ANNALS OF HEALTH LAW
Advance Directive

VOLUME 22 FALL 2012 PAGES 71-87

Changes to Reimbursement and Tax-Exempt Status Requirements May Raise Financial Concerns, But Non-profit Hospitals Stand to Benefit from HealthCare Reform

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I. INTRODUCTION

The United States overhauled its approach to healthcare and moved towards universal coverage by enacting the Patient Protection and Affordable Care Act (PPACA). This approach to universal healthcare mandates individuals to acquire health insurance. Since healthcare is expensive, the government will assist its citizens with acquiring healthcare in three ways: (1) by expanding Medicaid coverage to anyone under 133% of the federal poverty level,[1] (2) offering premium assistance tax credits to Americans earning up to 400% of the federal poverty level,[2] and (3) implementing cost-sharing reductions.[3] Together, the mandate and Medicaid expansion seek to increase access to the forty-seven million uninsured Americans.[4] The increase in access to healthcare is good news

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1. Patient Protection and Affordable Care Act [hereinafter PPACA], 42 U.S.C. § 1396A(a)(7)(B) (2010)
(there is a special deduction to income equal to five percentage points of the poverty level raising the effective eligibility level to 138% of poverty). *See* KAISER FAMILY FOUND., MEDICAID AND CHILDREN'S HEALTH INS. PROGRAM PROVISIONS IN THE NEW HEALTH REFORM LAW 3 (2010), *available at* http://www.kff.org/medicaid/upload/8349.pdf; KAISER FAMILY FOUND., A HISTORICAL REVIEW OF HOW STATES HAVE RESPONDED TO THE AVAILABILITY OF FED. FUNDS FOR HEALTH COVERAGE 1 (2012), http://www.kff.org/healthreform/upload/7952-03.pdf.

2. *See generally* PPACA, 26 U.S.C. §36B (2010).

3. *See generally* PPACA, 42 U.S.C. §18071 (2010).

4. GENEVIEVE M. KENNEY ET AL., MAKING THE MEDICAID EXPANSION AN ACA OPTION: HOW MANY LOW-INCOME AMERICANS COULD REMAIN UNINSURED 2 (The Urban Inst. Ed.,

for Americans. However, financial challenges may be created for some healthcare providers because the PPACA also changes funding and reimbursement methods for Medicaid and Medicare,[5] and includes additional requirements[6] for tax-exemptions.

These changes will impact the operations of a major player in the healthcare industry—non-profit hospitals. Non-profit hospitals make up slightly less than two-thirds of urban, general medical and surgical hospitals.[7] Specifically, non-profit hospitals make up 2,904 of the 4,985 registered United States Community hospitals.[8] These hospitals provide more charity care than for-profit hospitals,[9] provide many community benefits,[10] and are also more likely to provide unprofitable services.[11] In addition, non-profit hospitals are generally larger than for-profit hospitals, and are more likely to be teaching hospitals.[12]

Non-profit hospitals play a vital role in the United States because of their contribution to public health through these aforementioned benefits. Yet, certain changes to the healthcare industry, as a result of universal healthcare

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2012), http://www.urban.org/UploadedPDF/412606-Making-the-Medicaid-Expansion-an-ACA-Option.pdf.

5. *See generally* PPACA, 42 U.S.C. §1395ww (2010).

6. *See* Pamela C. Smith & Kelly Noe, *New Requirements for Hospitals to Maintain Tax-Exempt Status*, 38 J. OF HEALTH CARE FIN. 16, 18 (2012).

7. Jill R. Horwitz & Austin Nichols, *Hospital Ownership and Medical Services: Market Mix, Spillover Effects, and Nonprofit Objectives*, 28 J. OF HEALTH ECON. 924, 925 (2009).

8. AM. HOSP. ASS'N, FAST FACTS ON US HOSPITALS 1 (2012), *available at* http://www.aha.org/research/rc/stat-studies/fast-facts.shtml.

