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Managing Charity Care and Bad Debt from Initial Patient Touchpoint to S-10, 990 Filings

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Presenters

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Conflict of Interest Statement

I have no real or perceived conflicts of interest that related to this presentation

Objectives

1. Review the reimbursement impacts of revenue cycle charity care and bad debt collection practices

2. Reporting of charity care and bad debt for Community Benefit purposes

3. Efficiencies in reporting between hospital departments

4. IRS focus on charity care compliance under 501(r)

Tax exemption of hospitals

The hospital must be operated and operated exclusively for charitable purposes, meaning no part of its earnings can benefit private individuals.

The hospital must provide measurable benefits to the community, such as charity care, health education, and community outreach.

The hospital cannot engage in substantial lobbying or political campaign activities.

The hospital must be in compliance with IRC 501(r)

Pressures on tax exemption

"Proposed" elimination of nonprofit status for Hospitals

- Estimated $260 billion in 10-year savings
- Stated by House Ways and Means that more than half of all income by 501(c)(3) nonprofits is generated by nonprofit hospitals and healthcare firms
- Elimination would treat hospitals as ordinary for-profit businesses

Potential Increases of Charity Care and Bad Debt

- The Senate is expected to vote in April, $880 billion healthcare savings target over the next decade, which would likely require significant cuts to Medicaid or the CHIP. If all 41 states that expanded Medicaid eligibility over the past decade were to drop the program in response to federal cuts, nearly 11 million people would lose coverage.
- Feb 2025 – A draft bill introduced in the US House of Representatives includes a minimum work requirement for certain adults enrolled in Medicaid as a condition of coverage.

  Ohio has asked CMS to allow the state to reinstate work requirements - individuals would need to be at least age 55, or be employed, enrolled in school or a job training program, be in a recovery program, or have a serious physical or mental health illness to receive benefits. The Ohio Department of Medicaid (ODM) estimates that more than 61,000 Ohioans could lose their health insurance if the work requirements are implemented.

- 1/7/2025 - The Consumer Financial Protection Bureau (CFPB) finalized a rule that will remove an estimated $49B in medical bills from credit reports, eff. 3/17/2025 (stayed until 6/15/2025)

  Final rule amending Regulation V, which implements the Fair Credit Reporting Act (FCRA), concerning medical information. The FCRA prohibits creditors from considering medical information in credit eligibility determinations. The CFPB is removing a regulatory exception that had permitted creditors to obtain and use information on medical debts notwithstanding this statutory limitation. The final rule also provides that a consumer reporting agency generally may not furnish to a creditor a consumer report containing information on medical debt that the creditor is prohibited from using.

IRS focus on charity care compliance under 501(r)

IRS audits and Scrutiny

High focus areas

- Community benefit reporting
- Financial assistance policies
- Billing and Collection practices
- Community Health Needs Assessment and Implementation Strategies

Why hospitals?

- Call to action is largely driven by negative press regarding collections and current negative views on the purpose of exemptions.
- Healthcare and affordability is largely a bipartisan issue and concern (although different views on how to handle)

1.501(r)(4)- Financial assistance policy

- Establishment of a written financial assistance policy (charity care policy) and a written emergency medical care policy
  - Transparency of discount and eligibility calculation
  - Amounts generally billed calculation
  - Widely published

IRS audits of 1.501(r)(4)

- Transparency (can be subjective)
- Tracing billing practices to ensure FAP is followed
- Physical tours to confirm “widely publicizing” requirements are met

Review the reimbursement impacts of revenue cycle charity care and bad debt collection practices

S-10 Considerations

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	5,577,028	3,121,219	8,698,247	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,325,793	3,121,219	4,447,012	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	1,325,793	3,121,219	4,447,012	23.00
				1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
25.01	Charges for insured patients' liability (see instructions)			0	25.01
26.00	Bad debt amount (see instructions)			17,194,806	26.00
27.00	Medicare reimbursable bad debts (see instructions)			1,105,000	27.00
27.01	Medicare allowable bad debts (see instructions)			1,699,999	27.01
28.00	Non-Medicare bad debt amount (see instructions)			15,494,807	28.00

All hospitals that have reported DSH

- E part A Line 34
- Includes SCH/MDH providers, regardless of Hospital Specific/Federal Payment
- Termed providers excluded, including Acute hospitals that have converted to CAH. However, note current cost reporting instructions still require CAHs to complete the worksheet.

