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## **CAPITAL REGION MEDICAL CENTER ADMINISTRATIVE POLICY MANUAL**

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**TITLE:** Hospital Financial Assistance Program (Charity)

**ARTICLE:**

**SECTION:**

**NUMBER:**

**SUBJECT:** Director of Hospital Revenue Cycle

**DATE:**

**SUPERSEDES:** Policy No.

**Dated:**

**REVIEWED:**

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**PURPOSE:**

This policy serves to establish and ensure a fair and consistent method for the review and completion of requests for charitable medical care to Capital Region Medical Center (CRMC) patients in need.

**Note:** See separate policy for Clinic Financial Assistance Program (Charity).

**POLICY:**

CRMC may offer financial assistance (urgent or emergent) to patients who are unable to pay their medical bills due to difficult financial situations. A CRMC designated patient financial services representative with authority to offer financial assistance will review individual cases and make a determination of financial assistance that may be offered.

**Excluded services are:**

- *cosmetic*
- emergency room physicians
- *home health*
- *home medical equipment services*
- non-emergent/non-urgent as determined by the physician

CRMC determines the need for financial assistance by reviewing the particular services requested or received insurance coverage or other sources of payment, a person's historical financial profile and current financial situation. This method allows for a fair and accurate way to assist patients who are experiencing financial hardship. Partial and/or full charity care will be granted based on the individual's ability to pay the bill.

Eligible individuals include patients who do not have insurance and patients who have insurance but are underinsured. Patients must cooperate with any insurance claim submission and exhaust their insurance or potential insurance coverage, including any potential reimbursement from a lawsuit or lien before becoming eligible for financial assistance. Other factors affecting eligibility are as follows:

- **Service Area** – In keeping with effective stewardship, CRMC will limit our financial assistance program to those who are residents of our nine (9) service counties: Callaway, Cole, Moniteau, Maries, Miller, Osage, Boone, Morgan and Gasconade.
- **Income** – Assuming that other financial resources are not identified as viable funding sources, eligibility care will be determined based on Compliance, Safety, Accountability (CSA) Poverty guidelines in conjunction with other available resources. Federal Poverty Income Guidelines will be used in determining the amount of write-off. The Poverty Guidelines are updated annually each February.
- **Evaluation of Assets** – The patient's household savings, checking, investment assets, real property assets, and overall financial position will be considered.

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- **Evaluation of the Patient's Monthly Expenses** – Review of living expenses includes medical expenses, and other basic needs.
- **Nature of the Medical Condition or Care Required** – Consideration of services unique to CRMC versus potential of local facilities providing care.
- **Considerations:**
  - ♦ Any special circumstances that the patient would like CRMC to consider.
  - ♦ Eligibility is contingent upon patient cooperation with the application process, including Medicaid or Medical Assistance application completion where applicable, and submission of all information that CRMC deems necessary in order to determine the level of any financial assistance that may be considered, including written permission for CRMC to check consumer credit information.

**REGULATORY COMPLIANCE:**

If any portion of this policy conflicts with federal, state or local laws or regulations, the laws and regulations take precedence. This policy will be reviewed annually for compliance and applicable laws and regulations and revised as appropriate.

**DEFINITION:**

CRMC defines indigent (charity) care as medical care rendered to the low income due to personal lack of finances or catastrophic health care requirements which preclude the ability of the individual to pay the rendered services, regardless of income bracket.

**Catastrophic medical costs** are that portion of the patient's unpaid and outstanding medical bills in excess of what the patient or responsible guarantor can afford to pay in installments within four (4) years. In determining the amount a person can afford to pay, the assets, liabilities and monthly income of the household after the deduction of reasonable living expenses should be considered.

**Family Unit** is a group of people living together that a member identifies as a family unit, and for which one or more persons in the family unit have the legal responsibility or have voluntarily accepted the economic responsibility for providing the necessities of life for the members. Only those persons for whom financial information is provided (i.e. claimed on taxes) will be considered in determining the size of the family unit for purposes of determining eligibility for charity care in accordance with this policy.

**Resident of the United States** is anyone who **lives** in the United States, regardless of documented status.

**Traditional charity care** is defined as free or discounted health care services provided to persons who cannot afford to pay all or a portion of their financial liability for services. It is that portion of the patient's financial responsibility remaining after all third-party payments have been made to the provider for health care services provided to persons who have clearly demonstrated an inability to pay. Charity care also includes non-covered services for public aid programs (Medicaid/Medicaid out of state and other programs for the indigent).

