

*Flex Monitoring Team Briefing Paper No. 35*

# **Charity Care and Uncompensated Care Activities of Tax-Exempt Critical Access Hospitals**

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**The Flex Monitoring Team** is a consortium of the Rural Health Research Centers located at the Universities of Minnesota, North Carolina at Chapel Hill, and Southern Maine. Under contract with the federal Office of Rural Health Policy, the Flex Monitoring Team is cooperatively conducting a performance monitoring project for the Medicare Rural Hospital Flexibility Program (Flex Program). The monitoring project is assessing the impact of the Flex Program on rural hospitals and communities and the role of states in achieving overall program objectives, including improving access to and the quality of healthcare services; improving the financial performance of Critical Access Hospitals; and engaging rural communities in healthcare system development.

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## **The Medicare Rural Hospital Flexibility Program**

The Medicare Rural Hospital Flexibility Program (Flex Program), created by Congress in 1997, allows small hospitals to be licensed as Critical Access Hospitals (CAHs) and offers grants to states to help implement initiatives to strengthen the rural healthcare infrastructure. To participate in the Flex Grant Program, states are required to develop a rural healthcare plan that provides for the creation of one or more rural health networks, promotes regionalization of rural health services in the state, and improves the quality of and access to hospital and other health services for rural residents of the state. Consistent with their rural healthcare plans, states may designate eligible rural hospitals as CAHs.

CAHs must be located in a rural area (or an area treated as rural); be more than 35 miles (or 15 miles in areas with mountainous terrain or only secondary roads available) from another hospital, or be certified before January 1, 2006 by the state as being a necessary provider of healthcare services. CAHs are required to make available 24-hour emergency care services that a state determines are necessary. CAHs may have a maximum of 25 acute care and swing beds, and must maintain an annual average length of stay of 96 hours or less for their acute care patients. CAHs are reimbursed by Medicare on a cost basis (i.e., for the reasonable costs of providing inpatient, outpatient, and swing bed services). The legislative authority for the Flex Program and cost-based reimbursement for CAHs are described in the Social Security Act, Title XVIII, Sections 1814 and 1820, available at [http://www.ssa.gov/OP\\_Home/ssact/title18/1800.htm](http://www.ssa.gov/OP_Home/ssact/title18/1800.htm)

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## **EXECUTIVE SUMMARY**

**Introduction:** A number of policy issues are focusing attention on the safety net role of tax-exempt hospitals, including Critical Access Hospitals (CAHs), and the challenges they face in managing their charity care activities. These issues include the increasing local, state, and national attention on the charity care activities of tax-exempt hospitals; concerns about hospital billing, collection, and pricing policies; and the Affordable Care Act (ACA) amendments to the Internal Revenue Service (IRS) tax code requiring tax-exempt hospitals to establish written financial assistance and emergency care policies, limit charges to financial assistance patients, and refrain from extraordinary collection efforts unless reasonable efforts have been made to determine eligibility for financial assistance.<sup>1</sup> Understanding these issues and the safety net roles of CAHs will inform the development of technical assistance to help CAHs to:

- create balanced financial assistance, billing, and collections policies;
- improve billing and collection performance;
- use financial assistance programs to expand access to services for vulnerable populations;
- reduce inappropriate bad debt write-offs and related community ill-will;
- improve community benefit reporting; and
- safeguard their tax-exempt status.

**Methods:** This study provides a baseline analysis of the charity care, uncompensated care, and bad debt activities of CAHs, pre-implementation of the ACA-mandated financial provisions discussed above, using data from the 2009 IRS Form 990: Return of Organizations Exempt from Income Tax, Schedule H compiled by the National Center for Charitable Statistics. Our data include 2,074 hospital records for tax-exempt 501(c)(3) hospitals filing for their hospitals alone (rather than as part of a consolidated system filing) for tax year 2009 (with a tax year ending date in 2010). Our study population included 529 CAHs, 361 other rural hospitals, and 1,184 urban hospitals. Form 990 data were linked to the 2010 American Hospital Association Annual Survey to identify CAHs and to the United States Department of Agriculture, Economic Research Service's 2010 Rural-Urban Continuum Codes to classify hospitals by urban and rural location.

**Findings:** In comparison to other rural and urban hospitals, CAHs deliver more care for which they do not receive payment either due to an inability to pay as determined by the hospital's financial assistance eligibility criteria (charity care) or a refusal to pay (bad debt). CAHs report

lower rates of charity care, higher rates of bad debt, and a smaller percentage of bad debt expenses attributable to patients that would otherwise qualify for charity care but are not picked up by hospital charity care programs. CAHs are more likely than other hospitals to adopt more restrictive charity and discounted care eligibility criteria using lower multiples of the Federal Poverty Guidelines to assess eligibility, and have lower adherence to industry standard policies and protocols related to financial assistance, billing, and collections.

**Discussion:** These findings suggest the interconnectedness of hospital charity, discounted care, and bad debt policies. Changes to eligibility criteria, the complexity of the application and documentation process, the extent to which hospitals promote the availability of charity care, and the willingness of hospitals to assess eligibility for charity care at different stages of the billing process have a direct impact on hospital charity care and bad debt levels. Restricting access to charity care is likely to increase the level of bad debts incurred by hospitals, particularly for patients that are close to but do not qualify under the hospitals' existing eligibility criteria. As a result, it is hard to determine the actual level of charity care provided by CAHs as they are likely serving vulnerable individuals who cannot afford to pay for care but, due to the adoption of more restrictive eligibility criteria and application processes that may deter these individuals from applying for charity care, end up writing off the services provided to these individuals as bad debt. This study, however, does not permit us to quantify the extent to which these issues may be affecting the charity care and bad debt performance of CAHs. These issues warrant further study. Readers should be cautious in drawing conclusions from the results of this study regarding the extent to which all CAHs may or may not be meeting their community benefit obligations, serving vulnerable populations, or providing less charity care than other hospitals. First, these results only apply to tax-exempt CAHs and other rural and urban hospitals that file an individual IRS Form 990 (and not part of a consolidated filing for hospital systems). Second, our findings suggest that the allocation of uncompensated care may not be properly aligned, as CAHs provide greater levels of uncompensated care and some portion of the higher rates of bad debt incurred by CAHs may be more accurately classified as charity care if the strategies discussed later in this paper were more widely implemented. Finally, CAHs are often the only source of health care in vulnerable rural communities and serve a crucial safety net role for the elderly, low-income, uninsured, and other underserved populations, many of whom may face financial and/or travel barriers that restrict their ability to seek care outside of their communities.

