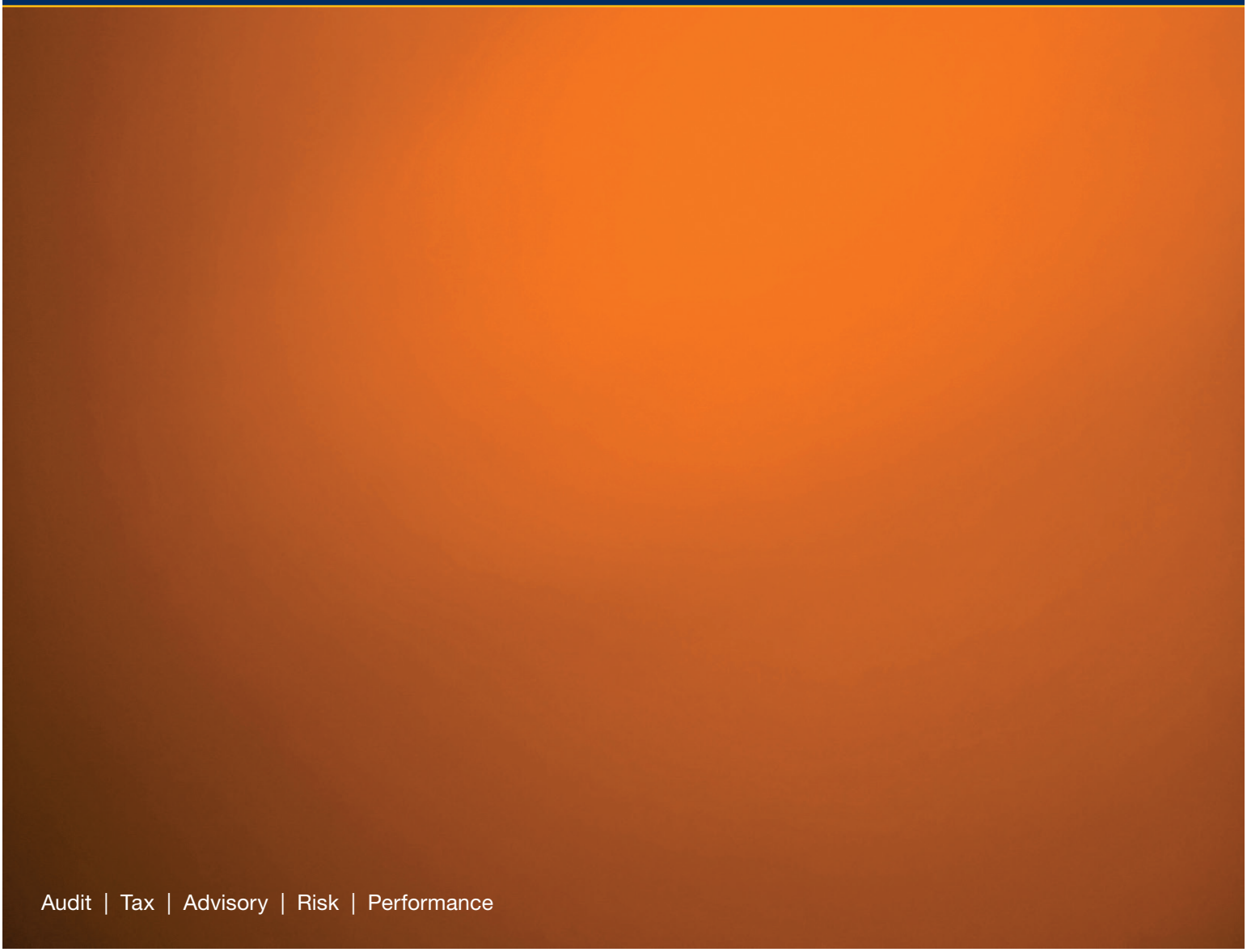
Crowe Horwath

Decreasing Charity Expenditures – Putting Medicaid Expansion State Hospitals at Risk?

