ALLIANCE FOR ADVANCING NONPROFIT HEALTH CARE

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SPECIAL BRIEFING

Ohio Attorney General's Proposed Rules for Charitable Hospitals, Nursing Homes and Other Health Care Organizations

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In late June 2006 Jim Petro, Ohio Attorney General (AG), issued proposed rules, with a thirty-day public comment period (since extended to August 21), that would significantly modify current reporting and other requirements for a variety of charitable organizations, but with some special provisions for charitable hospitals, nursing homes and other health care organizations (e.g., nonprofit health plans covered under the state's Charitable Trust Act).

The Grantmakers Forum of Ohio is seeking to take the lead on behalf of charitable health care and other organizations in the state in developing comments on these proposed rules.

These rules, if adopted, could represent the most detailed, far-reaching regulation by any state of charitable health care and other organizations' policies and practices with respect to conflicts of interest, executive compensation and expense reimbursement, and patient billing and collections. While technically the AG is not seeking to require charitable health care and other organizations to adopt and abide by his annual report request and "suggested" policies, there are very strong incentives for them to do so; i.e., avoidance of increased reporting burdens and potential investigations.

This proposed approach, entailing detailed "process" standards, can be viewed as the opposite end of the spectrum of regulation from that proposed recently by the Illinois Attorney General, which would entail an "outcome" standard--a quantitative test related to charity care. In addition, these proposed rules would require annual community benefit reporting by not only charitable health care organizations but also other large charitable organizations.

Because of the potential precedent-setting nature of this initiative, the Alliance has prepared this special briefing summarizing the key features of the Ohio AG's proposed rules.

Stated Goal

- To improve public and donor confidence in charitable organizations

Annual Reports

- All charitable organizations are "encouraged" to file a new Annual Report designed by the AG rather than to provide a copy of their federal Form 990 filing (There are separate recommended reports for charitable trusts, charitable organizations under $100,000 gross revenues, charitable organizations over $100,00 gross revenues, charitable hospitals or nursing homes, and other types of charitable health care organizations)
- If they do not file the AG's new Annual Report voluntarily, the AG "would have to launch an investigation to obtain the information requested on the new form"
- In addition to financial information, the AG's Annual Report form for all charitable organizations asks for certain information related to Conflicts of Interest and Executive Compensation/Expense Reimbursement/Insider Loans. Charitable hospitals and nursing homes are also asked questions related to Fair Billing and Collection Practices, and all charitable organizations with gross revenues greater than $1 million would be required to file a Community Benefit Report (full text and summary reports) annually using standardized criteria. Each of these specific areas is discussed below
- At the end of the Annual Report, the charitable organization's CEO and Treasurer/CFO are each requested to attest to a series of statements with notarized signatures.

Conflicts of Interest

- The AG proposes a specific Conflict of Interest Policy for adoption by all charitable organizations
- The Annual Report noted above asks if the organization has adopted and abided by a policy that substantially conforms to the AG's suggested Policy
- If the organization answers "no", it is to explain each activity and conflict of interest engaged in that would have or may have violated the AG's suggested Policy, had it been adopted, and explain why such activity was not or may not have been a breach of fiduciary duty.
- Key provisions of the AG's suggested Policy are as follows:
    - Persons covered include any director, trustee, officer, employee or agent
    - A significant relationship is considered to exist with another party if:
        - The other party is family member including a spouse, parent, sibling, child, stepchild, grandparent, grandchild, great-grandchild, in-law, domestic partner or intimate partner
        - The other party is an entity in which the covered person has a material financial interest (at a minimum more than 10% ownership)
        - The covered person is a director, trustee, officer, employee or agent of the other party

audit partner or reviewing audit partner cannot have performed audit services for the organization for the past five years.
    - The CEO and CFO of the organization cannot have been employed by the accounting firm providing audit services within the twelve months preceding the initiation of the audit
    - No more than one-third of the board's directors can be involved in covered transactions at any given time
    - The board will receive at least bi-annually a report that summarizes all board activities and minutes where board members have refrained from participating in activities due to a conflict of interest; discloses all contracts approved despite a conflict of interest as well as the percentage of such bids accepted compared to the percentage of other successful bids; and summarizes any instances of failure to comply with the financial reporting and audit provisions of this policy

Executive Compensation and Expense Reimbursement

- The AG proposes a specific Executive Compensation and Expense Reimbursement Policy for adoption by all charitable organizations
- The Annual Report noted above asks if the organization has adopted and abided by a policy that substantially conforms to the AG's suggested Policy
- If the organization answers "no", it must provide an explanation, identifying each person whose compensation would have or may have violated the AG's suggested Policy by more than $200
- If the organization answers on the Annual Report that it compensates board members (other than reimbursement of expenses), compensates in aggregate any person more than $321,360 ((thirty times the minimum wage) or more than 10% of the organization's annual gross revenues, and/or reimburses any person for expenses that would have or may have violated the terms of the AG's suggested Policy, the organization must explain, identifying the name and title of the person, the average hours per week worked and any contributions made to employee benefit plans, deferred compensation, expenses account payments, or any other allowances or fringe benefits
- If the organization answers in the Annual Report that any expense reimbursement exceeds the Federal Travel Regulations Rates for employee travel, the organization must explain, identifying the number of times this occurred and the total dollar amount in excess
- If the organization answers in the Annual Report that there were any outstanding loans between the organization or a related third party and an executive or board member, the organization must provide an explanation, listing the number of such loans and the terms, including total dollar amount, repayment terms and security received
- In all of the forgoing instances, the organization must explain why it believes that any such compensation, reimbursement or loan does not or may not violate the charitable purposes of the organization

