PULSE

May 2012 • Vol. 28 No. 5

www.acainternational.org

PUBLISHED FOR HEALTH CARE PROVIDERS BY
ACA INTERNATIONAL'S HEALTH CARE SECTION

The Future of Tax Exemption for Nonprofit Hospitals

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Nonprofit hospitals face an uncertain future as their tax exempt status remains under scrutiny by federal and state legislators, the Internal Revenue Service (IRS), the media, and the general public. With federal and state government deficits at a historic high, nonprofit entities are under considerable review. The repeal of nonprofit hospitals' tax exempt statuses could be a valuable source of revenue for federal and state governments at a time when increased tax revenue is needed. The federal and state governments' continued investigations into the business practices of nonprofit hospitals may result in changes to the way nonprofit hospitals operate.

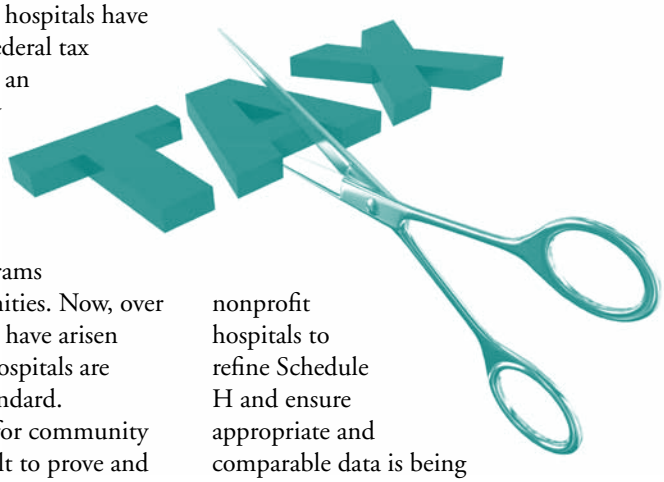
"The loss of a tax exempt status for a hospital is a significant financial burden that could have dire results for the hospital," said Tom Gavinski, vice president at IC System, Inc., in St. Paul, Minn.

Background

In 1969, the IRS adopted the community benefit standard as the basis for determining whether a nonprofit hospital is exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code. The reporting standard, at its core, is a facts and circumstances test that examines a variety of factors to determine whether a health care provider should be tax exempt—the standard does not include a specific threshold for how much hospitals must spend on charity care to qualify for the exemption.

Since 1969, nonprofit hospitals have been able to retain their federal tax exemption by engaging in an appropriate mix of charity care, financial assistance to low-income patients, subsidized health care, research, health education and other programs that benefit local communities. Now, over forty years later, questions have arisen about whether and how hospitals are meeting this reporting standard.

"The broad standard for community benefit can be very difficult to prove and quantify, which has led to intervention by the IRS and other government bodies," Gavinski said.



Community Benefit Standard

To better understand nonprofit hospitals and their community benefit reporting practices, the IRS conducted a study of nonprofit hospitals in 2006. The results of the study found the average hospital spent 9 percent of its revenue on community benefit expenditures; however, considerable diversity in hospitals' community benefit activities were reported.

In an effort to increase uniformity and transparency in reporting, the IRS introduced a redesigned Form 990 in 2008, along with Schedule H requiring hospitals to list and separate the cost categories that may qualify as community benefit expenses. The IRS evaluates Form 990 Schedule H annually and reports the results to Congress, and works with nonprofit hospitals to refine Schedule H and ensure appropriate and comparable data is being captured.

Despite intense federal interest, neither Schedule H nor any IRS guidance has provided specific standards regarding what community benefits a nonprofit hospital must provide in order to qualify for or maintain its tax-exempt status.

"Until the specific quantitative measures for the community benefit of charitable organizations are established, nonprofit tax-exempt status will remain cloudy," Gavinski said.

