

ADVANCED CARE HOSPITAL OF WHITE COUNTY

Policy/Procedure Manual

Policy/Procedure

Number: LT-9010.4040

Page: 1 of 12

Date: July 2017

Department: Patient Financial Services

Subject: Financial Assistance

PURPOSE:

To assist patients who are uninsured or underinsured to qualify for a level of financial assistance, in accordance with their ability to pay. Financial assistance may be provided in the form of free care for patients who qualify or a discount.

POLICY:

The determination of a patient's financial responsibility will be made according to a patient's ability to pay, as indicated by the eligibility criteria established within the procedural guidelines of this policy. These guidelines include:

- Completion of the Advanced Care Hospital income-based Financial Assistance Application

Resources are limited, so it is necessary to establish limits and guidelines. These limits are not designed to turn away or discourage those in need from seeking treatment. They are in place to assure that the resources Advanced Care Hospital can afford to devote to its patients are focused on those who are most in need and least able to pay, rather than those who choose not to pay. Financial assessments and the review of patients' financial information are intended for the purpose of assessing need, as well as gaining a holistic view of the patients' circumstances. Advanced Care Hospital is committed to the following:

- Communicating with patients so they can more fully and freely participate in providing the needed information without fear of losing basic assets and income
- Assessing the patients' capacity to pay and establish payment arrangements that do not jeopardize the patients' health and basic living arrangements or undermine their capacity for self-sufficiency
- Upholding and honoring patients' rights to appeal decisions and seek reconsideration, and to have a self-selected advocate to assist the patient throughout the process
- Providing options for payment arrangements without requiring that the patient select higher cost options for repayment.

DEFINITIONS:

Bad Debt Expense: Uncollectible accounts receivable that were initially expected to result in cash received (i.e. the patient did not meet Advanced Care Hospital's Financial Assistance eligibility criteria). They are defined as the provision for actual or expected uncollectible accounts resulting from the extension of credit.

Catastrophic Financial Assistance: Assistance available to all uninsured patients who have a balance owed for medical care who do not qualify for the Medical Assistance program but have an extraordinary balance owed; a debt that is catastrophic to the family income base. Determination is made through the

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Advanced Care Hospital Catastrophic Financial Assistance Committee on a case-by-case basis.

Charity Care: Charity care is care that represents the uncompensated cost to a hospital of providing funding or otherwise financially supporting healthcare services on an inpatient or outpatient basis to a person classified as uninsured or otherwise financially indigent. Charity care services are those that may not initially have been expected to result in cash received. Charity care results from a provider's policy to provide health care services free or at a discount to individuals who meet the established criteria.

Current Medical Debt: Self-pay portion of current inpatient and outpatient account(s). Depending on circumstances, accounts related to the same episode of illness may be combined for evaluation. Internal and external collection agency accounts are considered as part of the current medical debt.

Family/Household: A group of two or more persons related by birth, marriage (including any legal common law spouse), or adoption who live together. All such related persons are considered as members of one family.

Liquid Assets: Money that can be accessed in a relatively short period of time, which may include cash/bank accounts, certificates of deposit, bonds, stocks, cash value of life insurance policies, and pension benefits.

Living Expenses: A per person allowance based on the Federal Poverty Guidelines times a factor of two, and adjusted for the Arkansas Wage Index. Allowance will be updated annually when guidelines are published in the Federal Register.

Payment Plan: When the patient is unable to pay his or her portion of healthcare costs all at one time, Advanced Care Hospital will arrange to accept the amount due in regular installments over a defined period of time. Payment plans are expected to be resolved within one year. Payment plans extending beyond one year will be classified as bad debt expenses, and forwarded to the Internal Collections Unit for processing.

Projected Medical Expenses: A patient's significant, ongoing, annual medical expenses, which are reasonably estimated to remain as non-covered by insurance carriers (e.g., drugs, co-payments, co-insurance, deductibles, and durable medical equipment).

Prompt Pay Discounts: A 10% discount will be offered when a patient's account is paid in full within 30 days of first statement date, for private pay and any co-insurance and deductible amounts, excluding co-pays. The contracted service company business office director(Unity Health) is responsible for ensuring compliance with all state laws and regulations regarding discounts for healthcare services.