**Traditional Charity care does not include:**

- Charges disallowed through utilization review or denials.
- Any contractual allowances.
- Write-off of amounts due from third-party payers for any reason.
- Write-off of patient balances when there is not an indication that the patient is unable to pay.
- Other write-offs not related to the patient's ability to pay.
- Non-covered Medicare services when there is not an indication that the patient is unable to pay.

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- The shortfall between reimbursements from governmental programs for the poor or indigent (Medicaid) and the cost of the services provided. This amount will be disclosed separately in the Community Benefit Report, but is not included in the cost of traditional charity care.
- Supplies and equipment for home use.
- Clinic physician services.
- Emergency Room Physicians, Pathology, radiology pro-fees and anesthesiology services as they are billed separately through other providers.
- Cosmetic or elective services not considered medically urgent or emergent.

### **STANDARDS AND GUIDELINES OF CHARITY AND COLLECTIONS:**

The terms “charity care” and “financial assistance:” are used interchangeably throughout this document. CRMC has developed guidelines with terminology to reduce any stigma attached to the term “charity” and thereby, reach those individual patients who meet CRMC’s eligibility criteria for free or reduced-fee services.

It is important to distinguish between charity care (i.e. care provided to patients without expectation of payment for those services) and waivers of patient co-payment obligations for patients who have a third-party payment source such as Medicare, insurance or Managed Care. If there is a third-party payer source, CRMC is expected to bill full charges and collect the appropriate reimbursement from the third-party payer for the services rendered. CRMC may waive patient co-payment obligations, upon determination in accordance with the charity standards and guidelines verifying the patient are unable to pay that co-payment with completion of application for assistance.

### **IDENTIFYING PATIENTS UNABLE TO PAY FOR NEEDED SERVICES:**

- CRMC will treat any patient seeking urgent or emergent care regardless of the patient’s ability to pay for the care. CRMC will operate in accordance with all federal and state requirements for the provision of health care services, including screening and transfer requirements under the Federal Emergency Medical Treatment and Active Labor Act (EMTALA).
- Patients who qualify for charity care will be identified as soon as possible, either before the services are provided or after an individual has received services to stabilize their medical condition. If difficult to determine a patient’s eligibility for charity care prior to providing the service, the determination should be made as soon as possible after the provision of the service. Upon registration, patients without Medicare/Medicaid, adequate health insurance or other local health care financial assistance will receive either (1) a packet of information that addresses the financial assistance policy and procedures or (2) immediate financial counseling assistance from staff within established business hours. The packet of information will clearly indicate that CRMC provides care, without regard to ability to pay, to individuals with limited financial resources and explain how patients apply for financial assistance or (3) patients can obtain a charity care application by downloading and printing the application form on the CRMC website ([www.CRMC.org](http://www.CRMC.org)).
- CRMC provides a variety of services ranging from emergency services to inpatient and outpatient elective surgery, diagnostic testing and educational programs. Charity care policies and procedures are in place to address any instances in which patients may access services.
- CRMC has financial assistance signage in place advising patients of the service available.
- CRMC statements provide language referencing financial assistance and a number to call.

### **PROVIDING ASSISTANCE TO PATIENTS:**

Authorizations for charity care write-off amounts are restricted to Patient Financial Services staff and Directors based on levels and Administrative Council. Approval limits are set by the Vice President-Finance. An established assessment methodology is applied consistently which considers income, family size, available resources and likelihood of future earnings, net of living expenses, sufficient to pay for the healthcare services provided.

- All available financial resources will be evaluated before determining financial assistance eligibility. CRMC will consider financial resources not only of the patient but also of other persons having legal responsibility to provide for the patient, such as parent of a minor child or a patient’s spouse.

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- Eligibility care will be determined based on CSA Poverty guidelines in conjunction with other available resources. Once approved, applications will be reviewed every six (6) months. CRMC bases income and family size (for purposes of qualifying charity care) on the Federal poverty guidelines as published by the U.S. Department of Health and Human Services. The department of Health and Human Services publishes updates to the Federal poverty guidelines on its website:

A patient's income and family size must be at or below **200%** of the Federal poverty guidelines to receive 100% charity care.

