6-2015

Charity care and bad debt activities of tax-exempt critical access hospitals

John A. Gale MS
University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center

Jamar Croom MS
University of Southern Maine, Muskie School of Public Service

Zachariah T. Croll BA
University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center

Andrew F. Coburn PhD
University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center

A Performance Monitoring Resource for Critical Access Hospitals, States, and Communities

Flex Monitoring Team | University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine

Policy Brief #38

June 2015

Charity Care and Bad Debt Activities of Tax-Exempt Critical Access Hospitals

John A. Gale, MS, Jamar Croom, MS, Zachariah Croll, BA, Andrew F. Coburn, PhD
University of Southern Maine

INTRODUCTION

In response to concerns about hospital billing and charity care policies, the Internal Revenue Service (IRS) adopted the Catholic Health Association's community benefit guidelines for its 2007 revisions to Form 990, Schedule H used by tax-exempt (501(c)(3)) hospitals to report community benefit and related activities, including charity care and bad debt spending levels and associated policies.[1,2] To many policymakers, charity care activity remains a central component of hospital community benefit activity and an important part of the health care safety net.[3] Building on its 2007 revisions to Form 990, the IRS has issued final regulations implementing the Patient Protection and Affordable Care Act of 2010 (ACA) mandated changes to the IRS tax code requiring tax-exempt hospitals to (1) develop written financial assistance and emergency care policies for patients eligible for free or discounted care; (2) limit charges to patients who qualify for financial assistance to the amounts charged to insured patients; and (3) implement fair billing and debt collection practices.[4-7] The law also prohibits extraordinary billing and collection efforts unless reasonable efforts have been made to determine patient eligibility for financial assistance.[3,8-10] The underlying policy concerns are whether and to what extent tax-exempt hospitals, including Critical Access Hospitals (CAHs), are fulfilling their community and charitable obligations by providing care to the poor and underserved, as well as the extent to which their eligibility criteria and application processes may reduce access to charity care and financial assistance for their patients who might otherwise qualify for financial support.

Bad debt is different from charity and discounted care as it represents a "cost of doing business" arising from services provided to patients with the capacity to pay for those services but later refuse to do so.[11] Charity care results from services provided to patients with a demonstrated inability to pay for some or all of their care. Although conceptually different, charity care and bad debt, in practice, represent points on a continuum influenced by decisions involving the hospital's income eligibility criteria for charity care; the operation of screening programs to identify charity care-eligible patients; and the extent to which hospitals promote the availability of charity care to potentially eligible

Key Findings

Compared to other rural and urban hospitals, CAHs report:

- **Higher rates of uncompensated care (for which no payment is received);**
- **Lower rates of charity care;**
- **Higher rates of bad debt;**
- **A lower percentage of bad debt attributable to charity care eligible patients not recognized by charity care programs; and**
- **More restrictive charity and discounted care eligibility criteria.**

The challenge of disentangling charity care and bad debt makes it difficult to draw conclusions about the true extent of charity care provided by CAHs.

For more information on this study, please contact John Gale at jgale@usm.maine.edu

To view or download the full study, visit the Flex Monitoring Team website.

This study was conducted by the Flex Monitoring Team with funding from the Federal Office of Rural Health Policy (PHS Grant No. U27RH01080)

patients, implement more (or less) stringent application and income documentation requirements, and assess eligibility at different stages of the billing process.[12] The IRS recognized the complexity of qualifying patients for charity care in its revisions to Form 990, Schedule H.[2] In response to hospital advocates that called for the inclusion of bad debt as a community benefit, the IRS acknowledged that some portion of hospital bad debt was likely attributable to care provided to patients without an ability to pay (and not recognized by hospital charity care programs) but was unwilling to concede that all bad debt should be considered a community benefit. To collect data to support a decision on this issue, the IRS directs tax-exempt hospitals to report their bad debt in Schedule H, estimate the portion of their bad debt attributable to patients that might otherwise qualify for charity care but are not recognized by their charity care programs, and describe the methodology supporting their estimates.[12]

This brief compares the charity care and bad debt activity of CAHs with other (non-CAH) rural and urban hospitals as well as their charity care, billing, and collection policies. It discusses the implications of these policies on CAH charity care and bad debt levels and tax-exempt status. It concludes by identifying opportunities for state Flex Programs to develop technical assistance and program interventions to support CAHs in managing these important areas of hospital activity.