## **INTRODUCTION**

In response to concerns about hospital billing and charity care policies, the Internal Revenue Service (IRS) adopted the Catholic Health Association's (CHA) community benefit guidelines as the framework for revisions to IRS Form 990, Schedule H in 2007. Form 990 is used by tax-exempt (501(c)(3)) hospitals to report their community benefit activities and other information related to their tax-exempt status.<sup>2</sup> The CHA's community benefit guidelines encompass a wide range of programs and activities that include the provision of treatment and/or promotion of health and healing in response to identified community needs. The guidelines are designed to maximize the number and dollar value of activities that hospitals can count to justify their tax-exempt status.<sup>2,3</sup> Prior to the development of CHA's expanded framework, the provision of charity care (also known as free care) to the poor was a defining feature of hospital community benefit activity.<sup>4</sup> To many policymakers, the provision of charity care remains a central component of hospital community benefit activity and an important part of the health care safety net.<sup>5</sup> Building on the 2007 IRS changes, provisions in the Patient Protection and Affordable Care Act of 2010 (ACA) amended the IRS tax code requiring tax-exempt hospitals to establish written policies for the provision of financial assistance and emergency care and to limit charges for medical care provided to financial assistance patients.<sup>6</sup> The law also prohibits extraordinary billing and collection efforts unless reasonable efforts have been made to determine patient eligibility for financial assistance.<sup>7</sup>

This paper compares the charity and uncompensated care spending of tax-exempt CAHs with other rural (i.e., non-CAH rural hospitals) and urban hospitals. It also examines the charity care, billing, and collection policies of these hospitals, and discusses the implications of ACA-mandated hospital financial assistance, emergency care, and billing and collection policies for CAHs.

## **BACKGROUND**

### **The Evolution of Federal Policy**

The provision of charity care to low-income individuals has long been a central focus in the community benefit activity of tax-exempt hospitals<sup>3</sup> and is based on the view of community benefit as a social contract in which these hospitals have a public service obligation to the community in exchange for the tax exemptions they receive.<sup>8</sup> The importance of charity care as a

tax-exempt hospital community benefit has varied over time based on IRS rulings and legislative activity.<sup>4</sup> The standards for public charitable purposes, established in the mid-1950s, required tax-exempt hospitals to serve patients who could not afford to pay for their services, within limits of the hospital's financial capacity.<sup>8</sup> This emphasis remained in place through 1969 when the IRS eliminated the charity care mandate following the 1965 passage of Medicare and Medicaid.<sup>8</sup>

In the mid-1960s, following the implementation of Medicare and Medicaid and the subsequent elimination of the charity care mandate by the IRS, the early emphasis on the provision of care to the poor shifted to a broader focus: promoting the health of the community. The passage of the Emergency Medical Treatment and Active Labor Act of 1985 (EMTALA) re-established the charity care expectation by requiring all hospitals with emergency rooms to stabilize and treat all patients regardless of ability to pay.<sup>8</sup> Although current community benefit reporting standards retain an emphasis on community health improvement, the provision of services to the poor and uninsured remains a defining obligation of tax-exempt hospitals.

In the late 1990s, the Senate Finance Committee, under the leadership of Senator Charles Grassley of Iowa, began to scrutinize the charitable care activities of tax-exempt hospitals.<sup>9</sup> Based on the results of a 2006 hospital compliance study by the IRS, initiated in response to Senate Finance Committee concerns, the IRS revised its Form 990, Return of Organization Exempt From Income Tax, to include a new schedule (Schedule H) to collect information on the charity care and other community benefit activities of tax-exempt hospitals.

The IRS adopted the widely accepted CHA community benefit reporting framework as the basis for its revised Form 990, Schedule H with some modifications.<sup>3</sup> In response to hospital input received during the public comment period, the IRS added sections to Schedule H to collect information on hospital bad debt levels, estimates of the bad debt levels attributable to care rendered to low-income individuals that would otherwise qualify for charity care but are not recognized by hospital charity care programs, uncompensated costs of serving Medicare patients, and community building activities. The revised Form 990, Schedule H was fully implemented in tax year 2009 for all tax-exempt 501(c)(3) hospitals and requires filers to report their full range of hospital community benefit activity. These data will be used by the IRS to evaluate the extent to which these costs represent "true" community benefits and should be allowable costs in future iterations of the IRS's framework. The ACA implemented further oversight of hospital



community benefit activities by requiring the Secretary of the Treasury to: 1) review the community benefit activities of reporting hospitals at least once every three years; 2) report to Congress on the levels of charity care, bad debt, and unreimbursed costs for means tested government programs (i.e., programs with financial eligibility requirement such as Medicaid and the State Children's Health Insurance Program) and non-means tested programs (i.e., Medicare) incurred by all hospitals and on the community benefit activities of private tax-exempt hospitals; and 3) report to Congress on trends in the above not later than five years after the enactment of the ACA.<sup>6</sup>

### **Measuring Charity and Uncompensated Care**

Historically, a challenge to understanding hospital charity and uncompensated care involved the wide variation in the ways hospitals measured charity and uncompensated care which made cross-hospital comparison difficult.<sup>10</sup> Over time, CHA, VHA, Inc., and other hospital stakeholders developed consensus on the use of costs rather than charges to report charity and uncompensated care.<sup>11</sup> In 1993, the Principles and Practices Board of the Healthcare Financial Management Association (HFMA) released *Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers* clarifying the treatment and reporting requirements for charity care, uncompensated care, and bad debt.<sup>10</sup> Over time, Statement 15 has been updated to reflect evolving accounting guidelines and to address growing policy concerns about hospital charity care reporting practices including the Financial Accounting Standards Board's (FASB's) Statements No. 2010-23 on measuring charity care for disclosure<sup>12</sup> and 2011-07 on presenting and disclosing patient service revenue,<sup>13</sup> provision for bad debts, and allowances for doubtful accounts. HFMA Statement 15 and CHA's community benefit framework have become the de facto standards defining the handling and reporting of charity care and bad debt.<sup>14</sup>

