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# COMPLIANCE TODAY

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## **Cynthia Cooper**

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**PAGE 14**

**Also:**

## **Compliance and the rise in uncompensated care**

**PAGE 28**

**Earn CEU credit**

**SEE INSERT**

## **Regulatory review of recruiting and relocation**

**PAGE 4**

**Feature Focus:  
Code RAC**

**PAGE 24**



# Compliance and the rise in uncompensated care

By *Wes Jackson and Matthew Roberts*

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The current landscape of the health care industry presents many daunting challenges to hospitals. Providing care to an escalating number of uninsured patients is perhaps the greatest challenge confronting hospitals.

The rising number of uninsured and underinsured patients has caused the levels of uncompensated hospital care to skyrocket. This free care presents a bleak financial picture for many hospitals that have historically been operating on thin margins. Hospital emergency departments are the primary care provider for many patients; the fact that many of these patients are underinsured or uninsured is causing hospitals to reassess how they provide care to patients and how they charge for these services. This challenge appears to be particularly true for tax-exempt community and non-profit hospitals.

Related to the financial challenges that rising uncompensated care imposes on hospitals are compliance issues associated with dealing with patients who use the hospital but do not or can not pay for these services. These issues include the Emergency Medical Treatment and Labor Act (EMTALA)<sup>1</sup>, other laws applicable to charitable and tax-exempt hospitals,

and issues regarding the mission or purpose of hospitals.

The plight of America's uninsured or underinsured patients is well documented. Recent media reports estimate that the number of uninsured Americans is roughly 45 million. Even more troubling, the number of uninsured children is close to 8.3 million. America's health care crisis is a high profile political issue in the upcoming 2008 presidential election. Health care is also the focal point of popular and other media, including Michael Moore's latest political documentary, "Sicko,"<sup>2</sup> which is generating high levels of media coverage. According to the American Hospital Association (AHA), since 1996, community hospitals have seen the costs of uncompensated care rise from \$18 billion to \$28.8 billion.<sup>3</sup>

There are two components of "uncompensated care" which the AHA defines as:

[A]n overall measure of hospital care provided for which no payment was received from the patient or insurer. It is the sum of a hospital's "bad debt" and the charity care it provides. Charity care is care for which hospitals never expected to be reimbursed. A hospital incurs bad debt when it cannot obtain reimbursement for care provided. This happens when patients are unable to pay their bills, but did not apply for charity care, or are unwilling to pay their bills. Uncompensated care excludes other unfunded costs of care, such as underpayment from Medicaid and Medicare.<sup>4</sup>

There is appropriate focus on the plight of the uninsured and their access to care, but there has not been as much coverage on the impact that treating the uninsured for no reimbursement is having on hospitals. This issue is rapidly becoming a crisis scenario for hospitals, because of their perceived obligation to treat everyone who presents to their hospital, regardless of their ability to pay.

Contrary to media assertions and some popular belief, patients appear to benefit when hospitals become more profitable. Studies have shown that as hospital profits decline, adverse patient safety events increase for both nursing and surgical patients.<sup>5</sup> Without health revenue and ultimately, sufficient profit, hospitals cannot afford to provide charity care to uninsured patients. The late Sister Irene Kraus of the Daughters of Charity put it best with her famous "No Margin, No Mission" statement. Balancing this obligation to meet the mission and to have necessary margins is difficult, and the existence of compliance obstacles further exacerbates this problem.

The spike in bad debt and charity care have both contributed to diminishing hospital revenues, but the provision of increased charity care in particular has also created complex legal issues that deal with how hospitals bill and collect from the uninsured. In recent years, charity care class-action lawsuits and intense scrutiny from the federal government regarding the legitimacy of tax-exempt hospitals have emerged as related challenges. In 2004, numerous class-action lawsuits were filed against nonprofit hospitals, which alleged that the hospitals overcharged uninsured patients. Dozens of federal and state copycat lawsuits followed. The vast majority of these lawsuits have been dismissed, but their legacy, particularly those of the state court actions, could have a lasting impact on nonprofit health care delivery systems. Unfortunately, these cases

have had little to no impact on improved charity care and have been viewed more as a means to hold hospitals hostage for legal fees for plaintiff lawyers.