S-10 Considerations

Prior Year

- S-10 Audit Process for FFY 2022 Audits (FYBs 10/1/21-9/30/22) ended on December 31, 2024
- Possibly S-10 Factor 3's that will be published in the FFY 2026 Federal Register (4/11/2025 Proposed and August 2025 Final)
  - Pending CMS' issuance of the rule
  - 3-Year Average

The total proposed uncompensated care payment to eligible disproportionate share hospitals (DSHs) for FY 2026 is $7.29 billion, reflecting a $1.5 billion increase over the $5.78 billion finalized for FY 2025.

Current Year

- S-10 Audit Process for FFY 2023 Audits (FYBs 10/1/22 – 9/30/23) beginning on 3/10/2025, with final audit work due on December 31, 2025
- Possibly S-10 Factor 3's that will be published in the FFY 2027 Federal Register (April/May 2026 Proposed and August 2026 Final)
  - Pending CMS' issuance of the rule
  - 3-Year Average

S-10 Considerations

Charity Care

- Line 20.0
  - » Coinsurance/deductible
  - » Uninsured vs. Insured
  - » No duplicate reporting – PY Charity, current bad debt
  - » OK for the same account to have partial charity care and partial bad debt write-off
  - » OK to have Medicare primary accounts that do not qualify for MBD, and met FAP criteria
- Line 22.0
  - » Patient payment recovery against prior-year charity care write-offs. Expect a small amount, and do not report bad debt recovery here.
  - » Self-Pay Discount reversals – accounts with eligibility discovery, report as uninsured

S-10 Considerations

Bad Debt

- Patient responsibilities that providers are attempting to collect
- Claim at the time of GL recognition, time of bad debt transfer
    - » Non-Medicare bad debt – at the time of transfer to the primary bad debt agency
    - » Medicare primary accounts – at the time of transfer to the primary bad debt agency
    - » Medicare and Medicaid Dual eligible account
- Bad debt reversals
    - » recovery, partial recovery + prompt pay discount
    - » Eligibility discovery
    - » Charity care approval
- Reconciliation to WTB/AFS

Financial Assistance Policy

- Patient responsibilities that providers are not expecting to collect.
- Must adhere to the provider's policy and procedure, posted on the website, same version.
- Self-Pay discount, typically ranges from 20-60% discount on total charges, Amount Generally Billed (AGB), automated
- Must exclude professional fees, prompt pay discounts, and administrative discounts such as patient experience, employee, and clergy.
- Presumptive – Medicaid and other indigent, out-of-state Medicaid, out-of-network, homelessness, propensity to pay scoring/predicative analytical .
- FAP – sliding scale based on % below Federal Poverty Guidelines (FPL).
- Length of eligibility and retroactive eligibility.
- "Medically necessary" – Defined by Medicare

Revenue Cycle Considerations

- Timing of Financial Assistance Approval
  - Post-discharge first patient statement billing
  - Prior or at Point of Service?
  - After transfer to agency?
- Retention and retrieval of applications
  - Only approved?
  - For how long?

Revenue Cycle Considerations

- Transaction Codes
  - Self-Pay discount, automated
  - % discount FA
  - Distinct codes from adm, prompt, or other discounts not eligible for S-10
  - Deceased
  - Bankruptcy
  - Presumptive Charity
  - Bad Debt – transfer to agency, or agency transfer file
  - Bad Debt Recovery – payment vs. settlement
  - Mapping of codes to GL

Medicare Bad Debt

- Bad Debt incurred from patient responsibility of traditional Medicare primary accounts.
- Eff 7/1/2021, MBD write off code MUST be mapped to bad debt expense, not allowance.
  - » Medicare-Medicaid crossover (Medicare primary, Medicaid or Medicaid HMO secondary)
  - » Reclass during 13th Month, Journal entry Listings vs. MBD Listing
- Exhaust all collection activities, return from agency
  - » Collection agency closed reports “worked”, Uncollectible bad debt transaction code
- Medicare Advantage plan ded/co-coins amounts have increased. How to handle resulting HMO bad debt?

