

# A SYSTEMATIC METHOD OF ACCOUNTABILITY

*Sound Policies Allow Facilities to Account For the Level of Charity Care They Provide*

BY HOMER H. SCHMITZ, PhD;  
STEVEN J. WEISS; &  
CAROL MELICHAR, RN



*Dr. Schmitz is associate professor, School of Public Health, St. Louis University, St. Louis; Mr. Weiss is chief financial officer, St. Louis University Hospital; and Ms. Melichar is an administrative resident, Veterans Administration Medical Center, St. Louis.*

In today's uncertain economic environment, healthcare facilities may find it desirable to establish a charity care policy as a basis for strategic decisions. Such policies may also provide the foundation for responses to government regulators should they question the facilities about the amount of charity care they provide. And charity care policies can reinforce implementation of the organizational mission, guide the assessment of the community's needs, and ensure a consistent message of mission effectiveness in reporting to the community.

According to recent reports, the American Hospital Association has found that 5 percent of U.S. hospitals provide 37 percent of all uncompensated care.<sup>1</sup> Given this fact, most hospitals will find it desirable to accurately determine, define, and account for the level of charity care they provide. This information will help hospitals budget appropriately and measure trends that will ultimately affect their viability.

**Summary** Charity care policies can help hospitals accurately determine, define, and account for the level of charity care they provide. This information will help hospitals budget appropriately and measure trends that will ultimately affect the organization's viability.

State governments, the federal government, and the Internal Revenue Service are more closely scrutinizing not-for-profit hospitals' tax-exempt status. As a result, the American Institute of Certified Public Accountants (AICPA) has revised its requirement to report on charity care.

To meet the AICPA's requirement, healthcare providers must develop their own definition of charity and determine criteria for providing care free or at a reduced rate. Setting policies to support the organization's definition of charity is nec-

## THE CURRENT ENVIRONMENT

A large portion of hospitals' total reimbursement has not kept up with real economic growth in costs. As a result, many hospitals' ability to maintain the level of uncompensated care they now provide is in jeopardy. At the same time, state governments, the federal government, the Internal Revenue Service (IRS), and the business community are more closely scrutinizing not-for-profit hospitals' tax-exempt status. They want hospitals to increase the amount of charity care they provide to justify their tax exemption. To deal constructively with this movement, hospitals must document the charity care they are already providing and show it is a responsible and appropriate amount.

As a result of the increased scrutiny of the level of charity care provided by not-for-profit hospitals, the American Institute of Certified Public Accountants (AICPA) has revised its requirements to report on such care (see Martha Garner

essary for the development of internal systems that promote the early identification of individuals seeking healthcare who will be unable to pay for services.

Several policy implications may result from the facility's charity care determination process. For example, patients exhibiting extreme hardship might still be eligible to receive charity care even though their income and assets exceed the hospital's income guidelines.

An organization planning to develop a charity care policy must first thoroughly assess its current charity care practices and cost accounting capabilities. Obtaining input from all the departments involved in the development of the charity care policy is necessary to make the transition as smooth as possible.



and Woodrin Grossman, "Reporting Charity Care," *Health Progress*, January-February 1992, pp. 58-63). In 1990 the AICPA issued its new audit and accounting guide, *Audits of Providers of Health Care Services*. The guide requires hospitals to disclose the amount of charity care they provide and the policies they follow to allocate these services.

The new guide's most significant requirement is in the statements of revenue and expense, where revenues are to be reported as the expected collection amount rather than as "billed charges." Through this approach, charity and bad debts are segregated at the time services are rendered according to whether payment is expected from the patient.

