Acts of charity
Charity care strategies for hospitals in a changing landscape*
PricewaterhouseCoopers’ Health Research Institute

*connectedthinking
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Executive summary

In the unending debate about the nation’s uninsured and indigent population, the issue of charity care is often a footnote. Yet, discussion of it is integral to any healthcare solution regarding the uninsured. Hospital charity care is uniquely American, a safety net that is often unnecessary in nations with universal health coverage.

The availability of charity care at U.S. hospitals actually serves to mask the scope of our uninsured problem. Yet, these acts of charity are all that stand between a thorny policy dilemma and an access crisis for millions of Americans. Inconsistencies in the way charity care is delivered, reported and paid for have made it a confusing and difficult topic. However, these details have never been more important in today’s health system because charity care affects healthcare resources, bed capacity and physician time. Charity care costs are reallocated to other patients and failure to understand the costs muddies the issue for all.

The overwhelming majority of charity care is provided by not-for-profit and governmental hospitals. The debate around charity care is heightened by the renewed and critical focus on the covenant between a hospital’s not-for-profit tax status and the ensuing benefit to the community. Behind the court cases, congressional hearings, and newspaper stories on this issue is a complicated story that cannot be explained in simple sound bites.

To provide research-based insight, PricewaterhouseCoopers interviewed 15 healthcare leaders and commissioned a survey of more than 100 hospital financial executives on charity care issues. Survey respondents had a broad geographic representation across the U.S. and strong urban hospital representation. Hospital representation by type included, non-academic not-for-profit hospitals (54%), academic or teaching hospitals (38%), and for-profit hospitals (8%).

Industry leaders interviewed recognized that many of the forces that have boiled beneath the surface of the charity care issue are now boiling over. For example, the climate of charity care has changed dramatically as a result of the Sarbanes-Oxley era. The fallout from public company scandals and the rising number of uninsured has drawn heightened attention from trial attorneys, advocacy groups, the government, and the media. These shifts have compelled the industry to take a closer look at its charity care and financial assistance policies. Following are key findings and recommendations from our industry research, interviews, and survey:
Uncompensated care, of which charity care is a component, has been rising over the last five years. Uncompensated care increased 20% from $20.7 billion in 1999 to $24.9 billion in 2003. Tracking closely to these numbers, hospital industry bad debt as a percentage of net revenue increased from 7.6% in 1999 to 9.9% in 2003. As a strong bellwether, the for-profit hospital chains, HCA, and HMA reported a 60% and 70% increase respectively in charity care between 2002 and 2004.

No one knows the exact value of charity care provided by U.S. hospitals. PricewaterhouseCoopers 2005 Charity Care Survey showed that hospitals provide an average of 5% of net operating income in charity care, though some provided a substantially higher amount. The survey also showed that 76% of hospitals calculate their charity care in terms of charges, not costs, and an additional 9% use a combination of charges and costs, suggesting that the majority of charity care numbers are based on charges.

The true value of the charity care provided by hospitals may be more than what’s being reported. The burdensome and expensive process that hospitals must go through to classify a patient as charity care often means the amount of charity care blurs with bad debt. As a result, charity care numbers may be underestimated because 92% of hospitals surveyed said that at least part of their bad debt could be classified as charity care.

Hospitals are beginning to more widely communicate their charity care policies to the public. As an example, 51% of hospitals surveyed post their policies online.

Variation in hospital pricing and billing of the uninsured creates confusion and frustration among patients. Hospital costs and charges for services vary within geographies and are influenced by market conditions and competitive pressures.
expanding to incorporate discount policies for all uninsured regardless of whether they qualify for charity care. Public pressure and the number of uninsured, which has increased 1.4 million in one year, is forcing hospitals to establish procedures to deal with this growing population.

Hospitals often use reporting mechanisms that make charity care reporting problematic. Many hospitals report charity care on the basis of gross charges because they do not have cost accounting systems.

Recommendations
- Align patient charges to the uninsured with the same rates paid by Medicare and managed care
- Simplify qualification procedures for financial assistance and charity care and minimize requirements for patients
- Clearly communicate financial assistance policies to patients so they understand the program, how to access it, and who to contact with questions
- Staff patient access and patient accounting areas with highly skilled employees who are well trained on the charity care process, and preferably multilingual
- Work with patients on payment plans before sending accounts to collection agencies and taking legal action
- Clearly distinguish charity care from other community benefits
- Enhance transparency by developing and publicly disclosing an annual community benefit report
- Ensure complete and accurate submission of IRS Form 990
- Consider assigning financial counselors in the ER and on the inpatient floor to improve financial coordination for patients
Exhibit 1. Uninsured and uncompensated care track parallel trends, 1999-2003

Exhibit 2. Distribution of nonelderly uninsured by FPL

Source: Henry J. Kaiser Family Foundation
Charity care on the rise

Fueled by rising numbers of uninsured, charity care and bad debt levels are creeping upwards, forcing hospitals to shift these costs to other patients and payers. In theory, charity care and bad debt, in some regards, are like two different people sharing a meal together. Charity care is care provided to patients who do not have the ability to pay and are not expected to pay, so they were invited to a free meal. Bad debt is the value of care to patients who have the resources to pay but do not and so they decided to walk on the check. Even though in both cases the hospital doesn’t get paid, the big difference lies in whether they meet certain criteria for charity care or financial assistance. In other words, did they receive an invitation for a free dinner or did they walk on the check?

Uncompensated care increased 20% from $20.7 billion in 1999 to $24.9 billion in 2003. During that time, the amount of uncompensated care provided by hospitals increased every year. The largest dollar increase occurred between 2002 and 2003, when hospitals absorbed $2.5 billion in additional uncompensated care. The number of uninsured has grown in parallel fashion. For-profit chains have reported a substantial rise in their charity care numbers. HCA and HMA reported a 60% and 70% increase respectively in charity care between 2002 and 2004.

The uninsured aren’t necessarily unemployed. As illustrated in exhibit two, 35% of the uninsured in 2003 had incomes, when adjusted for family size, that were above 200% of the Federal Poverty Level (FPL). In 2003, roughly 45 million Americans were uninsured. Based on this data, over 15 million Americans were uninsured despite earning more than 200% of the FPL. This indicates that the cost of insurance can be prohibitive resulting in self employed and low wage workers being uninsured.

“Hospitals are flooded with more and more patients who can’t pay,” said Cathy Dougherty, service line director, revenue management at Gwinnett Hospital System, Inc. in Lawrenceville, Ga. “In only a few years, the amount of uninsured patients we serve has risen from 8% to 10%,” she added.

Immigration contributes to the number of uninsured because many new Americans come from countries where they don’t need to buy insurance.

The number of undocumented workers in the U.S. (estimated at 10.3 million) increased by about 23% from 2000 to 2004. Caring for uninsured
and undocumented patients falls disproportionately in certain regions. Exhibit 3 shows the population distribution by insurance status. Southern border states tend to have higher uninsured levels. In 2003, 25% of Texans were uninsured. New Mexico and Louisiana had uninsured rates of 22% and 20%, respectively.

As an example, Gwinnett’s Cathy Dougherty also notes that an increasing percentage of self-pay patients are undocumented residents.

Hospital executives say that rising charity care and bad debt costs have come at a time when increases in Medicare, Medicaid, and commercial insurance companies are not keeping up with rising expenses. Paul Salles, vice president of healthcare reimbursement policy at the Louisiana Hospital Association, says “The government wants to pay less, commercial insurers want to pay less — so who will ultimately pay for charity care?” He comments that “at this point in time, the dollars associated with that safety net are at risk.” Hospital executives are counting on commercial insurers and governmental payers to help offset the losses associated with caring for the uninsured and underinsured. This cross subsidization may be unsustainable.

Another association executive, Ken Robbins, president of the Illinois Hospital Association, agrees that the issue is problematic, adding, “My guess is until it’s a full-blown crisis, the country will do very little about it.”

Three factors are contributing to today’s rising uninsured rate. Small businesses are dropping coverage because it’s too expensive; rising insurance premiums mean that employees are opting out of coverage even when it’s offered; and the economic downturn has led to job losses and subsequently loss of health coverage.