Adding to the complexity of understanding hospital bad debt performance, FASB released Accounting Standards Update 2011-07, Health Care Entities (Topic 954), *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities* in July 2011.<sup>15</sup> FASB 2011-07 requires tax-exempt hospitals to report the provision for bad debts associated with patient service revenue as a deduction from patient service revenue rather than as an operating expense and is effective for financial years beginning after December 12, 2012.<sup>15</sup> This change enhances the comparability of

hospital financial statements by more accurately reflecting revenues that a hospital expects to collect.<sup>16</sup> Although not likely to impact operating results or the management of bad debt, FASB 2011-07 creates another bad debt reporting framework that does not align with the reporting standards for either the IRS Form 990 or the Medicare hospital cost report.

### **State Challenges to Hospital Tax-Exemptions**

In addition to the IRS community benefit reporting requirements, which include charity and uncompensated care reporting criteria, there is significant state and local activity underway targeting the tax-exempt status of hospitals.<sup>17-22</sup> In the context of budget crises, state and local governments are increasingly scrutinizing the charity and uncompensated care activities of tax-exempt hospitals as well as the use of aggressive billing and collection policies. The recent focus on hospital charity care and billing policies dates back to the early 2000s with high profile cases in Minnesota with Attorney General Mike Hatch's investigation of Fairview Health Services' billing and charity care policies and in Illinois with the Illinois Department of Revenue's 2004 denial of tax-exempt status for Provena Covenant Hospital in Urbana for reasons that included Provena's aggressive collection efforts.<sup>17</sup> During this period, Yale-New Haven Hospital was also the subject of a Wall Street Journal article for its aggressive billing and collection policies for patients without resources.<sup>23</sup> Numerous articles suggest that concerns over charity care and billing policies have not abated.<sup>18-22,24,25</sup>

### **ACA Mandated Financial and Billing Requirements**

Advocates, journalists and other have recently raised a number of concerns regarding hospital charity care and billing policies, including the extent to which tax-exempt hospitals are:

- Fulfilling their community and charitable obligations;
- Implementing formal charity care policies that expand rather than inhibit access;
- Promoting charity care policies to improve access for the poor and underserved;
- Pursuing inordinately aggressive billing and collection policies resulting in high rates of medical bankruptcy and reduced access to care; and/or
- Adopting pricing policies affecting self-pay, uninsured, and low-income patients differently (i.e., pricing policies that require self-pay, uninsured, and low-income patients

to pay full charges whereas patients with commercial, Medicare, or Medicaid coverage are charged less than full charges based on payer fee schedules or negotiated rates)<sup>5,24,26</sup>

Studies conducted prior to the implementation of the ACA-mandated financial and billing requirements for tax-exempt hospitals addressed the issues underlying these policies. A qualitative study of small town, informal safety net services (i.e., services provided to low-income and/or uninsured individuals by providers and clinics without a specific mandate or funding to do so) conducted in the spring and summer of 1999 found that it was difficult to obtain information about the availability of charity care and that uninsured and self-pay patients (including low-income individuals) were likely to be charged the full, non-discounted prices for the services they received.<sup>27</sup> In a larger study examining the rates that uninsured and self-pay patients were expected to pay for hospital services in 2004, Anderson<sup>28</sup> identified five groups of patients typically charged full, undiscounted prices: (1) the uninsured; (2) international visitors; (3) patients insured by health plans without a contract with the hospital; (4) patients covered by automobile insurers as a result of an accident; and (5) patients covered by workers compensation plans as a result of a work-related injury. Although the latter four categories involve patients covered by programs that typically have contracts with hospitals, these are usually categorized as “self-pay” patients. The uninsured comprise the vast majority of self-pay patients, however.<sup>28</sup> The evidence suggests that hospitals use full gross charges as the starting point for negotiations with uninsured patients and that patients will end up paying varying amounts for the same services depending on hospital-patient negotiations.<sup>24,28,29</sup> Prior work of the Flex Monitoring Team found that pre-ACA, CAHs did not widely promote the availability of charity care services and did not consistently train all staff likely to engage patients about the hospital’s charity care policies.<sup>30</sup>

In response to the concerns raised at the federal, state, and local levels about hospital charity care and billing policies, the ACA contained several financial provisions requiring hospitals to:

- Develop written financial assistance and emergency care policies for patients eligible for free or discounted care;
- Limit charges to patients who qualify for financial assistance to the amounts charged to insured patients; and
- Implement fair billing and debt collection practices.<sup>31,32</sup>

These provisions require tax-exempt hospitals to establish written “financial assistance policies” detailing the availability of charity care that, at a minimum, apply to emergency and other medically necessary care.<sup>33</sup> These policies should establish the eligibility for financial assistance, specify whether free and/or discounted care are covered under the hospital’s financial assistance policies, clarify how amounts charged to patients are calculated, explain the application process, identify collection policies for nonpayment, and establish a process to publicize the availability of assistance within the hospital itself and the community. They also require hospitals to make reasonable efforts to determine eligibility for their financial assistance policies before engaging in “extraordinary collection policies” such as reporting to collection agencies, garnishing wages, attaching bank accounts or personal property, placing liens on properties, and/or commencing legal action against the patient or the patient’s family. These provisions require hospitals to review and revise their charity care and financial assistance policies, apply them consistently to all patients, and widely promote their availability.