PPACA Requirements

The Patient Protection and Affordable Care Act (PPACA) also sets forth requirements for nonprofit, tax-exempt hospitals. Tony Rinkenberger, director of revenue cycle services at Ridgeview Medical Center, in Waconia, Minn., stated the PPACA requires nonprofit hospitals meet four requirements:

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CMS Releases Stage 2 EHR Criteria

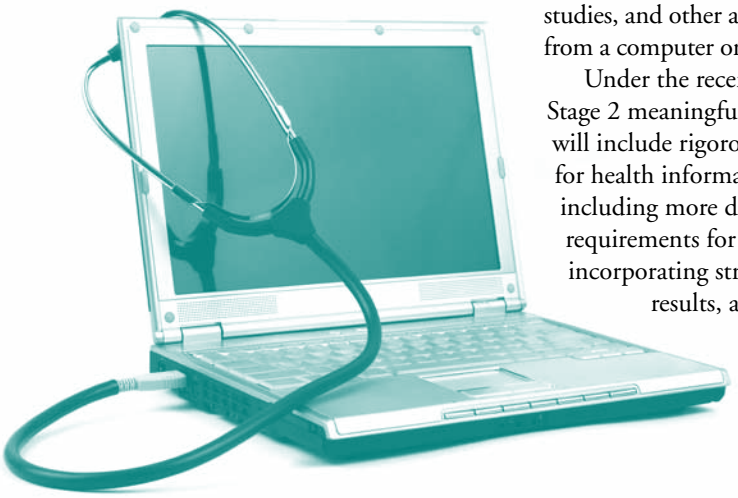
On March 7, 2012, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule outlining Stage 2 standards for certified electronic health records (EHR) and extending the effective date of Stage 2 requirements one year. Providers now have until 2014, rather than 2013, to implement Stage 2 meaningful use criteria.

Background

The Health Information Technology for Economic and Clinical Health (HITECH) Act established programs under Medicare and Medicaid to provide incentive payments to eligible professionals and eligible hospitals that adopt and make "meaningful use" of EHR technology.

Under the HITECH Act, the Medicare EHR incentive programs provide incentive payments to eligible professionals, eligible hospitals, and critical access hospitals that are meaningful users of certified EHRs.

CMS has established a three-stage approach to implement the requirements for demonstrating meaningful use, each with different implementation dates and varying requirements for establishing meaningful use.



Initially, reasonable criteria for meaningful use are based on currently available technological capabilities and providers' practice experience. Over time more extensive criteria will be required as developments in technology and providers' capabilities advance.

Stages

Stage 1, which began in 2011, sets forth a set of 15 core objectives eligible professionals must meet and 14 core objectives hospitals must meet. Eligible professionals and hospitals must choose five "menu" requirements to satisfy the meaningful use criteria. Some objectives set forth in the rule for Stage 1 are:

- Implement drug-drug, drug-allergy, drug-formulary checks.
- Report information for quality improvement and public reporting.
- Maintain an up-to-date problem list of current and active diagnoses
- Generate and transmit permissible prescriptions electronically (eRx).
- Use computerized physician-order entries (CPOE), which is defined as entailing the provider's use of computer assistance to directly enter medical orders (for example, medications, consultations with other providers, laboratory services, imaging studies, and other auxiliary services) from a computer or mobile device.

Under the recent proposed rule, Stage 2 meaningful use requirements will include rigorous expectations for health information exchange, including more demanding requirements for e-prescribing, incorporating structured laboratory results, and the expectation that providers will electronically transmit patient care summaries to support transitions in care across unaffiliated providers, settings and EHR systems.

Stage 2 also expands on Stage 1 criteria in the areas of disease management, clinical decision support, medication management support for patient access to their health information, transitions in care, quality measurement and research, and bi-directional communication with public health agencies.

These changes will be reflected by a larger number of core objective requirements for Stage 2. Every objective that is optional in Stage 1 will be required in Stage 2. All menu set items likely will be moved to core measures, percentages will be increased, and some new menu objectives will be added. For example, under the proposed Stage 2 regulations to qualify for meaningful use payments hospitals, physicians and other eligible professionals will have to place orders through CPOE for more than 60 percent of their medication, laboratory and radiology orders. Under Stage 1, there is only a 30 percent CPOE threshold and only medication orders are counted.

To view a full list of Stage 2 "core" and "menu" set objectives, see the HHS proposed rule available at: *http://www.gpo.gov/fdsys/pkg/FR-2012-03-07/pdf/2012-4443.pdf.*

For Stage 3 of the meaningful use criteria, beginning in 2016, the proposed rulemaking focuses on promoting improvements in quality, safety and efficiency, decision support for national high priority conditions, patient access to self-management tools, and access to comprehensive patient data and population health. Stage 3 will also provide higher standards for meeting meaningful use. Further clarification regarding Stage 3 requirements will be released as the effective date nears.