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Sliding Scale: An income-based scale that is adjusted to reflect the patient's ability to pay based on the income level of the household. Table A reflects household income levels indexed according to the Federal Poverty Level.

TABLE A

# Persons in the Family	Income Level				
1	\$18,826	\$21,180	\$23,533	\$25,886	\$28,239
2	\$25,480	\$28,665	\$31,850	\$35,035	\$38,220
3	\$32,134	\$36,151	\$40,168	\$44,185	\$48,201
4	\$38,788	\$43,637	\$48,485	\$53,334	\$58,182
5	\$45,442	\$51,123	\$56,803	\$62,483	\$68,163
6	\$52,096	\$58,608	\$65,120	\$71,632	\$78,144
7	\$58,750	\$66,094	\$73,438	\$80,782	\$88,125
8	\$65,404	\$73,580	\$81,755	\$89,931	\$98,106
Allowance to Give	100%	80%	60%	40%	20%

Episode of Illness: Medical encounters/admissions for treatment of a condition, disease, or illness in the same diagnosis-related group (DRG), or closely related DRG occurring within a 120-day period.

Supporting Documentation: Pay stubs, 1099s, workers' compensation documentation, social security letters, disability award letters, bank statements, brokerage statements, tax returns, life insurance policies, real estate assessments, credit bureau reports, and other documentation typically utilized to establish income levels and charity care or Medical Assistance eligibility.

Take Home Pay: Patient's and/or responsible party's wages, salaries, tips, interest dividends, corporate distributions, net rental income before depreciation, retirement/pension income, social security benefits, and other income as defined by the Internal Revenue Service after taxes and other deductions.

Underinsured: Advanced Care Hospital considers a patient underinsured when a patient's primary, secondary, and/or other insurance will not cover a specific service or procedure at any hospital or healthcare facility.

Uninsured: Advanced Care Hospital considers a patient uninsured when the patient has no insurance coverage.

Uninsured Allowance: A 75% uninsured allowance will be available to all patients who are without insurance and do not qualify for any financial assistance, for inpatient or outpatient services. This discount is determined by taking 12 months' claims paid by Medicare, and calculating the average discount given to payer. The discount percentage will be updated annually and distributed by

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Administration to all Advanced Care Hospital facilities and departments one month before the start of the new fiscal year, to be effective on the first day of the upcoming fiscal year.

SPECIAL INSTRUCTIONS/FORMS TO BE USED

- Financial Assistance Application (Attachment A)

PROCEDURE:

I. Identification of Potentially Eligible Patients:

1. An evaluation for Financial Assistance can be initiated in a number of ways, including the following:
 - a. A patient with a self-pay balance due notifies the self-pay collector that he/she cannot afford to pay the bill and requests assistance.
 - b. A patient presents at a clinical area without insurance and states that he/she cannot afford to pay the medical expenses associated with the current or previous medical services.
 - c. A physician or other clinician refers a patient for a financial assistance evaluation for potential admission.
2. When possible, prior to the admission or registration of the patient, Advanced Care Hospital will conduct a pre-admission/pre-registration interview with the patient, the guarantor, and/or his/her legal representative. If a pre-admission or pre-registration interview is not possible, this interview should be conducted upon admission or registration, or as soon as possible thereafter. At the time of the initial patient interview, the following information should be gathered:
 - a. Routine and comprehensive demographic and financial data.
 - b. Complete information regarding all existing third party coverage.
3. Identification of potentially eligible patients can take place at any time during the rendering of services or during the collection process (including bad debt collection).
4. Those patients who may qualify for financial assistance from a governmental program should be referred to the appropriate program, such as Medicaid, prior to consideration for financial assistance.

II. Determination of Eligibility:

1. All patients identified as potential financial assistance recipients should be offered the opportunity to apply for financial assistance. If this evaluation is not conducted until after the patient leaves the facility, a Social Worker/Case Manager will mail a financial assistance application to the patient for completion. When no representative of the patient is available, the facility should take the required action to have a legal guardian/trustee appointed or to act on behalf of the patient in this regard.

