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THE MEDICAID EXPANSION OF 2014

Screening for Medicaid Eligibility | Health Care Law's Requirements for Nonprofit Hospitals
Medicaid Service Cutbacks | Support for Immigrant Worker Organizing | Foster Youth Respondents in Child Welfare Cases

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LEVERAGING THE PATIENT PROTECTION AND AFFORDABLE CARE ACT'S NONPROFIT HOSPITAL REQUIREMENTS TO

Expand Access and Improve Health in Low-Income Communities

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The Patient Protection and Affordable Care Act makes significant strides toward increasing access to care and improving the overall health of low-income communities.[1] The Act's signal accomplishment, a massive expansion of coverage to previously uninsured and uninsurable populations, is expected to have large positive effects on access to care. However, the coverage expansion alone leaves many problems unsolved, particularly for low-income people and communities.

First, most of the Act's coverage expansion provisions will not go into effect until 2014. The promise of future coverage may be cold comfort to the many who now find themselves priced out of private coverage, ineligible for public programs, and forced to choose between delaying necessary care and depleting limited financial resources to cover out-of-pocket health care expenses. Second, although the Act is expected to reduce the number of uninsured by 32 million by 2019, many millions will remain without coverage even if the law is upheld by the U.S. Supreme Court and implemented as planned.[2] Third, recent research suggests that even those who will gain insurance in 2014 will continue to rely on nonprofit safety-net hospitals for at least some of their care.[3]

But the Act is more than the coverage expansion. By amending elements of the tax code that govern nonprofit hospital organizations, the Act establishes key protections for low-income and other self-pay patients against aggressive billing and collections policies and incentivizes tax-exempt hospitals to engage in longer-term community health improvements with public health and community partners.[4] Most of these changes went into effect immediately upon the Act's signing.

We begin by laying out the history of nonprofit hospital requirements and the problems that arise when low-income people cannot access affordable hospital care. We

[1]See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

[2]See Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Nancy Pelosi, Speaker, U.S. House of Representatives (March 20, 2010), http://1.usa.gov/tlxFtY.

[3]Leighton Ku et al., *Safety-Net Providers After Health Care Reform: Lessons from Massachusetts*, 171 Archives of Internal Medicine 1379, 1383 (2011).

[4]We use the terms "tax-exempt" and "nonprofit" interchangeably.

then explain the new federal requirements as well as similar regulations in many states. We conclude with a brief discussion of how advocates, working with vulnerable communities and nonprofit hospitals, can leverage these laws to improve access to hospital care and community health.

Nonprofit Hospitals, Community Benefit, and the Health Care Safety Net

In exchange for tax benefits, nonprofit hospitals must offer programs and services to benefit their communities. Many nonprofit hospitals meet their "community benefit" obligations through charity care, which fills a gap in the health care system for low-income people. However, "community benefit" is ill-defined, leading to discrepancies in the benefits offered by nonprofit hospitals.

Legal Framework for Hospital Nonprofit Status. About 59 percent of U.S. hospitals and 77 percent of community hospitals are recognized by the Internal Revenue Service as nonprofit organizations under Section 501(c)(3) of the Internal Revenue Code.[5] These nonprofit hospitals enjoy a number of benefits not available to profit-making corporations and organizations. According to the nonpartisan Joint Committee on Taxation, the federal income tax exemption and having tax-exempt bonds issued for their benefit resulted in nonprofit hospitals' savings of about $4.3 billion in 2002.[6] The Joint Committee on Taxation estimated that when state and local tax exemptions are reflected, nonprofit hospitals received tax benefits of $12.6 billion annually.[7] Nonprofit hospitals make up less than 2 percent of qualified nonprofit organizations but receive approximately 41 percent of nonprofit tax benefits.[8]

In exchange for this favorable tax treatment, nonprofit hospitals are required to provide certain benefits to the communities they serve. Before 1969, federal tax standards required a tax-exempt hospital to provide care at no or low cost to those who could not afford it to the extent that the hospital was financially able to do so.[9] Since 1969, however, hospitals have been required only to meet a broad and amorphous "community benefit" standard that they provide programs and services that benefit the community as a whole.[10] This standard accords to hospitals great flexibility, enabling them to tailor programs to meet a wide range of concerns that affect community health. However, it does not require hospitals to offer any set amount or type of community benefit.