The findings of this study should not be construed to indicate that CAHs are not meeting their community benefit obligations or are not serving vulnerable low-income uninsured or underinsured populations. Rather, they suggest that some portion of the higher rates of bad debt incurred by CAHs would likely be more accurately classified as charity care if the strategies discussed later in this brief were more widely implemented. It is also important to acknowledge that CAHs are often the only source of health care in vulnerable rural communities and serve a crucial safety net role for the elderly, low-income, uninsured, and other underserved populations, many of whom may face financial and/or travel barriers that restrict their ability to seek care outside of their communities.

Relevance to the Flex Program

Understanding the role of CAHs in providing charity and discounted care to vulnerable populations and their related financial assistance policies can inform the development of technical assistance to help CAHs safeguard their tax-exempt status by: (1) creating balanced financial assistance, billing, and collections policies; (2) improving billing and collection performance; (3) using financial assistance programs to expand access to services for vulnerable populations; (4) reducing inappropriate bad debt write-offs; and (5) improving community benefit reporting.

METHODS

This study provides a baseline analysis of the charity care and bad debt activities of CAHs, pre-implementation of the ACA-mandated financial provisions described above. The study uses data from the tax year 2009 IRS Form 990: Return of Organizations Exempt from Income Tax, Schedule H compiled by the National Center for Charitable Statistics (with a tax year ending date in 2010). Our data include a total of 2,074 hospital records for tax-exempt 501(c)(3) hospitals filing for their hospitals alone (rather than as part of a consolidated system filing). This figure includes the full population of tax-exempt CAHs (529), other rural hospitals (361), and urban hospitals (1,184) that filed an individual Form 990 for tax year 2009. Form 990 data were linked to the 2010 American Hospital Association Annual Survey to identify CAHs and to the United States Department of Agriculture, Economic Research Service's 2010 Rural-Urban Continuum Codes to classify hospitals by urban and rural location. The findings of this study are applicable only to the population of tax-exempt 501(c)(3) hospitals that filed an individual IRS Form 990 (and not part of a consolidated filing for multiple hospitals in a system) for tax year 2009 and are not generalizable to publically-owned or proprietary hospitals.

FINDINGS

Total Uncompensated (ie., Combined Charity Care and Bad Debt) Levels

CAHs report higher levels of uncompensated care (i.e., combined charity care and bad debt) at 7.4 percent compared to other rural (5.9 percent) and urban (5.1 percent) hospitals (Table 1). In terms of the component parts of uncompensated care, CAHs provide less charity care than other rural and urban hospitals when measured as a percentage of total expenses (1.8 percent, 2.3 percent, and 2.3 percent respectively) and incur greater levels of bad debt (5.6 percent, 3.6 percent, and 2.8 percent respectively). Although charity care and bad debt are conceptually two different areas of hospital financial activity, these data indicate that CAHs provide a higher volume of services for which they are not being paid and suggest, as described in the following sections, that the allocation between the two is driven by each hospital's efforts to develop financial assistance policies that reflect their own balance between two potentially conflicting goals: 1) to ensure that all eligible individuals

are served and 2) to prevent any abuse of the system by those that have the resources to pay for their care.

Charity and Discounted Care Policies

CAHs are as likely as other rural and urban hospitals to have written charity care policies covering the provision of free care to eligible patients (Table 2). They are less likely, however, to provide free and discounted care to patients determined to be medically indigent. CAHs are also less likely to use the Federal Poverty Guidelines (FPGs) to determine eligibility for charity and discounted care and are more likely than other hospitals to adopt more restrictive charity and discounted care eligibility criteria using lower multiples of the FPGs to assess eligibility. For example, 43.5 percent of CAHs use 0 to 100 percent of FPGs to assess eligibility for charity care compared to 33.8 percent of other rural and 18.8 percent of urban hospitals (Figure 1). Similarly, CAHs tend to use more restrictive discounted care eligibility standards (in which a patient is expected to pay some portion of his/her balance) with two-thirds using 0 to 250 percent of FPGs to assess eligibility compared to 56 percent of other rural and 36 percent of urban hospitals (Figure 2). Consistent with their more restrictive eligibility policies, CAHs provide less charity care than other rural and urban hospitals when measured as a percentage of total expenses.

