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# Healthcare

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A NEWSLETTER FOR THE HEALTHCARE INDUSTRY

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## Managed Care Contracts How to Win the Negotiating Game

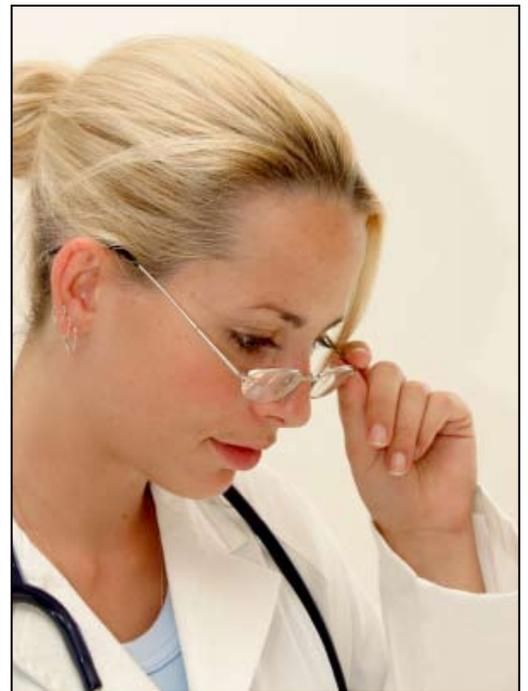
Physicians – especially those in small practices – often feel they have no choice but to accept the fees and terms dictated in their managed care contracts. After all, with insurance industry consolidation, the plans are getting bigger and experiencing less competition. The good news is that you may have more bargaining power than you think. But gaining concessions – whether you want an insurer to uniformly raise its rates or simply correct a lowball reimbursement – can only happen if you ask.

### Step 1: Gather Your Data

Bargaining with health plans involves crunching numbers. You'll need to compare what private payers are paying for your top billing codes and identify any inconsistencies. For example, if ABC Health Plan consistently pays 130 percent of the Medicare allowable while XYZ Health Plan is paying 105 percent for the same code, you may have some room for negotiation.

Start by generating a list of your charges for your top 25 billing codes in terms of dollar volume (the data should already be in your practice management software system). Add in the Medicare allowable for each code. Keep in mind that private payers typically express their rates as a percentage of the Medicare fee schedule. Repeat that process with allowables from your top five private payers, as well as any other payers you've targeted for negotiations.

In some cases, you may find that the blame for poor reimbursement falls on you. An insurer paying your fee in full may be a sign that you're undercharging (i.e., your fee is under or slightly above the Medicare allowable, and the insurer is willing to pay



a higher multiple). Before you do anything else, bring your fee schedule up to market levels. At the very least, set a Medicare multiple that tops the fee schedule of your best payer.

### Step 2: Gauge Your Market Power

You may be able to throw a little weight around in negotiations if, ultimately, you can make the case that an insurer needs your practice in this market. Start by researching two things: 1) the percentage of your community's patients who use your practice, and 2) the percentage of a given insurer's members in your region who use your practice. Regional demographics are available on the Web at the U.S. Census Bureau's site (<http://census.gov>).

# The Taxing Facts on Charity Care

By Keith A. Friedlein



*During these tumultuous economic times, when tax dollars are scrutinized as closely as ever, the nonprofit healthcare industry remains in the spotlight.*

At issue is whether nonprofit healthcare organizations are providing sufficient levels of charity care to support their tax-exempt status. Nonprofit hospitals have been the target of class action lawsuits and congressional review. State attorneys general have commenced investigative procedures in various states, including in Illinois. If you have not done so already, now is the time to review your charity care policy and the methodology used in computing charity care.

## Charity Care Defined

Nonprofit organizations qualify for federal tax-exempt status under section 501(c)(3) of the Internal Revenue Code, provided they are organized and operated exclusively for charitable, scientific or educational purposes. The government provides these organizations with tax breaks, or foregoes tax revenue, in exchange for the services provided by the organizations.