9. Horwitz & Nichols, *supra* note 7, at 925.

10. Kristine Principe et al., *The Impact of the Individual Mandate and Internal Rev. Serv. Form 990 Sch. H on Cmty. Benefits from Nonprofit Hosp.*, 102 AM. J. OF PUB. HEALTH 229, 234 (2012). Non-profits admit more mentally-ill patients in psychiatric emergency services, provide comprehensive services for substance abuse treatment, provide AIDS services, provide obstetrical care, and operate an emergency room and trauma center at rates higher than for-profit hospitals. *Id*.

11. *Id*.

12. CONG. BUDGET OFFICE, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS 12 (2006), http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/76xx/doc7695/12-06-nonprofit.pdf.

coverage from the PPACA, have raised concerns about the financial stability of these hospitals. Particularly, budget cuts and new methods of reimbursement will create financial concerns for non-profit hospitals. In addition, the resulting increase in insured individuals will force hospitals to approach their tax-exempt status differently. Hence, there are major hurdles associated with universal healthcare coverage for which non-profit hospitals must prepare.

Changes to reimbursement and tax-exemption requirements from the PPACA, along with Illinois' approach adopting similar changes, will have a profound impact on non-profit hospitals. However, non-profits can continue to survive, and perhaps even thrive, in the changing healthcare industry. Although there are challenges forthcoming, the new approach to healthcare in the United States will promote efficiency and drive down costs, helping non-profit hospitals reach their altruistic goals of serving the public's health needs.

II. CONCERNS TO OPERATING CONDITIONS FOR NON-PROFIT DUE TO MEDICAID EXPANSION AND CHANGES TO REIMBURSEMENT METHODS

The PPACA aims to increase healthcare coverage to the population of the United States by mandating citizens to purchase health insurance.[13] In order to assist individuals in purchasing health insurance, the PPACA provides premium assistance tax credits and cost-sharing reduction benefits.[14] Those below 138% of the federal poverty level are eligible for

13. *See* PPACA, 42 U.S.C. §18091 (2010).

14. *See* PPACA, 42 U.S.C. §18071 (2010); PPACA, 26 U.S.C. §36B (2010). Americans earning up to 400% of the federal poverty level are eligible for a tax credit if they purchase insurance through a government based health insurance exchange program. *See* PPACA, 42 U.S.C. §18071 (2010). The tax credit is calculated as the lesser of the following calculations: (1) the monthly premium cost for the plan that an individual or family is enrolled in, or (2) the excess from 1/12 of the product of the applicable percentage and the individual or family's income subtracted from the premium for the silver tier package that an

coverage under Medicaid expansion.[15] The PPACA also addresses the constantly expanding cost of healthcare by introducing sweeping reform to reimbursement from Medicaid and Medicare. The PPACA will require the secretary of Health and Human Services to establish a value-based payment program for hospitals, as opposed to performance based payments, thus, giving incentives for hospitals to provide care more efficiently.[16] Providers will also be subject to Medicare and Medicaid payment reductions for readmissions, payment linkages to quality measures, and a pilot program regarding bundled payments.[17] In addition, the PPACA encourages efficiency by incentivizing providers to form Accountable Care Organizations that will participate in the Medicare Shared Savings Program.[18]

The changes to the payment methods create concerns about how hospitals will be able to survive reform.[19] In 2012, for example, revenues from Medicare and Medicaid are expected to remain strained, leaving non-profit hospitals wondering how they will be adequately reimbursed under

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individual or family would be eligible for. *See* 26 U.S.C. §36B (2010). The applicable percentage is determined by an individual's or family's income expressed as a percentage of the federal poverty level. *See* 26 U.S.C. §36B (2010).

15. KAISER FAMILY FOUND., *See supra* note 1.

16. *See* PPACA, 42 U.S.C. §1395ww (2010).