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Exhibit 3. Percent of uninsured by state, 2002-2003
Why hospitals provide charity care

Charity care, in large part, is an unfunded mandate for hospitals. However, in some cases, hospitals receive financial benefit from their tax status as charitable organizations. Reasons that hospitals may provide charity care include:

**Mission**
Hospitals with a religious or community-focused mission provide charity care as a core value. These values are often delineated in charters, covenants, and mission statements or directed by the board and executive management. Mission-based organizations view serving the community as an obligation regardless of a patient’s ability to pay, regulations or mandates.

**EMTALA**
Medicare-participating hospitals are subject to the federal Emergency Medical Treatment and Labor Act (EMTALA), which requires hospital personnel to evaluate and stabilize patients with an emergency medical condition regardless of their ability to pay.\(^\text{11}\) A hospital emergency department is often the first point of care for charity care patients.

**Hill-Burton obligations**
In 1946, Congress passed the Hospital Survey and Construction Act, commonly known as the Hill-Burton Act, to encourage hospital construction. Hospitals received federal funds in exchange for providing care to the poor. Currently, 345 hospitals still have Hill-Burton obligations.\(^\text{12}\)

**Tax exemption**
Not-for-profit hospitals may qualify for exemptions from federal income tax as well as certain state and local taxes including income, franchise, sales and use, and property taxes. The value of that tax exemption is discussed in Appendix A. The criteria for receiving a tax exemption can vary based on applicable federal, state, and/or local standards and may include factors relating to the hospital’s provision of charity care. For example, the IRS has set forth the “community benefit standard” for determining whether a hospital is entitled to exemption from federal income tax as described in IRC section 501(c)(3).

**State regulation**
Some states have laws requiring not-for-profit hospitals to provide charity care at specific levels, usually a percentage of net patient revenue.\(^\text{13}\) Some states also have community benefit reporting requirements. For example, Texas mandates that charity care and community benefit make up at least 5% of the hospital’s net patient revenue\(^\text{14}\) and Massachusetts has moved to mandatory reporting of community benefit by not-for-profit hospitals.\(^\text{15}\)
Charity Care Definitions

Financial Assistance Policy
Any hospital policy that explains the provision of free or reduced price care or financial assistance to patients. Includes charity care and discount policies.

Charity Care
Healthcare services that never were expected to result in cash inflows. Charity care results from a provider’s policy to provide healthcare services free of charge to individuals who meet certain financial criteria.

Bad-debt Expense
The current period charge for actual or expected doubtful accounts resulting from the extension of credit.

Discounts
Sometimes called policy discounts or uninsured discounts, discounts are financial assistance for patients who do not qualify for charity care. Typically these discounts are provided to uninsured patients whose income may be higher than the limit set for charity care.

Community Benefit
In acting to fulfill their missions and their public trust, hospitals and other health service organizations strive to benefit the communities they serve. These “community benefit” activities relate to accessibility, quality and cost of the community’s health system, as well as to community health and well being.

Uncompensated Care
Uncompensated care is the total amount of healthcare services provided to patients who are either unable or unwilling to pay. Uncompensated care includes charity care, discounts, and bad debt.
Accounting for charity care

Traditionally, accounting for charity care and bad debt has been based on expectations. If there is no expectation of collecting payment from a patient because they have no ability to pay, then the healthcare services are classified as charity care. However, if the hospital does not qualify a patient for charity care and has an expectation of payment, then any non-payment results in a bad debt classification. Charity care, policy discounts, and bad debt rolled together are commonly called uncompensated care.

In the early 1990s, the American Institute of Certified Public Accountants (AICPA) mandated that hospitals separate bad debt from charity care in their financial reporting. According to the AICPA, the onus is on the hospital to establish a method to capture the charity care services it provides.

After nearly 15 years under this reporting requirement, one thing is clear – the calculation of charity care is inconsistent at best. Hospitals can calculate charity care using a variety of methods including; costs, charges, unit of service statistics, or a combination, including the use of cost to charge ratios. The use of multiple methods across the hospital industry makes it difficult to calculate the true cost of charity care, benchmark hospitals, or track aggregate trends. Ultimately, the numbers are often approximations because charges can vary widely by hospital and are typically much higher than actual costs.

PricewaterhouseCoopers’ survey showed that 76% of hospitals calculate their charity care in terms of charges, not costs, and an additional 9% use a combination of charges and costs. That would suggest that charity care numbers may be higher than true costs.

Reporting
Hospitals report charity care and bad debt depending on their payer mix and location. Following are types of reporting mechanisms:

Financial statements
Hospitals must report the level of charity care provided and must report bad debt as an expense in their financial statements.

Medicare cost report
The cost report manual defines charity care as services provided to patients that are unable to pay. Charity care includes full or partial discounts and is calculated by using charges. Bad debt includes charges not paid from a patient or third party payer.
State reporting requirements

Some states require hospitals to report charity care and/or community benefit numbers. For example, California, Texas, Rhode Island, Illinois, and Oregon require hospitals to report their community benefit numbers of which charity care is a component.

At least one state has a highly regulated charity care program. Hospitals in Massachusetts pay into an uncompensated care pool and at the end of the year, they’re reimbursed based on a cost to charge ratio. Regulations also specify eligibility for charity care, how to educate patients about charity care programs, and collection policies.

IRS reporting requirements

With few exceptions, tax-exempt hospitals must annually submit Form 990, Return of Organization Exempt from Tax, to the IRS. On it, hospitals have an opportunity to report an estimate of charity care and describe their exempt purpose in connection with describing their program accomplishments. Hospitals also can describe the community benefits they provide.

Charity care and discount policies

Not only are there a wide variety of methods to calculate charity care, but there are also a wide variety of charity care qualification policies. Traditionally, each hospital develops its own policy. Therefore, charity care qualification policies differ in format, content and procedure. As Nancy Kane, professor of health policy and management at Harvard University says, “This complexity stems from ambiguity in the rules, municipal rules and tax-exempt rules.”

Most hospitals have charity care policies for the poor, but often they find them difficult to implement. Without the cooperation of the patient providing documentation, hospitals cannot correctly classify patients. Difficulty in classifying patients often results in charity care cases becoming a bad debt. The Illinois Hospital Association’s Robbins noted, “In addition to what we say hospitals are responsible for here, we also say what we think patients are responsible for, and that presents a quandary. If the hospital asks for reasonable information about a patient’s financial condition and the patient refuses to provide that information so that the hospital can determine whether he is eligible for charity care, can you blame a hospital for seeking to collect for the care it provided?”

Further complicating matters are sliding scales and discounts. Hospitals may not be classifying bad debt and charity care correctly when applying a sliding scale or discount. In cases in which the hospital has a sliding scale program, only the portion that the hospital qualifies as charity care can be classified as charity care. For example, if a hospital qualifies an uninsured patient as charity care and eligible for a 50% sliding scale discount on a $100 patient bill, $50 is classified as charity care and never recognized as revenue, and $50 is due from the patient. If the patient’s $50 payment is not collected, it is classified as bad debt.

However, if that same patient is not qualified as a charity care patient, but still receives the 50% discount off charges as a policy discount, none of the bill can be considered charity care. If the patient fails to pay, the hospital would write off to bad debt only the $50 that was billed and recognized as revenue, not the entire $100 charge.

About 92% of hospitals in the 2005 PricewaterhouseCoopers Charity Care Survey believe that some of their bad debt could be classified as charity care (see Exhibit 5). This illustrates that charity care numbers reported by hospitals may be underestimated because of the difficulty in qualifying patients and the complications surrounding sliding scale discounts.

Exhibit 5. What % of bad debt could be classified as charity care?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Percentage of Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-25%</td>
<td>26%</td>
</tr>
<tr>
<td>25-50%</td>
<td>26%</td>
</tr>
<tr>
<td>50-75%</td>
<td>5%</td>
</tr>
<tr>
<td>76-100%</td>
<td>15%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>6%</td>
</tr>
<tr>
<td>N/A</td>
<td>3%</td>
</tr>
<tr>
<td>Source</td>
<td>2005 PricewaterhouseCoopers Charity Care Survey</td>
</tr>
</tbody>
</table>
Charity care: current climate

The courts, Congress and the IRS have focused on exempt organizations and the healthcare sector in the past year including looking at the community benefit standard, as well as charity care, as an appropriate standard for federal income tax exemption. Standardization could improve hospital qualifications, quantification, and reporting of charity care, ultimately leading to a better understanding of where strengths and weaknesses in the system lay. Industry expectations vary.