Crowe® RCA Benchmarking Analysis: July-September 2015



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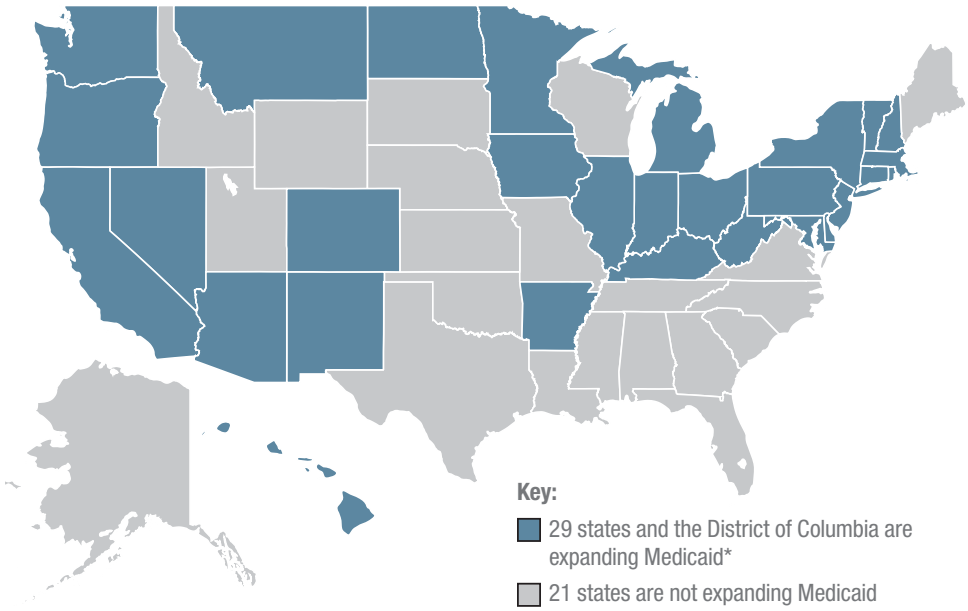
Since the inception of the *Patient Protection and Affordable Care Act* (ACA), hospitals across the country have experienced a decline in uncompensated care rates due to the declining uninsured population. This is particularly apparent in states that have expanded Medicaid. These Medicaid expansion states have seen their uninsured self-pay payer mix decline 31.2% since the start of 2014, while charity expenditures have declined 36.6% over the same period.[1]

Although the positive financial impact of the ACA has varied from facility to facility, the ACA also has created challenges for some hospitals. For example, there has been a negative effect associated with Disproportionate Share Hospital (DSH) payments, as well as Form 990 Schedule H charity care reporting for hospital organizations, with those in Medicaid expansion states seeing the most significant decline.

Medicaid Expansion – Impact on the DSH Program

The DSH Program will be overhauled, with much of the reform centered on declining funding year over year. Beyond the decreased funding levels, the traditional formula for determining DSH payment rates will undergo changes as well. The ACA, signed into law in March 2010, made significant changes to the Medicare DSH adjustment. The ACA set forth a new formula for calculating the DSH adjustment beginning in FY 2015. The *Health Care and Education Reconciliation Act of 2010* (Reconciliation Act) moved up the effective date of the new calculation to FY 2014 and altered the adjustment factors used in the new calculation.

Previously, the formula for determining DSH payments centered on Medicare Supplemental Security Income (SSI) and Medicaid Title 19 patient days. Under the new methodology, eligible hospitals receive 25 percent of the amount they previously would have under the statutory DSH formula. However, the remainder, equal to an estimate of 75 percent of what otherwise would have been paid as Medicare DSH, is aggregated nationally, adjusted for decreases in the rate of uninsured individuals and other factors, and then distributed to eligible hospitals based on their relative share of the total amount of uncompensated care. Thus, in the new model, 75 percent of the payment formula will be driven by uncompensated care and based on a hospital's share of



uncompensated care compared to all DSH hospitals in the U.S. This formula change has the potential to shift the largest percentage of DSH payments to facilities in states that have chosen not to expand Medicaid; however, the shift will be offset by the declining overall funding of the DSH program.