- Some persons may exceed the poverty guidelines but may still be eligible for charity when additional criteria are considered such as catastrophic medical costs, etc. Other obligations should be evaluated to determine if they are basic needs or luxury items. CRMC reserves the right to adjust monthly living expenses to reasonableness.
- The above guidelines are set forth in establishing charity care. These guidelines may be waived at any time by the CRMC Board of Directors. CRMC reserves the right to approve or deny an application received at our discretion.
- Individuals should **not be** required to complete charity application, additional forms or provide additional information if:
  - ♦ Medicaid pending applications that are not subsequently approved provided that the application indicates that the patient meets the criteria for charity care.
  - ♦ Patients or guarantors who have declared bankruptcy.
  - ♦ Patients or guarantors who are deceased with no estate in probate that no one else (such as spouse or legal guardian) is legally responsible for the liability.
  - ♦ Patients or guarantors determined to be homeless.
  - ♦ Patients of Capital Region Resident Clinic and Community Health Services.
  - ♦ Mentally incapacitated.
  - ♦ Incarcerated prisoners not expected to be released soon.
  - ♦ Low income/subsidized housing (Section 8) provided as a valid address.
  - ♦ Eligibility for other state or local assistance programs that are unfunded (i.e. Medicaid Spend-down).
- While charity applications are not required on the application exceptions listed above, discretion should be used to ensure that people classified for charity do meet the requirements of impoverished when reporting the services as charity.

**PRESUMPTIVE CHARITY**

CRMC will use Presumptive Charity software (PARO) to score potential accounts meeting the charity guideline. The PARO predictive model is calibrated to CRMC historical approvals for one or more fiscal years. This analysis and calibration ensures that the charity policy responds to regional economic conditions for the markets served.

**PARO SCORE:** The PARO charity predictive model provides a numerical score that defines the likely socio-economic conditions for the patient. This score is based on public record data for the consumer.

- CRMC patients must have a PARO score of less than or equal to 242% of the Federal poverty level.

**ESTIMATED HOUSHOLD INCOME INDEX:** This is an estimate of patient household income as a percentage of the Household Income Index (HHI) as defined by Health and Human Services (HHS). The estimates from household income and for household size are derived from public record data. The percentage of HHI was adjusted to take into account local cost of living and historical charity approvals. The patient must have an estimated HHI of less than or equal to the threshold of **242**. ***Any account exceeding the threshold will be offered an in-house six (6) month payment plan or referred to a bank loan program.***

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The Federal Poverty Level is used to estimate household income and family size identified by the Presumptive Charity software product in lieu of a completed application. Each patients account will proceed through the normal collection process up to and including a Final Notice letter. Prior to referral to the collection agency, CRMC will batch each account and process through the software to identify potential accounts meeting the established guidelines for charity. These accounts will then be processed for adjustment to 100% of the charity discount and not forwarded to the collection agency. If the account is balance after insurance they will not qualify for automatic charity as per our insurance contracts we are to collect these balances from the patient.

- If patient/guarantor does not meet their obligation after receiving charity care discount and are financially responsible for a portion of the charges the account will then follow the credit policies of the hospital. These policies may include collection activity up to and including placement to a collection agency, reporting on the credit bureau and filing of lawsuits.
  
- All information obtained from patients and family members will be treated as confidential. Financial applications will provide documentation of all income sources on a monthly and annual basis (taking into consideration seasonal employment and temporary increases, and or decreases in income) for the guarantor including the following:
  - ◆ Savings
  - ◆ Investments
  - ◆ Credit Availability
  - ◆ Other family members
  - ◆ Income from Wages
  - ◆ Income from self-employment
  - ◆ Alimony
  - ◆ Public Assistance
  - ◆ Social Security
  - ◆ Strike Benefits
  - ◆ Unemployment Compensation
  - ◆ Workers Compensation
  - ◆ Veteran Benefits
  - ◆ Pension
  - ◆ Child Support
  - ◆ Military family allotments
  - ◆ Other sources, such as income from dividends, interest or rental property
  - ◆ Other assets, including the ability to borrow on insurance or property
  - ◆ Potential change(s) in financial capability in the near future.
  
- In order to evaluate and process the application for assistance the guarantor/obligator will need to provide:
  - ◆ Most recently filed federal income tax form
  - ◆ Copies of current paycheck stubs
  - ◆ W2's
  - ◆ Social Security Checks
  - ◆ Bank StatementsIn addition the following items **may be** requested:
  - ◆ Copies of rental or mortgage payments
  - ◆ Copies of Utilities
  - ◆ Car payments
  - ◆ Medical bills
  - ◆ Copies of insurance policies/premiums
  - ◆ Savings, certificates of deposit, money market or credit union accounts
  - ◆ Descriptions of owned property

In situations where patients have other assets, liquid assets are defined as investments that could be converted into cash within one year; these will be evaluated as cash available to meet living expenses.

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Assets that **may not be** considered in determining the ability to pay include:

- ♦ The primary residence and home furnishings of the patient or guarantor
  - ♦ One personal automobile per spouse
  - ♦ Any vehicle or other property required in business or occupation of the patient or member of the family unit
  - ♦ Clothing, heirlooms, personal jewelry and other property held primarily for personal use
- In evaluating the financial ability of a guarantor to pay for health care services, questions may arise as to the guarantor's legal responsibility for purported dependents. While legal responsibility for another person is a question of state law (and may be subject to Medicaid restrictions), the guarantor's most recently filed federal income tax form may be relied upon to determine whether an individual should be considered a dependent.

