		
Written emergency medical care policy Can be integrated into the overall FAP or combined with your EMTALA policy.		
Written billing and collection policy Can be standalone or integrated as part of the FAP. Must outline the extraordinary collection actions that could be taken after reasonable efforts have been made to determine eligibility		
Limitations on charges (amount generally billed) Hospitals must choose a method for determining AGB and limit the charges for people who qualify under FAP to amounts generally billed to insurance patients. NOTE: This is intended to be amounts expected to collect from insurance companies given contractual allowances		
Authorized extraordinary collection actions (ECAs) Your Board should be voting on any ECM that the hospital is authorized to take		
120 day waiting period from date of first post-discharge statement prior to initiating ECAs Whether the patient has applied for or determined to be eligible for assistance or not		
Written notice provided at least 30 days in advance of initiating intended ECAs To be provided to the guarantor/patient		
Presumptive financial assistance described in policy If you are using presumptive means to determine eligibility, you must describe in your FAP		
Widely publicize policies Your FAP and application must be widely available, easily accessible, and free of charge. If a link is made available on your payment portal, make sure it is easily discovered. Your hospital's website is the easiest and first place you should look to post this information		
Authorized body approval financial assistance and billing/collection policies A subcommittee of the Board must sign off on your FAP, billing, and collections policies		
Develop procedures to inform and monitor 3rd party vendors Procedures must be in place to monitor vendor compliance with your FAP. This includes making sure they include a conspicuous notice of your FAP on their billing statements		

The content of this checklist is provided solely for informational purposes: it is not intended as and does not constitute legal advice. The information contained herein should not be relied upon or used as a substitute for consultation with legal, accounting, tax, and/or other professional advisors.

SOURCE: Mark Rukavina, Community Health Advisors

All rights reserved © 2019 Waystar Health