For FY 2014, 2015, and 2016 the Centers for Medicare & Medicaid Services (CMS) will use inpatient Medicaid days and Medicare SSI days from filed Medicare cost reports to determine Factor 3 of the uncompensated care DSH component of the new DSH formula. However, in the FY 2016 rule-making process, CMS indicated that it will:

- Give hospitals more time to learn how to submit accurate and consistent data through Worksheet S-10.
- Need more time to work with the hospital community and other stakeholders to develop appropriate clarifications and revisions to Worksheet S-10 to ensure standardized and consistent reporting of all data elements.
- Through future rulemaking, propose the use of Worksheet S-10 data for purposes of determining Factor 3.

CHARITY CARE IS DOWN 36.6% IN MEDICAID expansion states since 2014

Medicaid Expansion – Impact on Tax-Exempt Hospital IRS Reporting and Compliance

Over the past several years, policymakers and the public have raised concerns about hospitals' tax-exempt status and the lack of uniformity with regard to charity care and financial assistance reporting. A number of congressional hearings focused on what not-for-profit hospitals do to meet their charitable obligations and whether the current rules are sufficient. This scrutiny led to the expanded reporting on hospital tax forms 990, specifically Schedule H.

Although there are no definitive community benefit thresholds required by the IRS, a 5 percent threshold is often a baseline target for many hospital organizations.

With Medicaid expansion and a declining uninsured population, many hospitals will see a decrease in their charity care expenditures. Organizations should start thinking strategically now about how they will continue to justify their tax-exempt status in light of this shift. As financial assistance and charity care numbers decline, those dollars, theoretically, should be reallocated to other areas of community benefit, such as preventive care, wellness services, or other activities or programs by which the need is demonstrated through the hospital's Community Health Needs Assessment. It is likely that the IRS will monitor this reallocation.

In addition to heightening the impact of shifts in charity care, the ACA added new requirements – via Section 501(r) – that hospital organizations must satisfy in order to be described in Section 501(c)(3), as well as new reporting and excise taxes. IRC Section 501(r) requires[2] that tax-exempt hospital organizations (on a facility-by-facility basis):

1. Establish a written financial assistance policy (FAP) and emergency medical care policy

2. Limit the amounts charged for emergency or other medically necessary care to individuals eligible for assistance under the hospital's FAP
3. Make reasonable efforts to determine whether an individual is eligible for assistance under the hospital's FAP before engaging in extraordinary collection actions against the individual
4. Conduct a community health needs assessment and adopt an implementation strategy at least once every three years

On Dec. 29, 2014, the IRS issued long-awaited final regulations that provide guidance about the requirements for charitable hospital organizations under the ACA. Many tax-exempt hospitals are diligently working through these prescriptive regulations in order to achieve compliance. A Crowe Healthcare Connection article, "The 501(r) Challenge: Achieving and Maintaining Operational Compliance" provides recommendations on achieving and maintaining operational compliance.

Recommendations

Although there are no definitive community benefit thresholds required by the IRS or CMS at this time, hospitals in Medicaid expansion states must be mindful of increased regulatory scrutiny in light of the declining charity rates. Hospitals should be prepared to document the underlying methodologies used to support the amount of charity care reported, including a cross-walk of the charity care data reported on the CMS-2552-10 Medicare cost report, the Worksheet S-10, the IRS Form 990 Schedule H, and audited financial statements.

It is evident that organizations must evaluate, on a case-by-case basis, their DSH payment risk as well as their state and local exemption status. Medical centers with either large shares or declines of uncompensated care should evaluate risks related to the overall net effects of the ACA and the resulting impacts on financial performance moving forward. To adequately support charity care data, hospitals may want to consider taking the following steps, at least on an annual basis:

- Maintain a charity care log for claims with dates of service during each cost report period. Retain an electronic copy of the log until the cost report is final.
- Annually review the hospital's charity care and financial assistance policies, and maintain supporting documentation for each cost report period.
- Confirm that the hospital's charity policies are being followed and that they are accurately reflected in the billing system.
- Ensure charity care amounts are accurate. Establish separate transaction codes for bad debt and charity care and make sure these transactions cleanly map to general ledger accounts. Clearly communicate any new charity transaction codes or changes in proposed mapping.
- Identify the best source to track charity care and bad debt data and consistently use it for all uncompensated care reporting.

