Documenting Charity Care
Using a Self-Pay Management System

An nTelagent White Paper

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Executive Summary

A lack of standards within healthcare organizations often makes consistently defining and reporting charity care difficult. In addition, many healthcare providers do not have effective, integrated systems in place to deal with and accurately document charity care cases (and other "self-pay" patients who may be unwilling or unable to pay for care at the time of service).

Because a healthcare organization's primary mission should be providing high-quality care that achieves positive patient outcomes, the financial accounts of all patients--whether self-pay or not--must be handled in a consistent and non-discriminatory manner, with patients treated with respect and care.

In light of new Internal Revenue Service (IRS) guidelines that went into effect in 2008, providers need processes in place to account for charity care in a common, standardized way. This is especially critical for organizations that have a not-for-profit status, as government turns its attention to whether they provide enough community services to justify their tax-exempt status**. Tools that help document charity are essential in demonstrating compliance and consistency for a hospital or health system.**

Implementation of a comprehensive self-pay management system enables healthcare service providers to interact with all patients regarding financial responsibilities at the point of service, including offering price transparency and medical financing options. Such a system can and should provide registrars and financial counselors with interactive scripts that integrate patient demographic information with each provider's unique business rules, thereby eliminating any guesswork that goes along with determining a patient's financial responsibility. The system should then automatically identify discounting and charity care options when applicable and help to ensure that patient financial accounting--for both insured and uninsured patients--is handled appropriately and in a non-discriminatory manner.

Background

What Is Charity Care? What About Bad Debt?

Charity care is defined as subsidized or free healthcare provided to uninsured and low-income patients. Charity care is the most direct way a hospital can give back to its community; it is also the original rationale for granting hospitals not-for-profit status. (See Appendix for History of Charity Care.) A Health Forum/American Hospital Association (AHA) Annual Survey reports that in 2007, registered community hospitals provided $34 billion of uncompensated care, 5.8% of their total expenses. This number represents the estimated cost of bad debt *and* charity care to the hospital. According to the AHA:

"Bad debt consists of services for which hospitals anticipated but did not receive payment. Charity care, in contrast, consists of services for which hospitals neither received, nor expected to receive, payment because they had determined, with the assistance of the patient, the patient's inability to pay. In practice, however, hospitals often have difficulty in distinguishing bad debt from charity care… Depending on a variety of factors, including whether a patient self-identifies as medically indigent or underinsured in a timely manner, care may be classified as either charity care or bad debt. Bad debt is often generated by medically indigent and uninsured patients, making the distinctions between the two categories arbitrary at best. Therefore, it is reasonable to consider bad debt as a component of hospitals' total cost of care to medically indigent and underinsured patients."

Not-for-Profits and the Current State of Charity Care

Communities across the country are asking whether private, not-for-profit hospitals provide enough community services through charity care to retain their tax-free status. One article states: "At issue isn't just pressure from the growing need but also the business practices of not-for-profit hospitals. In key ways, critics say, the hospitals are difficult to distinguish from their for-profit, tax-paying cousins." (Source: *Star Telegram*, July 30, 2006)

Non-profits in particular must confront the problems associated with documenting charity care to accurately assess the amount of care being provided. According to an article in *Healthcare Finance News*, "The issue that not-for-profits must address has been percolating for years, as municipalities, townships, counties and states have, in a hardscrabble hunt for more revenue, taken a hard look at their tax-exempt status, questioning their validity and whether they are acting more like for-profit organizations. In 2006, the effort expanded to the federal level after a report from the minority staff of the U.S. Senate Finance Committee recommended that Congress consider placing

501(c)(3) hospitals that do not meet 'minimum charity care levels' into a new 501(c)(4) category that precludes them from issuing tax-exempt bonds and receiving tax-deductible charity contributions." (Source: www.healthcarefinancenews.com/story.cms?id=7494)

Currently, there is little consistency in the way hospitals measure and report their charitable services. According to one expert, "Some base their reports on cost, some on charges and some point to other services like community newsletters, education and research." (Source: www.healthcarefinancenews.com/story.cms?id=7494)

Determining clear, unambiguous guidelines related to charity care helps organizations better track and document charity care services--a task that has become increasingly important for hospitals. Using a tool such as an automated, integrated self-pay management system can assist healthcare providers in accomplishing these goals.

The Need for Consistency

In most healthcare environments, consistently determining opportunities for assistance for every needy patient on the front end is difficult due to a number of factors, including timing of patient treatment, inadequate staffing levels to see every patient, and lack of patient understanding in providing the necessary information to obtain assistance. In addition to point-of-service improvements, charity care reporting and documentation processes also need to be made more consistent.