In addition to these lawsuits for the uninsured, the federal government has now squarely set its sights on charity care as it relates to a hospital's tax-exempt status. On July 19, 2007, Senator Grassley posted a press release and a minority staff discussion that called for, among many other things, minimum charity care requirements and maximum charges for medically indigent, uninsured patients. Further, the IRS is due to release its final report on Tax-Exempt Hospitals and Community Benefit in September 2008. That report will include numerous action items, including recommendations for IRS administrative actions and/or investigations.<sup>6</sup> This will only heighten public scrutiny on hospitals, which could cause further reductions in patient revenue and increase hospital expenses if new legislation is passed to deal with the perceived problem.

Over the last decade, one thing has become clear: As health care consumers, we are going to have to pay more out of pocket for our health care. This will mean that hospitals will be forced to collect more from individuals. Hospitals are facing ever-increasing scrutiny of their charges to the uninsured and how they collect those charges, but hospitals also have to weigh their legal obligations when assessing methods to mitigate declining revenues due to uninsured and underinsured patients. One of the laws that hospitals must comply with in this context is EMTALA.<sup>7</sup>

Hospitals often mistakenly believe that EMTALA requires them to treat all patients who present at their hospital, irre-

spective of the patient's ability to pay. This is not true. The Centers for Medicare and Medicaid Services (CMS) has succinctly laid out EMTALA's general requirements as the following:

Medicare-participating hospitals must provide a medical screening exam to any individual who comes to the emergency department and requests examination or treatment for a medical condition. If a hospital determines that an individual has an emergency medical condition, it must then stabilize the condition or provide for

## Hospitals can comply with EMTALA while also taking various steps to stabilize patient revenues by becoming more aggressive about collecting money from the uninsured for the provision of health care services.

an appropriate transfer. The hospital is obligated to provide these services regardless of the individual's ability to pay and without delay to inquire about the individual's method of payment or insurance status. Hospitals may transfer unstable patients only if a physician determines that the benefits of the transfer outweigh the risks or if requested by a patient who has been informed of both the hospital's EMTALA obligations and the risks of transfer. Hospitals with specialized care facilities, such as burn units, must, within their capacity, accept requests for appropriate transfers of patients who require such specialized care.<sup>8</sup>

It is important to note that EMTALA may apply, even if the person does not actually

make a request for treatment. If a person presents without making an actual request, a request for treatment is deemed to exist if a prudent layperson observer would believe, based upon the individual's appearance or behavior, that the individual needs treatment for a medical condition or an emergency medical condition at that time.

CMS has clarified that the "prudent layperson" standard applies in any situation in which an individual has come to the hospital and a prudent layperson observer would believe the individual may have a medical condition or emergency medical condition (as applicable) and that the individual would request examination or treatment if he or she were able to do so, whether or not the individual is unaccompanied. The policy does not require hospitals to maintain emergency medical screening or treatment capabilities in each department or anywhere else on hospital property, other than the dedicated emergency department.<sup>9</sup>

In regard to the uninsured, EMTALA is relevant because it establishes the basic guidance on how hospitals treat patients, regardless of their ability to pay. Hospitals can comply with EMTALA while also taking various steps to stabilize patient revenues by becoming more aggressive about collecting money from the uninsured for the provision of health care services. The following options are examples of legal strategies hospitals can consider. These strategies are designed to attempt to increase revenue, decrease costs, and comply with federal law.<sup>10</sup> We will provide a general overview and discuss the pros and cons of each example, focusing on regulatory and statutory compliance, including laws applicable to tax-exempt hospitals.

*Continued on page 35*

### Pay when stabilized option

One option is to initiate payment inquiries after the initial medical assessment (if no other emergency treatment is required) or after the patient is stabilized. When the patient is stabilized or it is determined that the patient is stable for transfer, the hospital can refuse any further medical care, if payment ability is not confirmed or actual payment (or some portion thereof) is not rendered. EMTALA does not prohibit initiating the patient registration process, including inquiring about payment ability, during medical assessments and stabilizing treatment; however, such inquiries and processes may not delay the assessment or treatment. Following stabilizing treatment or determination that no emergency medical condition exists, EMTALA does not impose upon the hospital any further obligation to provide medical care to a patient. Consequently, under EMTALA, once the patient is stabilized or it is determined that no emergency medical condition exists, the hospital may require an uninsured patient to pay a “deposit” in order to receive further medical care. The hospital may refuse to provide further care if the patient cannot pay or verify the ability to pay.