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2. Requests for financial assistance may be received from:
 - a. The patient or guarantor
 - b. Physicians or other caregivers
 - c. Advanced Care Hospital Administration
3. Other approved programs that provide for primary care of indigent patients.
4. The patient should receive and complete a written application (Attachment A) and provide all supporting data required to verify eligibility.
5. In the evaluation of an application for financial assistance, a patient's family income and medical expenses will be the determining factors for eligibility. A credit report may be generated for the purpose of identifying additional expense, obligations, and income to assist in developing a full understanding of the patient's financial circumstances. The Administrator maintains the final authority to determine whether or not Patient Financial Services exerted reasonable effort to assist a patient in attaining Financial Assistance under this policy.

III. Screening Process:

1. It begins upon the completion of the Financial Assistance Application.
2. The application should be completed by either the patient, a family member of the patient, the Social Worker/Case Manager, Collector, Customer Service Representative, or a Medical Assistance Eligibility Determination Representative.

IV. Financial Assistance:

1. It will be granted, based on household income schedule associated with the sliding scale income table.

V. Family Assets:

1. They shall be considered when evaluating the applicant's level of medical indigence.
2. In doing so, patients qualifying for charity based on balances greater than \$5,000 will be referred to an outside entity for asset verification.

a. Responsible Party

Authority Limit

Financial Counselors or Customer Service Rep	< \$5000
Advanced Care Administrator	>\$5,000

- b. Upon the patient's completion of the application and submission of appropriate documentation, the Social Worker/Case Manager will complete the Advanced Care Hospital portion of the Financial Assistance Application using either the manual form (Attachment A) used by the patient or an electronic form (Advanced Care Hospital Financial Assistance

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application). The information shall be forwarded to the Patient Financial Services Director or designee for determination, as required. Financial Assistance approvals will be made in accordance with the guidelines, and documented on the form used to complete the application.

- c. Accounts for which the Financial Counselor, Customer Service Representative, or Patient Financial Services Director identified special circumstances that affected the patient's eligibility for financial assistance will be referred to the Advanced Care Hospital Administrator for final determination.
- d. Accounts that do not clearly meet the criteria will be reviewed by the Financial Counselor. The decisions and rationale for those decisions will be documented and maintained in the account file, and sent to the patient in a timely manner.
- e. A scanned electronic record shall be maintained, reflecting authorization of financial assistance. These documents shall be kept for 10 years.
- f. If, due to special circumstances, a patient refuses to cooperate, or if an incomplete application is submitted, the Financial Counselor will provide written notice to the patient explaining what is needed for completion, send a plain language summary of the financial assistance policy, and provide written notice to the patient of the collection actions that could occur if the application is not completed.

VI. Financial Assistance and/or Charity are based on the following:

1. State and county residency
2. Individual or family income
3. Individual or family net worth
4. Employment status and earning capacity
5. Family size
6. Amount and frequency of bills for healthcare services
7. Other sources of payment for the services rendered
8. Other financial obligations

VII. Financial Assistance Applications:

1. They will be completed within the fiscal year of the date of treatment, whenever possible.
2. Charges incurred within one year of a financial assistance application may be considered for write-off.
3. Balances incurred before that date are not eligible.

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VIII. Collection Efforts:

1. Including those by internal or external collection agencies, are to be considered part of the information collection process and can appropriately result in identification of eligibility for financial assistance.
2. In the event a patient does not qualify for financial assistance, and fails to make payments or arrangement for payments within 120 days of notification that the patient did not qualify, Advanced Care Hospital could utilize the services of external collection agencies to help collect the patient's debt to the hospital.

IX. Patient Co-payments:

1. Amounts totaling more than \$500.00 may be eligible for financial assistance write-off.
2. Applies if eligibility requirements are met.

X. Charges for non-covered services:

1. Charges that are remaining after third-party payments may be eligible for financial assistance write-off if they total more than \$500.00.
2. Eligibility requirements must be met.

