Revisiting Charity Care Policies in Light of Medicaid/Insurance Expansion

HFMA Forum Networking Event

March 18, 2014

Time: 10:00 – 11:00 a.m. Central (8:00 – 9:00 am Pacific/10:00 – 11:00 am Mountain/11:00 am – 12:00 pm Eastern)

Bob Wagner
Director of Revenue Cycle
Nebraska Methodist Health System

Mark Rukavina
Principal
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Director, Healthcare Finance Policy, Operational Initiatives
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Course Agenda and Learning Objectives

Agenda:

1. An Overview of Charity Care Principles and Practices
2. The 2014 Policy Environment
3. A Provider Case Study: Nebraska Methodist Health System

Learning Objectives:

- Understand how the expansion of health coverage under the ACA is impacting charity care policies.
- Identify new requirements under the ACA's 501(r) rule and how other rules and patient coverage are affected.
- Understand how current charity care policies should be revised to comply with the new rules and accommodate newly insured patients.
- Identify opportunities for improving revenue cycle processes and reducing bad debt by developing effective charity care policies.

An Overview of Charity Care Principles and Practices

Todd Nelson
Director, Healthcare Finance Policy, Operational Initiatives
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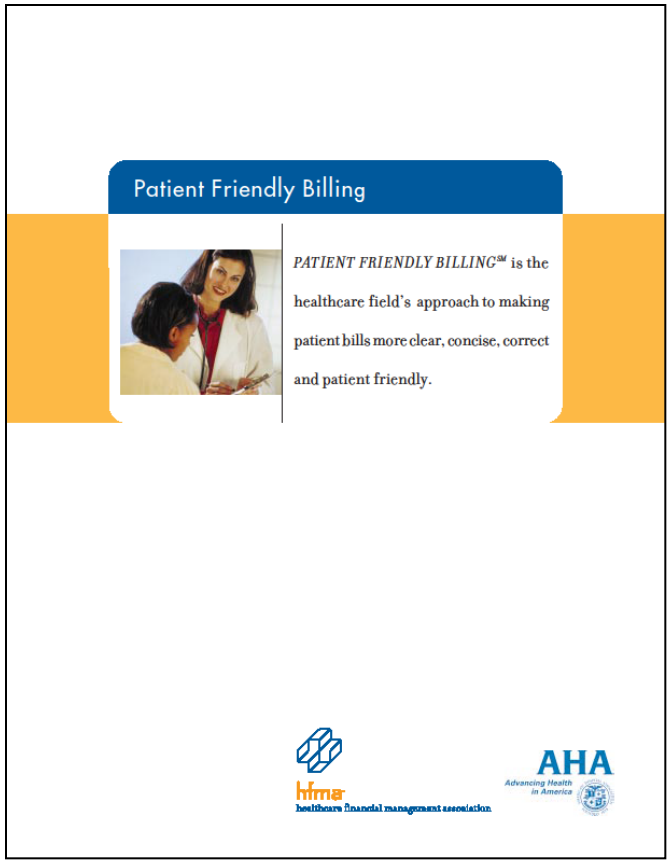
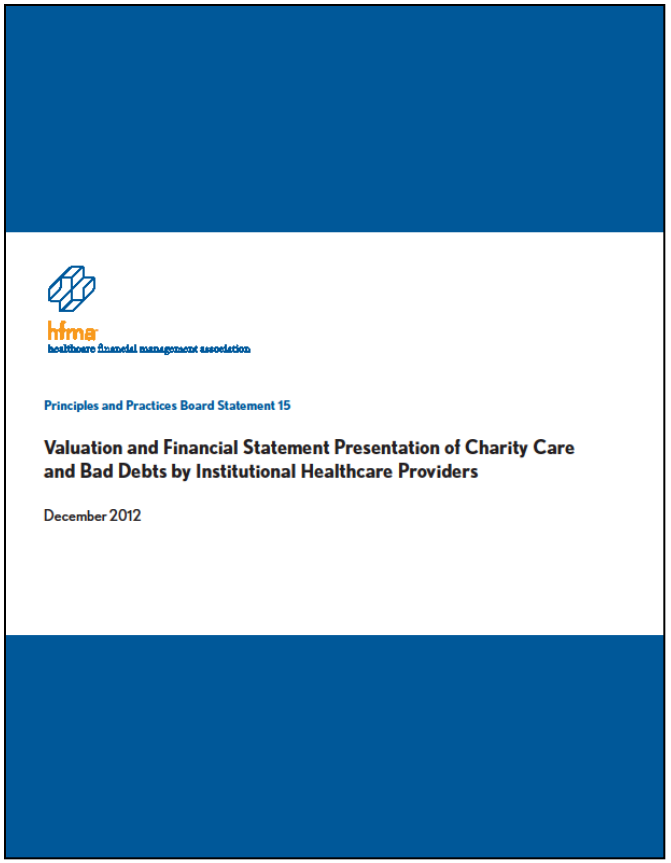
Patient Friendly Billing®