Says Dick Pettingill, chief executive officer of Allina Hospitals and Clinics: “I hope we’re able to responsibly regulate ourselves as an industry. My concern is, if we don’t take a leadership role then legislative mandates will be imposed.” However, this task is daunting. Noted Illinois Hospital Association’s Robbins: “When proposals for mandatory charity care, uniform charity care standards come up, one size truly does not fit all.”

Litigation and other significant rulings
Federal class action lawsuits against tax-exempt hospitals have prompted hospitals to review their charity care and collection policies. Many of these lawsuits have been filed by The Scruggs Law Firm, which has previously been active in major class action lawsuits in the asbestos and tobacco industries. Scruggs has filed 65 lawsuits in 24 states against 60 hospitals since the summer of 2004.

Most of the lawsuits have been dismissed at the federal level. Judges have ruled consistently that a tax exemption does not create a covenant between the federal government and a patient “because there is no legal authority, as described in one case, to support the notion that a theory of liability exists based on [the defendant hospital’s] status as a § 501(c)(3) organization”. In the meantime, Scruggs is taking his fight to the state courts.

The major allegations being made against non-profit hospitals include: alleged aggressive collection tactics not in line with their charitable missions; charging uninsured patients more than those with insurance; and violating federal and state regulations against profiting through a variety of private interests.

In addition, some state tax rulings have proven that governing bodies are willing to challenge a hospital’s tax exempt status. There have also been other recent cases filed and rulings at the state level that are putting pressure on not-for-profit hospitals.

Regulation and legislation
Congress
In 2004, the House Ways and Means Subcommittee on Oversight began
hearings focused on some broad topics regarding the tax-exempt status of charitable hospitals. Such topics included:

- How tax-exempt hospitals differ from their for-profit counterparts,
- The value tax-exempt hospitals provide to society
- Pricing practices of tax-exempt and other hospitals.

According to a press release in connection with the initial hearing, tax-exemption can be viewed as a subsidy for cost of charity care that the federal government would otherwise incur. The “community benefit standard,” which sets forth factors to illustrate whether a hospital qualifies for exemption from federal income tax as an organization described in IRC Section 501(c)(3), is detailed on page 29 in the “practice note” section. An issue that will likely receive continuing attention includes whether the “community benefit standard” of the IRS’ Revenue Ruling 69-545, (which states that a tax-exempt hospital must be organized and operated exclusively to further a purpose considered to be “charitable” in the generally accepted legal sense, and not for the benefit of private interests), provides adequate guidance for distinguishing a “charitable” hospital entitled to exemption from federal income tax under IRC section 501(c)(3) from a hospital that is not entitled to exemption.

On the Senate side, the Committee on Finance began hearings in the summer of 2004 focusing on oversight and reform of charitable organizations and released a discussion draft that reflects proposals for reforms and best practices for tax-exempt organizations. Significant items include:

- A recurring five year review of tax exempt organizations by the IRS improving the quality and scope of the Form 990 and financial statements (including CEO signature requirement)
- Requisite inclusion of a detailed description of an organization’s performance goals on Form 990 for organizations with $250,000 of gross receipts and requisite independent audit of the organization’s financial statements
- Proposed governance best practices for exempt organizations

IRS

The Commissioner of the IRS, while publicly acknowledging that many exempt organizations fulfill their mission to help the public, is focused on abuses. The IRS has engaged in several initiatives designed to improve the quality and quantity of information available to the IRS and the public. In this regard, the IRS has honed in on a number of issues:

- Focusing on the exam function, to enhance scrutiny of exempt status
- Closely looking at joint ventures between exempt organizations and for-profit entities
- Recognizing the evolutions and changes in the healthcare industry and the challenges this presents to the IRS in connection with the rules governing tax exemption

During an April 2005 Senate Finance Committee hearing, the IRS’ exempt organization (EO) enforcement efforts were discussed in light of recent increases in its budget. According to the Commissioner, the EO examination budget had been increased by 21% since 2003, resulting in a 30% increase in staffing. Healthcare organizations have been potential targets of this enforcement effort, especially as it relates to how their activities further their charitable purposes.

States

In addition to this federal interest, many states are enacting laws around the issue of charity care, specifically as it relates to accounting methodology, best practices for adopting charity care policies and mandated FPL for qualification. Exhibit 6 depicts where legislation has been introduced and passed in 2004 and 2005.

Last year, legislation relating to charity care was passed in nine of the 16 states where it was introduced. So far in 2005, legislation has been introduced in 15 states, including five new ones: Indiana, Mississippi, Maryland, Wyoming, and Washington. Notably, Indiana introduced legislation that would require hospitals to develop community benefits plans and report implementation progress of those plans to the state.

Key topics of proposed and passed legislation:

- Prices charged to self-pay patients and in some cases, capping prices
- Requiring hospitals to have policies and procedures to determine a patient’s ability to pay
- Mandated posting of signs or other communication about charity care policies
- Funds to assist hospitals in providing care to uninsured/underinsured patients
- Discounts for services to certain qualified self-pay patients
- Debt collections from self-pay patients
- Reporting requirements on the number of uninsured/underinsured treated
Exhibit 6. Charity care legislation activity by state

source
National Conference of State Legislatures 2005

- Legislation passed in 2004
- Legislation introduced in 2005
- Legislation passed in 2004 and additional legislation introduced in 2005
Exhibit 7. Which of the following policies do you use to determine charity care eligibility?

- Based on a maximum percentage of federal poverty guidelines for full eligibility for care: 91.2%
- Based on a maximum percentage of federal poverty guidelines for partial eligibility/sliding scale for care: 83.3%
- Based on medical indigence or catastrophic care eligibility: 59.8%

Source: 2005 PricewaterhouseCoopers Charity Care Survey

Exhibit 8. What is the maximum federal poverty level percentage for full charity care for your charity care policy?

- ≤ 100%: 57%
- 101-200%: 12%
- 201-300%: 17%
- > 300%: 6%
- N/A: 1%
- Don't know: 7%

Source: 2005 PricewaterhouseCoopers Charity Care Survey
Hospitals’ response

Hospitals are responding to the changing landscape of charity care and billing legislation, litigation, demands and expectations. PricewaterhouseCoopers’ survey found that nearly 70% of the hospitals had voluntarily revised their charity care policy within the last year which demonstrates their attention to this evolving issue. In almost every case, the change was to expand eligibility by raising the FPL percentage. Many hospitals also instituted sliding scale discounts or made existing sliding scale discounts more liberal.

Most hospitals use FPL levels to determine both full and partial eligibility for charity care discounts. PricewaterhouseCoopers Charity Care Survey found that 91% of hospitals have a full discount charity care policy and 83% a partial or sliding scale discounts based on FPL guidelines (see Exhibit 7). In addition, 60% of hospitals include in their policy a provision for eligibility based on medical indigence or catastrophic care costs. Catastrophic care provisions limit a patient’s financial liability, typically to a percent of their annual income.

Exhibit 8 shows that FPL qualification percentages vary from less than 100% to over 300% with the majority of policies in the 100% to 200% range. In general, FPL qualification percentages are greater for partial eligibility/sliding scale discounts (see Exhibit 9), with 33% of hospitals giving these discount to patients over 300% FPL.

Although FPL guidelines have traditionally driven hospital charity care and discount policies for the uninsured from a patient eligibility standpoint, more hospitals are moving toward flat-fee discounts for the uninsured who do not qualify for charity care. They’ve done this for three main reasons: (1) they’ve had to accommodate the increasing numbers of indigent and working uninsured—that population of people who make too much money to qualify for full charity care, but aren’t poor enough to qualify for medical assistance; (2) recent guidance from CMS and the Office of Inspector General (OIG) has given the industry more flexibility in how they offer discounts; and, (3) increased media and regulatory scrutiny.