Market Trends: Payer Mix

- Medicaid managed care saw the largest shift in Medicaid expansion states. It increased approximately 2.7 percentage points, from 9.7 percent in third-quarter 2014 to 12.4 percent in third-quarter 2015. The shift was driven largely by a drop in traditional Medicaid, a continuing trend caused by increased market appetite to shift Medicaid administration from the traditional government to a managed care setting.
- Another payer group showing deviation between Medicaid expansion and nonexpansion states was the commercial/managed care payer group. It saw a slight decline in expansion states of 0.2 percentage points, from 30.1 percent in third-quarter 2014 to 29.9 percent in third-quarter 2015; nonexpansion states saw an increase of approximately one percentage point, up from 31.8 percent in third-quarter of 2014 to 32.7 percent in third-quarter 2015.

Payer Mix	Medicaid Expansion			Nonexpansion		
Payer Group	**9/30/14**	**9/30/15**	**Change**	**9/30/14**	**9/30/15**	**Change**
Commercial/Managed Care	30.1%	29.9%	-0.2%	31.8%	32.7%	0.8%
Medicaid – Managed Care	9.7%	12.4%	2.7%	6.7%	6.9%	0.2%
Medicaid – Traditional	8.1%	6.0%	-2.0%	4.7%	4.5%	-0.2%
Medicare – Managed Care	11.4%	12.2%	0.8%	11.5%	11.8%	0.3%
Medicare – Traditional	32.6%	31.6%	-0.9%	32.7%	31.6%	-1.1%
Other	3.9%	4.2%	0.3%	3.7%	3.6%	0.0%
Self-Pay	4.3%	3.7%	-0.6%	9.0%	8.9%	0.0%
Total	**100%**	**100%**		**100%**	**100%**	

Percentages have been rounded to the nearest tenth. Due to this rounding, the percentages shown might not total exactly 100%.