https://www.hfma.org/patientfriendlybilling/

P&P Board Statement 15



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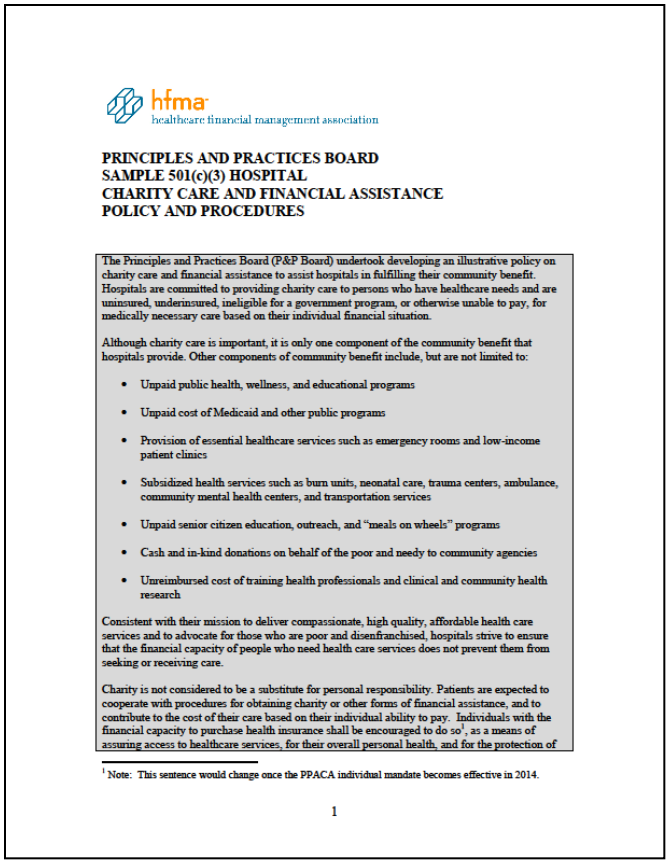
Principles and Practices Board Statement 15

Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers

December 2012



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PRINCIPLES AND PRACTICES BOARD
SAMPLE 501(c)(3) HOSPITAL
CHARITY CARE AND FINANCIAL ASSISTANCE
POLICY AND PROCEDURES

The Principles and Practices Board (P&P Board) undertook developing an illustrative policy on charity care and financial assistance to assist hospitals in fulfilling their community benefit. Hospitals are committed to providing charity care to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.

Although charity care is important, it is only one component of the community benefit that hospitals provide. Other components of community benefit include, but are not limited to:

- Unpaid public health, wellness, and educational programs
- Unpaid cost of Medicaid and other public programs
- Provision of essential healthcare services such as emergency rooms and low-income patient clinics
- Subsidized health services such as burn units, neonatal care, trauma centers, ambulance, community mental health centers, and transportation services
- Unpaid senior citizen education, outreach, and "meals on wheels" programs
- Cash and in-kind donations on behalf of the poor and needy to community agencies
- Unreimbursed cost of training health professionals and clinical and community health research

Consistent with their mission to deliver compassionate, high quality, affordable health care services and to advocate for those who are poor and disenfranchised, hospitals strive to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

Charity is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with procedures for obtaining charity or other forms of financial assistance, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so[1], as a means of assuring access to healthcare services, for their overall personal health, and for the protection of

[1] Note: This sentence would change once the PPACA individual mandate becomes effective in 2014.

1

https://www.hfma.org/Content.aspx?id=1069

Guiding Critical Conversations

Every day, healthcare professionals conduct sensitive financial discussions with patients.

Now there are accepted, consistent best practices to guide them in these communications.

hfma.org/communications

Improving the Patient Payment Experience

The New York Times

BUSINESS DAY

New Billing Standards to Help Patients With Debt

FEB. 13, 2014, 3:12 P.M. E.S.T.

The last thing anyone wants to deal with after a serious illness or injury is a mountain of debt and repeated calls from bill collectors. Yet that's the scenario in which many patients find themselves.

Patients can avoid some of those headaches and minimize the risk they'll need to file for bankruptcy protection. To do that, they must discuss costs and payment options early on with their hospital or medical provider, and be sure that they have tapped into any available discounts and financial assistance.

But new standards, coming from government and the hospital and bill collection industries, should make resolving disputes and paying bills easier and fairer for patients, experts say. That's really needed as consumers face growing medical bills.

hfma.org/medicaldebt

Best practices for medical account resolution take the uncertainty out of the billing and collection experience for patients.