17. Principe et al., s*upra* note 10, at 232. As an additional check on costs, the PPACA also establishes an Independent Payment Advisory Board, which has the purpose of reducing the per capita growth in Medicare. *See* PPACA, 42 U.S.C. §1395kkk

18. *See generally* AMERICAN ACAD. OF FAMILY PHYSICIANS, MEDICARE SHARED SAVINGS PROGRAM: ACCOUNTABLE CARE ORG.. FINAL RULE (2011), http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/background/medicare-aco-summary.Par.0001.File.dat/AAFPFinalMedicareACO.pdf [hereinafter AAFP]. An Accountable Care Organization in the Medicare Shared Savings program is a group of providers that will work together to provide coordinated care to Medicare beneficiaries. *Id.* at 3. These organizations will be eligible to share a portion of savings generated to the Medicare program. *Id.* at 5.

19. *See* STANDARD & POOR'S, THE U.S. NOT-FOR-PROFIT HEALTH CARE SECTOR'S RATING STABILITY IS VULNERABLE TO HEADWINDS AFTER 2012 (2012), http://www.standardandpoors.com/spf/upload/Events_US/US_FI_Event_hc6512art7.pdf (discussing the various challenges non-profit hospitals will face).

these new payment models.[20] Care provided to Medicare and Medicaid beneficiaries is often reimbursed at below-market rates, paying hospitals a substantially lower percentage of billed charges than most private insurers.[21] For example, Provena Covenant Medical Center was under-reimbursed by $7,418,150 from Medicare and $3,105,217 from Medicaid in 2002.[22] The Centers for Medicare and Medicaid Services (CMS) will continue to reduce inpatient payment rates in fiscal year 2013.[23] The Budget Control Act of 2011 also requires a two percent downward reduction to all lines of Medicare payment, set to take effect January 1, 2013.[24]

The potential insolvency of Medicare and Medicaid has already been felt by many states' budgets as well.[25] In fact, in 2012, thirteen states cut Medicaid funding to balance budgets.[26] Even with the reimbursement

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20. *See id.* at 3. Revenues from all insurance providers will remain strained. *Id*. Medicare provided small inpatient update factors of 1.1%, and Medicaid was cut in various states. *Id*.

21. Simone Rauscher & John R.C. Wheeler, *Hospital Revenue Cycle Mgmt. and Payer Mix: Do Medicare and Medicaid Undermine Hospitals' Ability to Generate and Collect Patient Care Revenue?*, 37 J. OF HEALTH CARE FIN. 81, 83 (2010).

22. Provena Covenant Med. Ctr. v. Dept. of Revenue, 925 N.E.2d. 1131, 1137 (2010).

23. *See* FLA. HOSP. ASS'N, FINAL RULE SUMMARY: MEDICARE INPATIENT PROSPECTIVE PAYMENT SYSTEM FEDERAL FISCAL YEAR 2013 1 (2012) (summarizing the Centers for Medicare and Medicaid Services final ruling CMS-1588-F). CMS has set the PPACA mandated market reductions at -0.8%, including the -0.1% predetermined market reduction, and also provides a provides a predetermined coding adjustment reduction of -1.9%. *See id*. at 2. Hospitals may encounter a one percent payment reduction under the new Value-Based Purchasing program. *See id*. at 6. Hospitals that have high readmission rates mayn also encounter an additional one percent reimbursement reduction for inpatient services. *See id*. 7.

24. *See id*. at 2.

25. MOODY'S INVESTOR SERVICE, TRANSFORMING NOT-FOR-PROFIT HEALTHCARE IN THE ERA OF REFORM 2 (2010), http://content.hcpro.com/pdf/content/251210.pdf [hereinafter MOODY'S].

26. *See* PHIL GALEWITZ & MATTHEW FLEMING, THIRTEEN STATES CUT MEDICAID TO BALANCE BUDGETS (Kaiser Health News, 2012), *available at* http:// www.kaiserhealthnews.org/Stories/2012/July/25/medicaid-cuts.aspx. Illinois made some considerable cuts to Medicaid, limiting enrollees to four prescriptions a month, imposing a copay on non-pregnant adults, and raising eligibility requirements to eliminate 25,000 adults

problems associated with Medicare and Medicaid, these two programs account for approximately fifty-five percent of care provided by hospitals.[27] Hospitals cannot refuse such a large revenue stream, and, therefore, must learn to operate with these new reimbursement policies.