In the past hospitals were unsure whether they could offer discounts at all because of Medicare regulations around uniform rates and anti-kickback statutes. However, the OIG guidance27 in 2004, and CMS guidance28 early this year instructed hospitals that they can offer discounts to uninsured patients without placing their Medicare reimbursement at risk. This guidance has helped facilitate a paradigm shift in hospitals extending discount policies to the uninsured. Although regulations
have not changed and some gray area still exists, many hospitals are changing their policies. In fact, some in the PricewaterhouseCoopers' survey said this guidance influenced their expansion of guidelines for discount eligibility.

**Pricing considerations: what are charges?**

Every product and service in a hospital has a price associated with it on the Charge Description Master (CDM). One of the closest analogies to hospital charges are hotel rack rates posted on the back of hotel room doors, but widely discounted. Government and commercial payers often base their payments and reimbursement on a percentage of hospital charges. In addition, Medicare requires hospitals to report charges on the Medicare Cost Report.

Much of the negative press against hospitals has focused on the uninsured being charged high prices for services, while managed care plans, Medicaid and Medicare receive deep discounts. Illinois Hospital Association’s Robbins describes how charges got so out of sync with costs: “All of the economic incentives forced you to want to make your charges as high as you reasonably could to make up for the losses you were incurring on the government and no-pay sides. All of this has a perfect logical root to it, but it also has reached a point where it’s not sustainable, either as good policy or as the kind of policy that someone who legitimately sees themselves as stewards of the community’s healthcare needs could support.”

Added Allina’s Pettingill, “The current charge base mechanism in this industry is not directly connected to reimbursement. Very few pay charges, so why even have it? I think that whole mechanism needs to be overhauled and we start over again.” The price gap for managed care, Medicare, and uninsured patients in California is illustrated in Exhibit 10. While insurance companies and managed care have negotiated contractual rates, uninsured or self-pay patients are often charged list price. Depending on each hospital’s unique financial assistance policy and whether

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**Exhibit 9. What is the maximum federal poverty level percentage for partial eligibility/sliding scale care for your charity care policy?**
While this may seem a separate issue from charity care, patient advocates argue that discount pricing policies for the uninsured must be part of a hospital’s uncompensated care strategy. “Pricing should be tied directly to a managed care discounted rate or Medicare. The average price paid by insured individuals is usually about 60% to 70% off the full ticket price,” said K.B. Forbes, executive director, Consejo de Latinos Unidos. “Discounted pricing must be tied to something or it is meaningless. When a patient qualifies for a 400% FPL level discount of 20%, but is paying a bill marked up 500%, that discount becomes meaningless. People should be guaranteed that when they walk through the door of a hospital, they are not going to face financial ruin.” Consejo de Latinos Unidos is a not-for-profit patient advocacy group for Hispanics, that was successful last year in pressuring a large hospital system to cut rates for uninsured patients and overhaul its collection practices.

PricewaterhouseCoopers’ survey indicated that approximately 5% of hospital respondents had revised their financial assistance policy in the past year to apply discounts similar to Medicare or managed care rates. A few hospitals said they gave uninsured patients the same discount as the average discount to managed care plans. At one hospital, uninsured patients are asked to pay an average private insurance amount instead of full charges. Some hospitals indicated that their reason for applying these flat-fee discounts is a result of media and public attention on hospital pricing.

The 2005 PricewaterhouseCoopers Charity Care Survey found a variety of ways hospitals apply discounts to the uninsured (see Exhibit 11). While about 70% (this includes those that use more than one method) of hospitals use discount off standard charges, many use other mechanisms.

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**Exhibit 10. List vs. net prices for insured vs. uninsured patients: appendectomy**

<table>
<thead>
<tr>
<th>List Price</th>
<th>Net Prices</th>
</tr>
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<tbody>
<tr>
<td>$18,229</td>
<td>$18,814</td>
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<tr>
<td>$6,174</td>
<td>$6,174</td>
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<td>$4,865</td>
<td>$4,865</td>
</tr>
<tr>
<td>$1,783</td>
<td>$1,783</td>
</tr>
</tbody>
</table>

- **Average Hospital Charge % Discount =** 66% Managed Care 73% Medicare
- **Uninsured (Indigent) 90%**
- **Uninsured (Non-Indigent) 55%**

**Exhibit 11. How are self-pay discounts for the uninsured determined?**

- **Discounts off of standard charges 69.6%**
- **Average managed care rate 15.2%**
- **Mark-up of fee schedule amount 5.4%**
- **Case-by-case basis 2.2%**
- **Don’t know 1.1%**
- **Other 1.1%**

*Source: 2005 PricewaterhouseCoopers Charity Care Survey*
Sample of state hospital association billing guidelines

<table>
<thead>
<tr>
<th>State</th>
<th>Adopted or proposed</th>
<th>Financial assistance recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>February 2004</td>
<td>Patients with incomes less than or equal to 300% of the FPL should be eligible to apply for financial assistance under each hospital’s charity care policy or discount payment policy.</td>
</tr>
<tr>
<td>New York</td>
<td>January 2004</td>
<td>Patients with incomes less than 200% of the FPL should be eligible for financial assistance. Hospitals may provide financial assistance to those earning more than or equal to 200% of the FPL.</td>
</tr>
<tr>
<td>Illinois</td>
<td>September 2003</td>
<td>Patients with incomes between 100% and 200% of the FPL should be offered partial discounts.</td>
</tr>
<tr>
<td>Louisiana</td>
<td>December 2003</td>
<td>Discounts should be offered on a consistent method based on need.</td>
</tr>
<tr>
<td>Maryland</td>
<td>October 2003</td>
<td>Hospitals should adopt AHA billing and collection practices.</td>
</tr>
<tr>
<td>Minnesota</td>
<td>May 2004</td>
<td>Patients with incomes less than 200% of the FPL are eligible for financial assistance. Hospitals may provide financial assistance to those who earning more than 200% of the FPL.</td>
</tr>
<tr>
<td>New Jersey</td>
<td>April 2004</td>
<td>Discounts should be offered on a consistent method based on need.</td>
</tr>
<tr>
<td>New Mexico</td>
<td>February 2004</td>
<td>Discounts should be offered for patients who need financial assistance. Absent any regulatory prohibition, such patients should not be charged more than the hospital would receive from government sponsored programs.</td>
</tr>
<tr>
<td>Oregon</td>
<td>Undated</td>
<td>Financial assistance should be available for families below 150% of the FPL. A sliding fee scale should be available when family income exceeds 150% of the FPL.</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>July 2004</td>
<td>Discounts should be offered for patients who need financial assistance. Absent any regulatory prohibition, such patients should not be charged more than the hospital would receive from government sponsored programs or commercial payers for the same services.</td>
</tr>
</tbody>
</table>
Guidance on charity care
For those states that have not regulated guidelines as a baseline for charity care policies, several state hospital associations and the American Hospital Association (AHA) have published recommended billing and collection policies during the past year. For example, many state associations are recommending specific sliding-scale discounts for patients. Other recommendations include utilizing payment plans and discounts to self-pay patients.

Hospital associations in 10 states have issued suggested policies and procedures in this area, as shown in the table at left.

Guidance on community benefit
As defined earlier in the paper, community benefit is the value that a hospital provides toward improving a community’s health. This is a much broader concept than charity care and is accounted for, and reported differently. Nonetheless, community benefit is an important element for tax-exempt organizations to collect, quantify and ultimately provide more transparency through public reporting.

Catholic Health Association, VHA, and Lyon Software published a community benefit reporting guide in 2005 that details accounting and reporting guidelines for community benefit reporting. The guide also defines and discusses numerous areas of benefit including:
- Community health services
- Health professions education
- Subsidized health services
- Research
- Financial contributions
- Community building activities
- Community benefit operations

Community benefit typically refers to activities and services provided by an organization that have a positive impact on society. According to the Public Health Institute, community benefits should extend beyond the traditional inpatient and emergency room care and free and discounted care to services that will address and reduce the unmet health needs of a community.

One such example would be to reach patients with preventable illnesses to avoid ER visits and expensive inpatient care. David Sklar, M.D., chairman of emergency medicine at the University of New Mexico School of Medicine, explains, “The broad management of patients with complex diseases that are very expensive to treat is and will be critical to managing cost. We must see this issue in a longer term perspective.”