The advantages of this option are that, if executed properly, it would satisfy the minimum requirements of EMTALA, albeit with some potential risk, and would be the most aggressive in terms of limiting the hospital's exposure to non-paying patients. This strategy may deter use of the emergency department as a private physician office, thereby reducing the emergency department volume and corresponding costs.

Due to its aggressiveness, this policy also exposes hospitals to the greatest amount of risk. The hospital would have to vigilantly document that its inquiries and registration process did not delay, in any manner, the pro-

vision of a medical assessment or stabilizing treatment. In addition, even if the hospital follows its policies, there is a risk under this option that the hospital would be subject to complaints and investigations related to EMTALA compliance, and would have to spend the time and money responding to such complaints or investigations.

Under this strategy, it is imperative for a hospital to develop specific policies for the process and document compliance with these policies every step of the way. All hospital staff must be fully educated on the reasons such a policy is needed and trained that patient care will not be compromised. Perhaps the greatest risk associated with this strategy is that if a hospital is a charitable, tax-exempt or governmental hospital, it could potentially expose itself to allegations that the hospital is not fulfilling its charitable or governmental purpose. Because a hospital's tax-exempt status is predicated on its charitable activities, these allegations could lead to a question by the IRS or state regulatory bodies regarding the hospital's tax-exempt status. Finally, if patients complain about the hospital's refusal to provide care and its aggressive collection efforts, the hospital could face negative publicity within its community as a result of this option.

This could include complaints being brought to the hospital's Board, hospital administration, and media outlets. Ultimately, the hospital's perception in the community could suffer.

### Collection option

Another option is to provide medical assessment, stabilizing treatment, and any other follow-up care, but aggressively pursue collection efforts for the full charges the patient incurs. This option presents less EMTALA risk because the hospital would not initiate registration or inquiries regarding payment during the medical assessment or stabilizing treatment, nor refuse to provide

ongoing care once the assessment or stabilization has been achieved.

A potential advantage to this strategy is that by aggressively pursuing collection efforts against these patients, it may be possible to increase the amounts collected from uninsured patients. Currently, many tax-exempt hospitals do not aggressively pursue collections, which would include taking people to court for unpaid medical bills. If this policy is implemented over time, people could become accustomed to consequences for not paying for health care services, and this could possibly reduce the emergency department volume.

This option does expose the hospital to greater risk of failing to collect for services rendered, because collecting money for services after they have been provided is more difficult. Further, because of the aggressive collection efforts against these patients under this option, tax-exempt hospitals could still face allegations that they are failing to provide quantifiable and material charitable care. Consequently, questions could be raised regarding their tax-exempt status. Finally, as with the previous option, if patients complain about the hospital's aggressive collection efforts, the hospital could face negative publicity and questions about compliance with their applicable mission or purpose as a result of this option. The hospital would also have to establish policies to ensure that it complies with all existing debt collection laws in their state.

Failure to comply with these laws can result in fines and other penalties.

### Financial counseling option

A third option would be to provide medical assessment, stabilizing treatment, and any required follow-up care without requiring any prior up-front payment, and provide financial

*Continued on page 37*

counseling to patients, including: (a) assisting the patient in investigating any available insurance, government programs, or grants and assisting the patient in applying for any such benefits and/or (b) setting up payment plans for the patient.

If the hospital follows its policies and procedures under this option, the hospital faces the lowest risk of violating EMTALA or other applicable laws. Again, although there can be no guarantee that complaints or investigations will not be filed or initiated, the risk of such occurrences is substantially reduced under this option. By focusing on counseling the patient regarding financial options and alternatives, the hospital increases the potential for the patient to find a way to pay at least a portion of the charges incurred. This option appears to be consistent with the hospital's charitable mission and reduces the likelihood that the hospital could face negative publicity.

Because this option is the least aggressive in terms of collection activity, however, it may be the least aggressive in dealing with the uninsured issue. Many hospitals already follow some variation of this option. The possibility exists, however, that by aggressively assisting patients with finding payment sources following treatment and offering payment options, the hospital could find that its collection of money from uninsured patients will increase under this proposal. This option also involves a lot of administrative effort that may not result in affecting a positive change in the current problem.