Some healthcare policymakers worry that stringent reimbursement policies will lead to "cost-shifting."[28] Under this strategy, a hospital charges one payer more because it has received less from another.[29] In the context of Medicare and Medicaid, some policymakers argue that if public payers are less generous, then hospitals will raise prices for private payers.[30] If a hospital charges private payers a higher price to recover Medicare and Medicaid shortfalls, then, in turn, insurance premiums from private payers would rise more quickly.[31] This would increase the cost of healthcare and put strain on the healthcare industry.

Another concern about Medicaid reimbursement stems from the decision of the United States Supreme Court in *National Federation of Independent Businesses v. Sebelius*. In *Sebelius*, the court dealt with the constitutionality of the individual mandate, and the penalties that would be imposed on states that fail to expand Medicaid coverage; the Court upheld the constitutionality of the individual mandate because the mandate is essentially a tax, stating that "[t]he Federal Government has the power to impose a tax on those without health insurance.[32]

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from Medicaid. *Id.* At 1.

27. Rauscher & Wheeler, *supra* note 21, at 81.

28. Austin B. Frakt, *How Much do Hospitals Cost Shift? A Review of the Evidence*, 89 MILBANK Q. 90, 91 (2011). This study found that approximately twenty-one percent of Medicare and Medicaid shortfalls were cost-shifted to private payers between 1996 and 2000. *Id*. at 113.

29. *Id*.

30. *Id*. at 92.

31. *Id*.

32. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S.Ct. 2566, 2601 (2012).

The Court, however, found the imposition of penalties against states that failed to expand Medicaid was unconstitutional, stating "what Congress is not free to do is to penalize states that choose not to participate in that new program by taking away their existing Medicaid funding."[33] Therefore, the Court held that it was unconstitutional for the Secretary of the Department of Health and Human Services to have the ability to withdraw existing Medicaid funds for states that did not comply with Medicaid expansion.[34] Nonetheless, the Court held that the penalty sanction did not affect the constitutionality of the Medicaid expansion itself.[35] Thus, the state has the option to join and reap the benefits of such expansion. However, the government can withdraw funds provided to a state that chooses to participate in the Medicaid expansion, but fails to comply with the PPACA's requirements.[36]

The result in *Sebelius* may have a big impact on the financial stability of non-profit hospitals because it prompts concerns that some states will refuse to expand their Medicaid programs.[37] A portion of the 22.3 million people who are newly eligible for Medicaid under the PPACA's expansion could remain uninsured.[38] Additionally, these states would be unable to reap the benefits of accepting Medicaid expansion under the PPACA – namely that Medicaid expansion would be 100% federally funded for the first three

33. *Id.* at 2607.
34. *Id.*
35. *Id.*
36. *Id.*
37. As of December 12th, 2012, governors from 9 states (Alabama, Georgia, Louisiana, Maine, Mississippi, South Carolina, South Dakota, Oklahoma, and Texas) have expressly stated that they will not expand Medicaid in their state. *See Where each state stands on ACA's Medicaid expansion*, THE ADVISORY BOARD COMPANY, http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap (last updated Dec. 20, 2012).
38. *See* Kenney et al., *supra* note 4, at 1. Of the 22.3 million newly eligible individuals, 17.8 million would not be eligible for premium subsidies via insurance exchanged. *Id.*

years (2014-2016), and at least 90% federally funded after that.[39] Rejecting the expansion could mean less funding for Medicaid reimbursement to non-profit hospitals.