In an article published in *Healthcare Financial Management* (January 2007), Dr. Richard Clarke, president and chief executive officer of the Healthcare Financial Management Association (HFMA), writes: "**In charity care reporting, consistency is king**… The growing number of uninsured and underinsured patients is fueling an increase in the amount of charity care hospitals are providing. This increase has also fueled the need among various stakeholders to quantify the amount of charity care hospitals are providing.

"Policymakers want to know this amount so that health policy is based on a factual understanding of the financial effect of the uninsured and underinsured. Community groups want to know this amount so that they can determine the dimension and effects of the uninsured and underinsured in their community and determine the extent to which hospitals are providing a benefit to the community. Rating agencies want to know this amount so they can more accurately predict the creditworthiness of the hospitals they rate. Hospitals want to know this amount in order to demonstrate their community benefit and to facilitate accurate financial planning.

"None of these stakeholders has been able to effectively use the available information about charity care because the definition, valuation, and reporting have not been consistent across hospitals. The result has been confusion over just how much charity care--and community benefit--hospitals are providing. The complexities of charity care policies and the difficult task of documenting charity care qualification have generally resulted in many charity care patients being classified as bad debt. At its root, this is an accounting issue, and any accountant will tell you that standards must be established and followed to ensure uniformity and comparability of financial information."

Indeed, correctly documenting charity care has become paramount as the number of uninsured and underinsured patients increase. Next we turn our attention to some of the details involved in this documentation, to illustrate the intricacies of the system.

Elements of Charity Documentation

The purpose of charity documentation is to establish a mechanism to provide financial assistance to qualifying patients and an effective and consistent means of administration without discrimination. According to a *Healthcare Financial News* article published in September 2007, to identify charity care patients, hospitals should:

- **Communicate with patients at the point of service**
- **Make qualification for charity care as simple as possible**
- **Use electronic databases to check patient ability to pay**
- **Use predictive modeling techniques**
- **Identify the frequent users of the emergency department**

Specific to the importance of keeping the process simple, the author writes: "By keeping the eligibility verification process as simple as possible within the limits of state regulations and hospital-specific policies, a hospital can more effectively identify uncompensated care. By keeping qualification screens simple, the hospital can eliminate cases on the front end that have the potential to consume great amounts of time and effort on the back end for very little return."

Charity care objectives generally include:

- To fairly apply a charity, uninsured and indigent policy
- To identify those patients in need of financial aid
- To document a patient's liability for services
- To establish a methodology for collection of liabilities assigned as a result of this policy

Definitions around charity care documentation include but are not limited to:

- **Indigent Care**--Care provided to those patients whose gross income is at or below poverty based upon the poverty guidelines.
- **Uninsured**--Patients for whom no third party is responsible for their medical claims.
- **Medically Underinsured**--Any patient having incurred out of pocket liability, which exceeds $5,000 in a single encounter. For mother and newborns, both accounts should be combined as a single encounter.
- **Non-Covered Services**--Special promotion/package priced procedures which have reduced or special pricing arrangements associated with them such as cosmetic surgery performed purely for the purpose of enhancing one's appearance.
- **Charity Care**--Provision of help or relief to those patients whose gross income is above poverty based upon the poverty guidelines but doesn't exceed

four times the income amount for their particular category.

- **Discount**--To anticipate and make allowance from, deduct or subtract from the gross charges.

Documentation is dependent upon the patient providing requested information necessary for determining eligibility. (Source for objectives and definitions: Baptist Memorial Health Care's Charity, Uninsured, and Indigent Policy)

Determining categories and achieving the above-mentioned objectives requires educated, experienced staff, as well as a large amount of time. Many facilities still conduct the process entirely on paper. Patients often give up, get lost in the shuffle, or forget to follow up with the appropriate contacts. One report quotes Terry Allison Rappuhn of the Patient Friendly Billing project: “It’s an overwhelming task to manage that amount of paperwork--it’s hard for patients to gather and submit the documents and hard for staff to process. I’ve seen hospitals with compliance rates as low as 20 percent, which means that **many people who would qualify for assistance just can’t handle the paperwork. Hospitals with these volumes should automate if they can, and simplify the type and amount of information they request of patients**.” (Source: Today’s Charity Care Challenges: What Should You Be Doing?)