The Public Health Institute report points out that providing effective community
benefit activities such as preventative healthcare may reduce the amount of charity care a community needs.

Harvard’s Nancy Kane comments, “Should you only provide [charity care] when patients are sick? Maybe communities should be setting up free clinics off provider grants.” University of New Mexico’s Dr. Sklar explains that if there is a way to reach patients in the underserved areas and provide early treatment, then care would improve for all patients. Training additional primary care physicians and applying for grants that provide services to the indigent population are important steps that need to occur. “How do you manage these patients better, instead of waiting for their crisis?”

Communicating these benefits to the public is a way for a hospital to tell its story in the community and expand the focus beyond charity care to give a more complete picture. The challenge is that unless a standardized community benefits methodology and reporting mechanism are identified, each hospital is responsible for voluntarily developing and communicating such information.

The table below provides sources for charity care and community benefit guidance.

<table>
<thead>
<tr>
<th>Organization</th>
<th>Guidance</th>
<th>Current issues</th>
<th>Best used for</th>
</tr>
</thead>
</table>
| American Institute of Certified Public Accountants (AICPA) | The AICPA Audit and Accounting Guide, Health Care Organizations provides accounting and financial reporting standards for charity care and bad debt | ● Distinguishing, measuring and presenting charity care in financial statements  
● Revenue recognition in the healthcare industry | Compliance with Generally Accepted Accounting Principles (GAAP) and financial reporting |
| Healthcare Financial Management Association (HFMA) and the American Hospital Association (AHA) | HFMA and AHA provide industry guidance on financial, operational and reporting issues through A Report from the Patient Friendly Billing Project: Hospitals Share Insights to Improve Financial Policies for Uninsured and Underinsured Patients | ● Treatment of uninsured patients  
● Community benefit and tax exempt status issues | Developing policies and procedures for the uninsured and understanding high-level community benefit issues |
| VHA Inc., the Catholic Health Association of the United States, and Lyon Software | Community Benefit Reporting: Guidelines and Standard Definitions for the Community Benefit Inventory of Social Accountability | ● The treatment of community benefit | Determining what is a community benefit and developing a methodology to quantify community benefit |
| Public Health Institute (PHI) | Advancing the State of the Art in Community Benefit: A User’s Guide to Excellence and Accountability | ● The role of public health in community benefit | Measuring and responding to community needs with an emphasis on public and preventative health |
Strategies for charity care. Charity policies and financial assistance policies are a mission, governance, accounting, tax, operational, financial, marketing, and public relations issue for hospitals. To address the issue in a holistic way, hospital managers should develop a comprehensive uncompensated care strategy. The following are elements to this strategy:
Align patient charges to the uninsured with the same rates paid by Medicare and managed care.

Hospitals typically have a complex charge structure. The CDM is essentially a price list, but competitive pressures often lead hospitals into setting charges higher than actual reimbursement. The Patient Friendly Billing Project report recommends that hospitals may want to modify their charge structure to consider the individual patient as a retail customer.31

The 2005 PricewaterhousCoopers Charity Care Survey found that when offering discounts to patients, approximately 70% (this includes those that use more than one method) of hospitals use a discount off standard charges methodology. If standard charges are viewed as excessive, a percent of charges discounting methodology may continue to leave hospitals vulnerable to allegations of price-gouging. Developing uninsured discounts that are more tied to payer reimbursement rates may be the most reasonable approach.

For example, two for-profit hospital chains, Tenet Healthcare Corporation and HCA now offer flat discounts that charge patients average managed care rates.

Many hospitals are also finding success in the use of prompt-pay discounts. Patients are often motivated to pay when they are billed at discounted rates. Prompt-pay discounts may be applied for payments received at the time of service, or a certain number of days after the service. Gwinnett Hospital in Georgia, for example, uses a 40% payment discount at time of service or within the first 30 days after the service for qualified patients. For accounts settled between 30 and 60 days after service, a 30% discount is applied. Accounts settled between 60 and 90 days are given a 20% discount. Thereafter, no discount is provided.
Simplify qualification procedures for financial assistance and charity care and minimize requirements for patients.

Most hospitals have complex and cumbersome paperwork that must be filled out prior to qualification for financial assistance. In addition, patients must supply a wide range of supporting documentation that could include pay check stubs, tax returns, notarized letters from employers, bank account information, and other asset verification information. This process can intimidate and in some cases deter eligible patients from applying for charity care.

Practice note
Implementing a qualification checklist in patient access areas (e.g., admitting, outpatient registration, ED etc.) may assist in quickly identifying and processing patients who may qualify for charity care or other financial assistance prior to receiving services (exception is patients requiring emergency care). Patients who communicate financial or medical hardship should be directed to a financial counselor who can assist with completing applications for government-sponsored health insurance such as Medicaid and/or begin the paperwork to assess patients for charity care. Inpatients requiring financial assistance should receive financial counseling services during their inpatient stay. The qualification checklist may include the following questions:

- Has the patient applied for government assistance?
- Does the patient have a catastrophic or medical hardship?
- Does the patient have a financial hardship?
- Is the patient indigent?
- Is the patient homeless?

Additionally, financial worksheets should be easy to administer. Documenting the hospital’s charity care assessment and application process for each patient who expresses medical or financial hardship is essential.

Hospitals in the PricewaterhouseCoopers 2005 Charity Care Survey cited serious concerns about not being able to get information from patients, both at the time of treatment and afterwards. Many people do not come to the hospital with detailed financial paperwork. Sometimes patients will not respond to questions and don’t give or provide information to make correct decisions about classification. Categorization is not a science, and the subjectivity involved in a myriad of paperwork can lead to errors.

“From an operational perspective the biggest problem is educating patients on what’s available and then getting them to comply with the paperwork,” says Beverly Wallace, president, financial services group at HCA, the nation’s largest for-profit hospital chain. “A lot of people could qualify but don’t follow through. You try to get as much information as you can and educate them but it’s very tough.” According to HFMA’s Patient Friendly Billing Project report, some hospitals have documentation compliance rates that hover around 50%, meaning that many people who may qualify for discounts aren’t getting them because they can’t or won’t complete the paperwork.

Exhibit 14 in appendix B shows a Patient Accounting Process Flow that can help hospitals improve their charity care and discount processes.

In one example of paperwork simplification, Pheobe Putney Memorial Hospital has begun to issue “care cards” to individuals who are eligible for free or reduced care.

The PricewaterhouseCoopers 2005 Charity Care Survey found that about 40% of those surveyed said they used automated systems to collect charity care eligibility information. Some systems are tied to patient registration software and some to billing software and collection cycle data. Such technology can reduce errors by helping staff comply with appropriate policies and cutting down on human error. Working with information technology resources to improve existing registration, billing and accounts receivable systems will assist with communicating and standardizing the charity care process. Creating an online charity care checklist as part of the registration process may help minimize the number of patients who may be overlooked because of a misplaced paper referral. Also, automating the back-end billing and accounts receivable functions will save time resolving accounts and help to reduce errors.
Clearly communicate financial assistance policies to patients so they understand the program, how to access it, and who to go to for questions.

The PricewaterhouseCoopers 2005 Charity Care Survey found that 88% of hospitals surveyed communicated policies at admission (see Exhibit 12). Posting information in public places and providing information via the billing office at discharge were other major methods of informing patients of policy. About half of the hospitals surveyed posted their charity care policies online.

“Hospitals have got to do a better job of communicating with their communities,” said Illinois Hospital Association’s Robbins. Eligibility criteria should be in a written policy and applied consistently.

Practice note
Consider including the following in a written policy:
• The types of documentation a patient must provide to qualify for the various forms of financial assistance
• The timeframe allowed for a patient to submit the required documentation (if there is a time limit to apply for financial assistance)
• The qualifying levels of income (typically related to the Federal Poverty Level)
• Other considerations or circumstances unique to the hospital’s culture, environment etc. that may be taken into account when determining eligibility

Hospitals should consider posting signs in English and other commonly spoken languages in the emergency department, admissions area and business office. The signs should inform patients about the opportunity to receive financial aid, give a brief description of the documents required to apply for such aid, the location providing eligibility forms and contact information for questions and further information. Wellstar Health Systems in Marietta, GA, which has a large constituency of Spanish speaking patients is considering Spanish language audio and video programming in patient areas that explain the hospital’s charity care eligibility procedures and other alternative methods of funding.