Non-profit hospitals that provide care for a disproportionate share[40] of Medicare and Medicaid beneficiaries will be at further financial risk because the PPACA will begin to remove Disproportionate Share Hospital (DSH) payments.[41] Charitable and safety-net hospitals have long provided uncompensated care to low-income and underserved individuals.[42] Medicaid DSH payments are the largest source of federal funding for such uncompensated care, totaling nearly $11.3 billion in 2011.[43] However, the PPACA will begin to reduce Medicaid DSH payments by $14.1 billion between the years 2014 to 2019.[44] Therefore, non-profit hospitals in states that do not expand Medicaid will see funding for uncompensated care fall, while likely seeing the amount of uninsured remain relatively stable.[45]

III. CONCERNS STEMMING FROM THE CHANGING REQUIREMENTS FOR FEDERAL TAX EXEMPT STATUS AND STATE RESTRICTIONS TO TAX EXEMPTIONS

In addition to these reimbursement issues, non-profit hospitals must also be concerned with maintaining their tax-exempt status. A non-profit

39. KAISER FAMILY FOUND., *supra* note 1, at 1.

40. Hospitals that qualify for Medicaid DSH payments must a Medicaid inpatient utilization rate one standard deviation above the mean, or have a low-income utilization rate higher than twenty-five percent. *See* COREY DAVIS, Q & A: DISPROPORTIONATE SHARE HOSPITAL PAYMENTS AND THE MEDICAID EXPANSION 2 (Nat'l Health Law Program, 2012), http://www.apha.org/NR/rdonlyres/328D24F3-9C75-4CC5-9494-7F1532EE828A/0/NHELP_DSH_QA_final.pdf. Hospitals that qualify for Medicare DSH payments must have a ration of low-income patients treated by the hospital exceeding fifteen percent. *See id*. 3.

41. *Id*. at 1.

42. *Id*.

43. *Id*. at 2.

44. *Id*. at 4. Medicare DSH payments will also be reduced by twenty-five percent from its base level beginning in 2014. *Id*. at 5.

45. *Id*. at 6.

hospital must meet the requirements of the Internal Revenue Code (IRC) Section 501(c)(3) in order to be granted an exemption from federal income taxes.[46] Section 501(c)(3) requires that a non-profit organization (1) serves a common good, (2) is not a for-profit entity, (3) had no net earnings benefitting the owners, and (4) does not exert a political influence.[47] The organization must be organized and operated exclusively for religious, charitable, scientific, or educational purposes.[48] The code does not define charitable for purposes of the tax exemption.[49]

With the growing concern that non-profit hospitals are providing insufficient benefits to their communities, the IRS and the PPACA have introduced new requirements. The PPACA introduces four new requirements: (1) a community health needs assessment, (2) a documented financial assistance policy, (3) no gross charges, and (4) no extraordinary billing and collection practices.[50] The PPACA also creates the new IRC section 501(r), which mandates tax-exempt hospitals to justify and document their community impact.[51] The new requirements indicate that the government is now concerned with non-profit hospitals preserving their end of the tax-exempt status bargain by providing adequate charity care.[52] Federal tax exemptions for non-profit hospitals result in billions of dollars saved.[53] With such considerable savings, meeting the requirements tax-

46. Smith & Noe, *supra* note 6, at 16. The Internal Revenue Service (IRS) is responsible for granting tax-exempt status from federal taxes to non-profit entities that meet the requirements in IRC § 501(c)(3). *Id*.

47. *Id.*

48. *Id.*

49. *Id.*

50. *Id*. at 18.

51. *Id*. at 17.

52. *See id.*

53. CONG. BUDGET OFFICE, *supra* note 12, at 3. In 2002, for example, the value of tax exemptions for non-profit hospitals totaled $12.6 billion. *Id*. Federal tax exemptions and state tax exemptions each compromised about half of this value. *Id.*

exempt status must be continuously scrutinized by hospital management.