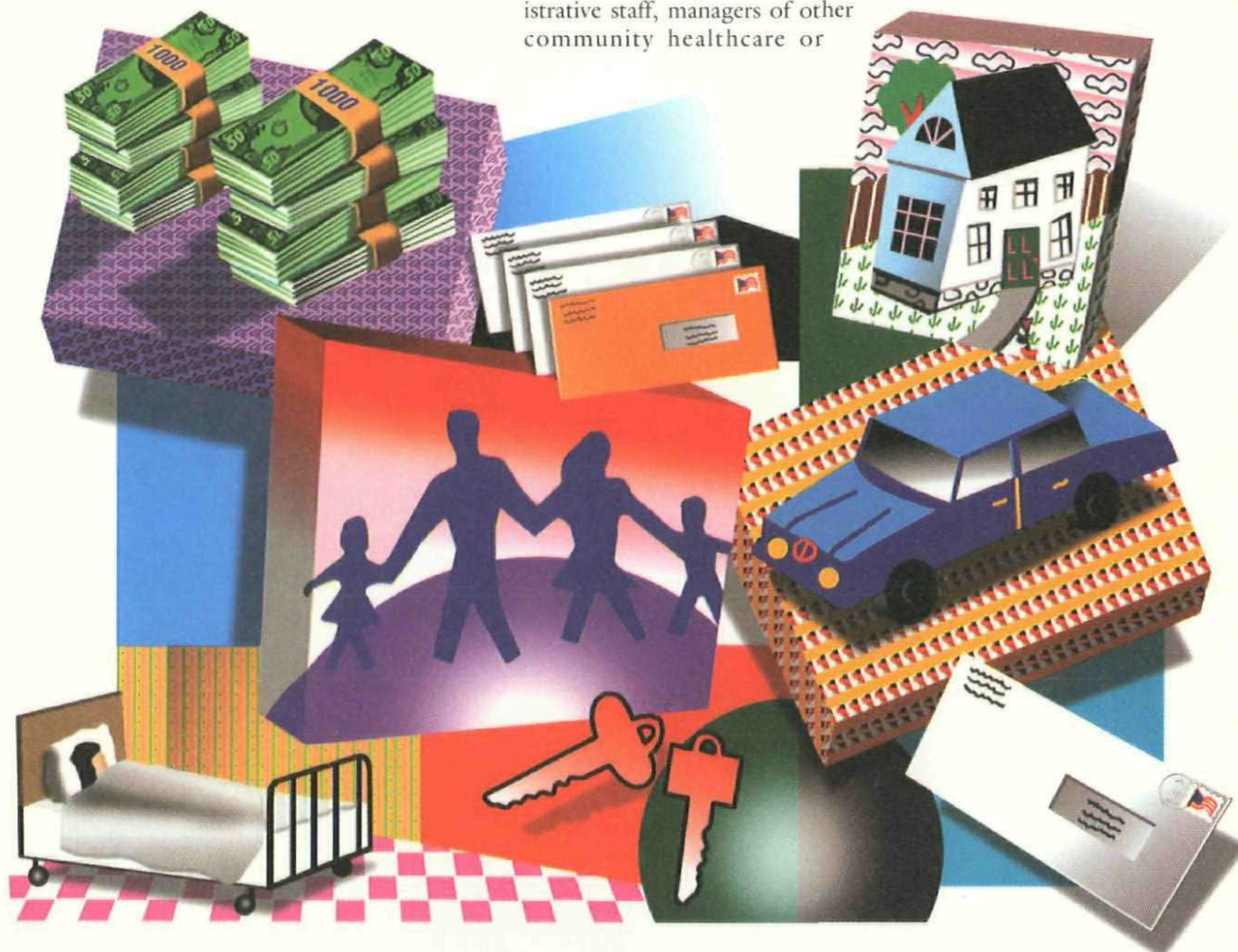
The guide defines charity as service that is provided for which no payment is expected because of a person's inability to pay. Bad debt occurs as a result of care given for which payment was originally expected but never received. The amount of a patient's bill not collected under these circumstances becomes bad debt expense. In the case of

bad debt, the amount that was expected to be received is reported as revenue. For charity, payment is not expected, so the amount is not included as revenue on the statement of revenue and expense. Charity care is instead reported separately in the notes to the financial statement.<sup>2</sup>

### DEVELOPING A POLICY

To meet the AICPA's financial statement reporting requirement, healthcare providers must develop their own definition of charity and determine criteria for providing patients care free or at a reduced rate. Setting policies to support the organization's definition of charity is necessary for the development of internal systems that promote the early identification of individuals seeking healthcare who will be unable to pay for services.