Bad Debt Levels and Collection Practices

CAHs are less likely to report bad debt expense in accordance with Healthcare Financial Management Association (HFMA) Statement 15 (the recognized standard for classifying and reporting charity care, other forms of uncompensated care, and bad debt) than other rural and urban hospitals (Table 3). CAHs and urban hospitals are slightly less likely than other rural hospitals to have written collection policies. CAHs are also somewhat less likely than other rural hospitals and far less likely than urban hospitals to have collection policies that contain provisions on collection practices for patients known to qualify for charity care or financial assistance. CAHs report greater levels of bad debt when measured as a percentage of total expenses than urban and other rural hospitals. In comparison to other rural and urban hospitals, CAHs also report that a lower percentage of their bad debt expenses are attributable to patients

Table 1. Combined Charity Care and Bad Debt Levels by Hospital Type

Indicator	CAH (n=529)	Other Rural (n=361)	Urban (n=1,184)
Combined uncompensated care (charity care and bad debt)			
Charity care as a percent of total expense	1.8%	2.3%	2.3%
Bad debt as a percent of total expense	5.6%	3.6%	2.8%
Combined uncompensated care as percent of total expense	7.4%	5.9%	5.1%

Source: IRS Form 990, Schedule H, Fiscal Years 2009

Table 2. Charity Care Policies and Spending Levels by Hospital Type

Indicator	CAH (n=529)	Other Rural (n=361)	Urban (n=1,184)
Charity Care at Cost			
Net charity care expense (mean)	$479.692	$1,899,423	$5,958,638
Percent of total expense	1.8%	2.3%	2.3%
Hospital Charity and Discounted Care Policies			
Has a written charity care policy	99.1%	99.7%	97.7%
Uses federal poverty guidelines to determine eligibility for charity care	89.3%	95.0%	96.6%
Uses federal poverty guidelines to determine eligibility for discounted care	83.9%	85.7%	90.3%
Provides free or discounted care to the "medically indigent"	87.6%	90.0%	94.7%

Source: IRS Form 990, Schedule H, Fiscal Years 2009

that would likely to qualify for charity care under the hospital's eligibility criteria but, for various reasons, are not recognized by the hospital's charity care program either at the initiation of care or at various stages of the billing process.

Relationship between Charity Care and Bad Debt Spending Levels

Several interrelated factors likely contribute to the lower rates of charity and discounted care and the higher rates of bad debt reported by CAHs, including more restrictive eligibility requirements implemented by CAHs and the lower likelihood of CAHs providing free and/or discounted care to medically indigent patients. Although we could not analyze the following issues using the Form 990 data, prior studies have identified other factors that influence charity care and bad debt levels including the complexity of the charity care application process, the level of documentation required to "prove" eligibility, and the extent to which hospitals actively and publicly promote the availability of charity and financial assistance.[3] Higher bad debt rates may be attributable, in part, to the lower implementation rate of policies that adjust collection practices for patients known to qualify for financial assistance; lower adoption rates by CAHs of industry recommendations related to financial assistance and billing policies; and less sophisticated financial assistance, billing, and collection systems. In addition, the higher rates of uninsurance, underinsurance, and poverty present in rural areas must be explored as contributing factors to higher rates of bad debt experienced by CAHs. Finally, higher bad debt rates for at least some hospitals may be influenced by revenue cycle management deficiencies.

The extent to which hospitals adopt more or less inclusive approaches to charity care and financial assistance has a direct impact on the amount of charity care provided and bad debt incurred. Hospitals that implement more restrictive eligibility criteria and/or more demanding income/asset evidence requirements during the application process are likely to exclude more low income individuals from their charity care programs. As a result, they are likely to provide lower levels of charity care and incur higher levels of bad debt. Conversely, those that implement less restrictive eligibility criteria and/or less onerous application processes are likely to provide greater levels of charity care and incur lower levels of bad debt.