## **METHODS**

This study examined tax-exempt 501(c)(3) hospitals that filed an individual IRS Form 990 (not part of a consolidated filing for multiple hospitals in a system) for Tax Year 2009, with a fiscal year ending date of 2010. It provides a baseline analysis of the charity care, uncompensated care, and bad debt activities of tax-exempt 501(c)(3) CAHs, prior to the implementation of the ACA-mandated financial provisions described above. The study uses data from the tax year 2009 *IRS Form 990: Return of Organizations Exempt from Income Tax, Schedule H* compiled by the National Center for Charitable Statistics.<sup>34</sup> All 501(c)(3) hospitals are required to file Form 990 annually.<sup>i</sup>

Hospitals that are part of systems may file Form 990 individually or as part of a consolidated filing for all hospitals in the system. We eliminated all hospitals included in a consolidated system filing. Our data include 2,074 filings for all tax-exempt 501(c)(3) hospitals filing for their hospitals alone. This figure includes the full population of tax-exempt CAHs (529), other rural

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<sup>i</sup> We intend to use these data on an on-going basis to track CAH charity care, uncompensated care, and bad debt performance as part of the FMT’s ongoing monitoring and reporting of CAH performance measures related to quality of care, financial sustainability, and community benefit and engagement.

hospitals (361), and urban hospitals (1,184) that filed an individual Form 990 in Tax Year 2009.<sup>ii</sup> The Form 990 data were linked to the 2010 American Hospital Association Annual Survey data to identify CAHs and describe their characteristics. Additionally, we linked the analytic file to the United States Department of Agriculture, Economic Research Service’s 2010 Rural-Urban Continuum Codes to classify hospitals by urban and rural location.

## **LIMITATIONS**

The findings of this study are applicable only to the population of tax-exempt 501(c)(3) hospitals that filed an individual IRS Form 990 (and not part of a consolidated filing for multiple hospitals in a system) for Tax Year 2009 (with a fiscal year ending date of 2010). The results are not generalizable to publically-owned or proprietary hospitals.

## **FINDINGS**

For purposes of this briefing paper, the use of the terms CAH, other rural hospital, and urban hospital refer only to those facilities that qualify for tax-exempt status under Section 501(c)(3) of the IRS tax code and file a Form 990 covering only their hospital.

### **Charity and Discounted Care Policies**

As indicated in Table 1, CAHs are similar to other rural and urban hospitals in the extent to which they have charity care policies, have written policies, and, for hospitals that are part of systems, have policies that apply uniformly to all hospitals. CAHs are less likely, however, to provide free and discounted care to “medically indigent” patients (87.6 percent) than other rural hospitals (90.0 percent) and urban hospitals (94.7 percent).<sup>iii</sup>

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<sup>ii</sup> Our data include all Form 990s submitted to the IRS by tax-exempt hospitals for tax year 2009 cleared for public release through GuideStar as of September 2012. Our analytic file consists of the universe of tax-exempt hospitals that file their Form 990s for their hospital alone (and not as part of a consolidated filing).

<sup>iii</sup> According to the IRS, “medically indigent” persons are individuals whom the organization has determined are unable to pay some or all of their medical bills because their medical bills exceed a certain percentage of their family or household income or assets (for example, due to catastrophic costs or conditions), even though they have income or assets that otherwise exceed the generally applicable eligibility requirements for free or discounted care under the organization’s charity care policy.<sup>32</sup>

**Table 1. Charity Care and Other Community Benefit Activity by Hospital Type**

Indicator	CAH (N = 529)	Other Rural (N=361)	Urban (N=1,184)
Hospital has a charity care policy	99.6%	99.7%	99.2%
Has a written charity care policy	99.1%	99.7%	99.7%
If organization has multiple hospitals, applies charity care policy uniformly to all hospitals	97.4%	96.3%	97.2%
Uses federal poverty guidelines to determine eligibility for charity care	89.3%	95.0%	96.6%
Uses federal poverty guidelines to determine eligibility for discounted care	83.9%	85.7%	90.3%
Provides free or discounted care to the “medically indigent”	87.6%	90.0%	94.7%
Budgets amounts for charity or discounted care	90.7%	94.2%	92.2%
Charity care expenses exceeded budgeted amount	55.6%	63.7%	64.9%
Exceeded budget but still able to provide charity care to all eligible patients	99.6%	98.2%	98.9%

Source: IRS Form 990, Schedule H, Fiscal Year 2009

CAHs are also less likely than other rural hospitals and slightly less likely than urban hospitals to report that they budget for the provision of charity or discounted care. Among hospitals that budget for the provision of charity and discounted care, CAHs were less likely to report that they exceeded their charity care budgets than other hospitals but slightly more likely to report that they were still able to provide charity care to all eligible patients when they did exceed their charity care budgets.

### **Charity and Discounted Care Eligibility Guidelines**

Under the ACA, tax-exempt hospitals are required to clearly define their financial assistance policies in writing. One common approach to defining eligibility for charity or discounted care (frequently referred to as a sliding fee scale)<sup>iv</sup> involves assessing an applicant’s income in relation to established Federal Poverty Guidelines (FPGs).<sup>v</sup> Updated annually,<sup>35</sup> FPGs provide consistently accepted criteria by which to determine eligibility for hospital financial assistance

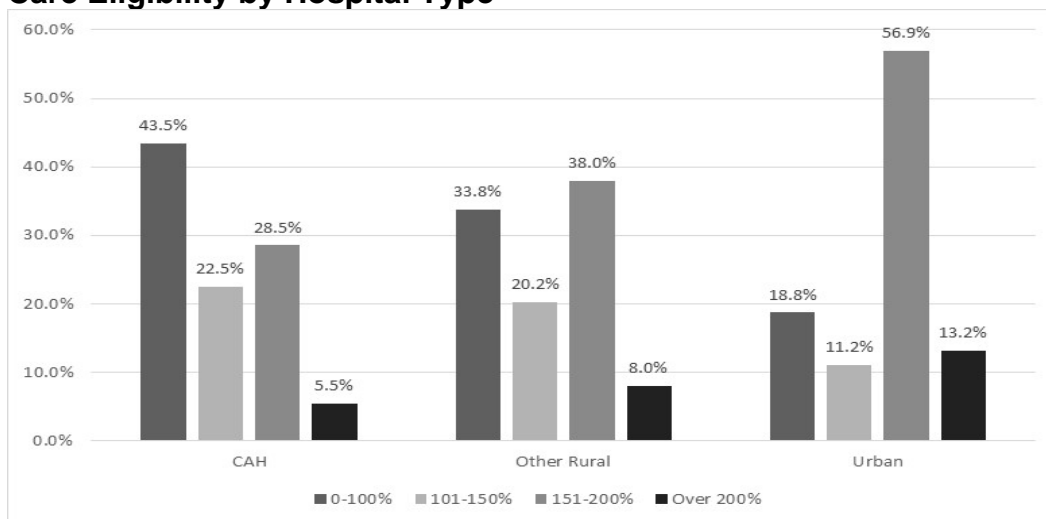
<sup>iv</sup> Sliding fee scales offer varying levels of discounts on hospital services depending on the patient’s income and family size.