Hospitals also should consider communicating their financial assistance policies outside the walls of their hospitals. Phoebe Putney Memorial in Albany, Ga., pays for newspaper advertisements to let uninsured potential patients know about their policies. Congress has noted that very little, if any information is available to the public about pricing rates and methods. Not-for-profit hospitals can include a clear mission statement and financial assistance policy on their website in a good-faith gesture in line with their charitable mission.

Hospitals surveyed by PricewaterhouseCoopers said they communicate their policies in the following ways:
• Given upon request by patient
• Communicated at outpatient clinics as well as the hospital
• Included in billing statements, including final bill notice
• Provided by financial assistance counselors; patients are visited and interviewed in their rooms by these counselors
• Included on voicemail system and at the help desk
• Provided on financial assistance applications and by affiliated collection agencies
• Communicated and coordinated with employed medical group physicians.
• Published in the press as an advertorial
• Posted on signage in multiple languages in the emergency area

Exhibit 12. How do you communicate your charity care policy to your patients?

| Source | 2005 PricewaterhouseCoopers Charity Care Survey |

24 Acts of Charity | Charity Care Strategies for Hospitals in a Changing Landscape*
With 45 million uninsured, some experts believe that hospital systems cannot provide care to all who come to their door. In 2004 North Mississippi Health Services (NMHS) entered into a memorandum of understanding (MOU) with the Scruggs Law Firm, to outline potential terms for a settlement to provide discounts to the uninsured.

However, less than a year after beginning discussions with the Scruggs Law Firm, the hospital withdrew from talks stating that the proposed changes would have a devastating economic impact on its organization. Beginning March 2005, NMHS implemented a discount policy for the uninsured that provides discounts equivalent to the predominant discount provided under NMHS’s managed care agreements.

If the mission of the hospital is dependent on financial resources, can charity care and policies for the uninsured be too generous? Can serving too many uninsured put a hospital in jeopardy? According to Dr. Sklar at the University of New Mexico School of Medicine, “Hospitals need a mix of payers, along with the indigent patients in order to meet the bottom line requirements. If a hospital is treating too many indigent patients, there may not be room to treat patients with insurance. This seriously affects the hospital’s ability to remain viable.”

Reluctance to publicize charity care policies may stem from fears that they could open the floodgates for charity care patients. Louisiana Hospital Association’s Salles agreed, saying, “Hospitals are concerned that having a policy that is too publicly available will cause problems. The open communication of free care is a major issue as it may create unintended consequences. Hospitals already have an ER full of people. Hospitals must balance providing the most service they can for the least amount of money.”
Staff patient access and patient accounting areas with highly skilled employees who are well trained on the financial assistance process and preferably multilingual.

Patient access and patient accounting staffs should be thoroughly trained on the hospital’s charity care policy, how to administer it consistently, and what documentation should be collected to establish medical or financial indigence. Staff should be trained to consistently apply the financial guidelines without regard to race, creed, color, sex, national origin, sexual orientation, disability, age, or source of income.

“We used to only have one financial counselor,” explained Gwinnett Hospital’s Dougherty. “Charity care decisions used to take about 45 days. Now, we have more counselors that are better trained and make the decision within 10 days. Our recruitment processes have changed. There are degree requirements and language requirements. If this stuff was black and white, anyone could do it, but it’s not. Financial counselors must make an assessment of a patient’s ability to pay based on our policies. We have to consider patients on a case-by-case basis. We now have counselors in the ER 24/7, which has helped increase our point of service collections.” The hospital also provides a dedicated phone number for patients to call to request price estimates for medical care. If financial assistance is indicated, a referral is made to a financial counselor.

Staff should be trained on which documents are necessary to determine financial need. Documentation may include pay stubs, tax returns, bank account information, as well as other documents to assess the financial need of patients. The correct documentation can protect the hospital against lawsuits and criticism in the event that they must send an account to collections.

Documentation should also be retained as it relates to contact with patients regarding the hospital informing them of the charity care policy and their outstanding bills.

At some hospitals, doctors and nurses are trained in financial policies. However, some hospital executives say that such training could create a conflict of interest on the part of clinicians who should be solely focused on a patient’s well-being and treatment. However, medical staff should at least be able to direct patients to the appropriate person or source of information.

Training is important, as is thoughtful evaluation of whether a policy is effective. Phoebe Putney Memorial Hospital in Georgia has used focus groups, for instance, to determine how to better serve charity care patients. Kerry Loudermilk, the hospital’s chief financial officer, says, “We ask our inpatients when they register and our outpatients are called. We say ‘if you can’t pay we can help.’” The hospital has also doubled the number of its financial patient assistance counselors.

Practice note
Patient access and patient accounting management should be able to answer the following questions about financial assistance policies:

- What is the organization’s policy for charity care?
- How is that policy enforced?
- What determines if a patient is not able to pay?
- How is the amount of charity care determined? Based on discounted rates? Full charge rates?
- What if the patient can make a partial payment?
- When is charity care determined to take place? Before substantial collection efforts? After sent to collection?
- Does charity care exclude services provided where payment is accepted under a third-party arrangement that is less than the full charged rates?
Work with patients on payment plans before sending accounts to collection agencies and taking legal action.

In light of the Scruggs litigation, hospitals may want to modify their processes for billing patients who don’t qualify for full charity care. The policy should honor the hospital’s duty to reasonably seek collection, while protecting the patient against undue harassment. Hospitals should work carefully with patients before they leave the hospital to establish reasonable payment plans that are realistic for uninsured patients.

**Practice note**

In establishing a mechanism for uninsured and underinsured patients to pay, hospitals should consider:

- Working with patients to establish a payment plan before they leave the hospital
- Implementing a discount fee schedule that is more in line with average reimbursement rates
- Only taking legal actions, such as the garnishment of wages, if evidence suggests the patient has income and/or assets to meet his/her obligations
- Not forcing sale or foreclosure of a patient’s primary residence
- Utilizing reasonable efforts in relation to billing payment plans prior to sending an account to a collection agency
- Directing outside collection agencies to follow the guidelines above

“We advocate reasonable payment plans over a reasonable period of time,” said Consejo’s Forbes. “Hospitals must say ‘before we’ll sue you we need to check our documentation and make sure you were offered every option whether that be charity care or some kind of state care.’” For example, Forbes points out that there are funding sources for crime victims.

Clearly distinguish charity care from other community benefits.

One way that hospitals can respond to recent challenges regarding inflated or inaccurate charity care is to pay close attention to the calculation and quantification of charity care. As defined and discussed previously in the paper, charity care is based on policy. If a provider qualifies a patient for charity care and the services are provided with no expectation of payment, then the provision of services can be categorized as charity care. However, charity care does not include discounts or community benefits such as health education and screenings at health fairs. Services such as these should also be quantified and reported but only as community benefit, not as charity care.

In addition, charity care should not include contractual allowances or the difference between a payer’s reimbursement and the actual cost of providing the services. The AICPA’s Health Care Guide Revision Task Force addressed this issue and stated that because providers voluntarily agree to serve low-income patients under the terms of government programs such as Medicaid that any difference between cost and reimbursement should be considered contractual allowances.
Enhance transparency by developing and publicly disclosing an annual community benefit report.

With limited exception, tax-exempt hospitals are required by law to file IRS Form 990 which provides an opportunity to report community benefit. In some states, hospitals are required to report community benefits to state agencies. However, many hospitals are taking the additional steps of reporting their community benefits publicly.

Calculation of the value of community benefit activities provided by the hospital can be difficult. Similar to issues with charity care, many hospitals calculate these benefits differently. Susan Moore, director of finance at UCSF Medical Center, notes that some Public Health departments compare the tax breaks provided to non-profit hospitals to the reported charity care and community benefits that these hospitals provide. These tax breaks may be relatively simple to calculate, while the charity care and community benefits are often not easily available from the hospital’s accounting systems. She stated that because Public Health departments and others may be paying increased attention to community benefit planning and reporting, hospitals may need to develop a framework for community benefit planning similar to the timeline and decision-making around the capital allocation process. Gwinnett Hospital in Georgia develops an annual community benefit self-assessment that includes all uncompensated care. It includes all clinic activities, donations and community education. All of these costs are added together and compared to an estimate of the tax-exempt benefit that the hospital receives.