IN MEDICAID NONEXPANSION STATES

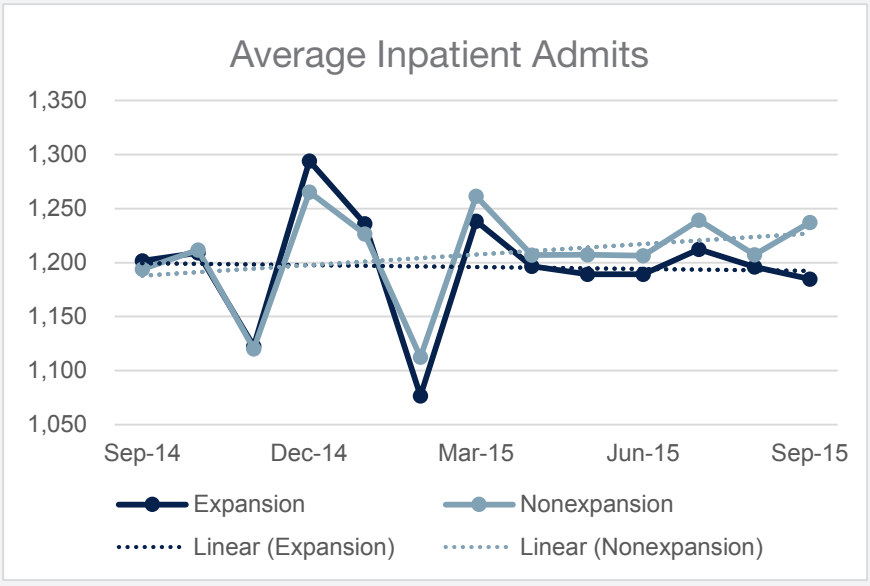
Commercial/Managed Care Payer Mix

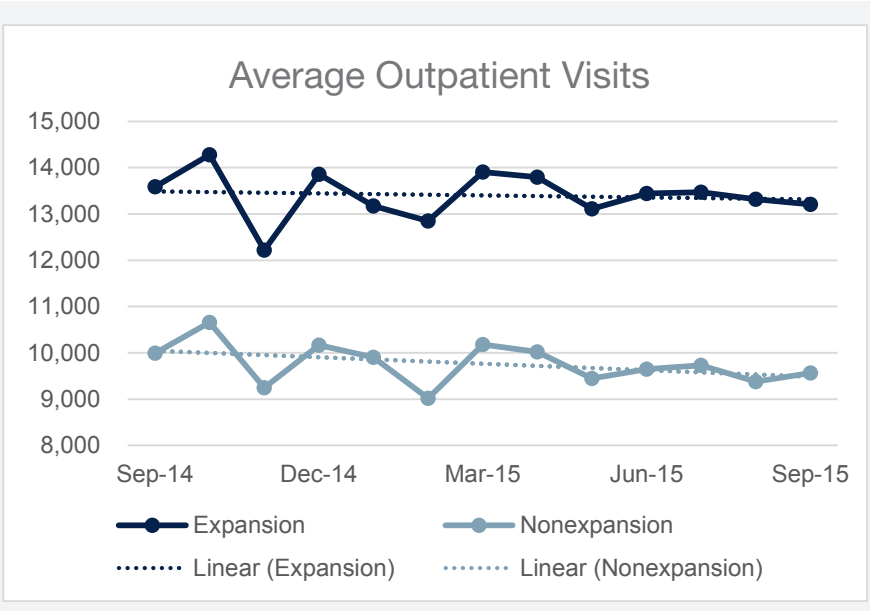
INCREASED approximately **ONE PERCENTAGE POINT**

WHILE MEDICAID EXPANSION STATES SAW A SLIGHT DECLINE

Market Trends: Volume

- From September 2014 to September 2015, inpatient admissions increased 3.6 percent for nonexpansion states while decreasing 1.4 percent for expansion states.
- Outpatient visits from September 2014 to September 2015 dropped for both expansion and nonexpansion states, declining by 2.8 percent and 4.3 percent respectively.
- The elevated outpatient visits rate for Medicaid expansion states, compared to nonexpansion states, was driven largely by high volume and low net revenue laboratory services delivered at a handful of hospitals in expansion states.