**REASONS FOR DENIAL:**

- Sufficient Income.
- Sufficient asset level.
- Patient is uncooperative or unresponsive despite reasonable efforts to work with the patient and after determining their financial status does not meet charity guidelines.
- Incomplete Charity Care Application despite reasonable efforts to work with the patient.
- Withholding insurance payment and/or insurance settlement funds, including insurance payments sent to the patient to cover services provided by CRMC, and personal injury and/or accident related claims.
- Patient is uncooperative in applying with Human Arc for Medicaid Assistance unless against religious beliefs.
- Patient's accounts are already at a collection agency after the required 240 day timeframe from the 1<sup>st</sup> notice of patient liability or potential suit pending.

**CRMC PROCEDURE:**

- Uninsured (Self Pay) patients will automatically receive a 65% discount on billed charges. This discount is based on the IRS 501R calculation of Medicare fee for service and all private health insurers that pay claims to the hospital or facility. Discount will not be given if the facility finds that there are other funds (i.e. lien or lawsuit) pending. Hospital will reverse discount as all claims need to be exhausted before discount given.
- Patient, guardian or responsible party may initiate a request for financial assistance.
- The attached request for financial information form must be completed and signed by responsible party.
- If the patient is not financially able to pay for health care services provided and has been evaluated by above criteria the patient will be referred to the Patient Account Representative (PAR) for assistance in explaining the program and assisting in completing the application.
- Completed and signed applications should be returned to CRMC within **10 days** to be considered for charity.
- If an application is returned and not enough detail is supplied to make a determination, the application and a letter stating missing documentation will be returned to the patient.
- If the patient is outside the nine (9) county service area a letter will be sent denying charity application.
- When a completed application is received the PAR will complete the "Patient Evaluation for Charity" worksheet. Completed evaluations are provided to the Director of Hospital Revenue Cycle for approval.
- If an application is denied, the form is returned to the PAR with the reason for denial.
- The original copy of the application and completed worksheet are filed in the Patient Financial Services department.
- The applicant is notified of approval or denial. If financial assistance is denied, the collection process will continue up to and including collection agency referral after the 30 day notification process.
- If an account is in Bad Debt and the patient qualifies within the 240 days for charity assistance and they have filled out the application, the account will be pulled back from the collection agency and any amounts paid by the patient will be refunded and the balance written off to charity.

**APPROVAL PROCESS:**

Authorization limits for charity care applications are as follows:

\$5.00 to \$500.00	Patient Account Representative
\$501.00 to \$4,999	Patient Account Manager
\$5,000 to \$24,999	Director of Hospital Revenue Cycle
\$25,000 and greater	Vice President-Finance

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**GRIEVANCE PROCEDURE:**

If a patient has a complaint about the application process, decision made on an application, or fairness of the application, the patient should be referred to the Director of Hospital Revenue Cycle. Patients have the right to call or write the Vice President-Finance if the complaint is not settled to their satisfaction with the Director of Hospital Revenue Cycle.

**NOTICE OF POLICY:**

CRMC provides information to the public regarding its charity care policies and qualification requirements in the following communications:

- Signs in all waiting, registration and admitting areas.
- Brochures provided at the time of registration and available in the financial counseling areas.
- Notices printed with every patient statement.
- Applications provided to uninsured patients at the time of registration.
- Applications available on the website.
- Assistance provided to inpatients by Human Arc for Medicaid eligibility services.
- Applications available and education to Community Health Clinic.

**SELF ASSESSMENT:**

CRMC will review its charity care policies at least annually to ensure the fairness and is consistently applied according to written policies and procedures.

**DOCUMENTATION:**

CRMC will maintain records of its charity care applications, determinations of charity care and notices to patient adequate to document its fair and consistent application of this policy in accordance with the system policy of Record retention and destruction.

**VENDOR COMPLIANCE**

All third party vendors (i.e. collection agencies, early out agencies) will follow the 240 day rule of ECA (extraordinary collection activity) as outlined in the hospital policy and in compliance with the IRS 501R Final Regulations. No credit report, law suit or garnishment will take place prior to the 240 day timeframe (i.e. from the first patient notification of liability). All efforts to validate the patient's qualification for financial assistance will be completed prior to any ECA. CRMC will audit and review all accounts for lawsuit request prior to approving such activity.

Approved by	Date