States may establish standards for hospitals to qualify for preferential tax treatment. Not all states have adopted such standards, and there is considerable variation among those standards.[11] While twenty-seven states require nonprofit organizations to qualify for federal 501(c)(3) status to receive state tax exemptions,

[5]See U.S. Government Accountability Office, GAO-08-880, Nonprofit Hospitals: Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements 8 (Sept. 2008), http://1.usa.gov/tL8Pck; U.S. Congressional Budget Office, Nonprofit Hospitals and Tax Arbitrage 3 (2006).

[6]See U.S. Congressional Budget Office, *supra* note 5, at 4.

[7]*Id.* at 4 n.6.

[8]*Pricing Practices of Hospitals: Hearing Before the Subcommittee on Oversight of the House Committee on Ways and Means*, 108th Cong. 2 (2004), http://1.usa.gov/vX7pBF (Advisory, House Subcommittee on Oversight, Committee on Ways and Means, Houghton Announces First Hearing in a Series on Tax-Exemption: Pricing Practices of Hospitals (June 15, 2004)).

[9]See Rev. Rul. 56-185, 1956-1 C.B. 202, http://1.usa.gov/uAmGni.

[10]See *Geisinger Health Plan v. Commissioner of Internal Revenue*, 985 F.2d 1210, 1217 (3d Cir. 1993) (examining state of law and concluding that "no clear test has emerged to apply to nonprofit hospitals seeking tax exemptions"); Rev. Rul. 69-545, 1969-2 C.B. 117, http://1.usa.gov/u4OgVl.

[11]See U.S. Government Accountability Office, *supra* note 5, at 16–19. See also Donna C. Folkemer et al., Hilltop Institute, Hospital Community Benefits After the ACA: Building on State Experience 7–10 (April 2011), http://bit.ly/rzsVLG; Community Catalyst, Free Care Compendium: National Snapshot (2011), http://bit.ly/tbytmq.

many have stricter standards.[12] About one-third of states have developed specific standards or reporting requirements governing hospital community benefit programs. Among these states, approaches to defining what "counts" as community benefit, in addition to the processes required for assessment, implementation, and reporting community benefit, can best be described as heterogeneous.[13]

Nonprofit Hospitals in the Health Care Safety Net. Charity care—referred to as "financial assistance" in the Patient Protection and Affordable Care Act—is still widely regarded as the cornerstone of hospital community benefit programs.[14] Free and reduced-cost hospital services are certainly needed. More than fifty million U.S. residents live without health insurance due to income, employment status, and other factors.[15] For these patients, access to hospital financial assistance may be critical to receiving timely, appropriate services. There is a growing need for financial assistance programs that are open to patients with insurance: One recent study found that 76 percent of those with medical debt reported having health insurance when they acquired the debt, due partly to higher out-of-pocket expenses and an increase in plans that either limit benefits or cap coverage.[16]

Hospital billing and collections practices, together with financial assistance, affect the financial health of low- and moderate-income patients. For example, hospitals routinely charge self-pay patients higher amounts for the care they receive than they do insured patients, insurance companies, and government payers.[17] Under this perverse system, in which those that have the least are charged the most, the average uninsured patient can afford to pay for only 12 percent of the bills incurred during a hospitalization.[18] Even at higher income levels (over 400 percent of the federal poverty level), uninsured patients have fewer financial assets from which to draw than do the insured.[19]

Academic and community-based researchers have linked medical debt and aggressive provider collection efforts to ruined credit ratings, wage garnishment and bank account seizures, and liens on private property, including primary resi-

[12]See Woods Bowman et al., *Preferential Tax Treatment of Property Used for Social Purposes: Fiscal Impacts and Public Policy Implications*, in Erosion of the Property Tax Base: Trends, Causes, and Consequences 269, 273 (Nancy Y. Augustine et al. eds., 2009).