- Key provisions of the AG's suggested Policy are as follows:
    - Persons covered include any director, trustee, officer, employee or agent with respect any entity in a health care system or other multiple organization of which the charitable organization is a part or any related third party. Related third parties include people and firms: supplying goods and services; leasing property or equipment; involved in giving, purchasing, or selling real estate, securities or other property; making donations; and "affecting the operations of the organization"
    - Covered compensation includes direct salaries, wages, or amounts payable under a separate contract by the charitable organization, any other entity in a health care system or other multiple organization of which the charitable organization is a part, or a related third party
    - Reasonable compensation will be defined as an amount that would ordinarily be paid for like services by like enterprises under like circumstances
    - As a rule, payment of compensation to directors of the board, other than reimbursement of expenses, will be deemed not to be in furtherance of the charitable purposes of the organization. In cases where it is deemed necessary due to the complexity of the responsibility, time commitment, needed skills, or other factors, the organization will first review information on compensation provided by similar organizations (size, programs, geographic scope, board responsibilities). No such compensation will be provided by a related third party, except for reasonable compensation paid for services rendered to that third party for matters unrelated to governance of the charitable organization
    - As a rule, compensation exceeding thirty times the current federal minimum wage ($321,360) or ten percent of the organization's annual gross revenues will be deemed to be not in furtherance of the charitable purposes of the organization. Where it exceeds this threshold the board will have procedural safeguards to ensure that the compensation is not excessive, to include:
        Approval by a supermajority of the full board, with full knowledge by all members the total compensation by the charitable organization and any other related third parties and with tangible evidence provided to the full board of the reasonableness of the compensation
        Tangible evidence may include: compensation paid by similarly situated organizations for functionally comparable positions; the availability of similar services in the geographic area; current compensation surveys compiled by independent experts; and actual written offers from similarly situated organizations for the services of the covered person
    - As a rule, the issuance of loans to covered persons by the organization or related third parties will be deemed not to be in furtherance of the charitable purposes of the organization. Where such loans are deemed to be necessary to further those purposes or to not interfere with those purposes, procedural safeguards must be in place, to include at a minimum approval by a majority of the full board, with their full knowledge of the total number and amount of

the loans to the covered person by the organization and any related third parties

- As a rule, reimbursement of expenses at rates greater than those of established by the Federal Travel Regulations for federal employees will be deemed not to be in furtherance of the charitable purposes of the organization. Receipts must be provided for all expenses exceeding $25.00
- The board will receive at least bi-annually a report on: all director compensation; all covered compensation to any covered person exceeding thirty times the federal minimum wage or ten percent of annual gross revenues; and all loans made to covered persons by the organization or related third parties including amount, history of repayment and description of any defaults or write-offs

Fair Billing and Collection Practices

- The AG proposes a specific Fair Billing and Collection Practices Policy for adoption by all charitable hospitals and nursing homes
- The Annual Report noted above asks if the organization has adopted and abided by a policy that substantially conforms to the AG's suggested Policy
- If the organization answers "no", it must provide an explanation, identifying each activity or practice engaged in by the organization that would have or may have violated the AG's suggested Policy, had it been adopted, as well as an explanation, if any, of why that activity or practice does not or may not violate the organization's charitable purposes
- Key provisions of the AG's suggested Policy are as follows:
  - General principles will include: fair and reasonable charges to uninsured, underinsured, and indigent patients; zero tolerance for abusive, harassing, oppressive, false, deceptive or misleading conduct by employees, attorneys or agents involved in collections; and charitable and humane practices in connection with all debt collection practices
  - The Policy will be communicated in a clear and concise and manner, and multi-lingually where needed, to patients and the community through signage, bills, and brochures
  - Staff involved in billing, collections, admissions, and patient treatment will receive training on these policies, including how patients may obtain more information and submit applications for financial assistance
  - No patient whose annual household income is less than $125,000 for any uncovered treatment will be charged at a rate greater than that paid by the organization's most favored (providing the most revenue in the previous calendar year) nongovernmental insurer.