**Assessing the Current System** Developing a system to gather the information the AICPA requires is a challenge. A facility should begin by documenting its current system to identify deficiencies and better understand its admitting, billing, and charity-granting process. Flow diagrams are useful tools for this analysis. Interviews with the administrative staff, managers of other community healthcare or



Adam Cohen



trade organizations, auditors, and legal consultants can also provide practical information for developing a charity care policy and help make the transition smooth.

The information gathered could help a facility identify categories of patients who have historically been the largest recipients of charity care and who therefore require the greatest amount of oversight. For example, a hospital might initially focus on self-pay patients seeking admission and on patients seen in the emergency department. Once a system for identifying charity care patients is in place in these departments, it can be expanded to include other departments.

**Establishing Eligibility Criteria** An effective charity policy must include specific criteria to be systematically applied in determining charity care eligibility. Hospitals can use the federal poverty guidelines as a starting point for establishing such a policy. These guidelines are based on a combination of family size and income level. Depending on how an institution structures its charity care policy, patients with individual or family incomes below the amount designated in the federal poverty guidelines could be eligible for complete charity care. Some persons with annual incomes exceeding the federal poverty level may qualify for partial charity care after their financial status is adjusted for liabilities. Most facilities use 150 percent or more of the poverty level as the cutoff point for charity care.

Healthcare entities can retain the right to reclassify patients as charity care recipients if additional financial information becomes available or if patients' circumstances change during the course of treatment or the course of collection activities (as long as it is done before the providers initiate legal action). Ideally, charity care accounts should be identified as early as possible. However, healthcare entities cannot arbitrarily reclassify a patient's bill from bad debt to charity, unless new information presents additional compelling reasons. Providers may wish to reevaluate patients' charity status each time they are admitted but should at least reevaluate the criteria annually. The federal poverty guidelines are updated annually, and patients' financial status

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can change during that time.

**Identifying Charity Care Recipients** At times the effort to gather financial information on patients is duplicated within the organization. This practice not only is inefficient, but also could deprive some parts of the organization of critical information because it is not gathered and stored in a systematic manner.

The facility must clarify social workers' and financial counselors' roles in dealing with charity care. The hospital should develop a composite Medicaid and charity care eligibility information form that all employees who deal with patients can use. Social workers should visit self-pay patients within 24 hours of inpatient admission to collect financial information and complete the form. The social worker can then determine whether the patient will qualify for Medicaid or for complete or partial charity care. Then the social worker can give the information to the organization's business services side so the level of charity care is readily available.

Documentation of information a patient provides is necessary for making a charity care determination. Documents include photocopies of income tax forms, bank statements, and any other financial information that would establish a person's financial status. Some of these documents are necessary when a person files for Medicaid and therefore might be readily available. Also, if patients are aware that providing this documentation will be to their benefit, they may be more cooperative.

**DETERMINING CHARITY CARE**

This section describes an approach a hospital might use in developing a charity care policy. Although it is difficult to determine who is eligible for charity care, the Healthcare Financial Management Association (HFMA) believes it is important because it will make reporting more uniform and will establish a basis for responding to the new guidelines. HFMA has suggested that "ability to pay" could be measured by annual income, employment status, net worth, family size, other financial obligations, frequency of healthcare bills, and outside resources available.<sup>3</sup>

Patients whose financial status is below the fed-



eral poverty level and who do not qualify for Medicaid might qualify for complete charity care. A hospital can determine who is eligible for partial charity care by using a calculated adjusted-income bracket after analyzing patients' income, assets, family size, and outstanding liabilities.

The first step is to adjust income for family size. Income is often defined as income plus assets minus liabilities. On the basis of adjusted income level, the second step is to assign the patient to the appropriate adjusted income bracket. This income bracket will correspond to a percentage of the patient's adjusted income for which collection will be pursued. The **Box** shows one method for calculating an adjusted income level.