<sup>v</sup> The Federal Poverty Guidelines are updated annually by the U.S. Department of Health and Human Services using the Consumer Price Index for All Urban Consumers (CPI-U). The poverty guidelines are used as an eligibility criterion by many Federal programs. The guidelines are updated by increasing the latest published Census Bureau poverty thresholds by the relevant percentage change in the CPI-U. The guidelines are then rounded and adjusted to standardize the differences between family sizes. The poverty guidelines are derived from the Census Bureau’s current official poverty thresholds. The guidelines figures represent annual incomes adjusted for family size. Due to differences in cost of living, separate guidelines are established for Alaska and Hawaii.

policies. In lieu of using FPGs to determine eligibility, hospitals often create their own criteria. As reflected in Table 1, CAHs are less likely (89.0 percent) than either other rural (95.0 percent) or urban hospitals (96.6 percent) to use FPGs to determine eligibility for charity care. CAHs (85.0 percent) are also slightly less likely to use FPGs to determine eligibility for discounted care compared to other rural hospitals (86.0 percent) and less likely than urban hospitals (90.0 percent).

As shown in Figure 1, CAHs are more likely to use a lower, more restrictive multiple of the FPGs to determine eligibility for charity care than other hospitals, with 43.5 percent establishing an income standard of 0 to 100 percent of FPG to determine eligibility. In contrast, 33.8 percent of other rural hospitals and 18.8 percent of urban hospitals use this standard. Similarly, more CAHs (22.5 percent) use 101 to 150 percent of FPG to determine eligibility compared to 20.2 percent of other rural hospitals and 11.2 percent of urban hospitals. Urban hospitals are much more likely to use higher income eligibility standards (151 to 200 percent and over 200 percent) than CAHs and other rural hospitals. Lower percentages of CAHs report using either of these higher income eligibility standards than other rural and urban hospitals.

**Figure 1. Percentage of Federal Poverty Guidelines Used to Determine Charity Care Eligibility by Hospital Type**

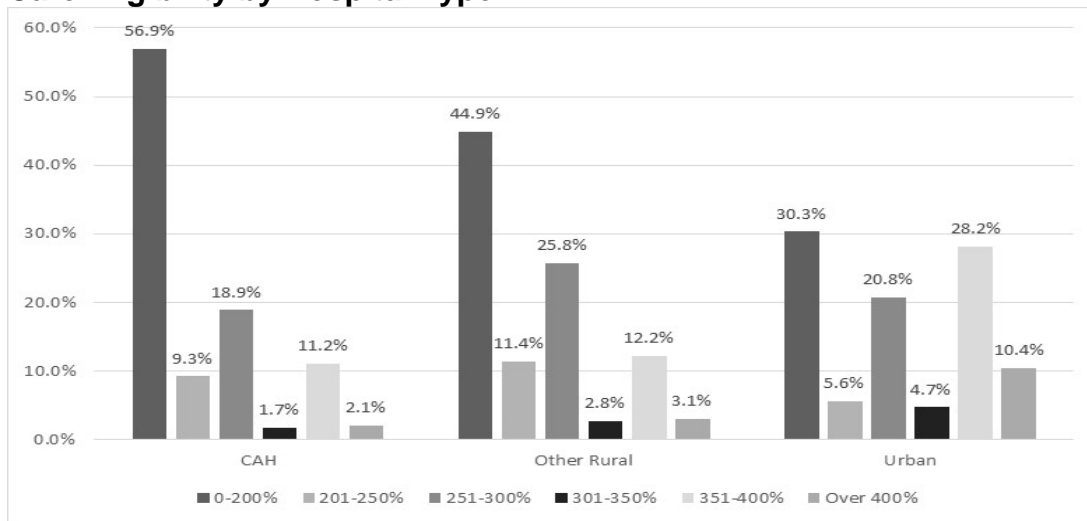


Source: IRS Form 990, Schedule H, Fiscal Year 2009

As with charity care eligibility standards, CAHs are more likely to use more stringent eligibility standards for discounted care (in which a patient is expected to pay some portion of his/her balance) than other rural or urban hospitals with 56.9 percent and 9.3 percent of CAHs using eligibility standards of 0 to 200 percent and 201 to 250 percent respectively (Figure 2). In

comparison, 44.9 percent and 11.4 percent of other rural hospitals and 30.3 percent and 5.6 percent of urban hospitals use the 0 to 200 percent and 201 to 250 of FPG respectively to determine discounted care eligibility.

**Figure 2. Percentage of Federal Poverty Guidelines Used to Determine Discounted Care Eligibility by Hospital Type**



Source: IRS Form 990, Schedule H, Fiscal Year 2009

### Cost of Hospital Charity Care and Other Community Benefits

We also explored the volume of charity and other community benefits related to the costs of unreimbursed care provided by hospitals. Table 2 shows the average dollar value of charity care costs, unreimbursed costs of Medicaid services, and unreimbursed costs of other means-tested government programs. To allow comparison across facility types, we calculated the ratio of these expenses to total expenses.

CAHs provide lower levels of charity care than other rural and urban hospitals both when measured in total dollars and as a percentage of total expenses (1.8 percent, 2.3 percent, and 2.3 percent respectively). This same pattern holds true for the ratio of unreimbursed Medicaid costs to total costs provided by CAHs (2.9 percent) compared to other rural hospitals (3.6 percent), and urban hospitals (3.2 percent). CAHs record similar levels of unreimbursed costs for other means-tested programs (0.2 percent) compared to other rural (0.2 percent) and urban hospitals (0.4 percent). Overall, CAHs record lower total rates of uncompensated care to total expenses (4.9 percent) than other rural (6.2 percent) and urban hospitals (5.8 percent).