Moving Toward Price Transparency

Price Transparency Task Force Members

- American College of Physician Executives
- American Hospital Association
- America's Health Insurance Plans
- The Blackstone Group
- California Hospital Association
- Catalyst for Payment Reform
- Catholic Health Association
- Community Health Advisors
- Equity Healthcare
- Federal Trade Commission*

** Advisory capacity*

- Florida Blue (Blue Cross/Blue Shield)
- Geisinger Health System
- Healthcare Consumers
- Healthcare Incentives Improvement Institute
- HFMA
- The Leapfrog Group
- Maricopa Integrated Health System
- Medical Group Management Association
- National Rural Health Association
- Priority Health
- Sidley Austin LLP

Polling Question #1

Which response most accurately describes when your institution last revised its financial assistance policy?

- Within the past year
- Within the past two to three years
- More than three years ago
- I do not know

The 2014 Policy Environment

Mark Rukavina, Principal

Community Health Advisors, LLC

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Section 501(r) Requirements for Non-Profit Hospitals

Financial Assistance Policy

- Written financial assistance policy
- Criteria for eligibility (i.e., percentage of federal poverty guidelines, whether assets considered)
- Type of assistance provided (i.e., free care, discounted care, medical indigent or hardship)
- Widely publicize financial assistance

Section 501(r) Requirements for Non-Profit Hospitals

Billing & Collection Policy

- May stand as a separate policy or be incorporated into the overall financial assistance policy
- Describes permissible collection actions that may be taken in the event of nonpayment and defines time frame for taking action
- Applies to both internal hospital collection efforts and efforts undertaken by authorized third parties
- Prohibits engaging in extraordinary collection actions until reasonable efforts have been made to determine eligibility under financial assistance policy.

Extraordinary Collection Actions

Actions taken by the hospital, or a third party acting on behalf of the hospital, that require legal or judicial processes.

They include, but are not limited to the following:

- Reporting adverse information to credit bureaus
- Selling of debt to another party
- Initiating civil litigation
- Initiating liens on property
- Foreclosing on real estate
- Attaching or seizing bank accounts
- Causing an individual's arrest
- Requiring body attachments
- Garnishing wages

Polling Question #2

Since passage of the ACA and the Section 501(r) provisions, have you revised your financial assistance or billing/collection policies to ensure that "extraordinary collection actions" are not pursued prior to informing patients of your financial assistance policy?

- Yes
- No
- I do not know

Affordable Care Act Coverage Expansion Options

- Medicaid expansion – Increase income eligibility level to 138 percent of the federal poverty level covering most people, including single adults
- Health insurance marketplace - Subsidies for health insurance premiums for those with family incomes between 100 to 400 percent of the federal poverty level
  - Health insurance premiums limited to:
    - 2 to 9.5 percent of family income

Affordable Care Act
Health Insurance Marketplace

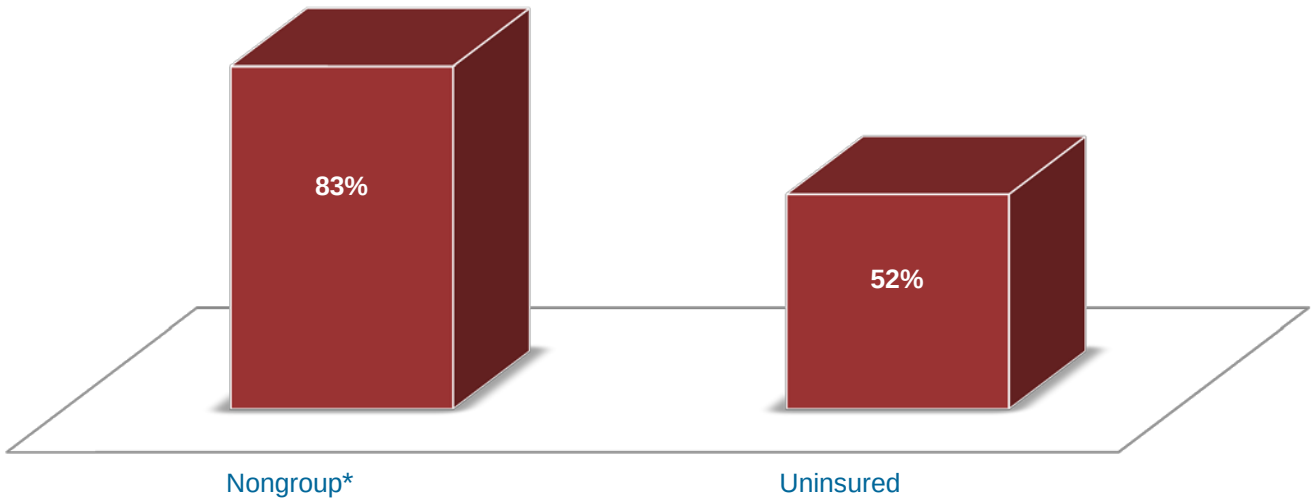
- Family of four in Omaha, NE
- Income – 300 percent of the federal poverty level = $70,650/year
- Health insurance premium for silver plan = $9,937 per year
  - Subsidy = $3,225
  - Amount to be paid by family = $6,712 or 9.5 percent of family income
- Out of Pocket Maximum for Silver Plan = $12,700