### Charity discount option

A fourth option is to offer charity discounts to the patient's charges. Many tax exempt hospitals currently offer some type of charity discount. Despite the prevalence of these policies, this option by itself does not appear to be very effective in negating the impact of

the increasing number of uninsured patients. The focus of this article is on the changes impacting how hospitals deal with uninsured and underinsured patients, but changes are also occurring in the way patients are insured. Many patients these days either have high-deductible, low-cost insurance or have health care savings accounts. Technically, these patients have insurance, but most would fall within the underinsured designation. Offering charity discounts to these patients and those without insurance can have multiple benefits.

By offering a discount, the hospital may increase revenues by having more patients who pay, thus reducing collection actions and costs and decreasing costly accounts receivable balances. The federal government has addressed discounts on numerous occasions and has approved their use, as long as the patient has a documented financial need. Further, by itself, offering discounts does not implicate EMTALA or jeopardize a hospital's tax-exempt status. This option further reduces the likelihood that the hospital could face negative publicity and actually creates the opportunity for the hospital to highlight its charitable efforts to the community. The risks associated with this option are limited as well. Without combining discounts with another mechanism, it is unclear if discounts will actually increase revenue. Thus, a hospital could institute charity discounts, yet see a decrease in revenue.

### Combination option

In addition to implementing one option at one time, hospitals may want to consider combining elements of various options and simultaneously or contemporaneously implementing the various elements of these options. Ultimately, the option each hospital chooses will depend on the particular situation it faces and its organizational structure.

Regardless of the reasons for implementing such a policy, however, it is imperative that the hospital evaluate their potential strategies to ensure compliance with the applicable laws.

### Conclusion

In this age of increasing numbers of uninsured patients and reduced private and government reimbursement, it is important for hospitals to implement strategies to ensure financial viability. All of the options listed above set forth efforts that any hospital can undertake to potentially increase collections while complying with the requirements of EMTALA. The hospital can also position itself to comply with all other federal and state requirements, such as the tax-exempt laws. In light of the breadth of the uninsured problem, these options are not permanent solutions, but rather are mitigating strategies designed to lessen the overall impact on hospitals. Until there is systemic change that addresses the underlying lack of insurance, providing care to the uninsured and underinsured will continue to be a financial and compliance challenge for hospitals. ■

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- 1 Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395 (1965), 42 C.F.R. § 489.24 et seq.
- 2 Sicko (Dog Eat Dog Films 2007).
- 3 Uncompensated Hospital Care Cost Fact Sheet, American Hospital Association (2006) (citing Health Forum, AHA Annual Survey Data, 1980-2005).
- 4 Interim Report on Tax-Exempt Hospitals and Community Benefit, Internal Revenue Service (July 23, 2007) (reporting that 56% of hospitals reported they did not include bad debt expense as uncompensated care. Therefore, the number reported by the AHA could be significantly lower than it should be).
- 5 Didem M. Bernard, William E. Encinosa, "Hospital Finances and Patient Safety Outcomes," 42 Inquiry, 60-72 (2005) (See also "Patient Safety Problems Increase When Hospital Profit Margins Decline Over Time," Nursing Economics (July-August 2006); Lee Bowman, "Hospital Profitability Affects Patient Care, Study Finds," Scripps Howard News Service (June 7, 2005)).
- 6 See Supra note 2 (The IRS released its interim report on July 23, 2007. The report discussed numerous issues but the most striking figure was that about one half of the hospitals reported community benefit expenditures of less than 5% of total revenue. This statistic will undoubtedly be an area the IRS dedicates significant time to in its final report next year).
- 7 42 U.S.C. § 1395; 42 C.F.R. 489.24 et seq.
- 8 The Emergency Medical Treatment and Labor Act: The Enforcement Process, Department of Health and Human Services, Office of the Inspector General (January 2001), available at <http://oig.hhs.gov/oig/reports/oei-09-98-00221.pdf> (page 3) (The interpretive guidelines make it clear that EMTALA also applies if a person presents to a hospital outside of its emergency department and requests treatment for an emergency medical condition).
- 9 Interpretive Guidelines to EMTALA, 42 U.S.C. § 1395, 42 C.F.R. § 489.24 et seq.
- 10 This article does not analyze the potential impact of state law but it clearly bears on the situations and option presented herein. Before implementing any of these options, hospitals should have knowledgeable counsel review all applicable state laws.