Revenue Ruling 56-185 ruled that charity care is care for the sick, as well as providing care regardless of ability to pay.[54] Nonetheless, there is no mandate on a specific level or amount of charity care to be provided.[55] Thus, the standard for charity care for federal tax-exemption purposes is vague. State law, on the other hand, tends to be stricter, requiring specific amounts of charity care in order to qualify for state tax exemptions.[56] Even when specific amounts are not expressly required, the courts are free to interpret charity care law based on the common law. For example, the Supreme Court of Illinois affirmed the withdrawal of Provena Covenant Medical Center from state property tax exemption, resulting in a tax liability of $1.1 million dollars.[57] The court in this case held that charity care under Illinois law was defined as a gift to be applied for the benefit of an indefinite number of persons, for their general-welfare, or in some way reducing the burdens of government.[58] By this definition, Provena had only provided $831,724 in charity care, or only .723% of the hospital's revenue, which is far less than $1.1 million tax exemption.[59] Illinois law now provides that a non-profit must provide charity care that matches the amount granted on tax-exemption.[60]

The new requirements for tax exemption under the PPACA, as well as strict requirements in Illinois law, could leave non-profit hospitals incurring new tax liability that was previously exempted. These tax issues, taken

54. Smith & Noe, *supra* note 6, at 17. Revenue rulings provide guidance for complying with the internal revenue code. *See id*.
55. *Id.*
56. *Id.*
57. Provena, s*upra* note 22, at 1156.
58. *Id*. at 1145.
59. *Id*. at 1140.
60. 35 ILL. COMP. STAT. 105/3-8(b) (2012).

with reimbursement issues, raise financial concerns for the non-profit hospitals. However, these disruptions to the status quo will force non-profit hospitals to provide care efficiently, resulting in efficient and cost-effective non-profit hospitals.

IV. ROOM FOR HOPE: WHY HEALTHCARE REFORM DOES NOT HAVE TO STRAIN THE FINANCIAL FUTURE OF NON-PROFIT HOSPITALS

The new law is a radically different system with new payment methods and different incentives. Understandably, these organizations should be concerned about the new landscape of healthcare. Yet, since the PPACA became law, and on the eve of the implementation of the mandate and tax credits, there is information indicating that non-profit hospitals are adapting well.

A. Non-profit hospitals can adapt to the changing reimbursement methods and become more efficient

Many non-profits have feared that the lessening of Medicare and Medicaid reimbursements, due to budget cuts or losses from participating in shared savings programs, may cause too much financial strain. Yet, the reimbursement methods (or lack thereof) from government payers are not a death sentence with adequate planning and financial strategies.

Many studies have countered the conventional wisdom that a high Medicare and Medicaid payer mix undermines a hospital's ability to generate revenues. One study found that hospitals with high profit margin from private payers based on strong market power had weaker cost controls and higher cost per unit of service, which led to narrower margin on Medicare profits.[61] Moreover, hospitals with high financial pressure were

61. Jeffrey Stensland et al., *Private-Payer Profits Can Induce Negative Medicare Margins*, 29 HEALTH AFFAIRS 1045, 1048 (2010).

able to post a four percent Medicare margin due to the lower costs per case; this study ultimately suggests that high Medicare payer mix combined with low private payer mix can still result in profitable operations of a hospital.[62] Some of this margin may be due to payments to hospitals with a disproportionate share of Medicaid patients.[63] Nonetheless, a key reason for the difference in Medicare profits between hospitals is the difference in costs per case, as opposed to just reimbursement amount.[64]

Furthermore, some studies have failed to find evidence that government payers undermine a hospital's ability to generate and collect patient care revenue.[65] In fact, hospitals with higher Medicare and Medicaid payer mixes collected slightly higher average patient revenue.[66] One of the main reasons behind higher average patient revenue can be attributed to Medicare payments being collected at a faster rate than private payers.[67] For some hospitals, taking action to improve their revenue cycle by initiating a variety of organizational and managerial changes has resulted in higher patient revenue.[68]

History suggests that it is also unlikely that states will continue to opt out of the Medicaid expansion under the PPACA.[69] Over time, states have met new federal requirements to extend Medicaid, despite budget constraints.[70] In addition, several states have analyzed the potential impacts of opting out