Among the tax breaks organizations receive are federal and state income tax exemptions, sales and use tax exemptions, and property tax exemptions. The services organizations provide in return must serve a particular public purpose. The Internal Revenue Service has used the term "community benefit" to describe

these services in reference to nonprofit hospitals. Others have used the term "charity care." Charity care, relative to nonprofit healthcare organizations, is defined as the provision of health services at no cost, or at a reduced cost, to poor and low-income individuals who cannot afford to pay for their care.

## Bad Debts and Medicare Shortfalls

In meeting the above definition of charity care, healthcare organizations must make distinctions that can be blurry at times. Every healthcare organization has unrealized revenues from patients who fail to pay for medical services provided to them. Are these bad debt write-offs considered charity care?

Organizations that accept Medicare patients expect to encounter shortfalls between reimbursements received and the actual cost of the care. Does this subsidized care constitute charity care? More and more the answer appears to be "no" in both instances.

The IRS has indicated that bad debts and Medicare shortfalls are to be reported in a separate section on the newly redesigned Form 990, apart from costs of charity care and community benefits. The Illinois Department of Revenue has ruled that neither bad debts nor Medicare shortfalls constitute charity care for Illinois property tax exemption purposes.

The key to reporting bad debts and Medicare shortfalls as charity care appears to be one of timing. The determination of whether a patient is eligible for free or discounted services under an organization's charity care policy must be made at the time service is rendered. Thereafter, once patient services have met the accounting criteria for revenue recognition, subsequent write-offs or shortfalls will not meet the current definition of charity care

as developed by the IRS and the Illinois Department of Revenue.

However, the quandary for many organizations, especially hospitals, is that they do not have adequate disclosure of patient finances at the time service is provided to make this distinction. If they did, a significant amount of bad debts would likely qualify as charity care.

## The Redesigned Form 990

The focus on charity care provided by healthcare organizations can be traced back to several lawsuits that were brought against nonprofit hospitals earlier this decade. The hospitals were charged with using aggressive collection tactics against uninsured patients.

One such case resulted in Provena Covenant Medical Center in Urbana, Illinois losing their property tax exemption. The Illinois Court of Appeals recently affirmed that Provena failed to provide enough charity care in 2002 to merit its \$1.1 million dollar property tax exemption. Provena is now likely to petition the Illinois Supreme Court to hear its case.

The unfavorable media attention that these cases brought to the healthcare industry led to the Senate Finance Committee opening hearings on the matter in 2005. Committee members strongly encouraged the IRS to take a more active approach to determining what properly constitutes community benefit. The eventual result was the release of a redesigned Federal Form 990 that is effective for 2008.

Nonprofit hospitals must complete and attach Schedule H - Hospitals as a supplemental schedule to Form 990. Schedule H requires hospitals to disclose their charity care policies, quantify costs of charity care and community benefits, provide information on community building activities, and report bad debt,

*Continued on page 3*

Medicare and collection practices. The information provided by hospitals on Schedule H, which is being phased into use over the next two years, will provide the IRS with a basis for determining whether the community benefit standard is being met by nonprofit hospitals.

Meanwhile, Illinois Attorney General Lisa Madigan has also expressed dissatisfaction with the level of charity care provided by nonprofit hospitals located in Illinois. The attorney general has threatened hospitals with the loss of their state and local tax exemptions if they do not improve the levels of their charity care. In addition, the attorney general's office has commenced an information gathering process relative to charity care provided by other nonprofit healthcare

organizations. The purpose of this process and where it may lead is unclear at this time.

### What to Do

It is apparent that federal and state taxing authorities are aggressively seeking new sources of tax revenue by questioning the tax exemptions of nonprofit healthcare organizations. Accordingly, healthcare organizations need to proactively review their charity care policies and revise them as necessary.

Each organization should establish criteria for charity care based on their mission, community needs, resources, and state laws. An analysis of Schedule H of Form 990 will provide an indication of the types of items the IRS has classified as charity care and

community benefits. Community benefits may include health education and training programs for the broader community, clinical services provided at a financial loss, research that results in knowledge made available to the public, and unreimbursed Medicaid charges, among other items.