At Allina in Minnesota, the board has a specific committee for overseeing community benefit and understanding how the community is deriving value from the hospital. The organization is reinvesting back into their community to justify their tax-exempt status. “We’ve been very active in promoting the enhanced economic health and vitality of our communities,” said CEO Pettingill. “When we made a decision to relocate our corporate headquarters, it was based on our commitment to enhance the health and well-being of the community. My guess is you come back here 10 years from now, you’re going to see a very different neighborhood due to our commitment to community benefit. We have obligations to have relationships with our communities that go well beyond the walls of our institutions.”

As previously mentioned, some states have taken a proactive role in regard to the statewide implementation of community benefit programs. The Commonwealth of Massachusetts tracks hospital success in this area. Community benefits should be consistent, verifiable, and able to be re-performed. The community benefit plan written by a hospital should be designed to target the most important community needs and should be linked to the mission statement.

Currently, there is no standardized calculation and reporting format for community benefit; however, there are several sources for guidance as provided previously in the report. Ultimately, hospitals should develop a community benefit report that is much like an annual report with clearly defined metrics that can be easily viewed and tracked over time. The community benefit report should be publicly disclosed in all available forms including the IRS Form 990, state hospital associations, state agencies, hospital websites and other public forums. Appendix C includes a community benefit reporting template that can be used to develop and organize a community benefit report. The template is based on the community benefit reporting categories from the VHA, CHA, and Lyon Software report, Community Benefit Reporting: Guidelines and Standard Definitions for the Community Benefit Inventory of Social Accountability.
Ensure complete and accurate submission of IRS Form 990.

Form 990 presents a good opportunity for hospitals to disclose important financial information on charity care, as well as how they continue to meet the “community benefit standard.” The Form 990 annual information filing is filed with the IRS, and is a document open to public inspection. Such information can be disclosed on Part III of Form 990, “Statement of Program Service Accomplishments.” Part III of Form 990 also allows an organization to provide detailed information regarding its charity care and compliance with the “community benefit standard.” Hospitals may want to consider having a tax adviser review Part III to ensure the scope is appropriate and that they have captured all appropriate items.

Practice note
Hospitals should be able to demonstrate how they satisfy the “community benefit standard” as set forth in Revenue Ruling 69-545. In this regard hospitals may want to refer to the IRS’ Health Care Provider Reference Guide as a resource for which activities should be highlighted in Part III of Form 990. Although the document is non-precedential guidance, it lays out a comprehensive outline of key issues, including a summary of important factors to address and to demonstrate compliance with community benefit standards such as:

- Does the hospital have a governing board composed of prominent civic leaders and not just hospital administrators, physicians and others professionally connected to the hospital?
- Is admission to the medical staff open to all qualified physicians in the area consistent with the size and nature of the facility?
- Does the hospital operate a full-time emergency room open to everyone regardless of ability to pay (unless a limited exception is available)?
- Does the hospital provide non-emergency care to everyone in the community who is able to pay either privately or through third-parties, including Medicare and Medicaid?
- Does the hospital serve a broad cross section of the community through research or charity care?

As pressure from communities, lawsuits, legislation, and regulation mounts, hospitals are being forced into increased transparency. Forms 990 of many tax-exempt healthcare organizations are available on www.guidestar.org, a public website devoted to “facilitating access to information about the operations and finances of nonprofit organizations.”

Penalties can be assessed by the IRS for failure to file a timely, complete, or accurate Form 990. Further, the IRS has indicated its intent to increase audits in the not-for-profit sector and has recently announced an initiative aimed specifically at compensation practices and Form 990 reporting practices by tax-exempt organizations.

The more care hospitals take to provide and exhibit benefit, the more favorably the IRS, local Departments of Revenue, and courts will be liable to treat them under scrutiny.

U.S. hospitals might consider their community benefit reporting in light of the European example of social audits. Social auditing applies specific metrics to draw conclusions on the social benefits an enterprise produces for a community. These audits attempt to gauge whether a firm provides societal benefits and effectively utilizes assets in the community. As multibillion dollar businesses continue to have more influence on more economies, people, and the environment, advocates argue that social audits can gauge how well all organizations add value to communities.
Consider assigning financial counselors in the ER and on the inpatient floor to improve financial coordination for patients.

Financial counselors assigned to the ER and inpatient service are able to identify patients earlier in the care process. Accessing care through a hospital’s emergency room is often the point of entry for many uninsured patients. In some instances these patients may qualify for charity care but are registered as a self-pay patients. If payment for services is not received then the accounts may be inappropriately classified as bad debt. Identifying patients that require financial help while they are on site is key. Financial counselors can educate patients about the various financial assistance programs including the hospital’s charity care process and assist patients with applying for government-sponsored insurance or other assistance programs.

Analyzing the point of entry for charity care patients can help a hospital focus its efforts. For example, eight San Francisco hospitals reported emergency room care accounted for 15% of all charity care services. And they reported that outpatient services made up 80% of all charity care provided. Qualifying outpatients for charity care can be especially challenging because there is less time to explain charity care policies and work with the patient to gather information than with inpatients.
PricewaterhouseCoopers’ Health Research Institute

Appendix A

Tax case study

Potential tax effect of losing tax-exempt status (see applicable assumptions):

Recent challenges to the exempt status of healthcare organizations has renewed the debate regarding the value of tax-exemption relative to the value of charity care and other benefits provided by the institution. PricewaterhouseCoopers modeled the value of tax-exempt status for a typical not-for-profit hospital, (Hospital “A”). In this case study, the tax benefit equaled $6.5 million, which was nearly 5% of revenues and twice its profit margin. The hospital would have gone from a 2.6% profit margin to a loss if it had to pay all of the applicable taxes. This hospital was modeled as:

- 300-bed acute care hospital is exempt from federal income tax under IRC section 501(a) by reason of being described in IRC section 501(c)(3), and also qualifies for all applicable state and local exemptions.
- The hospital does not engage in any activity that is subject to federal or state unrelated business income tax.
- The hospital’s net revenue is $135.1 million, about average for a community hospital. Its total profit margin is $3.5 million, or about 2.6%.
- The hospital spends $39.4 million on supplies annually; its total property, plant, and equipment is $39.9 million; and it has 1,650 employees.

Exhibit 13 shows a graphic representation of tax exposure based on the facts above.

Exhibit 13. Exempt hospital: case study of tax assessment

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<th>Tax</th>
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<tr>
<td>Federal Net Income Tax</td>
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<td>Federal Unemployment Tax</td>
<td>$92,400</td>
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<td>$6,479,780</td>
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</table>

Assumptions for case study:

1. As an organization exempt from federal income tax under IRC section 501(a) that does not engage in any unrelated trade or businesses, Hospital A would not be subject to federal income tax.
2. As an organization described in IRC section 501(c)(3) is not subject to the Federal Unemployment Tax Act (FUTA).
3. In general, Hospital A is exempt from state and city sales and use taxes as a charitable organization which uses all tangible personal property in the accomplishment of its exempt purposes. However, some purchases would still likely be subject to sales and use tax, but the resulting tax liability would be “de minimis.”
4. Hospital A is exempt from city, county, and school district real property taxes by reason of being an organization described in IRC section 501(c)(3) that uses all of its real property in furtherance of its exempt purposes.
5. As an organization exempt from federal income tax under IRC section 501(a) that does not engage in any unrelated trade or businesses, Hospital A is not be subject to state or city income tax.
6. Hospital A, as an organization described in IRC section 501(c)(3), is exempt from the state unemployment compensation tax.
7. Net profit margin does not necessarily equal taxable income for federal income tax purposes, but will be used as taxable income for purposes of this example. Hospital A’s rate of 34% is used for purposes of this example.
8. The FUTA tax rate is 6.2% of the first $7,000 of wages, but Hospital A should qualify for a 5.4% credit due to its state unemployment compensation tax liability, which would result in a 0.8% FUTA tax rate.
9. The state imposes a 6% tax on the retail sale or use of tangible personal property. The city also imposes a 1% sales and use tax on tangible personal property. For this example, it was assumed that no purchases qualified for any other applicable exclusion.
10. City, county, and school district real estate taxes are $82.00 per $1,000 of assessed value. It is assumed that the fair market value of Hospital A’s real property is $25 million, with an assessed value of $12.5 million.
11. The state imposes a 10% tax on corporate net income, and the city imposes a 6.5% tax on net income. Net profit margin does not necessarily equal net income, but will be used as taxable income for purposes of this example.
12. The state imposes a 6.34% tax on employers on the first $8,000 of wages.
Exhibit 14 shows the optimal process to effectively identify charity care patients. The process must start as soon as a patient enters the hospital.