[13]See Community Catalyst, Health Care Community Benefits: A Compendium of State Laws (Nov. 2007), http://bit.ly/vdtMRs. See also Catholic Health Association of the United States, Comparison Between the Catholic Health Association and VHA Inc.'s *A Guide for Planning and Reporting Community Benefit* and State Community Benefit and Related Laws, Guidelines, and Standards (Sept. 12, 2006), http://bit.ly/uHs2oH.

[14]Patient Protection and Affordable Care Act § 9007(a) (codified as amended at 26 U.S.C. § 501(r)(4)). See also Internal Revenue Service, 2010 Instructions for Schedule H (Form 990), at 2 (n.d.), http://1.usa.gov/sG3RJl ("Financial assistance includes free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are thereby deemed unable to pay for all or a portion of the services. Financial assistance does not include: bad debt or uncollectible charges that the organization recorded as revenue but wrote off due to failure to pay by patients, or the cost of providing such care to such patients; the difference between the cost of care provided under Medicaid or other means-tested government programs or under Medicare and the revenue derived therefrom; or contractual adjustments with any third-party payors.").

[15]Carmen DeNavas-Walt et al., U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2009, at 22 (Sept. 2010), http://1.usa.gov/sJzOxL.

[16]See David U. Himmelstein et al., *Illness and Injury as Contributors to Bankruptcy*, Health Affairs (Feb. 2005), http://bit.ly/uoJFvw. See also Sara R. Collins et al., Commonwealth Fund, Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007 (Aug. 2008), http://bit.ly/uVOJ5R (more than half of families with incomes under $40,000 struggled with medical bills in 2007).

[17]See Gerard F. Anderson, *From "Soak the Rich" to "Soak the Poor": Recent Trends in Hospital Pricing,* 26 Health Affairs 780 (2007), http://bit.ly/rMwXrw.

[18]See Office of Health Policy, U.S. Department of Health and Human Services, The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills 1 (May 2011), http://1.usa.gov/um1o3F.

[19]See Glenn A. Melnick & Katya Fonkych, *Hospital Pricing and the Uninsured: Do the Uninsured Pay Higher Prices?* 27 Health Affairs w116 (2008), http://bit.ly/uwRo73.

dences.[20] A 2005 study indicated that over half of all bankruptcies could be attributed to medical debt or illness.[21] According to the Commonwealth Fund, over 20 percent of American adults 19 to 64 were paying off a medical debt over time in 2006, with one-third of those surveyed reporting that they had either struggled to pay a medical bill in the past year or were paying off accrued debt.[22] In 2007 a similar survey revealed that nearly two-thirds of adults were struggling with medical bills or avoiding care due to cost.[23]

These numbers are particularly troubling in light of community-based research studies that fault hospitals for failing to give information about financial assistance programs. One recent study conducted by two nongovernmental organizations found that fewer than half of ninety-nine hospitals surveyed supplied application forms for financial assistance; only about a quarter gave information on eligibility; and only about one-third gave information in a language other than English.[24] Such problems, which can have the effect of preventing medically needy low-income people from accessing hospital care, appear to be widespread.

Increased Scrutiny of the Nonprofit Hospital Sector. Without clear or consistent laws governing the requirements for achieving and maintaining nonprofit status, hospitals have largely been left to determine for themselves what activities qualify as community benefit. Not surprisingly, these activities vary with hospitals and hospital organizations. Even where similar benefits are recognized, they are often measured inconsistently.[25] In 2005 the U.S. Government Accountability Office reported that it was "not able to discern a clear distinction among the government, nonprofit, and for-profit hospital groups" on community benefit expenditures.[26] That same year the Internal Revenue Service commissioner testified before a House committee that "abuse is increasingly present in the tax-exempt [hospital] sector" and that changes in the hospital system had made it difficult for the Internal Revenue Service to "distinguish[] tax-exempt hospitals from their for-profit counterparts."[27]