Public Understanding of Basic Health Insurance Concepts

- Urban Institute Health Policy Center - Health Reform Monitoring Survey, conducted in June and July 2013, asked respondents how confident they were in their understanding of health insurance terms.
- Interviewed nonelderly adults with incomes above 138 percent of the federal poverty level.
- Marketplace subsidies are available to nonelderly adults with family incomes between 138 and 400 percent of the federal poverty levels who are not eligible to buy health insurance through an employer or other group coverage (nongroup), have employer-sponsored coverage that is unaffordable, or are uninsured. Those with family incomes exceeding 400 percent federal poverty level will buy coverage entirely with their own funds.

Public Understanding of Basic Health Insurance Concepts

Very or Somewhat Confident in Understanding of the Term "Premium"

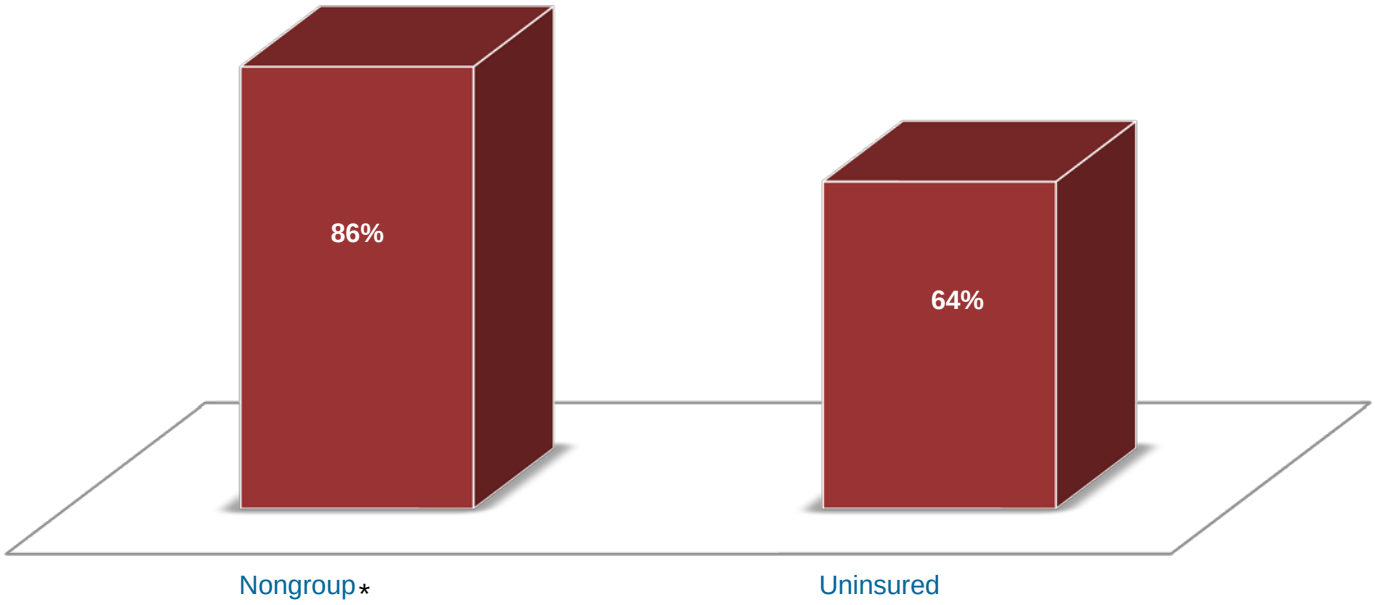


* Nonelderly adults currently purchasing individual coverage and not eligible to buy health insurance through an employer or other group.