The Redesign of IRS Form 990

From a Dec. 20, 2007 press release from the IRS: The IRS issued an updated version of Form 990, the return that charities and other tax-exempt organizations are required to file annually, and provided transition relief so that small exempt organizations will have time to adjust to the new form.

"When we released the redesigned draft form this past June, we said we needed a Form 990 that reflects the way this growing sector operates in the 21st century," said Steven T. Miller, Commissioner of the IRS' Tax Exempt and Government Entities division. "The public comments we received in response to our draft form helped us develop a final form consistent with our guiding principles of transparency, compliance and burden minimization."

The final form released today retains the redesigned draft's format of a core form and a series of schedules. In response to public comments, the new core form allows an organization to describe its exempt accomplishments and mission up-front and provides more opportunities throughout the form for the organization to explain its activities. Other major changes were made to the form's summary page, governance section, and various schedules, including those relating to executive compensation, related organizations, foreign activities, hospitals, non-cash contributions and tax exempt bonds. A checklist of schedules was also added.

"We could not have done this without the tremendous input of the tax-exempt sector, the practitioner groups and the states," said Lois G. Lerner, Director of Exempt Organizations. "The almost 700 public comment letters, the advice and counsel of numerous nonprofit experts and state regulators, and the input from the nonprofit sector's leaders, were invaluable as we moved from the June discussion draft to the final form we released today."

The new form will be used for the 2008 tax year (returns filed in 2009). The IRS plans to release the related instructions in early 2008. "We are continuing to work with the nonprofit sector to complete the new form's instructions," said Lerner.

The IRS also announced a graduated transition period for smaller organizations. These organizations will be allowed to file the Form 990-EZ instead of the Form 990. For the 2008 tax year (returns filed in 2009), organizations with gross receipts over $1.0 million or total assets over $2.5 million will be required to file the Form 990. For the 2009 tax year (returns filed in 2010), organizations with gross receipts over $500,000 or total assets over $1.25 million will be required to file the Form 990. The filing thresholds will be set permanently at $200,000 gross receipts and $500,000 total assets beginning with the 2010 tax year. Also, starting with the 2010 tax year, the IRS will increase the filing threshold for organizations required to file Form 990-N (the e-postcard) from $25,000 to $50,000.

“This phase-in process will allow organizations to become familiar with the new Form 990,” Lerner said.

The IRS also announced a phase-in of the form’s new hospital and tax exempt bond schedules. Certain identifying information will be required for the 2008 tax year, with completion of the entire schedules required for the 2009 tax year. In response to the nonprofit sector's safety and security concerns regarding disclosure of certain foreign workers and volunteers, the IRS revised the form to permit reporting of foreign activities by region, rather than by country, until other safeguards may be implemented to protect the privacy interests of such persons.

“We believe the transition relief we are providing is appropriate and meaningful, and will ease the concerns raised by commenters,” said Lerner.

The final Form 990 and background material explaining the changes from the current form and the June draft are available on the Exempt Organizations portion of the IRS Web site, IRS.gov/eo.

(Source: IRS Releases Final 2008 Form 990 for Tax-Exempt Organizations, Adjusts Filing Threshold to Provide Transition Relief)

Legal Exposure for Inconsistent Pricing

The billing and collection practices of healthcare providers have emerged as a controversial issue, as many facilities have been accused of charging uninsured patients significantly more than they charge insured patients, and then aggressively seeking to collect payments from them. Recent legal disputes between not-for-profit hospitals and plaintiff's attorneys over the billing of the uninsured have resulted in a spate of settlements, indicating the need for equitable discounting and charity policies.

With reports such as the May 2007 *Heath Affairs* study--showing that "in 2004, U.S. hospitals charged patients without health insurance and those who paid for care out of their own pockets an average of 2.5 times more for services than fees paid by health insurers, and 3 times more than Medicare-allowable costs"--there is a tremendous need for hospitals to provide price transparency to patients at the point of service, including discounts and medical financing available.

A comprehensive self-pay management system allows service providers to automate their charity documentation and discounting policies consistently, ensuring that patient financial accounting--for both insured and uninsured patients--is handled appropriately and in a non-discriminatory manner.

Conclusion

Determining and reporting charity care can be complicated and time consuming, and inconsistencies in charity care policies will continue to grow as the uninsured and underinsured populations rise.

Without a self-pay management system in place, it is impossible to know at the point of service a patient's capacity to pay. A self-pay management system can automatically screen patients through an online interface at the point of service, requiring no additional staff to process cases.