Partial charity care should be based on a patient's income, not on the charges incurred during the hospital stay; that is, charity care should be determined by the ability to pay, not the amount owed. Valuable hospital resources are often wasted trying to collect from individuals who cannot pay. This can add to patients' and families' stress and decrease their dignity.

Facility managers must arbitrarily determine the percentage of adjusted income for which collection will be pursued. This percentage should be consistent with the organization's overall collection policy, depending on how aggressive an institution is in collecting from patients who can pay for part of their care. Facility administrators can explore collection patterns to determine a realistic collection level for various income and payer categories.

### POLICY IMPLICATIONS

Several policy implications follow from the facility's charity care determination process. The first is that patients exhibiting extreme hardship (e.g., patients with large outstanding hospital bills) might still be eligible to receive charity care even though their income and assets exceed the hospital's income guidelines. A related issue is that hospital managers must decide whether to routinely consider patients' liabilities when determining adjusted income.

A second issue relates to the hospital's cost accounting system. Although currently the amount of charity care a hospital renders can be measured on the basis of its charges, in the future it might be necessary to measure charity on the basis of the cost of services provided.

HFMA speculates this could happen because of the increasing number of bills discounted by payers. Billed charges are more concept than fact.<sup>4</sup> In addition, measuring charity care based on costs "would greatly clarify both absolute and

relative levels of charity care in response to the public demand for more accountability."<sup>5</sup> Either the AICPA or other regulatory bodies could force this issue in the name of uniform reporting.

This reporting procedure will require a sound

## DETERMINING ADJUSTED INCOME LEVEL

### STEP 1: ADJUST PATIENT'S INCOME FOR FAMILY SIZE

Family Size	Income Level	Percentage Change between Income Levels	Percentage Difference	Accumulated Percentage
1	< \$ 6,810			0.0%
2	< 9,190	34.9%	9.1 %	9.1
3	< 11,570	25.9	5.3	14.4
4	< 13,950	20.6	3.5	17.9
5	< 16,330	17.1	2.5	20.4
6	< 18,710	14.6	1.9	22.2
7	< 21,090	12.6	1.41	23.7
8	< 23,470	11.3	1.0	24.7

< 8 — Add \$2,260 for each additional member

NOTE: The income levels given are the 1992 federal poverty guidelines.

The formula to adjust the income level for family size is:

$$(1 - \text{Accumulated percentage}) \times \text{Income}$$

For example, if a patient has an income of \$11,500 with a family of four, the calculation would be as follows:

$$(1 - 20.4\%) \times \$11,500$$

Adjusting for family size and the fact that the \$11,500 income is significantly less than the poverty guideline of \$13,950 for a family of four, the adjusted income level is \$9,154.

### STEP 2: DETERMINE WHAT PERCENTAGE OF ADJUSTED INCOME TO COLLECT ON

Based on the patient's adjusted income, place the patient in the appropriate income bracket. The percentage corresponding to that income bracket represents the percentage of the patient's adjusted income for which collection will be pursued.

For this example, the adjusted income level would place the patient in the \$6,811 to \$10,000 income bracket. Therefore the hospital would attempt to collect 10 percent of \$9,154, or \$915, on a partial-pay charity basis. Time payment terms might be one option to consider in the collection effort.

Income Bracket	Percentage of Income On Which to Collect
\$ 6,811 - \$10,000	10%
10,001 - 20,000	15
20,001 - 30,000	50
30,001 - 40,000	70

NOTE: These percentages are only examples and would be determined by hospital managers depending on how conservative or aggressive the hospital wishes to be in pursuing collection.



cost accounting system, perhaps dictating substantial changes in some existing systems. In a good cost accounting system the difference between the cost of services provided and the reimbursement by Medicaid for those services can be classified as charity. The formula is:

$$\text{Charity} = \text{Medicaid cost} - \text{Medicaid payments}$$

If the result is positive, that amount contributes to the hospital's total charity care. If the result is negative, Medicaid costs did not exceed the payments.