62. *Id.* at 1049.
63. *Id.* at 1050.
64. *Id.*
65. Rauscher & Wheeler, *supra* note 21 at 82.
66. *Id.* at 91.
67. *Id.*
68. *Id.* at 92. Such managerial changes include requiring patients to pay up front for deductibles and copay and changing services to focus on more profitable procedures. *Id*. at 91-92.
69. *See* KAISER FAMILY FOUND., *supra* note 1, *passim*.
70. *Id*. at 2.

of the Medicaid program.[71] These states found significant coverage and fiscal impacts, including increased uncompensated care costs, revenue losses for providers and hospitals, cost-shifting to private insurers leading to higher premiums, and loss of federal revenues that support other state agencies, such as mental health departments.[72] These studies also mentioned broader economic impacts on jobs and businesses.[73] This, along with the near complete federal subsidy of Medicaid, should provide enough incentive for states to adopt the expansion.

Non-profit hospitals can also secure future financial success by joining or forming an Accountable Care Organization (ACO).[74] An ACO may consist of a group of physicians, one or more hospitals, and other providers that come together to provide coordinated care for Medicare beneficiaries.[75] The PPACA incentivizes the creation of ACOs through the creation of the Medicare shared savings program, in which a qualifying ACO is able to share from any savings that the ACO generates for Medicare.[76]

The shared savings program begins with first assigning a certain population of Medicare beneficiaries to an ACO.[77] At the beginning of the year, CMS calculates a benchmark dollar amount for the ACO based on the typical Part A and Part B expenditures fee-for-service expenditures of the assigned beneficiary population.[78]The ACO continues to file claims for reimbursement under a typical fee-for-service program throughout the

71. *Id.* at 4.
72. *Id.*
73. *Id*.
74. *See generally* AAFP, *supra* note 18.
75. *Id.* at 3.
76. *Id*. at 5.
77. *Id*.
78. *Id.* This, essentially, is what CMS expects to pay out in reimbursement in the upcoming year.

year.[79] If the ACO's expenditures fall below the benchmark amount, then Medicare has saved money, and the ACO may share a certain percentage of the savings.[80] This provides an opportunity for non-profit hospitals to increase their revenue.

ACOs provide an organizational structure in which non-profit hospitals can capitalize on savings via Medicare shared savings.[81] If non-profit hospitals join an ACO, these hospitals will share the financial risk of loss, but can also reap the benefits of being a part of a more integrated system that is thought to improve quality and slow spending growth.[82] The benefits from more coordinated care, and the shared savings that may result, helps secure financial stability in the future.

Non-profits can also take this ACO value-based methodology and apply it to private payer and Managed Care Organizations. Advocate Health Care of Illinois (Advocate) contracted with Blue Cross Blue Shield of Illinois using value-based payments and risk sharing.[83] Advocate's financial statement indicated that by March 2011, its cost-of-care increase was 6.1% lower than the control group.[84] This suggests that value-based payment methods helped lower costs, but also, and more importantly, increases the

79. *Id*.

80. *See id*. at 5-6. CMS calculates the expenditures of the beneficiaries as opposed to totaling the reimbursement claims from the ACO. *Id*. at 5. This means that the ACOs are responsible for all expenditures of the Medicare beneficiaries. Even if the assigned beneficiary receives care outside the ACO network, the expenditures still count toward the ACO benchmark. *See id*. If the amount exceeds the benchmark, the ACO will be responsible to pay a percentage of the losses. *See id*. at 6. This model holds these organizations accountable for their care by changing the typical fee-for-service model by including the risk/benefit of loss/gain.

81. *Id*. CMS also requires an ACO to create its own separate governance structure. *See id*. at 3-5.

82. *See* Elliott S. Fisher & Stephen M. Shortell, *Accountable Care Organization Accountable for What, to Whom, and How*, 304 J. AM. MED. ASS'N 1715, 1715 (2010).

83. KAUFMAN HALL, REPORT FROM THE FRONT: ADVOCATE'S EARLY RESULTS (2012), *available at* https://www.kaufmanhall.com/DocumentDetails.aspx?did=68a3942b-ccf6-4f86-b8a2-e497c25b0e64.

84. *Id*.

value of the care provided.