In response to these and similar findings, members of Congress held hearings in the mid-to-late 2000s to determine whether and what changes should be made in the way nonprofit hospital community benefits are determined and reported. In 2010 recommendations made by the Senate Finance Committee to resolve these issues within the nonprofit hospital sector were written into the Patient Protection and Affordable Care Act.[28]

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[20]See, e.g., Access Project et al., The Consequences of Medical Debt: Evidence from Three Communities (Feb. 2003), http://bit.ly/rykrjh; Community Catalyst, Not There When You Need It: The Search for Free Hospital Care (Oct. 2003), http://bit.ly/rAHTDW; Sidney D. Watson et al., Access Project, Living in the Red: Medical Debt and Housing Security in Missouri (2007), http://bit.ly/vBsUkZ.

[21]Himmelstein et al., *supra* note 16.

[22]Sara R. Collins et al., Gaps in Health Insurance: An All-American Problem: Findings from the Commonwealth Fund Biennial Health Insurance Survey (April 2006).

[23]Collins et al., Losing Ground, *supra* note 16.

[24]Carol Pryor et al., Access Project & Community Catalyst, Best Kept Secrets: Are Non-Profit Hospitals Informing Patients About Charity Care Programs? (May 2010), http://bit.ly/vtCFC6.

[25]See U. S. Government Accountability Office, *supra* note 5, at 19 ("Variations in the activities nonprofit hospitals define as community benefit lead to substantial differences in the amount of community benefits they report."); *id.* at 41 ("[T]he IRS standard allows nonprofit hospitals broad latitude to determine community benefit.").

[26]U.S. Government Accountability Office, GAO-05-743T, Nonprofit, For-Profit, and Government Hospitals: Uncompensated Care and Other Community Benefits 19 (May 26, 2005), http://1.usa.gov/sXpwSn (reporting on hospitals in five states). The U.S. Government Accountability Office found that uncompensated care costs were spread unevenly across nonprofit hospitals, with some incurring much more than others (*id.* at 14).

[27]*The Tax-Exempt Hospital Sector: Hearing Before the House Committee on Ways and Means*, 109th Cong. 10, 13 (May 26, 2005), http://1.usa.gov/tmbB1K (statement of Mark Everson, Commissioner, Internal Revenue Service).

[28]See U.S. Senate Finance Committee, Description of Policy Options: Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options 30 (May 20, 2009), http://bit.ly/rLR5Dp. See also Patient Protection and Affordable Care Act § 9007.

At around the same time, uninsured patients across the United States commenced a number of class action lawsuits alleging that certain hospitals were violating their obligations as tax-exempt charitable institutions by overcharging uninsured patients, failing to inform them of the availability of charity care, and aggressively pursuing them for collection.[29] Within a few months more than seventy lawsuits had been filed in federal courts in more than forty states, with more than six hundred hospitals named as defendants. The complaints alleged a variety of state contract and fraud claims as well as violations under the Fair Debt Collection Practices Act and the Emergency Medical Treatment and Active Labor Act.[30] In general, the federal claims raised in these suits failed, while some of the state claims survived and led to settlements.[31]

State and local officials challenged hospital charitable behavior and tax-exempt status. For example, in 2004, the Champaign (Illinois) County Board of Review recommended revoking the state property tax exemption for the Provena Covenant Medical Center in Urbana, Illinois, after finding that the hospital failed to meet its charity care obligations by billing all patients—including the uninsured poor—for services and then aggressively pursuing debt collection against them.[32] The recommendation was accepted by the State Department of Revenue and recently upheld by the Illinois Supreme Court.[33]

Consumer Protection, Community Engagement, and Greater Transparency

In an attempt to hold nonprofit hospitals accountable, the Patient Protection and Affordable Care Act establishes new billing and collection standards for nonprofit hospitals and requires them to perform a periodic community-health-needs assessment. Likewise, the Internal Revenue Service now requires nonprofit hospitals to report their community benefit activities.