Source: Urban Institute Health Policy Center - Health Reform Monitoring Survey, 2013

Public Understanding of Basic Health Insurance Concepts

Very or Somewhat Confident in Understanding of the Term "Copayments"

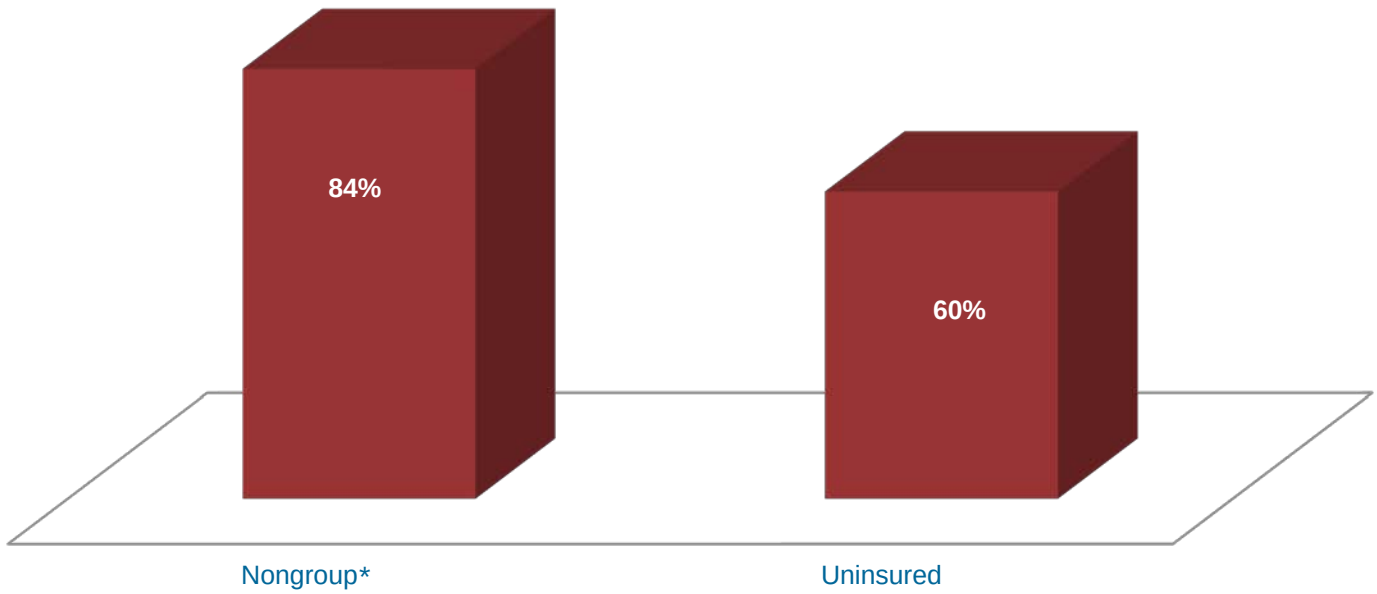


* Nonelderly adults currently purchasing individual coverage and not eligible to buy health insurance through an employer or other group.

Source: Urban Institute Health Policy Center - Health Reform Monitoring Survey, 2013

Public Understanding of Basic Health Insurance Concepts

Very or Somewhat Confident in Understanding of the Term "Deductible"