**Table 2. Charity Care and Other Community Benefits at Cost**

<b>Indicator</b>	<b>CAH (n=529)</b>	<b>Other Rural (n=361)</b>	<b>Urban (n=1184)</b>
<i>Charity care at cost</i>			
Net charity care expense (mean)	\$479,692	\$1,899,423	\$5,958,638
Percent of total expense	1.8%	2.3%	2.3%
<i>Unreimbursed Medicaid</i>			
Net unreimbursed Medicaid expense (mean)	\$716,741	\$3,017,762	\$8,644,376
Percent of total expense	2.9%	3.6%	3.2%
<i>Unreimbursed costs for other means-tested government programs</i>			
Net unreimbursed other means-tested government program expense (mean)	\$39,351	\$151,581	\$811,016
Percent of total expense	0.2%	0.2%	0.4%
<i>Total charity care and means-tested government programs</i>			
Net charity and unreimbursed care expense (mean)	\$1,234,464	\$5,107,580	\$15,143,008
Percent of total expense	4.9%	6.2%	5.8%

Source: IRS Form 990, Schedule H, Fiscal Year 2009

### **Unreimbursed Medicare Costs**

As adopted by the IRS, the CHA framework does not count unreimbursed Medicare costs as a community benefit.<sup>3</sup> CHA's rationale for this position is that for-profit, non-profit, and publicly-owned hospitals compete aggressively for Medicare patients and, as such, Medicare shortfalls are not useful in distinguishing differences between for-profit and non-profit hospitals.<sup>36</sup> CHA conceded that the inclusion of Medicare shortfalls as a community benefit expense might warrant further consideration if access issues were to emerge for Medicare patients. The American Hospital Association and other trade organizations submitted comments to the IRS supporting the inclusion of Medicare shortfalls as a community benefit. Given these conflicting positions, the IRS created a separate section of Schedule H to collect data on Medicare shortfalls and to allow hospitals to justify why they should be counted as a community benefit. The IRS will use this information to inform its future decisions regarding the inclusion of Medicare shortfalls as a community benefit.

Not surprisingly, given that CAHs are reimbursed at 101 percent of allowable Medicare costs, CAHs report an average Medicare surplus of \$108,502 representing 0.5 percent of total expenses (Table 3). In contrast, other rural and urban hospitals report Medicare shortfalls of close to \$2.3

million (2.7 percent of total expenses) and close to \$6.0 million (2.6 percent of total expenses) respectively.

**Table 3. Unreimbursed Cost of Medicare by Hospital Type**

Indicator	CAH (n=529)	Other Rural (n=361)	Urban (n=1184)
Medicare surplus (shortfall) (mean)	\$108,502	(\$2,251,411)	(\$5,964,195)
Unreimbursed Medicare surplus/shortfall as a percent of total expense	0.5%	(2.7%)	(2.6%)

*Source:* IRS Form 990, Schedule H, Fiscal Year 2009

### **Bad Debt Levels and Collection Practices**

The inclusion of bad debt as a community benefit was another area that received considerable attention during the comment period for the IRS’s revisions to Form 990, with the majority of organizations advocating for inclusion of bad debt as a community benefit.<sup>36</sup> There are important distinctions between bad debt and other forms of uncompensated care. Bad debt is a “cost of doing business” that arises when services provided to a patient with the capacity to pay for those services who later refuses to do so.<sup>10</sup> In contrast, charity care results from the provision of services to a patient with a demonstrated inability to pay. Although the distinction between the two appears to be relatively simple, determining each patient’s ability (or inability) to pay for services, assessing their potential eligibility for charity care, and the timing of when those determinations are made are part of a complex administrative and accounting process. This process is complicated by EMTALA rules that require hospitals to render emergency care without regard for ability to pay; the unpredictability of a patient’s treatment needs; the complexity and delays of third party payment systems; and, in many ways, hospitals’ own financial assistance and billing and collection systems, which may not actively promote the availability of financial assistance programs or re-evaluate eligibility for charity care at different stages of the billing and collection process.

As with Medicare shortfalls, bad debt is not considered a community benefit in the CHA framework. Proponents of the inclusion of bad debt as a community benefit argue that bad debt represents services provided by hospitals without compensation.<sup>36</sup> CHA opposed the inclusion of bad debt as a community benefit, reasoning that it does not differentiate the behaviors of nonprofit and for-profit hospitals. CHA agreed that some portion of hospital bad debt is legitimately attributable to patients that cannot afford to pay (and, for various reasons, are not

recognized by hospital charity care application processes) but suggested that hospitals should improve their charity care/financial assistance programs and billing systems to better identify eligible patients at the start of the care process and during the billing and collection processes.

After considering these arguments, the IRS acknowledged that some portion of hospital bad debt was likely attributable to care provided to patients with an inability to pay but was unwilling to concede that all bad debt should be considered a community benefit.<sup>3</sup> Instead, it included a schedule in the revised Schedule H to capture information on hospital bad debt levels and asked hospitals to estimate the portion of their annual bad debt expense attributable to patients that might otherwise qualify for charity care but had not been picked up in their financial assistance programs. Hospitals were also asked to provide a narrative statement justifying their estimates.

As shown in Table 4, CAHs were less likely during the 2009 tax year to report bad debt expense in accordance with HFMA Statement 15 (54.6 percent), the recognized standard for classifying and reporting charity care, other forms of uncompensated care, and bad debt, than other rural hospitals (60.5 percent) and urban hospitals (64.6 percent). CAHs reported greater levels of bad debt (5.6 percent) when measured as a percentage of total expenses than other rural (3.6 percent) and urban hospitals (2.8 percent). CAHs are slightly less likely than other rural hospitals (94.8 percent and 96.9 percent respectively) to have written collections policies whereas CAHs and urban hospitals are equally likely to have such policies (94.8 percent). CAHs are also somewhat less likely (78.5 percent) than other rural hospitals (81.9 percent) and significantly less likely than urban hospitals (91.4 percent) to have collection policies that contain provisions on collection practices for patients known to qualify for charity care or financial assistance.