Reporting of charity care and bad debt for Community Benefit purposes

Form 990, Schedule H- Reporting charity care

7	Financial Assistance and Certain Other Community Benefits at Cost						
	Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a	Financial assistance at cost (from Worksheet 1)						
b	Medicaid (from Worksheet 3, column a)						
c	Costs of other means-tested government programs (from Worksheet 3, column b)						
d	**Total.** Financial assistance and means-tested government programs						
	Other Benefits						
e	Community health improvement services and community benefit operations (from Worksheet 4)						
f	Health professions education (from Worksheet 5)						
g	Subsidized health services (from Worksheet 6)						
h	Research (from Worksheet 7)						
i	Cash and in-kind contributions for community benefit (from Worksheet 8)						
j	**Total.** Other benefits						
k	**Total.** Add lines 7d and 7j						

Form 990, Schedule H- Reporting bad debt

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 Managemen
2	Enter the amount of the organization's bad debt expense. Explain in Part methodology used by the organization to estimate this amount . . . . .
3	Enter the estimated amount of the organization's bad debt expense attribut patients eligible under the organization's FAP. Explain in Part VI the methodolo by the organization to estimate this amount and the rationale, if any, for includ portion of bad debt as community benefit . . . . .
4	Provide in Part VI the text of the footnote to the organization's financial statemer expense or the page number on which this footnote is contained in the attached fi

Form 990, Schedule H- Reporting

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 on line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:		

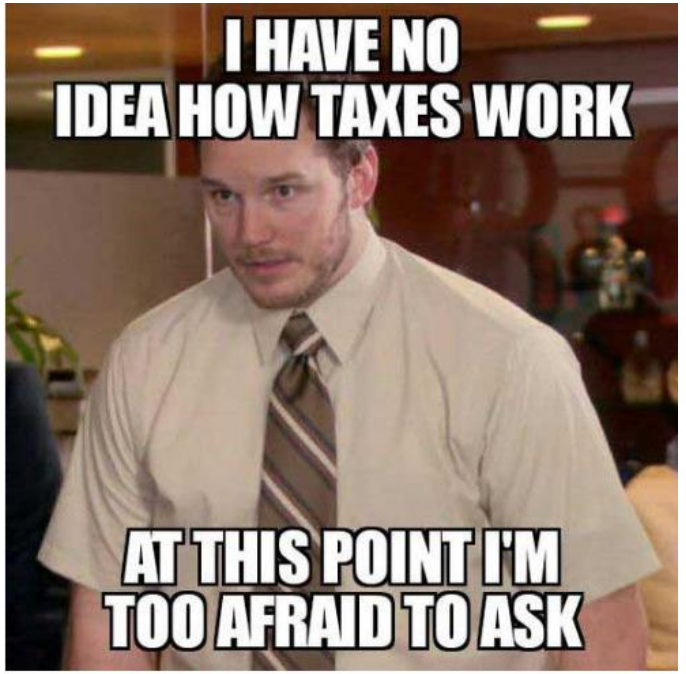
☐ Cost accounting system ☐ Cost to charge ratio ☐ Other

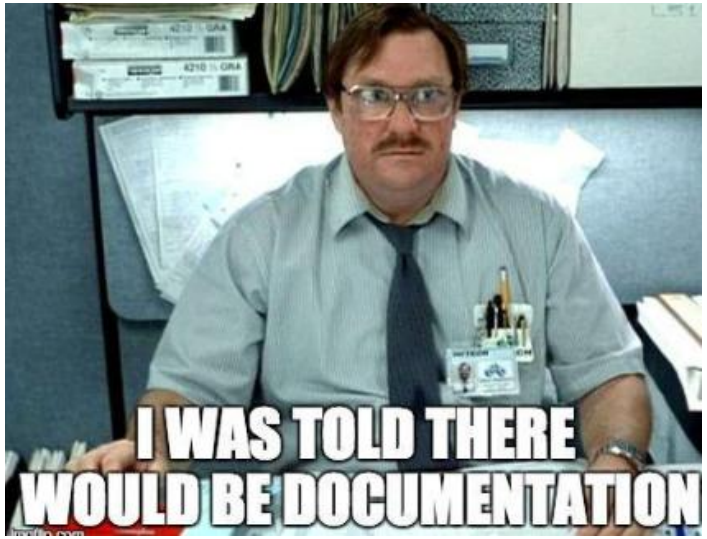
Efficiencies in reporting between hospital departments

Tips

- Compliance awareness
- Interdepartmental training
- Clear communication channels
- Reconciliation of reporting between S-10, Form 990, financial statements, community benefit reporting, etc.
- Community benefit reporting team: reimbursement, finance, tax, marketing, etc.

Self assessment- Act like an auditor!





Q&A