XI. Determination of Eligibility for Financial Assistance:

1. Once this occurs, Advanced Care Hospital will discontinue all billing or collection efforts on the account and adjust the patient receivable by writing-off the account as Charity Care
2. Appropriate adjustment code must be used.

XII. Patients may qualify for financial assistance as medically indigent:

1. Medical indigence is established when a patient has catastrophic medical expenses but does not qualify for Medical Assistance through the guidelines of Table A.
2. In such cases, an application for assistance may be completed and considered. Determination is through the Advanced Care Hospital Catastrophic Financial Assistance Committee on a case-by-case basis.

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XIII. After qualifying for financial assistance:

1. The patient will be contacted and the patient's account will be documented to reflect that charity care approval was granted.
2. The following adjustment codes are to be used for write-offs:
 - a. 99026: A/R Charity Write-off
 - b. 99079: Under-insured Adjustment
 - c. 99026: Bad Debt Charity Write-off

XIV. Notification of Eligibility Determination:

1. Clear guidelines as to the length of time required to review the application and provide a decision to the patient should be provided at the time of application. A prompt turnaround and a written decision, which provides a reason for denial (if appropriate), will be provided, generally within 45 days of the Financial Counselor's decision after reviewing a completed application. Patients will be notified in the denial letter that they may appeal this decision and will be provided contact information to do so. If a patient is determined to be eligible, Advanced Care Hospital will provide a billing statement that indicates the amount owed that is eligible for financial assistance.
2. If a patient disagrees with the decision, the patient may request an appeal process in writing within 45 days of the denial. The Financial Counselor will again review the application, and escalate it to the LTAC Administrator for a determination. Decisions reached will normally be communicated to the patient within 45 days, and will reflect the Committee's final and executive review.
3. Collection activity will be suspended during the consideration of a completed financial assistance application, or an application for any other healthcare coverage (e.g., Medicare, Medicaid, Family Care, etc.). A note will be entered into the patient's account to suspend collection activity until the financial assistance or other application process is complete. If the account has been placed with a collection agency, the agency will be notified by telephone to suspend collection efforts until a determination is made. This notification will be documented in the account notes. The patient will also be notified verbally that the collection activity will be suspended during consideration. If a financial assistance determination allows for a percent reduction, but leaves the patient with a self-pay balance, payment terms will be established on the basis of disposable income.
4. If the patient complies with a payment plan to which Advanced Care Hospital has agreed, the facility shall not otherwise pursue collection action against the patient. However, if a patient misses one monthly payment, the account could be referred to the Internal Collections Unit, and the account could be referred to a collection agency if more payments are missed.

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5. A patient will be given a discount only if the account has an open self-pay balance. The determining factor for refunding monies back to the patient will be the date the patient becomes eligible. For example, if a patient is making payment arrangements on an account and part way through the agreed upon contract term the patient becomes eligible for financial assistance (e.g., they lose their job, etc.), then the monies paid (before the date of job loss and financial assistance eligibility) will not be refunded. If a patient makes payments on an account, and during the time in which the payments were made the patient qualified for financial assistance, then those monies will be refunded to the patient. The LTAC Administrator is authorized to make exceptions to these guidelines.
6. If the patient has a change in financial status, the patient should promptly notify the facility's LTAC Administrator or designee. The patient may request and apply for financial assistance or a change in their payment plan terms.

XV. Availability of policy:

Advanced Care Hospital will provide any member of the public or state governmental entity a copy of its financial assistance policy, upon request. The policy will also be available on the hospital website, at all points of registration within the facility, and will be provided by mail to anyone requesting it at no charge. A plain language summary of the policy will be made available in these locations as well.

XVI. Application forms:

1. Advanced Care Hospital will make the financial assistance application form available on the hospital website, at all points of registration within the facility, and via mail to anyone requesting it at no charge.
2. This will determine a patient's eligibility for financial assistance.