Nonprofit Hospital Billing, Collections, and Financial Assistance. The Patient Protection and Affordable Care Act establishes new standards that nonprofit hospitals must meet to retain their federal tax-exempt status. Under these new requirements, charges for emergency or other medically necessary care given to individuals eligible for assistance under the hospital's financial assistance policy are limited to the lowest amounts charged to individuals who have insurance covering such care, and gross charges are prohibited.[34] Nonprofit hospitals are prohibited from engaging in "extraordinary collection actions" unless and until they have made "reasonable efforts" to determine whether the patient is eligible for financial assistance.[35] They must have a written policy to provide emergency medical care regardless of the patient's ability to pay.[36]

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[29]See Beverly Cohen, *The Controversy Over Hospital Charges to the Uninsured—No Villains, No Heroes*, 51 Villanova Law Review 95, 127–38 (2006) (initial ruling on federal and state claims in charity care class actions).

[30]See *Nonprofit Hospital Charity Care Litigation*, Health Law Reporter, Nov. 22, 2004.

[31]See, e.g., *Kizzire v. Baptist Health System Incorporated*, 441 F.3d 1306 (11th Cir. 2006) (dismissing contract and Emergency Medical Treatment and Active Labor Act claims); *Jellison v. Florida Hospital Healthcare System Incorporated*, No. 6:04-CV-1021-ORL-28K, 2005 WL 4732730 (M.D. Fla. 2005) (no language in 26 U.S.C. § 501(c)(3) demonstrates that plaintiffs were intended beneficiaries of hospital's tax-exempt status).

[32]See Valerie McWilliams & Alan A. Alop, *The Dearth of Charity Care: Do Nonprofit Hospitals Deserve Their Tax Exemptions?*, 44 Clearinghouse Review 110, 115–18 (July–Aug. 2010).

[33]*Provena Covenant Medical Center v. Department of Revenue*, 925 N.E.2d 1131, 1146 (Ill. 2010).

[34]Patient Protection and Affordable Care Act § 9007(a) (codified as amended at 26 U.S.C. § 501(r)(5)).

[35]*Id.* § 9007(a) (codified as amended at 26 U.S.C. § 501(r)(6)).

[36]*Id.* § 9007(a) (codified as amended at 26 U.S.C. § 501(r)(4)).

Nonprofit hospitals are required to have a written financial assistance policy that explains how the policy will be widely publicized, the eligibility criteria, whether free or discounted care is available to low-income individuals, how charges to patients are calculated, and how to apply for financial assistance.[37] All of the above requirements went into effect immediately upon the Act's signing. Failure to comply with them can result in revocation of the hospital's nonprofit status.

Public Health and Community Involvement in Community Benefit Programming. The Patient Protection and Affordable Care Act requires that nonprofit hospitals conduct a community-health-needs assessment every three tax years. This assessment must reflect input from persons who "represent the broad interests of the community served" by the hospital facility and must be made widely available to the public. The hospital must have an implementation strategy for meeting the needs identified in the assessment, report how it is meeting those needs, and describe any needs that are not being met and why.[38] The penalty for not conducting a community-health-needs assessment is $50,000 per year, per noncompliant facility and possible revocation of tax-exempt status.[39] Hospitals must report that they have completed the community-health-needs assessment requirements beginning in tax years after March 23, 2012.[40]

Initial draft guidance from the Internal Revenue Service specifies that the community-health-needs assessment will be expected to consider input from "[l]eaders, representatives, or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility."[41] Public health experts and "[f]ederal, tribal, regional, [s]tate, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility" must be consulted.[42]

Increasing Transparency. In 2008 the Internal Revenue Service introduced a new form, Schedule H, to "combat the lack of transparency surrounding the activities of tax-exempt organizations that provide hospital or medical care" and "quantify, in an objective manner, the community benefit standard applicable to tax-exempt hospitals."[43] Schedule H, which must be filed by nonprofit hospitals each year with their Form 990 tax returns, requires hospitals to report their community benefit activities, such as free or discounted care. Schedule H has been amended to incorporate questions aimed at determining hospitals' compliance with the new requirements under the Patient Protection and Affordable Care Act and will likely serve as a primary method for monitoring hospital performance on community benefit.[44]