The difference between billed charges and reimbursement from third-party payers is considered a contractual allowance, not charity. Patients whose benefits have run out under Medicaid, Medicare, or commercial insurance, however, might be reclassified as charity care recipients if they meet the facility's policy guidelines. Usually facilities do not initially classify as charity the services rendered to patients with pending litigation or possible eligibility for workers' compensation. Complete or partial collection of billed charges may be feasible in these situations.

Finally, open lines of communication between physician billing services and hospital billing services are important. If hospital billing services inform physician billing services of patients' charity care status, physicians may choose to write off corresponding portions of their bills. The inverse should occur when physicians are the first healthcare provider to become aware of patients' lack of financial resources.

#### MEASURING CHARITY CARE

To account for the charity care it renders, a facility may want to establish a new charity financial classification along with a charity care allowance account. This allowance account would be similar to the account relating to the provision for bad

debt. The hospital could estimate and record an annual allowance for charity care, with specific charity accounts written off against the allowance as they occur. The hospital can thus maintain a year-to-date balance of the amount of charity care delivered.

Some hospitals compute the amount of taxes they *would have paid* if their tax-exempt status were not intact. This offers an opportunity for hospitals to prove that the charity care they provide is equal to or greater than the amount of foregone taxes. Some healthcare systems in our area use another measure to demonstrate their charity contribution: dividend to the community. This approach, normally based on charges rendered rather than cost of rendering the services, is calculated by the following formula:

$$\text{Dividend to the community} = \frac{\text{Charity care}}{\text{Net operating income} + \text{Charity care}}$$

Both approaches are legitimate measures of an institution's charity contribution to the community. The approach that uses the theoretical tax liability focuses more directly on the IRS's concerns about tax-exempt status.

Until recently charity care has only been measured as care provided directly to patients in the healthcare setting. Today, charity may also include intangible services provided to the community as a whole. Hospitals must document these services, estimate their value, and communicate this information to the public. The Catholic Health Association's *Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint* (1989) is a useful tool to accomplish these tasks. Through the use of less traditional methods of accounting for charity, such as those described in the *Social Accountability Budget*, organizations can more accurately capture and report their cost of charity care.

The *Social Accountability Budget* provides worksheets and guidelines to measure and report community benefits, such as community health education, free healthcare screenings, advocacy efforts aimed at influencing local and national health policy, and efforts directed toward groups with special healthcare needs. Certain unprofitable specialty services are also sometimes included as charity care if these services are rendered as a commitment to the community.<sup>6</sup> Such services include burn units and poison control centers. This demonstrates part of the hospital's mission to provide certain

## KEY PRINCIPLES IN ESTABLISHING A CHARITY CARE POLICY

As a hospital establishes its charity policy, several principles emerge as the foundation on which to base a charity classification system:

- If a patient qualifies for complete charity care, the hospital will not solicit any payment from the patient.
- Patients designated to receive partial charity care are billed on a sliding scale on the basis of adjusted income and assets.
- Amounts not billed will be classified as charity care.
- Billed amounts for which no payment is received will be classified as bad debt.



needed community services and to pursue its commitment to mission.

### **AN INTENSIFYING NEED**

New reporting procedures for charity care can lead to:

- A more accurate representation of costs incurred by a community's medically needy population
- Comparisons of the uneven distribution of

uncompensated care among hospitals

The need to define, measure, and distribute charity care will intensify as the needs of communities grow and resources become less available. Rationing is already a reality in our healthcare system. A policy for charity care is simply a systematic method for hospitals to provide and measure the care and to demonstrate the level of their participation.

Although the AICPA guidelines provide some  
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## **MERCY HEALTH SYSTEM'S HEALTHCARE FINANCIAL ASSISTANCE POLICY**

The Healthcare Financial Assistance (HFA) program established in 1992 by Mercy Health System, Cincinnati, identifies, documents, and monitors patients who are in need of healthcare services but are unable to pay. In keeping with Mercy Health System's mission of respecting human dignity, the term "healthcare financial assistance" is used rather than "charity care," notes Gary Prala, Mercy's vice president of patient accounting services. "The HFA program ties together Mercy's financial mission with its nonfinancial mission," he explains.