B. Tax-exempt status can still be maintained by non-profit hospitals

Another reason non-profit hospitals can remain financially profitable is due to maintaining tax-exempt status. Maintaining this status could easily be accomplished with proper management and planning. Although there are new requirements from the PPACA, meeting these requirements should not be difficult due to the lack of specificity regarding the charity care requirement.[85] Although the PPACA should decrease the pool of uninsured through the individual mandate, opportunities to provide charity care still exist because eight percent of the population will still lack meaningful coverage by 2019, amounting to an estimated $46.6 billion uncompensated care expenditure.[86] In addition, non-profits can also direct their charitable impulses by focusing on other methods of community benefits to secure their federal tax-exempt status.[87]

Non-profit hospitals in Illinois also have the opportunity to preserve their state tax-exemptions due to changes in Illinois law. The Illinois legislature addressed the strict standards set forth in *Provena* and responded by expanding the definition of charity care.[88] The legislature recognized that non-profits not only provide charity care, but also provide "substantial financial subsidization of the Illinois Medicaid program."[89] The broadened definition of charity care allows non-profit hospitals to include other forms

85. Smith & Noe, *supra* note 6, at 17.
86. Principe et al., *supra* note 10, at 233.
87. *Id.* at 234 (discussing how additional community benefits include: community health improvement, community building activities, community health operations, or subsidized health services).
88. 35 ILL. COMP. STAT. 105/3-8(b) (2012).
89. 35 ILL. COMP. STAT. 200/16-86(a)(4) (2012).

of services as charity care,[90] as opposed to simply "gifted care[91]," giving non-profits in Illinois more flexibility.

V. CONCLUSION

Even though healthcare reform will begin to grow beyond the walls of a hospital[92], there will still be a meaningful role for the non-profit hospitals because the "services available through community benefit programs are designed to respond to unmet public health needs[93]." Further, new value based payment methods have had a positive impact, as some studies have showed that hospitals that serve poor patients improved the quality of care after a pay-for-performance model was introduced.[94]

Changes caused by healthcare reform also stress the importance of sound financial strategies. The Moody's investor service suggests that hospitals should gain market share to create pricing leverage against private payers, integrate care by employing physicians to align incentives, and improve efficiency by creating a unified information technology platform to ensure that all hospitals, clinics, and physician offices are electronically connected.[95] These techniques can increase efficiency, and prepare non-profit hospitals for these new payment methods.[96] Financial and managerial ingenuity can help overcome the forthcoming challenges. This will create a

90. The definition now includes typical charity care, health services provided to underserved individuals, subsidy of state and local government, subsidies of state healthcare programs, and relief from any other burden related to healthcare. 35 ILL. COMP. STAT. 105/3-8(c) (2012).

91. *See* Provena, *supra* note 22, at 1145.

92. 35 ILL. COMP. STAT. 200/15-86(a)(3) (2012).

93. Principe et al., *supra* note 8, at 235 (quoting Julie Trocchio, *Does Cmty.-Oriented Mission Fit With Health Reform*, OCT.-SEPT. HEALTH PROGRESS, 11, 11 (2009)).

94. Ashish K. Jha et al., *The Effect of Financial Incentives on Hospitals that Serve Poor Patients*, 153 ANNALS OF INTERNAL MED. 299, 305 (2010).

95. MOODY'S, *supra* note 24, at 3, 4, 6.

96. *See id*. at 8.

more efficient healthcare system with stronger non-profit hospitals.

Moving towards universal coverage for healthcare is an expensive endeavor that will create challenges for providers to overcome. Federal and state budgets for Medicare and Medicaid will likely be tightened, and tax-exempt statuses will be scrutinized. The PPACA is a lengthy and complicated law that brings about a vast overhaul of the healthcare system in the United States. However, this does not create an impossible obstacle to achieving the goals of non-profit hospitals. When the initial obstacles are understood and defeated, a new and more efficient system will emerge. Non-profit hospitals that have quality management and the pulse on its community's necessities will be able to survive this transition and thrive in the future.