Health Care Consumers Equate Higher Costs with Better Quality

When asked to choose a health care provider based only on cost, consumers choose the more expensive option, according to a new study funded by HHS' Agency for Healthcare Research and Quality (AHRQ).

The study found that consumers equate cost with quality and worry that lower cost means lower quality care. But higher costs may indicate unnecessary services or inefficiencies, so cost information alone does not help consumers get the best value for their health care dollar, according to the study.

The study found that when consumers were shown the right mix of cost and quality information, they were better able to choose high-value health care providers – defined as those who deliver high-quality care at a lower cost.

> Consumers equate cost with quality and worry that lower cost means lower quality care.

Health care consumers want to visit high-quality doctors and hospitals, and many public report cards are available to help them compare providers. However, few report cards include information on cost, and there has been little scientific evidence to guide the presentation of that information to help consumers choose high value providers.

The study's findings have implications for the design of public report cards that offer consumers information on the quality and cost of health care providers. Although report producers have been adopting strategies to help consumers process and use comparative information on quality and cost, many reporting websites still use overly technical information or present other barriers to easy comprehension, according to the study.

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Community health needs assessment and implementation strategy

"Hospitals must work with community representatives and experts in public health to develop a community needs assessment made available to the public, as well as an implementation strategy," Rinkenberger said.

Financial assistance policy

Hospitals must develop a financial assistance policy that indicates: eligibility criteria; how hospital charges are calculated; the process for qualifying for financial assistance; and whether assistance includes free or discounted care.

Limitations on patient charges

Hospital charges for medically necessary care provided to patients who are uninsured or in need of financial assistance may not exceed the lowest amounts charged to insured patients.

Limitations on collections policies

Collection actions may not be performed until the hospital has undertaken reasonable efforts to determine if the patient is eligible for financial assistance.

"Nonprofit hospitals will have to be in compliance with all of the PPACA requirements," Rinkenberger said. "These requirements will greatly impact hospitals' technology, quality reporting and care coordination."

State and Local Actions

In the absence of federal specificity, state and local governments have also taken various courses of action to clarify community benefit standards and their application to nonprofit hospitals for purposes of evaluating whether hospitals are entitled to exemption from various state and local taxes.

For example, in 2010, the Illinois Supreme Court denied three state hospitals nonprofit tax-exempt status because they did not offer enough charitable care. One of the hospitals provided charity care to less than one-half a percent of its patients.

Gavinski noted, based on case law, nonprofit hospitals must be sensitive to several issues, including:

1. Providing appropriate free or discounted care to the indigent;
2. Aggressive collection tactics;
3. Charging full service rates to the uninsured;
4. Not publicizing Medicare and Medicaid services and indigent care policies;
5. Not providing adequate community benefit in research, training or education;
6. Not promoting community health;
7. Excessive consultant or executive compensation; and
8. Providing excessive benefits to certain executives, board members or physicians.

"Nonprofit hospitals will continue to be scrutinized as charitable tax exempt organizations," Gavinski said. "Nonprofit hospitals must ensure they are complying with all of the PPACA guidelines and case law issues to protect their tax-exempt status."

PULSE
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Policies Give States More Flexibility to Establish Affordable Insurance Exchanges

On March 12, 2012, the U.S. Department of Health and Human Services (HHS) announced its new policies to assist states in building Affordable Insurance Exchanges. Starting in 2014, these one-stop market places will allow consumers and small businesses to choose a private health insurance plan and offer the public the same kinds of insurance choices as members of Congress.

The policies provide states with the guidance and certainty they need as they continue to work to build these marketplaces for their residents for operation in 2014. The policies offer guidance about the options on how to structure Exchanges in two key areas:

- Setting standards for establishing Exchanges, setting up a Small Business Health Options Program (SHOP), performing the basic functions of an Exchange and certifying health plans for participation in the Exchange; and
- Establishing a streamlined, web-based system for consumers to apply for and enroll in qualified health plans and insurance affordability programs.

The final rule builds on the flexibility and resources provided by HHS already to build state-based Exchanges.

PULSE is a monthly bulletin that contains information important to health care credit and collection personnel. Readers are invited to send comments and contributions to:

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