XVII. Monitoring and Reporting:

1. Advanced Care Hospital will maintain a computerized log of approved Charity Care accounts, reflecting the appropriate information to claim the adjustment of charity for Disproportionate Share funding. A financial assistance log from which periodic reports can be developed shall be maintained, aside from any other required financial statements. Financial assistance logs will be maintained for ten years. At a minimum, the financial assistance logs are to include:
 - a. Account number
 - b. Date of service
 - c. Application mailed (y/n)

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- d. Application returned and complete (y/n)
 - e. Total charges
 - f. Self-pay balances
 - g. Amount of financial assistance approved
 - h. Date financial assistance was approved
2. The cost of financial assistance will be reported annually in the Community Benefit Report. Charity Care will be reported as the cost of care provided (not the charges for that care) using the most recently available operating cost and the associated cost-to-charge ratio, which is generated monthly.

XVIII. Presumptive Financial Assistance Guidelines and Eligibility Criteria:

In the following situations, a patient is deemed to be eligible for a 100% reduction from charges (i.e. full write-off):

- a. If a patient is currently eligible for Medicaid, but was not eligible on a prior date of service. Instead of making the patient duplicate the required paperwork, the facility will rely on the financial assistance determination process from Medicaid up to 12 months prior to the eligibility date.
- b. If a patient states he or she is homeless and the facility, thru its own due diligence, does not find any evidence to the contrary. The due diligence efforts are to be documented.
- c. If a patient dies without an estate.
- d. If a patient is mentally or physically incapacitated and has no one to act on his/her behalf.

XIX. Payment Plans (See Policy Payment Plans):

1. Advanced Care Hospital may provide care for a patient whose financial status makes it impractical or impossible to pay the patient portion balance in a single lump sum payment. In such circumstances, establishment of payment arrangements is consistent with, and essential to, the execution of our mission, vision, and values.
2. To assist the patient in meeting his/her financial responsibilities, Advanced Care Hospital allows patients to make payment arrangements when payment in full is not possible. Advanced Care Hospital will provide long and/or short-term payment plans, based on patient/guarantor needs and financial situations. If the patient/guarantor qualifies for a payment plan, then the Financial Counselor, or Patient Financial Services Representative will inform the patient about his/her responsibilities under the payment arrangement program, as detailed in the Advanced Care Hospital "Payment Plans" policy.

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3. All Advanced Care Hospital registration representatives will inform eligible patients/guarantors of the Advanced Care Hospital payment plan policy if a patient is unable to pay his/her self-pay amount in full.
4. Insured patients will not be referred to a collection agency unless first offered the opportunity to request a reasonable payment plan for the amount owed. Uninsured patients must be given the opportunity to assess the accuracy of their bill, apply for financial assistance, and avail themselves of a reasonable payment plan prior to the pursuit of collection agency activity.
5. If the patient cannot meet the requirements of the payment arrangement program, the patient should be evaluated for financial assistance.
6. Payment plans on partial charity care accounts need to be individually developed with the patient.

XX. In administering this policy, Advanced Care Hospital will:

1. Ensure the dignity of the patient/guarantor
2. Encourage upfront financial counseling
3. Be patient-centric and patient-friendly
4. Serve the healthcare needs of everyone, regardless of ability to pay
5. Communicate collection procedures

XXI. Exclusions: Medical expenses excluded from uninsured discounts:

1. Individuals eligible for administrative discounts
2. Accounts for which any third parties may be liable for services
3. Balances due (such as deductibles and co-pays) after payment are made by a primary insurer

XXII. Uninsured Allowance:

1. A 75% uninsured allowance will be available to all patients without insurance and do not qualify for any financial assistance.
2. This discount is determined by taking 12 months' claims paid by Medicare Fee for Service and all Private Insurers, and calculating the average discount given to those payers.
3. The allowance percentage will be updated annually and distributed by Administration to all Advanced Care Hospital facilities and departments one month before the start of the new fiscal year, to be effective on the first day the upcoming fiscal year

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XXIII. Prompt Pay Discounts:

1. A 10% discount will be offered when a patient's account is paid in full within 30 days of first statement date, for private pay and any co-insurance and deductible amounts, excluding co-pays.
2. The Patient Financial Services Director is responsible for ensuring compliance with all state laws and regulations regarding discounts for healthcare services.

Distribution:

Hospital-wide

Related Materials:

[Financial Assistance Application.docx](#)

Filing Instructions:

General

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