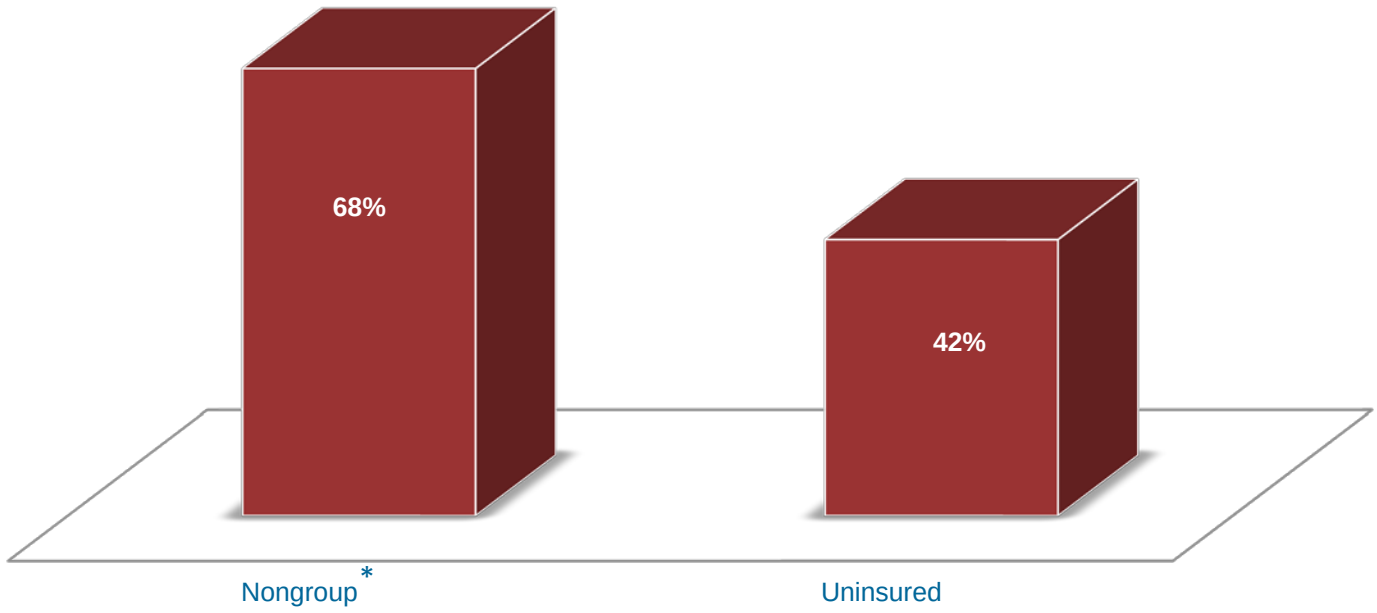


* Nonelderly adults currently purchasing individual coverage and not eligible to buy health insurance through an employer or other group.

Source: Urban Institute Health Policy Center - Health Reform Monitoring Survey, 2013

Public Understanding of Basic Health Insurance Concepts

Very or Somewhat Confident in Understanding of the Term "Coinsurance"

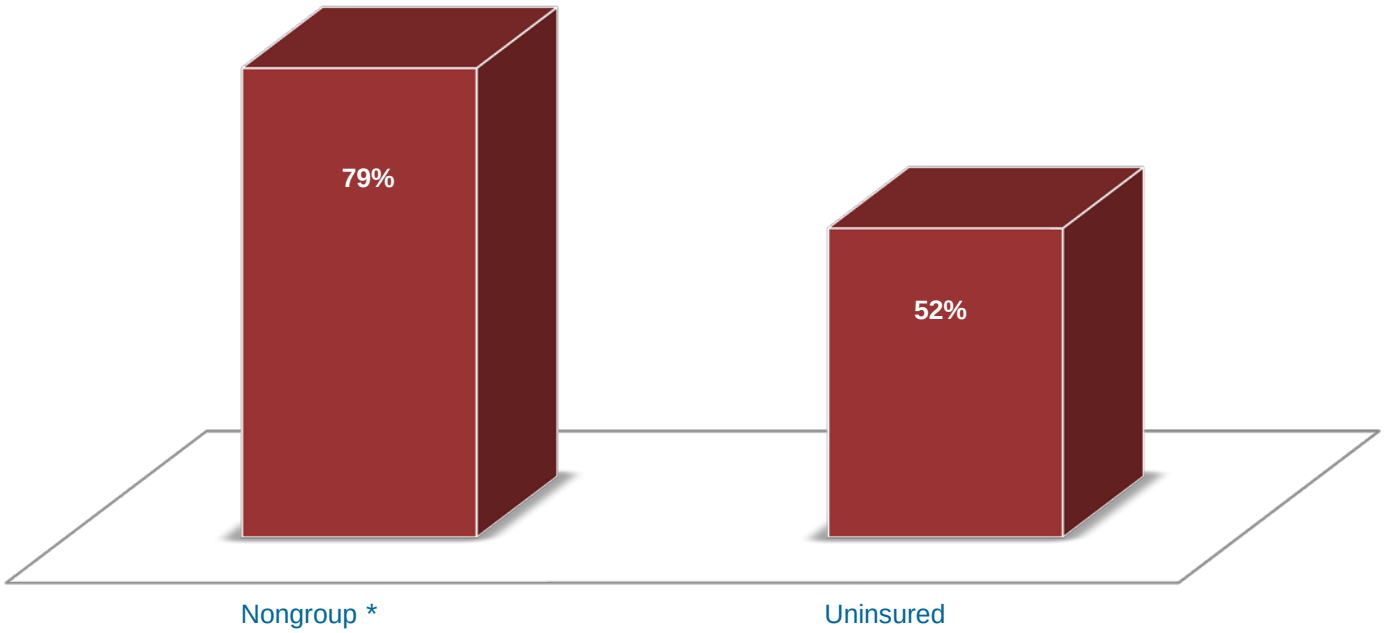


* Nonelderly adults currently purchasing individual coverage and not eligible to buy health insurance through an employer or other group.

Source: Urban Institute Health Policy Center - Health Reform Monitoring Survey, 2013

Public Understanding of Basic Health Insurance Concepts

Very or Somewhat Confident in Understanding of the Term "Maximum Annual Out-of-pocket Spending"



* Nonelderly adults currently purchasing individual coverage and not eligible to buy health insurance through an employer or other group.