    This threshold will be adjusted annually for inflation

    Patients receiving financial assistance will be billed using the same charge description master prices for non-covered services that it utilizes for treatment provided to a policyholder of its most favored insurer

The total charge to such patients will be no more than it would have been paid in aggregate from its most favored insurer and its policy holder under applicable cost-sharing provisions

Such patients will receive the same percentage discount as applies to a policyholder of the most favored insurer

- Measures to estimate patients' income levels and ability to pay, and to ensure collection will be simple, dignified and not interfere with or discourage patients' access to care. When uninsured patient income information is not obtainable before or at the time service is rendered, the organization will contact the patient at least twice in writing, if necessary, to obtain the information, giving the patient at least 30 days to respond to each request
- If the organization mistakenly sends a bill to a patient for more than the Policy allows, the patient will be notified promptly of the revised bill
- Patients indicating lack of insurance or inability to pay will be assisted in obtaining discounted or free care or government-sponsored care, with standardized payment plan options that are reasonable taking into account income and necessary living expenses, after deducting from income expenses for necessary medical costs or existing medical debt payments. Once offered, payment plans will not be withdrawn even if other collection measures have been instituted
- Restrictions against full charges-billing will apply only to medically necessary services
- Claims will be submitted in a timely and accurate manner to third party payers, with the patient not liable for the organization's failure to do so if the patient provided its insurance information in a timely manner
- No bill will be referred to a collection agency or attorney for collection while a claim is pending with a third party payer with whom the organization contracts. Such referrals can be made where the claim was denied through no error by the organization
- The organization will have a steam-lined billing dispute process on all bills and collection notices, providing an address and toll-free phone number, with phone calls to be returned within one business day and correspondence responded to within ten days

  If the patient claims that all or part of the bill is not owed, that a third party should pay or that billing documentation is needed, the organization, its collection agency or attorney will cease collection efforts until the patient is provided with supporting documentation on the validity of the bill, which will be provided within ten days with collections suspended for thirty days

  Records will be kept of all complaints received by the billing offices and where received
- The board will receive at least bi-annually a report on: the current Policy; the name, income level, and medical debt amount of each patient currently being sued; the number of collection cases involving bankrupt debtors, including those where the organization's claim represents more than 40% of the their

outstanding debt; and a summary o

answered the complaint, is able or unable to answer it, and has or hasn't received service
    - The organization will have a sample lawsuit information sheet to give patient debtors that contains specific information set forth by the AG in this proposed rule
    - The organization or its agent will not contact a patient if it knows that he is represented by an attorney for debt collection purposes
    - The organization will not give blanket authorization to a debt collection agency or attorney to garnish the patient's wages or bank accounts, and the agency or attorney will not proceed with garnishment until the organization's designated individual with authority so approves, after verifying that: the patient's wages or funds are unlikely to be exempt from garnishment; the patient is reasonably believed to owe the debt; all known third party payers have been properly billed and amounts owed by the patient are not obligations of any third party payers; a reasonable payment plan was offered where the patient indicated and demonstrated an inability to pay; and the patient was given a reasonable opportunity to apply for free or discounted care where warranted. Also, the organization will not proceed until it has first obtained a court judgment for the amount of the debt
    - The organization will provide a garnishment information sheet to the patient that: contains language specified by the AG in this rule; summarizes any potential bases for exemption from garnishment that may be available to the patient and any time limits that may apply; and provides the garnishment percentages and wage amount
    - The organization will have its general counsel review any request by a patient for an exemption from garnishment
- The AG may waive any requirements when the organization can demonstrated that compliance would impose a substantial hardship or unjustifiable burden

Annual Community Benefit Report

- In addition to describing the community benefit program, the report must include:
    - Community benefit mission statement approved by the board indicating the target population (and the process used to define it) and objectives and affirming the organization's commitment to addressing the needs of its community and allocating resources to that end
    - Community health needs assessment, including: the health resources in the community and deficiencies in the target population; members of other organizations in the community involved in the assessment; how the assessment was done; and sources of information used
    - Community benefit plan, which describes: the organization and management structure for the program, individuals responsible and qualifications; process and considerations used to determine the budget; process for measuring outcomes and evaluating effectiveness; process for reviewing, evaluating and updating the program; and current activities under the following categories

that closely follow those contained in the Catholic Health Association's updated Guide for Planning and Reporting Community Benefit:

- Subsidized health services
- Charity care, including policies related thereto
- Shortfalls in government-sponsored health programs
- Community health services, including community health education, community-based clinical services and health care support services
- Health professions education and support
- Research
- Financial contributions, including cash donations, grants and in-kind donations of facilities, equipment, food or supplies
- Community-building activities
- Other mandated charity care programs
- Community benefit infrastructure/support costs
- Other community benefit programs not reported in the forgoing categories

- The description of the community benefit program must include:
  - Net costs and aggregate contributions by others, both overall and by activity
    - Bad debts must be excluded
    - Medicare losses can only be included if the organization can "definitively document that such services were not developed for marketing purposes, the losses are not due to operational inefficiencies, losses in any one program are not offset by gains in any other Medicare program, and there is a negative operating margin greater than five percent"
  - Calculations of the total of all net costs for the program as a percentage of total operating revenue (net patient revenue and other revenue) and of total operating expenses
  - Any additional non-quantifiable benefits