### **PROGRAM GOALS**

Because many system members had no clearly defined way to determine patient financial assistance, they asked Mercy to develop a consistent financial assistance program. Also, Mercy Health System wanted to provide its members with a procedure for documenting financial assistance that would be recognized as such by government entities. Finally, Mercy envisioned the HFA program as a way to help its members correctly categorize revenues so that healthcare financial assistance accounts were not improperly categorized as bad debt.

### **STAFF EDUCATION**

In introducing the program, Mercy Health System held regional in-service training for its facilities. "We made sure that everyone felt comfortable with the HFA program," notes Prala. An established network of Mercy employees are always available to answer the ques-

tions of facility staff as they work through the HFA program.

In 1992 Mercy Health System also launched the HFA program in its own collection agency. Accounts sent to the collection agency that its staff believe are financial assistance cases are returned to the facilities. The facilities review the accounts and, when necessary, reclassify them as HFA. So far about \$150,000 in accounts that facilities had written off as bad debt have been reclassified as financial assistance, according to Prala.

### **ELIGIBILITY DETERMINATION**

Patients may be granted HFA under the following circumstances:

- When they do not have adequate financial resources to pay
- When third-party insurance coverage does not cover the entire amount
- When catastrophic financial situations arise

Mercy Health System facilities determine patients' eligibility for HFA primarily by family income on the basis of the Hill-Burton Poverty Income Guidelines. Facilities can use a range of 100 percent to 200 percent of the guidelines. Mercy Health System recommends facilities use 150 percent of the poverty level, which equates to an \$18,500 annual income for a family of four.

### **APPLICATION AND REVIEW**

Staff members in each facility provide patients with preadmission and postadmission financial counseling. If patients are believed to be eligible for Medicaid, a Medicaid eligibility special-

ist helps them complete the Medicaid application. Patients who are ineligible for Medicaid complete the HFA application, with help from hospital-based financial counselors or other staff persons from the facility's accounting department.

Various facility staff review HFA applications and, on the basis of the poverty level guidelines, decide who is eligible for Mercy's assistance program. Patients can receive as much as \$10,000 in financial assistance. For large amounts, each facility's chief executive or financial officer or his or her designee considers the request. For lesser amounts the patient accounting director reviews the application. Applicants then receive approval letters telling them the amount of financial assistance authorized. The facility's patient accounting director notifies record keeping of patients' names and amounts of assistance.

### **SIGNS OF SUCCESS**

All Mercy members (19 hospitals and 5 long-term care facilities) have established the HFA program. Each year each facility is expected to report on the amount of HFA care it provides. Early in 1993 Mercy Health System plans to review the HFA program and measure its success.

Prala works closely with each Mercy facility's staff handling the HFA program, and he says he has received only positive feedback on the program. He notes that hospital employees believe the HFA program is consistent and they feel comfortable working with it. —MH



## ACCOUNTABILITY

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suggestions for reporting charity care, it is still unclear how hospitals will put these changes into practice. The multiplicity of approaches to delivering healthcare, coupled with the numerous points of access to the system, complicates arrival at a straightforward, practical solution to the problem of defining and reporting charity care. A solution must be found, however, and hospitals' ingenuity in transcending previous reimbursement and regulatory problems will undoubtedly be applied to this case too.

Some institutions may be bearing a disproportionate charity burden that could ultimately affect their quality of care and long-term viability. Unless hospitals adopt a consistent method for determining the level of charity care they can render, and unless they systematically measure this care, comparing charity care levels among hospitals will remain difficult.

The benefit of the new AICPA rules is the requirement for hospitals to more critically examine the amount and types of charity care they provide and to improve planning for charity care on the basis of community need and within the economic parameters of their ability to provide these services. If the present pattern continues, quantifying the level of charity care in the future will be necessary to defend tax-exempt status, improve the community's perception of and relationship with the hospital, and reassure the organization that it is fulfilling its mission. □

### NOTES

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