Table 3. Bad Debt Expense and Collection Practices by Hospital Type

Indicator	CAH (n=529)	Other Rural (n=361)	Urban (n=1,184)
Bad Debt Expense			
Reports bad debt expense in accordance with HFMA Statement No. 15	54.6%	60.5%	64.6%
Bad debt expense (mean)	$1,330,097	$3,078,550	$6,294,845
Bad debt as percent of total expense	5.6%	3.6%	2.8%
Bad debt attributable to charity care (mean)	$139,662	$540,708	$1,177,497
Percentage of bad debt expense estimated to be attributable to charity care	10.5%	17.6%	18.7%
Collection Practices			
Has written debt collection policy	94.8%	96.9%	94.8%
Collection policy contains provisions on collection practices for patients known to qualify for charity care or financial assistance	78.5%	81.9%	91.4%

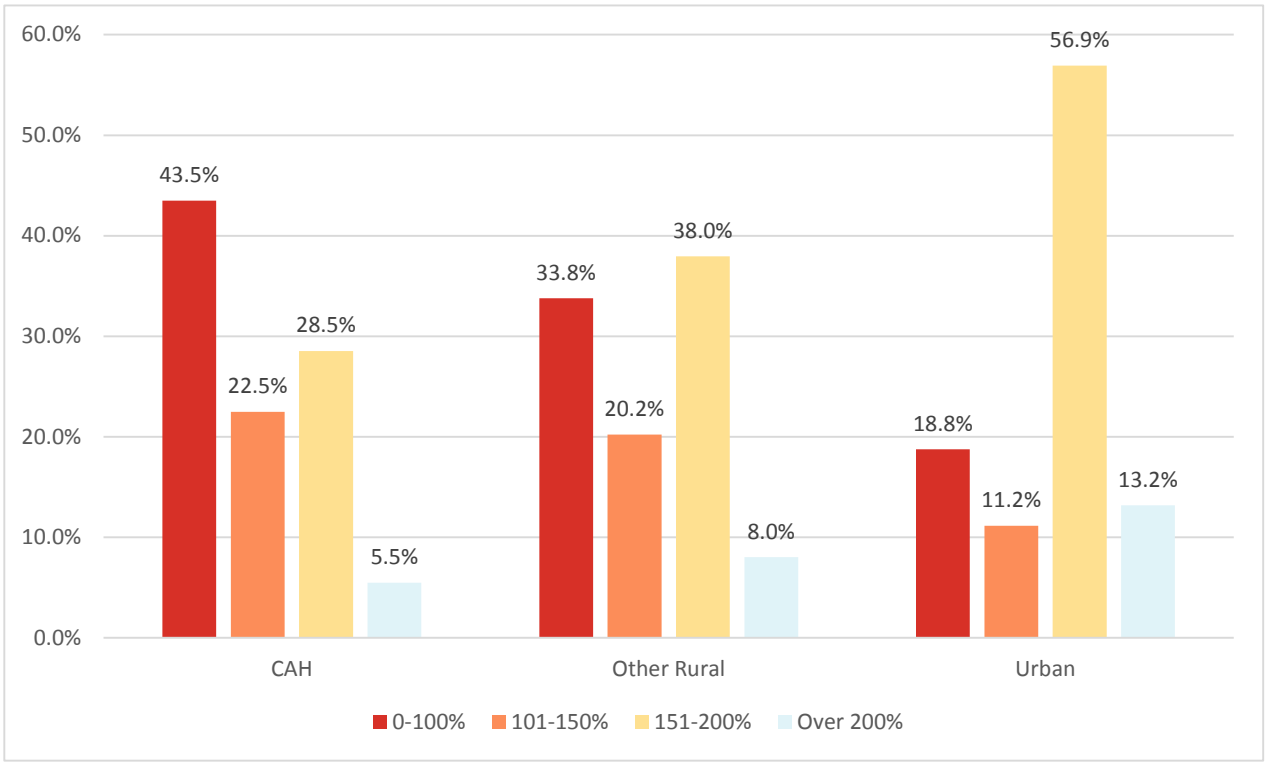
Source: IRS Form 990, Schedule H, Fiscal Years 2009