While it can be difficult to quantify the costs of charity care and community benefits provided, steps taken today to do so will allow you to support your level of care if it is ever challenged and react quickly to further legislative changes that undoubtedly are on the horizon. ■

*Keith Friedlein is a partner at Wolf & Company LLP and a member of the Healthcare Services Group. You can reach him at 630-545-4505.*

## How to Win the Negotiating Game *Continued from page 1*

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### Step 3: Make Your Case

You generally won't be successful in demanding more payment or better terms unless you can prove you are worth it to a health plan. Here, point out how your practice adds to the insurer's bottom line.

If you faithfully comply with the insurer's formulary or shorten hospital stays through timely discharge, for example, be sure to point that out. And as positive clinical outcomes fall under increased scrutiny, share clinical data. Demonstrate how you provide care that is based on best practices.

### Bring Your "A Game"

As you head to the negotiating table, keep these tips in mind:

**Keep it professional.** Don't worry about giving offense by getting tough in negotiations. Business people respect those they can't trample. As long as the negotiation is done in a professional manner, and you have reasonable

arguments and data to back up what you're asking for, you have a stronger position to bargain hard.

#### **Be willing to do your part.**

Remember that negotiation is a two-way street. Consider asking what you can do for the insurer. It could be as simple as agreeing to follow a practice guideline — one that doesn't affect the quality of patient care but helps the health plan manage costs.

**Pick your battles.** For example, don't waste your time arguing over clauses that are required by statutes or by regulations. Indemnification clauses, for example, which prohibit physicians from attempting to collect payment from plan members in the event of a plan bankruptcy, are required by virtually every state insurance department.

**Be willing to walk away.** Some managed care contracts simply aren't worth signing. But you can't make this decision lightly (especially if you

depend on an insurer for 20 or 30 percent of your patients). But dropping an insurer doesn't have to be the end of the world. You could very well retain a large number of patients who may choose to switch to another plan or use your practice as an out-of-network provider.

Get some guidance. On a national level, the AMA offers a Model Managed Care Contract that can help you familiarize yourself with the structure and language of a fair contract. A free copy is available at <http://ama-assn.org/ama/pub/category/9559.html>.

Along those same lines, The American Academy of Family Physicians has developed a policy on family physicians' interaction with health care plans. You can find it at <http://aafp.org/online/en/home/policy/policies/h/healthplans.html>. ■

*For more information contact Steve Lutz at 630-545-4550.*

# Wolf & Company LLP

Certified Public Accountants

## Healthcare Services Group

2100 Clearwater Drive  
Oak Brook, IL 60523-1927  
www.wolfcpa.com



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## Vital Signs



### Caring for (and Keeping) Your Office Manager

Office managers are an indispensable part of successful medical practices. But keeping one may very well depend on how well you care for him or her.

**DO provide authority.** As you assign tasks, clearly impart authority as well. Ensure that your manager feels secure enough to take care of problems without asking permission at inopportune times.

**DON'T micromanage.** Instead, provide what organizational behavior experts call "freedom and accountability." Send the message that you are going to give your manager the freedom to figure out how to do the job the right way —

but, along with that freedom comes accountability for results.

**DO pay them well.** Low wages and a lack of benefits are true "demotivators." A good rule of thumb is to ensure that your office manager is paid at least 75 percent to 90 percent of similar workers in your community. Check out Web sites such as <http://payscale.com> or <http://cbsalary.com>.

**DON'T skimp on professional development.** Create a budget for career development and training, and encourage your office manager to attend relevant workshops, seminars and other self-improvement activities. Smaller practices

might simply offer paid time off for continuing education at the employee's cost.

**DO recognize and reward.** The management adage to "praise publicly and reprimand privately" really applies here. Provide opportunities for informal socializing outside of the office (hosting a barbecue at your home or treating your staff to a local sporting event).

**DON'T skip reviews.** Practices with good review programs, coupled with ongoing training and mentoring, have the lowest turnover rate. ■