Within a short amount of time, the provider learns the patient's potential qualification for eligibility programs. The system can and should also be set up to ensure appropriate documentation is obtained and completed by the patient. In sum, an effective self-pay management system will:

- **Eliminate inconsistencies in choice of accounts to be reviewed for assistance**
- Offer assistance to all patients meeting income guidelines
- Allow healthcare providers to offer community benefits on a consistent basis by assisting patients in understanding their choices
- Reduce turnaround time for approvals and notifications to healthcare providers
- Assist providers in meeting required application filing guidelines
- Provide consistency in application of charity care for those who do not qualify for assistance
- Reduce outstanding days in accounts receivable due to pending eligibility status

Appendix: History of Charity Care

The concept of charity care has been closely linked to the development of hospitals. As these institutions have evolved, so has the relatively vague definition of charity care. Today's hospitals differ considerably from their predecessors. Founded in Europe during the middle ages, and centuries later in America, hospitals served as the last resort for the infirm, the mentally and physically disabled, and the homeless. Hospitals performed multiple functions, but primarily provided shelter for the poor. Those who were better off usually received care in their own homes from private physicians. The growing number of epidemics and the need to isolate those affected led to establishment of city and voluntary hospitals during the 19th century. However, it was not until the advent of anesthesia and antiseptics that modern hospitals began to develop.

In the United States at the beginning of the 20th century, the prevailing hospital systems in major cities consisted of municipal and private secular hospitals, most of which were charitable in character and affiliated with medical schools. They relied upon government appropriations rather than fees to sustain their operations. Religious and ethnic hospitals, less prominent at the time, relied entirely on fees and donations to finance their operations. Until the 1970s, some hospitals managed to provide care for the poor by marking up the standard charges of the medical services they provided to the general population, a practice known also as cost-shifting. Insurance plans emerged in the 1930s, as the non-poor began to demand hospital care.

The Hill-Burton Act of 1946, which sought to promote hospital modernization, provided government grants to non-profit hospitals. In exchange for these grants, Hill-Burton required non-profit hospitals to provide charity care or discounted care for those who could not afford care at regular costs. Financing of the hospital industry shifted again with the creation of Medicare and Medicaid in the 1960s. By the end of that decade, about 90 percent of hospital revenue came either from government programs or private insurance.

Significantly, political pressure in the 1960s and early 1970s resulted in new state laws prohibiting hospitals with emergency care facilities to deny treatment to those in critical condition. Texas and New Jersey were among the first to pass such laws. However, it was not until the enactment of the Emergency Medical Treatment and Labor Act (EMTALA) in 1986 that a federal law required hospitals participating in the Medicare and Medicaid programs to provide a minimum of care to all patients coming to an emergency room regardless of their ability to pay.

The Internal Revenue Service (IRS) revised the definition of "charitable services" for non-profit hospitals in 1969, eliminating the clause requiring free or below-cost care except for hospitals that had emergency rooms. Moreover, the IRS also provided guidelines for tax exempt hospitals for assessing "community benefits" and as a result the promotion of health and the advancement of medical education were added to the mix of benefits allowed. In 1983, the IRS redefined charity care once again by allowing hospitals without an emergency room to have a tax-exempt status under special circumstances.

As a result of these changes, what constitutes charity care and community benefits has historically had no clear, universal definition. Lack of federal standards, and creative accounting practices on the part of hospitals, have only added to the confusion. Nevertheless, it is important to understand the language implications surrounding many of the concepts related to charity care.

(Source: Issue Overview, Hospital Charity Care in the United States, Summer 2005. Prepared for: The Missouri Foundation for Health, Health Policy Committee)

About nTelagent, Inc.

nTelagent, Inc. has developed The Retail Application for the healthcare industry, called the Self-Pay Management System (SPMS). Similar to applications used in the retail industry at the point of sale, the company's proprietary, automated system tells healthcare registrars and financial counselors exactly what to do and what to say to each patient at the point of service regarding financial responsibilities.

Moving workflow to the front end of the revenue cycle, nTelagent helps providers ensure a better patient experience through clearer communication and better handling of patient accounts, while improving upfront and overall cash flow, receivables and profitability by reducing bad debt.

Using non-credit scoring data, SPMS provides interactive scripts that integrate patient demographic information with each provider's business policies and rules. The system allows for price transparency and automatically identifies discounting options, social services eligibility and charity care options when applicable, ensuring that patient financial accounting—for both insured and uninsured patients—is handled appropriately and consistently.

Visit www.ntelagent.com for more information.