DISCUSSION

The results of this study indicate that, compared with other rural and urban hospitals, CAHs reported higher levels of care for which they do not receive payment (i.e., greater rates of uncompensated care which includes both charity care and bad debt), lower levels of charity care and discounted care, and higher levels of bad debt. In terms of the allocation between charity care and bad debt, CAHs report lower levels of charity and discounted care and higher rates of bad debt. Compared to other hospitals, CAHs also reported that a smaller percentage of their bad debt expenses are attributable to services provided to individuals who would otherwise qualify for charity care but are not recognized by hospital charity care programs.

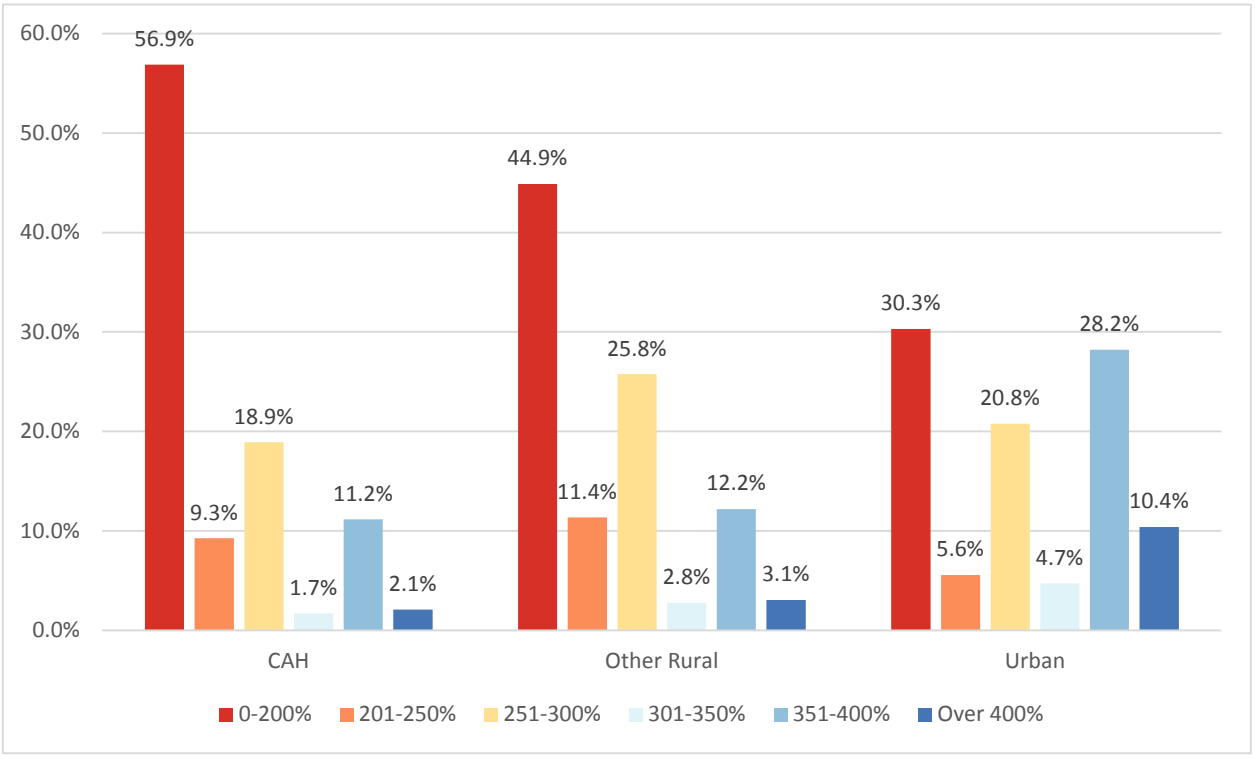
The lower charity care and higher bad debt levels reported by CAHs do not mean that CAHs are not serving their tax-exempt missions. CAHs, many which continue to struggle financially,[13] are often the only source of health