Implications for Low-Income Communities and Their Advocates

Federal rules on implementing the Patient Protection and Affordable Care Act's requirements for nonprofit hospitals are forthcoming. Several states have gone beyond this federal baseline with stronger protections for low-income patients. Legal advocates can participate in the rulemaking, educate officials and patients about these new requirements, and monitor nonprofit hospitals' compliance with federal and state laws.

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[37] *Id.*

[38] *Id.* § 9007(a).

[39] *Id.* § 9007(b)(1) (codified as amended at 26 U.S.C. § 4959).

[40] *Id.* § 9007(f).

[41] I.R.S. Notice 2011-52, Internal Revenue Bulletin 2011-30 (July 25, 2011), http://1.usa.gov/vpZxW1.

[42] *Id.* § 3.06.

[43] Internal Revenue Service, Draft Form 990 Redesign Project—Schedule H, at 1 (June 14, 2007), http://1.usa.gov/seJcmH. See also Internal Revenue Service, Instructions for Schedule H (Form 990) (2008), http://1.usa.gov/tBgxQS.

[44] Patient Protection and Affordable Care Act § 9007(a) (codified as amended at 26 U.S.C. § 501(r)).

Robust Federal Rules. The Patient Protection and Affordable Care Act grants the secretary of the Treasury broad authority to issue regulations that implement the new requirements for nonprofit hospitals. Initial draft guidance on the community-health-needs assessment requirement was released for public comment in the summer of 2011, and regulations on all of the provisions are anticipated in 2012.[45] These regulations are expected to deal with such issues as what constitutes a "reasonable effort" and an "extraordinary collection action" and what "taking ... input" from community and public health representatives must entail. Advocates should monitor these developments and participate in public comment to ensure that the final rules serve the needs of low-income communities.

State Laws and Policies. The new federal requirements are a floor. States can accord more protections to low-income patients, and many do. For example, thirteen states and the District of Columbia mandate free care for patients who are unable to pay.[46] Some states, such as Maryland and New Jersey, set minimum income requirements under which hospitals must provide free care. Others, such as Florida and Utah, allow hospitals to determine whether patients are eligible for financial assistance.[47]

Hospitals in twenty states and the District of Columbia must notify patients and the public of available financial assistance programs, although these requirements vary.[48] Fifteen states have adopted billing and debt collection requirements that apply exclusively to medical debt.[49] Some require hospitals to post financial assistance policies on hospital websites, with no further direction in the statute.[50] Others are much more prescriptive, requiring hospitals to use the same format or file policies online with state agencies for dissemination to the broader community.[51] Still others require hospitals to disseminate policies in non-English languages commonly spoken in the community served by the hospital or distribute policies directly to patients or both.[52]

Eight states have enacted legislation limiting what hospitals may charge for services delivered to uninsured and self-pay patients.[53] In some states, such as New Hampshire and Tennessee, hospital charges are limited for all patients, regardless of income. In other states, such as California and Minnesota, hospital charges are limited only for uninsured patients who meet specified income guidelines.[54]

Legal advocates can take steps to ensure that state laws are implemented well. Several state attorneys general have taken investigative action to ensure that nonprofit hospitals within their states meet their

[45]U.S. Department of the Treasury, 2011–2012 Priority Guidance Plan (Sept. 2, 2011), http://1.usa.gov/txyixV.

[46]Folkemer et al., *supra* note 11, at 7.

[47]See Community Catalyst, Free Care Compendium (2011), http://bit.ly/skxNpK (interactive map showing state-specific information on financial assistance policies).

[48]Folkemer et al., supra note 11, at 7.

[49]These states are Maryland, Massachusetts, Michigan, Missouri, New Hampshire, New Mexico, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Washington, West Virginia, and Wisconsin (*id.* at 8, 14 n.10).