Source: Urban Institute Health Policy Center - Health Reform Monitoring Survey, 2013

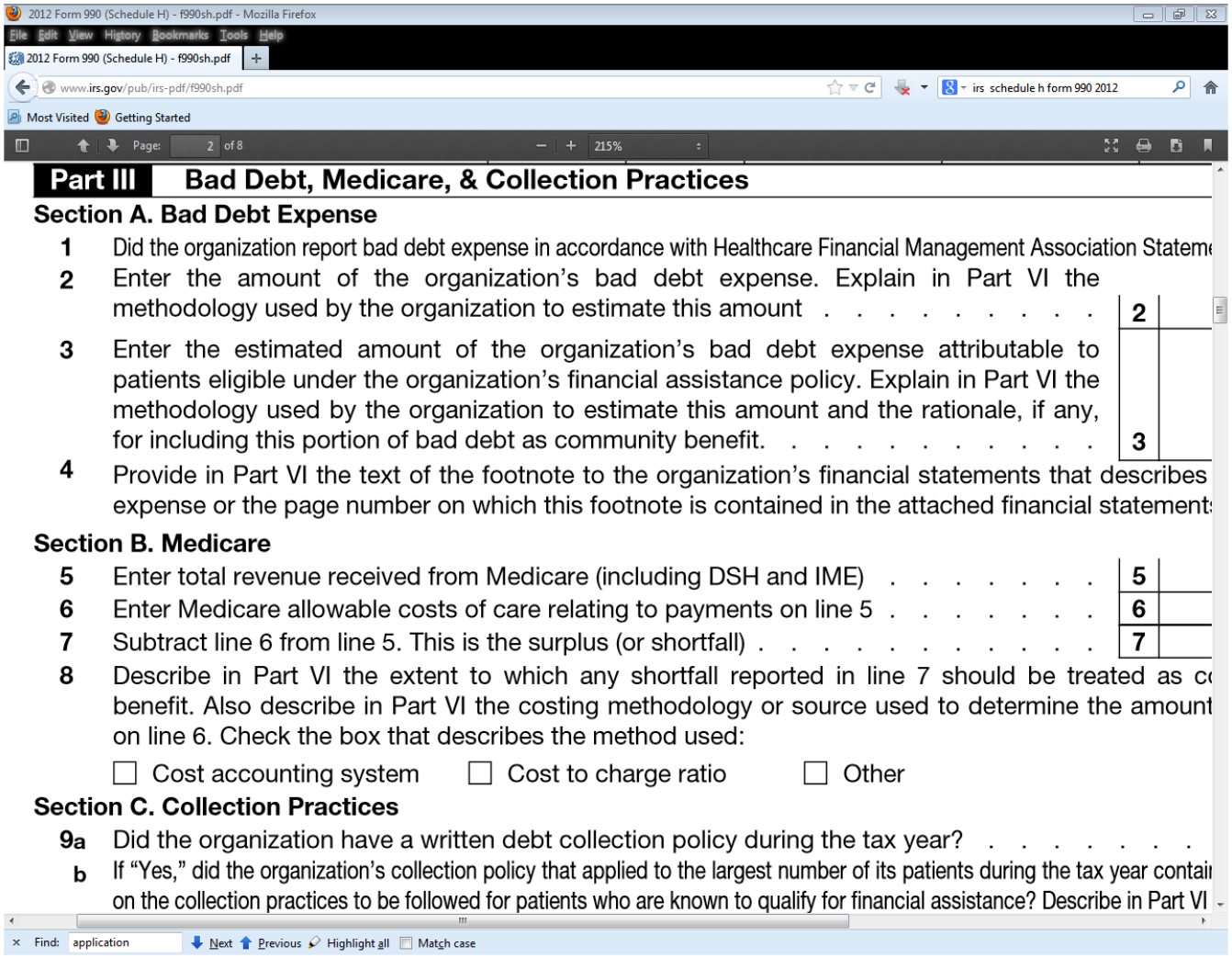
New Reform Environment: Implications for Healthcare Providers

- Number of privately insured patients ▲
- Number of patients with Medicaid ▲ or =
- Patients with no insurance ▼
- Confusion regarding out-of-pocket expenses ▲
- Balance after insurance bad debt ▲

Uncompensated Care: An Ongoing Concern

- Financial assistance
- Bad debt
- Revenue implications
- Schedule H reporting – community benefit

Schedule H – Reporting Bad Debt Expense



2012 Form 990 (Schedule H) - f990sh.pdf - Mozilla Firefox

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irs schedule h form 990 2012

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Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statem

2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount 2

3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit. 3

4 Provide in Part VI the text of the footnote to the organization's financial statements that describes expense or the page number on which this footnote is contained in the attached financial statement