Figure 1. Variations in Hospital Use of Federal Poverty Guidelines for Charity Care Eligibility



Source: IRS Form 990, Schedule H, Fiscal Years 2009-2010

Figure 2. Variations in Hospital Use of Federal Poverty Guidelines to Assess Discounted Care Eligibility



Source: IRS Form 990, Schedule H, Fiscal Years 2009-2010

care in vulnerable rural communities, serving a crucial safety net role for the elderly, low-income, uninsured, and other underserved populations, many of whom face financial and/or travel barriers that restrict their ability to seek care outside of their communities. Rather, they suggest that some portion of the higher rates of bad debt incurred by CAHs would likely be more accurately classified as charity care if the strategies for managing charity care and bad debt discussed in following sections (Figures 3 and 4) were more widely implemented. CAHs report more restrictive eligibility criteria for patients to access charity care, which likely increases the level of bad debt incurred, especially for patients just over the eligibility criteria. As a result, it is hard to determine the extent to which CAHs are serving vulnerable individuals who legitimately cannot afford to pay for care. To do so, we need to understand the extent to which CAHs' more restrictive eligibility criteria are reflective of the economic realities of their communities as well as the context in which decisions regarding their eligibility criteria were made. We also need to understand whether or not charity or discounted care application processes may deter eligible individuals from applying for charity care and the extent to which services provided to these individuals end up being written off as bad debt.

In light of increased federal and state scrutiny, hospital boards and management need to carefully examine decisions they have made regarding charity care, discounted care, and bad debt policies and programs to more accurately and strategically capture, classify, and manage charity care and bad debt. Hospital boards and administrators must find the balance, on the one hand, between adopting financial assistance policies that reflect the economic realities of their communities and distinguish those patients who legitimately cannot pay their bills and, on the other, fulfilling their fiduciary obligation to ensure that those who can pay for services do so. This is no simple task as it requires careful and honest consideration of the economic conditions of the community, the needs of the residents of a hospital's service area, the availability of other safety net services, the effectiveness of the hospital's billing and revenue management systems, and how well the hospital is currently serving the needs of uninsured and low-income residents.

Technical Assistance Needs and Opportunities

Study findings suggest that CAHs may have somewhat greater difficulty than other hospitals meeting the ACA-mandated changes to the IRS tax code related to financial assistance and billing policies. They also suggest opportunities to assist CAHs in developing and implementing balanced financial assistance policies; improving billing, collection, and revenue cycle management systems; using financial assistance programs to enhance access to care for vulnerable populations; enhancing community benefit strategies; and improving operational performance.

Revenue Cycle Management: First and foremost, CAHs may need support to develop a unified approach to revenue cycle management and their charity care, financial assistance, and collection policies. This involves analyzing charity care and bad debt expenditures to understand what types of patients are represented in these categories, the services used, their eligibility issues, the reasons for and timing of classification of patient obligations as bad debt, and the economic context of the hospital service area. CAHs can use the results of this analysis to revise their financial assistance, billing, and collection policies using the strategies described in Figure 3. Doing so will support their efforts to better respond to the needs and economic situations of their communities and patient populations, better manage their charity care and community benefit obligations as tax-exempt organizations, improve revenue cycle management, and ensure compliance with the ACA-mandated revisions to IRS tax code.

Billing and Debt Collection: Little is known about the extent to which CAHs have implemented fair billing and debt collection practices, although their higher rates of bad debt expense suggest that CAHs may perform less well in this regard. We also do not know the extent to which CAHs make reasonable efforts to determine eligibility for financial assistance before engaging in "extraordinary collection policies." Given the potential challenges to the tax-exempt status of 501(c)(3) CAHs for failure to comply with these financial provisions, this is an important and often overlooked area of technical assistance needed by CAHs and an opportunity for state Flex programs to further support the hospitals in their states. Similarly, little is known about the extent to which CAHs have implemented written charity care/financial assistance policies that are sufficiently robust to meet the expectations of the IRS guidelines. For example, are their eligibility criteria clearly defined? Do their policies describe how amounts charged to patients are calculated, clearly explain the charity care application process, and specify collection policies for nonpayment? Do they widely publicize the availability of financial assistance and post their policies and applications to their websites?