[50]*Id.* at 9.

[51]E.g., Maine requires hospitals to use common language in signage about financial assistance; Rhode Island requires hospitals to get approval from the Department of Health for notices about financial assistance; Connecticut requires hospitals to file financial assistance policies and debt collection practices with the State Office of Health Care Access annually; and California requires hospitals to file financial assistance policies with the Office of Statewide Health Planning and Development, which in turn must post them online in a searchable format (Community Catalyst, *supra* note 47; see also California Office of Statewide Health Planning and Development, California Hospital Free and Discount Payment Programs (n.d.), http://bit.ly/ss3IRz).

[52]Folkemer et al., *supra* note 11, at 9.

[53]These states are Colorado, Massachusetts, New Jersey, New York, Rhode Island, South Carolina, Tennessee, and Washington (*id.* at 7, 14 n.7; see also Tenn. Code Ann.§ 68-11-262 (West, Westlaw through 2011 Legis. Sess.)).

[54]See Community Catalyst, *supra* note 47.

tax-exempt obligations.[55] However, many regulators and elected and appointed officials remain unaware of the state and federal laws on hospital community benefit and may need to be educated about them and their effect on access to care. Legal advocates can assess whether further state or local public policy reforms are needed. Decisions to proceed with state-level policy reforms will likely turn on the strength of the federal rules, as well as state and local environments.[56]

Leveraging New Federal Requirements Locally. At the local and regional level, advocates can monitor hospital compliance with state and federal laws by gathering data from local hospitals' Internal Revenue Service reports and documenting client complaints and concerns. Tracking issues that arise out of individual client work to identify systemic problems can help establish a baseline for hospital performance and best practices for financial assistance and community involvement. Advocates can educate consumers about the new federal billing and debt collection protections and use these to evaluate medical debt and billing cases.

The community-health-needs assessment requirement is an opportunity for more in-depth collaboration among nonprofit hospitals, community advocates and members, and public health departments where they already interact, and the assessment requirement may be an opportunity to develop partnerships where there are none. In many cases the community-health-needs assessment may be completed as a joint venture between a nonprofit hospital and a health department. Legal advocates may become involved in the community-health-needs assessment, either directly or by training and educating other organizations about the new requirements and their potential roles in the assessment. Advocates can organize affected community members and involve them in conversations with hospital leaders, building alliances with providers to push for stronger consumer protections and better institutional practice toward low-income communities' priorities.[57]

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The Patient Protection and Affordable Care Act's new requirements for nonprofit hospitals aim to protect against aggressive billing and debt collection practices, encourage greater transparency on financial assistance policies, and emphasize hospitals' deliberate engagement of public health and community partners in assessing and meeting community health needs. A number of states have enacted laws limiting abusive financial practices and requiring greater transparency, although more can be achieved. The requirements are not perfect, but they present unique opportunities for advocates of low-income patients and communities.

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[55]See, e.g., Press Release, Minnesota Hospital Association & Office of Minnesota Attorney General Mike Hatch, Agreement Between Attorney General and Minnesota Hospitals Will Provide Fair Pricing to Uninsured Patients, Establish Code of Conduct for Debt Collection Practices (May 5, 2005), http://bit.ly/v4caub.

[56]By way of illustration, legal advocates can recommend that public funding for care to low-income patients, such as county-level funding for indigent care or state-administered Medicaid Disproportionate Share Hospital funds, be limited to hospitals that meet standards similar to the requirements for nonprofit hospitals in the Patient Protection and Affordable Care Act. In states with significant numbers of for-profit hospitals, advocates can seek to expand billing and collections protections to the entire hospital sector. States can take up areas likely to be left to hospitals' discretion in federal rulemaking, such as establishing minimum eligibility criteria for financial assistance.

[57]For a more detailed list of suggestions, see Corey Davis, National Health Law Program, Nonprofit Hospitals and Community Benefit (July 2011), http://bit.ly/vsvnc2.

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