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME) 5

6 Enter Medicare allowable costs of care relating to payments on line 5 6

7 Subtract line 6 from line 5. This is the surplus (or shortfall) 7

8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as c benefit. Also describe in Part VI the costing methodology or source used to determine the amount on line 6. Check the box that describes the method used:

☐ Cost accounting system ☐ Cost to charge ratio ☐ Other

Section C. Collection Practices

9a Did the organization have a written debt collection policy during the tax year? . . . . . .

b If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contai on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI

Find: application Next Previous Highlight all Match case

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Questions for Hospitals to Consider

- Do hospital policies satisfy federal and state laws?
- Have policies been calibrated with the local marketplace?
- Does financial assistance apply to uninsured and underinsured?
- How do contractual obligations interface with financial assistance policy?
- Are connections made between financial assistance and financial barriers identified in community health needs assessments?

Questions for Hospitals to Consider

- Has financial assistance policy been widely publicized?
- Are policies applied consistently?
- Are safeguards in place to ensure that collection actions are not taken prior to making reasonable efforts to inform patients of financial assistance?
- Has the hospital board reviewed and approved the financial assistance, billing, and collection policies?

Leading Practices

- Financial assistance, billing, and collection policies updated and approved by governing body
- Financial assistance widely publicized and shared with community, policymakers, and the media
- Presumptive eligibility used to qualify financially needy patients for assistance
- Safeguards are in place to ensure extraordinary collection actions are not pursued prior to making reasonable efforts to determine eligibility for assistance
- Rationale for estimating bad debt is attributed to patients eligible for financial assistance

Polling Question #3

To what group of patients do you extend financial assistance (charity care) under your policy?

- Only the uninsured
- Uninsured and underinsured (balance after insurance)
- I do not know

Case Study: Nebraska Methodist Health System

Bob Wagner

Director of Revenue Cycle
Methodist Health System

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NEBRASKA METHODIST HEALTH SYSTEM

- **NEBRASKA METHODIST HOSPITAL**
  OMAHA, NEBRASKA
  - 472 beds (staffed 369)
  - Net Patient Revenue - $333 M
- **METHODIST WOMEN'S HOSPITAL**
  OMAHA, NEBRASKA
  - 128 beds (staffed 128)
  - Net Patient Revenue $80 M
- **METHODIST JENNIE EDMUNDSON MEMORIAL HOSPITAL**
  COUNCIL BLUFFS, IOWA
  - 256 beds (staffed 129)
  - Net Patient Revenue $84 M
- **METHODIST PHYSICIANS CLINIC**
  OMAHA/COUNCIL BLUFFS
  - 20 plus locations in the metro area
  - 168 + employed physicians and 60 mid-level practitioners
  - Net Patient Revenue - $127 M

NEBRASKA METHODIST HEALTH SYSTEM

- Financial assistance policy in place
  - Did not incorporate all points of ACA & 501(r)
  - Somewhat complex
  - Consistency a challenge

- Billing and collection policy in place
  - Did not address 501(r)
  - Schedule H

NEBRASKA METHODIST HEALTH SYSTEM

- Engaged Mark Rukavina to assist with revising both policies
- Performed market comparison of charity care
  - Form 990 schedule H
  - Website
  - Documented
  - Shared with board
- Goal of treating patients consistently, fairly, and compassionately

NEBRASKA METHODIST HEALTH SYSTEM

- Policy revisions
  - Wording consistent with ACA & 501(r)
  - Wording aligned between policies
  - Simplified where possible
  - Clarify consideration of excess assets
  - Added medical hardship eligibility
- Financial assistance worksheet
  - Instructions - walk staff through process

NEBRASKA METHODIST HEALTH SYSTEM

- Policy changes – many stakeholders
  - Clinical services (i.e., cancer center)
  - Accounting
  - External vendors
    - ✓ Pre-collections
    - ✓ Collections
  - Legal counsel
  - External auditors
  - Tax advisors

NEBRASKA METHODIST HEALTH SYSTEM

- Audit committee and board approval
  - Subject to modification with final regulations
- Training sessions
  - In depth
  - High level
  - Staff training on financial assistance worksheet
- Revisions
  - Application
  - Website
  - Billing notices and patient brochures

Polling Question #4

Since the beginning of this calendar year, have you seen an increase in the number of patients struggling to pay out-of-pocket costs?

- Yes
- No
- I do not know

Questions & Answers

Ask the speakers a question or share your charity care policy experiences. Just type your question or comment into the Q&A box on your computer screen.

Contact Information

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To Complete the Program Evaluation

The URL below will take you to HFMA on-line evaluation form.
You will need to enter your member I.D. # (can be found in your confirmation email when you registered)

Enter this Meeting Code: 14AT18

URL: http://www.hfma.org/awc/evaluation.htm

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