During the 12 months **ending Sept. 30, 2015**

OUTPATIENT VOLUME

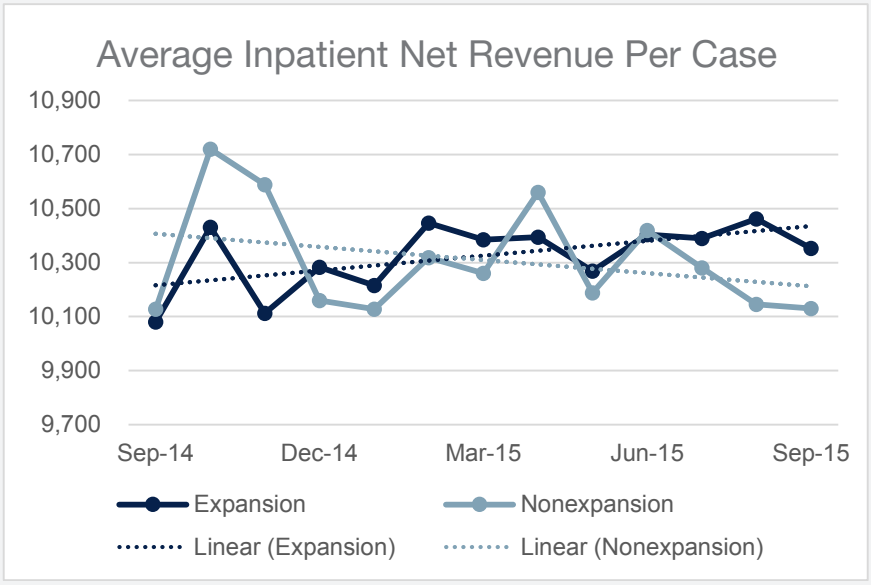
DROPPED

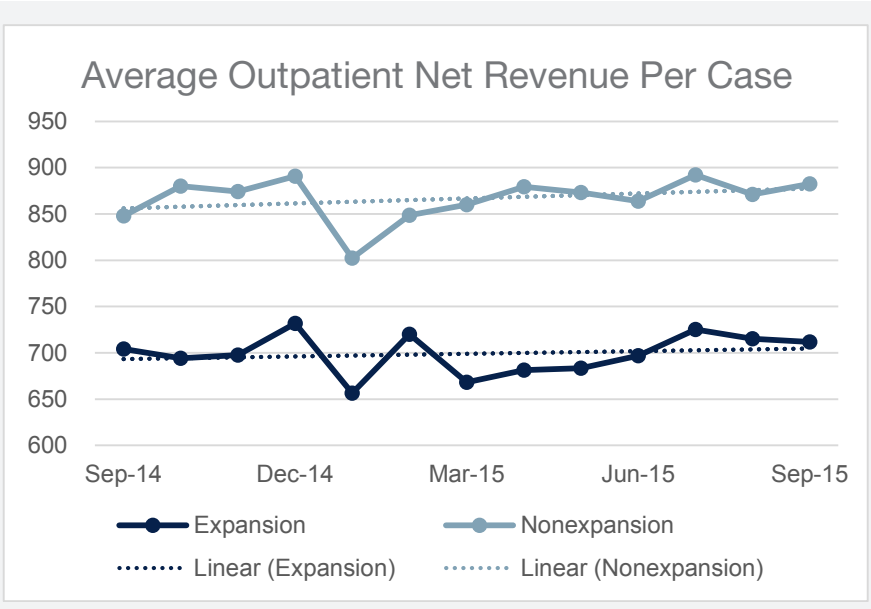
2.8% IN MEDICAID EXPANSION STATES AND

4.3% IN MEDICAID **NONEXPANSION** STATES

Market Trends: Net Revenue Per Case

- Compared with September 2014, average inpatient net revenue per case in Medicaid expansion states increased 2.7 percent while nonexpansion states remained flat over the same period.
- Average outpatient net revenue per case trended up in Medicaid nonexpansion states with a 4.1 percent increase from September 2014 to September 2015, while expansion states increased slightly, up 1.1% over the same period.





During the 12 months **ending Sept. 30, 2015**

OUTPATIENT NET REVENUE PER CASE

INCREASED

1.1% IN MEDICAID EXPANSION STATES AND

4.1% IN MEDICAID **NONEXPANSION** STATES

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Methodology Overview

The Crowe RCA benchmarking initiative comprised 491 distinct hospitals in a database as of Sept. 30, 2015. Of those, 295 are classified as acute care facilities, 69 were classified as critical-access facilities, and the remaining 127 were classified as rehabilitation, psychiatric, or cardiovascular clinics. Regarding bed counts, 186 facilities have 25 or fewer beds, 137 have 26-150 beds, 85 have 151-300 beds, and 83 have more than 300 beds. For the market-level analysis presented in this report, we considered 192 facilities – 94 in expansion states and 98 in nonexpansion states. All had 125 or more beds. The hospitals with 124 or fewer beds contained a significant number of highly specialized facilities that introduced an undesirable level of inconsistency to the data distribution.

The database has information from hospitals in 37 states. The following states are represented by 20 or more facilities apiece: Colorado, Florida, Illinois, Indiana, Kansas, Kentucky, Ohio, South Dakota, Texas, and Wisconsin. The database also has fields in which Crowe can customize specific peer groups to analyze hospitals in the most meaningful segments, including geographic regions, urban versus rural, academic hospitals only, outsourced versus internal revenue cycle functions, patient accounting systems, net revenue per day, and payer mix. Our method uses daily feeds of account transaction information and is supplemented by a monthly upload used for generating a variety of finance and revenue cycle metrics.

Contact Information

For more information on the Crowe® Revenue Cycle Analytics (Crowe RCA) benchmarking program, visit crowehorwath.com/benchmarking or please contact:

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[1] Per Crowe Horwath LLP benchmarking analysis, October 2015

[2] "New Requirements for 501(c)(3) Hospitals Under the *Affordable Care Act*"

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