- Once an uninsured or underinsured patient presents for care, he or she should be registered and then interviewed by a financial counselor.
- The financial counselor should determine whether the patient is eligible for Medicaid or any other type of insurance. Even if the patient has insurance or is eligible for Medicaid, he or she may qualify for a charity care discount.

To determine if the patient is eligible for charity, he or she must furnish documentation, according to the hospital’s charity care guidelines.

If the patient is eligible for a charity care discount, then any balances will be written off as charity care. If the patient is not eligible for charity, the account is classified as self-pay. The hospital may decide to provide a partial discount based on each individual’s unique circumstance.

Exhibit 14. Charity care determination process flow

Note: Lettered circles provide an on-page reference for the continuation of the process flow.
The Charity Care classification decision tree (Exhibit 15) operates on the assumption that all fiscal activity ends up in one of five “buckets”: Realized Revenue, Contractual Discount, Self Pay Discount, Bad Debt, and Charity. The high level process is outlined below:

- Determination of charity care eligibility
- Write-off expense to charity or file claim with insurer
- If a discount is applied to an account, it should be done so before patient receives their bill
- Payment may or may not be remitted by patient resulting in revenue or bad debt
- In some instances, an account could go unpaid for a month or two before it is transferred to charity care and resolved

Exhibit 15. Charity care qualification decision tree
## Appendix C

### Community benefit reporting template

#### Demographic information

<table>
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<th>Name of Organization</th>
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<tbody>
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</tr>
<tr>
<td>Description of Organization</td>
<td></td>
</tr>
<tr>
<td>Governance/Organizational Structure</td>
<td></td>
</tr>
</tbody>
</table>

- [number of facilities, bed size, major services and centers of excellence]
- [tax exempt status, affiliated entities]

#### Community benefits structure

<table>
<thead>
<tr>
<th>Hospital Mission Statement</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Vision</td>
<td></td>
</tr>
<tr>
<td>Hospital Values</td>
<td></td>
</tr>
<tr>
<td>Hospital Community Benefit Plan</td>
<td></td>
</tr>
</tbody>
</table>

- [groups to target, decision makers, goals]

#### Mission mapping

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your mission map to your strategic planning process?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have a dedicated community benefits coordinator?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have a charitable foundation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you conduct teaching and research?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you required to report community benefits to the state?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you operate a Level I or Level II trauma center?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you the sole provider in your geographic area of any specific clinical services? If answer is yes to above, please list the services:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Provision of direct healthcare services

<table>
<thead>
<tr>
<th></th>
<th>Benefit $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government Health Programs [Provide the difference between costs of providing services and the reimbursement rate]</td>
<td></td>
</tr>
<tr>
<td>Unpaid cost of Medicaid</td>
<td>$x,xxx</td>
</tr>
<tr>
<td>Unpaid cost of CHIP</td>
<td>$x,xxx</td>
</tr>
<tr>
<td>Unpaid costs of other government health programs</td>
<td>$x,xxx</td>
</tr>
<tr>
<td>Government Health Programs Subtotal</td>
<td>$x,xxx</td>
</tr>
</tbody>
</table>
## Provision of community health services, outreach and education

<table>
<thead>
<tr>
<th>[Describe your community health services and outreach and education programs]</th>
<th>Benefit $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health services</td>
<td>$x,xxx</td>
</tr>
<tr>
<td>Community health outreach</td>
<td>$x,xxx</td>
</tr>
<tr>
<td>Community health education</td>
<td>$x,xxx</td>
</tr>
<tr>
<td>Other community health services</td>
<td>$x,xxx</td>
</tr>
<tr>
<td>Community Health Services Subtotal</td>
<td>$x,xxx</td>
</tr>
</tbody>
</table>

## Provision of professional education and research

<table>
<thead>
<tr>
<th>[Describe your professional education and teaching program]</th>
<th>Benefit $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical professional education</td>
<td>$x,xxx</td>
</tr>
<tr>
<td>Scholarships and funding</td>
<td>$x,xxx</td>
</tr>
<tr>
<td>Other education funding</td>
<td>$x,xxx</td>
</tr>
<tr>
<td>Professional Education Subtotal</td>
<td>$x,xxx</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>[Describe your research program]</th>
<th>Benefit $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical research services</td>
<td>$x,xxx</td>
</tr>
<tr>
<td>Other research services</td>
<td>$x,xxx</td>
</tr>
<tr>
<td>Donated to research organizations</td>
<td>$x,xxx</td>
</tr>
<tr>
<td>Research Services Subtotal</td>
<td>$,x,xxx</td>
</tr>
</tbody>
</table>

## Community building

<table>
<thead>
<tr>
<th>[Describe your community building activities]</th>
<th>Benefit $</th>
</tr>
</thead>
<tbody>
<tr>
<td>System/enterprise charitable donations</td>
<td>$x,xxx</td>
</tr>
<tr>
<td>Grants</td>
<td>$x,xxx</td>
</tr>
<tr>
<td>Value of in-kind contributions [use of facilities and equipment]</td>
<td>$x,xxx</td>
</tr>
<tr>
<td>Employee charitable donations organized and administered by system</td>
<td>$x,xxx</td>
</tr>
<tr>
<td>Value of employee volunteer time organized and administered by system</td>
<td>$x,xxx</td>
</tr>
<tr>
<td>Economic development activities [public works, small business development]</td>
<td>$x,xxx</td>
</tr>
<tr>
<td>Workforce development</td>
<td>$x,xxx</td>
</tr>
<tr>
<td>Other community building activities</td>
<td>$x,xxx</td>
</tr>
<tr>
<td>Community Building Subtotal</td>
<td>$,x,xxx</td>
</tr>
</tbody>
</table>
### Other community benefits

<table>
<thead>
<tr>
<th>Benefit $</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Briefly explain other community benefits provided but not captured in sections above]</td>
</tr>
<tr>
<td>$x,xxx</td>
</tr>
</tbody>
</table>

**Other Community Benefits Subtotal** $x,xxx

### Total community benefit

<table>
<thead>
<tr>
<th>Benefit $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Community Benefit</td>
</tr>
<tr>
<td>$x,xxx</td>
</tr>
</tbody>
</table>

### List and briefly explain educational classes offered

### List and briefly describe other community benefits provided to the community for which the costs cannot be captured

**CEO Signature:** ____________________________ **Date:** ________________________
About PricewaterhouseCoopers
PricewaterhouseCoopers Healthcare practice is one of the leading healthcare professional services organizations, providing assurance, tax, advisory and consulting services to this highly integrated sector. The firm works with organizations that represent the healthcare delivery spectrum: integrated delivery systems, hospitals, physician organizations, payer and managed care organizations, pharmaceutical and health science companies, ministries of health, government and other policymakers, professional associations, and investors. Visit PwC on the web at www.pwc.com/healthcare.

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Health Research Institute
PricewaterhouseCoopers Health Research Institute provides new intelligence, perspective, and analysis on trends affecting all health-related industries, including healthcare providers, pharmaceuticals, health and life sciences, and payers. The Institute helps executive decision-makers and stakeholders navigate change through a process of fact-based research and collaborative exchange that draws on a network of more than 4,000 professionals with day-to-day experience in the health industries. The Institute is part of PricewaterhouseCoopers larger initiative for the health-related industries that brings together expertise and allows collaboration across all sectors in the health continuum.

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