Responding to Needs of Vulnerable Populations: As CAHs revise their hospital charity and discounted care policies, they may need assistance to respond to the needs

Figure 3. Strategies to Revise Hospital Charity Care and Bad Debt Policies (Based on the Analysis of Patients Represented in Hospital Bad Debt Category)

Patients with incomes at or near the hospital's eligibility criteria:

- Revise financial assistance policies to reflect the economic status of their patient populations and expand eligibility.

Low-income patients that otherwise qualify for charity/discounted care:

- Revise application process;
- Simplify eligibility documentation;
- Promote awareness of the hospital's financial assistance program; and
- Improve screening programs to identify patients eligible for public insurance coverage options or the hospital's financial assistance program.

Low-income patients (working poor) with high out-of-pocket cost health plans:

- Improve screening process to identify these individuals at the outset of care, and
- Revise billing systems to capture and manage charity care charges at different stages of the billing process.

of vulnerable patients and populations. The circumstances that lead patients to seek charity or discounted services are often complicated and typically involve problems of poverty, literacy, and other challenges. For patients who are functionally illiterate, for example, completing an application for charity care can be an issue. Undocumented immigrants may face cultural, language, and social barriers to obtaining care and may be unwilling to seek care for fear of deportation or legal exposure. Moreover, many charity care and discounted care patients may be episodic users of the health system, lacking access to primary care. Ideally, hospital financial assistance programs will encourage appropriate utilization of services and early intervention in health problems to avoid unnecessary utilization of high cost services. The use of charity care and financial assistance policies to expand access to care for vulnerable populations (as part of a population health focus), rather than as a reactive approach to dealing with charges after a health care encounter, provides an opportunity for hospitals to better serve undocumented immigrants and other vulnerable populations. Figure 4 discusses strategies that can be used to improve the efficiency and effectiveness of hospital charity care programs, improve access to care by reducing financial and administrative barriers, and reduce unnecessary utilization of charity care and discounted services.

Conclusion

Although efforts to better distinguish charity care from bad debt will not directly improve a hospital's cash flow or bottom line, there are other substantial incentives for a hospital to do so including maximizing the levels of charity care and community benefits reported, better serving vulnerable populations, and supporting its tax-exempt status. This last issue is particularly important two reasons. The first is the IRS's mandate to conduct triennial reviews of each tax-exempt hospital's community benefit activity and to prepare reports for Congress on the charity care, bad debt, and uncompensated care activities of all hospitals. The second is the growing concern of state and local policymakers with the impact of hospital tax exemptions on income, sales, and property taxes in light of well publicized budget crises.

Charity care and financial assistance programs will remain an important obligation of tax-exempt hospitals for the foreseeable future. Although the expansion of health insurance coverage under the ACA may reduce the demand for charity care and financial assistance, it will not eliminate the demand as an estimated 20 million or more people will remain uninsured after full implementation of the ACA's coverage.[14,15] At the same time, the challenge of serving the working poor with high out-of-pocket plans (i.e., the underinsured) will continue, particularly in states where coverage options are more limited due to state decisions not to expand Medicaid. Although low-income individuals in non-Medicaid expansion states may have access to private coverage that will pay a portion of their bills, they are likely to still need financial assistance with their out-of-pocket obligations.

CAHs, like all tax-exempt hospitals, face significant challenges managing their community benefit programs including changing charity care demands; new IRS financial provisions on hospital financial assistance policies, charge structures, and billing and collection activities; and ongoing national and state scrutiny of hospital tax-exempt status. The implementation of the

Figure 4. Strategies to Manage Hospital Charity Care and Improve Access to Primary Care and Prevention Services

Revise charity care and financial assistance policies to reduce financial barriers to care for vulnerable patients, and Revise patient assistance programs to:

- Ensure patient access to public insurance coverage options;
- Provide culturally and linguistically-sensitive assistance with charity care applications; and
- Improve awareness of financial assistance programs among vulnerable populations.