### **Total Uncompensated Care (Combined Charity Care and Bad Debt Levels)**

Hospital charity care and bad debt performance are interconnected with levels of either category influenced by hospital decisions discussed earlier. The extent to which hospitals adopt a more or less inclusive approach to charity care and financial assistance influences the relative levels of charity care and bad debt, as greater numbers of low-income individuals either qualify for or are excluded from charity care and financial assistance based on hospital decisions on the above factors. In other words, a more inclusive approach is likely to lead to higher levels charity care but lower bad debt; whereas a less inclusive approach is likely to lower levels of charity care but higher bad debt.

**Table 4. Bad Debt and Collection Practices by Hospital Type**

<b>Indicator</b>	<b>CAH (n=529)</b>	<b>Other Rural (n=361)</b>	<b>Urban (n=1184)</b>
<i>Bad Debt Expense</i>			
Reports bad debt expense in accordance with HFMA Statement No.15	54.6%	60.5%	64.6%
Bad debt expense (mean)	\$1,330,097	\$3,078,550	\$6,294,845
Bad debt as a percent of total expense	5.6%	3.6%	2.8%
Bad debt expense for services provided to individuals who would otherwise qualify but are not recognized by charity care programs (mean)	\$139,662	\$540,708	\$1,177,497
Percentage of bad debt expense for services provided to individuals who would otherwise qualify but are not recognized by charity care programs	10.5%	17.6%	18.7%
<i>Collection Practices</i>			
Has written debt collection policy	94.8%	96.9%	94.8%
Collection policy contains provisions for patients known to qualify for charity care or financial assistance	78.5%	81.9%	91.4%

Source: IRS Form 990, Schedule H, Fiscal Year 2009

It is reasonable to assume that many individuals who do not qualify for charity care and financial assistance, particularly those with incomes just above the cut off for eligibility, may still have difficulty paying their hospital bills. Even though bad debt is defined as write-offs resulting from services provided to a patient with the capacity to pay for those services that later refuses to do so, it also includes write-offs for patients who are “deemed able pay their bills” (even though they may not be able to) as they do not qualify under the hospital’s charity care eligibility guidelines.

Although charity care and bad debt, as reflected in the IRS community benefit standards and as defined by HFMA Statement # 15, are two different concepts and are treated differently for purposes of community benefit reporting, the two concepts should be viewed as a continuum rather than as distinctly separate categories of activity. This is particularly the case for patients with income levels clustered at or just above the hospital’s eligibility criteria. We conclude this section therefore by looking at the combined levels of charity care and bad debt performance of hospitals in our study. This approach is consistent with the reporting practices of the American Hospital Association and others in the hospital industry that typically report combined charity care and bad debt as uncompensated care.<sup>37</sup>

**Table 5. Total Uncompensated Care (Combined Charity Care and Bad Debt) by Hospital Type**

Indicator	CAH (n=529)	Other Rural (n=361)	Urban (n=1184)
Charity care as a percent of total expense	1.8%	2.3%	2.3%
Bad debt as a percent of total expense	5.6%	3.6%	2.8%
Total uncompensated care as a percent of total expense	7.4%	5.9%	5.1%

*Source:* IRS Form 990, Schedule H, Fiscal Year 2009

As indicated in Table 5, CAHs report higher rates of uncompensated care (7.4 percent) compared to other rural (5.9 percent) and urban hospitals (5.1 percent).

## DISCUSSION AND CONCLUSIONS

The results of this paper indicate that, compared with other rural and urban hospitals, CAHs reported higher levels (measured as a percentage of total expenses) of uncompensated care (i.e., combined charity care and bad debt), lower levels of charity and discounted care, and higher levels of bad debt expense. CAHs, compared with other hospitals, reported that a smaller percentage of their bad debt expenses are attributable to services provided to individuals who would otherwise qualify for charity care but are not recognized by hospital charity care programs.

The lower charity care and higher bad debt levels reported by CAHs in this study do not mean that CAHs are not serving their tax-exempt missions. CAHs, many of which continue to struggle financially,<sup>38</sup> are often the only source of health care in vulnerable rural communities, serving a crucial safety net role for the elderly, low-income, uninsured, and other underserved populations, many of whom face financial and/or travel barriers that restrict their ability to seek care outside of their communities. Rather, they suggest that some portion of the higher rates of bad debt incurred by CAHs would likely be more accurately classified as charity care if strategies for managing charity care and bad debt were more widely implemented. CAH's report more restrictive eligibility criteria for patient to access charity care, increasing the level of bad debt incurred, especially for patients just over the eligibility criteria. As a result, it is hard to determine the extent to which CAHs are serving vulnerable individuals who legitimately cannot afford to pay for care. To do so, we need to understand the extent to which CAHs' more restrictive eligibility criteria are reflective of the economic realities of their communities as well as the context in which decisions regarding their eligibility criteria were made. We also need to understand

whether or not charity or discounted care application processes may deter eligible individuals from applying for charity care and the extent services provided to these individuals end up being written off as bad debt.

In light of increased federal and state scrutiny, hospital boards and management need to carefully examine decisions they have made regarding charity care, discounted care, and bad debt policies and programs to more accurately and strategically capture, classify, and manage charity care and bad debt. Hospital boards and administrators must find the balance, on the one hand, between adopting financial assistance policies that reflect the economic realities of their communities and distinguish those patients who legitimately cannot pay their bills, and, on the other, fulfilling their fiduciary obligation to ensure that those who can pay for services do so. This is no simple task as it requires careful and honest consideration of the economic conditions of the community, the needs of the residents of a hospital's service area, the availability of other safety net services, the effectiveness of the hospital's billing and revenue management systems, and how well the hospital is currently serving the needs of uninsured and low-income residents.

### **Technical Assistance Needs and Opportunities**

Study findings suggest that CAHs may have somewhat greater difficulty than other hospitals meeting the ACA-mandated changes to the IRS tax code related to financial assistance and billing policies. They suggest in particular opportunities to assist CAHs in developing and implementing balanced financial assistance policies, improving billing, collection, and revenue cycle management systems, using financial assistance programs to enhance access to care for vulnerable populations, enhancing community benefit strategies, and improving operational performance.