Adopt population health strategies to better serve vulnerable patients, encourage early intervention in health problems, and reduce unnecessary utilization of use of high cost inpatient and emergency department services by:

- Expanding access to culturally sensitive primary care and other essential services;
- Developing care management programs;
- Providing preventive and chronic care services; and
- Developing programs to overcome travel barriers.

IRS tax code provisions for tax-exempt hospitals creates an imperative for CAHs and other non-profit hospitals to carefully evaluate and revise hospital financial assistance policies and programs to ensure they adequately address the needs of the low-income, uninsured and underinsured populations in our evolving health care environment. This imperative provides an opportunity for state Flex programs to assist CAHs in meeting the many requirements of IRS tax code and in better serving their communities.

REFERENCES

1. Catholic Health Association of the United States. *IRS Form 990*. n.d. Available at: http://www.chausa.org/communitybenefit/irs-form-990. Accessed May 30, 2014.
2. Lunder E, Liu EC. *Tax-Exempt Section 501(C)(3) Hospitals: Community Benefit Standard and Schedule H*. 2008, July 31. Available at: http://congressionalresearch.com/RL34605/document.php?study=Tax-Exempt+Section+501%28c%29%283%29+Hospitals+Community+Benefit+Standard+and+Schedule+H. Accessed May 30, 2014.
3. Pryor C, Rukavian M, Hoffman A, Lee A. *Best Kept Secrets: Are Non-Profit Hospitals Informing Patients About Charity Care Programs*? Boston, MA: The Access Project and Community Catalyst;2010.
4. *Patient Protection and Affordable Care Act*. 2010. Available at: http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf. Accessed March 5, 2013.
5. Federal Register. *Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return*. 2014, December 31. Available at: https://www.federalregister.gov/articles/2014/12/31/2014-30525/additional-requirements-for-charitable-hospitals-community-health-needs-assessments-for-charitable. Accessed April 7, 2015.

6. Internal Revenue Service. *New Requirements for 501(C)(3) Hospitals under the Affordable Care Act*. 2014, March 4. Available at: http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501%28c%29%283%29-Hospitals-Under-the-Affordable-Care-Act. Accessed May 30, 2014.
7. National Health Policy Forum. *Can I Get a Break? Hospital Financial Assistance, Billing, and Debt Collection*. Washington, DC: National Health Policy Forum; April 26, 2013. Forum Session.
8. Brill S. Bitter Pill: How Outrageous Prices and Egregious Profits Are Destroying Our Health Care. *Time Magazine*. March 13 2013;181(8):16-55.
9. Marietta CS. *PPACA's Additional Requirements Imposed on Tax-Exempt Hospitals Will Increase Transparency and Accountability on Fulfilling Charitable Missions* Houston, TX: University of Houston Law Center, Health Law and Policy Institute, Health Law Perspectives;2010.
10. Pryor C. The Hospital Billing and Collection Flap: It's Not Over Yet. *J Healthcare Compliance*. May 30 2005;online.
11. Healthcare Financial Management Association. *Valuation and Financial Statement Presentation of Charity Service and Bad Debts by Institutional Healthcare Providers*. Washington, DC: HFMA; December, 2012. Principles and Practice Board Statement 15.
12. Gale J, Croom J, Croll ZT, Coburn A. *Charity Care and Uncompensated Care Activities of Tax-Exempt Critical Access Hospitals*. Portland, ME: University of Southern Maine, Flex Monitoring Team; June, 2015. Briefing Paper No. 35.
13. Holmes GM, Pink GH, Friedman SA. The Financial Performance of Rural Hospitals and Implications for Elimination of the Critical Access Hospital Program. *J Rural Health*. 2013;29(2):140-149.
14. Berg JW. What Is Left of Charity Care after Health Reform? *Hastings Cent Rep*. 2010;40(4):12-13.
15. Kaiser Permanente Institute for Health Policy. *The Implications of Health Reform for U.S. Charity Care Programs: Policy Considerations*. Oakland, CA: Kaiser Permanete; Summer, 2010. In Focus, No. 7.

This study was supported by the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) under grant # U27RH01080.

The information, conclusions and opinions expressed in this policy brief are those of the authors and no endorsement by FORHP, HRSA, or HHS is intended or should be inferred.