Revenue Cycle Management: First and foremost, CAHs may need support to develop a unified approach to revenue cycle management and their charity care, financial assistance, and collection policies. This involves analyzing charity care and bad debt expenditures to understand what types of patients are represented in these categories, the services used, their eligibility issues, the reasons for and timing of classification of patient obligations as bad debt, and the economic context of the hospital service area.

Once this is done, hospital boards and management can use the information to make informed decisions regarding their financial assistance, billing, and collection policies. If, for example,

patients at or near the hospital's eligibility criteria are over-represented in the bad debt category, it suggests that hospitals may need to revise their financial assistance policies to reflect the prevailing economic status of their patient populations. On the other hand, if patients that would otherwise qualify for charity or discounted care are over-represented in the bad debt category, it suggests the need for hospitals to revise their application processes; simplify eligibility documentation requirements; better promote the availability of hospital charity care and financial assistance programs; and/or improve their screening programs to better identify patients eligible for government medical assistance programs (i.e., Medicaid and the State Children's Health Insurance Program) or the hospital's charity and discounted care programs. If low-income, insured patients with high out-of-pocket cost health plans are heavily represented in the bad debt category, it suggests the need for hospitals to improve their screening process to better identify these individuals at the outset of care and to revise their billing systems to better identify and manage charity care charges at different stages of the billing process.

Billing and Debt Collection: Little is known about the extent to which CAHs have implemented fair billing and debt collection practices, although their higher rates of bad debt expense suggest that CAHs may perform less well in this regard. We also do not know the extent to which CAHs make reasonable efforts to determine eligibility for financial assistance before engaging in "extraordinary collection policies." Given the potential challenges to the tax-exempt status of 501(c)(3) CAHs for failure to comply with these financial provisions, this is an important and often overlooked area of technical assistance needed by CAHs and an opportunity for state Flex programs to further support the hospitals in their states.

Although CAHs are as likely as other hospitals to have written charity care/financial assistance policies, little is known about the extent to which their policies are sufficiently robust to meet the expectations of the IRS guidelines. For example, have tax-exempt CAHs established a written financial assistance policy with clearly defined eligibility criteria? Do their policies indicate whether free and/or discounted care are covered under the hospital's policies, describe how amounts charged to patients are calculated, clearly explain the charity care application process, and specify collection policies for nonpayment? Have they established a process to publicize the availability of assistance within the hospital itself and the community? Are their financial assistance policies and applications posted to their websites?

Responding to Needs of Vulnerable Populations: As CAHs consider revising their hospital charity and discounted care policies and programs they may need assistance responding to the needs of vulnerable patients and populations. The circumstances that lead patients to seek charity or discounted services are often complicated and typically involve problems of poverty, literacy, and other challenges. For patients who are functionally illiterate, for example, completing an application for charity care can be an issue. Moreover, many charity care and discounted care patients may be episodic users of the health system, lacking access to primary care. In addition to revising charity care policies, therefore, hospitals can also develop patient assistance and care management programs to ensure patient access to public insurance coverage options, provide assistance with charity care applications, and reduce unnecessary utilization of charity care and discounted services. Each of these strategies will contribute to increasing the efficiency of hospital charity care programs.

Undocumented immigrants may also create challenges for hospitals to effectively serve these individuals through their financial assistance programs. Ideally, hospital financial assistance programs will encourage appropriate utilization of services and early intervention in health problems to avoid unnecessary utilization of high cost services. The use of charity care and financial assistance policies to manage access to services for vulnerable populations (as part of a population health focus) rather than as a reactive approach to dealing with charges after a health care encounter provides an opportunity for hospitals to better serve undocumented immigrants and other vulnerable populations.

## **Conclusion**

Although efforts to better distinguish charity care from bad debt will not directly improve a hospital's cash flow or bottom line, there are other substantial incentives for hospitals to do so. First, improving the recognition and reporting of charity care charges will enhance the level of community benefit that hospitals can report, improve their service to vulnerable low-income populations, and support their tax-exempt status. Second, charity care charges are used in calculation of Medicare and Medicaid Meaningful Use incentive payments.<sup>39,40</sup> Third, ACA-mandated changes to the Medicare disproportionate share hospital payment program, although not applicable to CAHs, are influenced by hospital charity and uncompensated care spending.<sup>41</sup> Fourth, the ACA mandates the IRS to conduct triennial reviews of each tax-exempt hospital's



community benefit activity and prepare reports for Congress on the charity care, bad debt, and uncompensated care activities of all hospitals. Finally, state and local policymakers, in light of well publicized budget crises, are increasingly concerned with the impact of hospital tax exemptions on income, sales, and property taxes.

Charity care and financial assistance programs will remain an important obligation of tax-exempt hospitals for the foreseeable future. Although the expansion of health insurance coverage under the ACA may significantly reduce the demand for charity care and financial assistance, past experience following the implementation of the Medicare and Medicaid programs in 1965 suggests otherwise. An estimated 20 million or more people (including individuals exempt from the coverage mandate, individuals who ignore the mandate, undocumented immigrants, and legal residents of less than five years) will remain uninsured after full implementation of the ACA's coverage.<sup>42,43</sup> At the same time, the challenge of serving the working poor with high out-of-pocket plans (i.e., the underinsured) will continue, particularly in states where coverage options are more limited due to state decisions not to expand Medicaid. Although low-income individuals in non-Medicaid expansion states may have access to private coverage that will pay a portion of their bills, they are likely to still need financial assistance with their out-of-pocket obligations.

CAHs, like all tax-exempt hospitals, face significant challenges managing their community benefit programs including changing charity care demands, new IRS financial provisions on hospital financial assistance policies, charge structures, and billing and collection activities, and ongoing national and state scrutiny of hospital tax-exempt status. The implementation of the IRS tax code provisions for tax-exempt hospitals creates an imperative for CAHs and other non-profit hospitals to carefully evaluate and revise hospital financial assistance policies and programs to ensure they adequately address the needs of the low-income, uninsured, and under-insured populations in our evolving health care environment. This imperative provides an opportunity for state Flex programs to assist CAHs in meeting the many requirements of IRS tax code and in better serving their communities.

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