

<p>Title/Description: CHARITY CARE PLAN - FINANCIAL ASSISTANCE POLICY</p>	<p>Policy Manual #108.000 Revised Date: 2/9/07, 2/1/11, 5/13/13, 1/14/16, 3/7/16, 8/28/17, 9/25/17; 5/01/18</p> <p>Effective Date: 5/13/13, 2/1/16, 8/28/17, 10/25/17, 5/01/18</p>
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POLICY STATEMENT

In adherence with the mission and traditions of the Medical Center, respect and compassion will be exhibited to all persons who seek our services, including those with limited or no capacity to pay for services. The Medical Center is committed to providing services to persons regardless of their ability to pay or to satisfy related financial obligations.

PURPOSE

1. To further the mission of providing healthcare and to ensure that patients without insurance will be treated fairly, with respect and with compassion during and after their treatment, regardless of their ability to pay for the services they receive.
2. To provide financial counseling to all the uninsured and underinsured, including help in understanding and applying for local, state and federal health care programs such as Medicare, Medicare Disability, Medicaid, Healthcare Assurance Program (HCAP), the Federal Insurance Market Place and other assistive programs which may be available.
3. To describe the qualifications for eligibility to the uninsured and eligible underinsured to receive substantially discounted services equivalent to those commonly received by managed care payers, and provide education to those who are eligible to ensure they are in a position to make an informed decision based on in-depth understanding of available options. The amount generally billed will be used to discount services. The Look Back Method will be used. The percentage of discount for true Self Pay will be **40%**. The calculation is based on hospital insurance expected reimbursement divided by hospital total charges.
4. The Financial Assistance Policy will be publicized on the hospital website and information regarding how to apply for assistance will be on patient statements. Patient Access staff will offer the Plain Language Summary to all patients.
5. To establish reasonable, interest-free payment mechanisms based on the patient’s ability to make payments.
6. To establish reasonable payment mechanisms, which may include bank card (charge card) options, bank loan options, and other available vehicles which suit the immediate and long-term benefit of the individual.
7. **To remain in compliance with the requirements of Section 501 (r) of the Internal Revenue Code.**

POLICY

Patients are to receive charity only after all other methods of financing the patient’s care have been exhausted, such as insurance coverage, public assistance, Medicare, Bureau of Children with Medical Handicaps, Victims of Crime, Hospital Motor Vehicle Claims Program, or any financial resource.

Patients requesting charity, or thought to require such aid, will be referred to a customer service representative or financial counselor in Patient Accounts. A financial statement (maintained in Patient Accounts) will be sent to the legally responsible person to be completed and returned with proof of income and expenses. The information obtained will be reviewed, and final charity determination made at that time. The hospital shall accept HCAP applications for services until three years from the date of the first follow-up notice. This would be approximately three years and 30 days from the date of service.

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Final approval is made by the Director and/or appropriate Manager in Patient Accounts.

Hospital may deny out-of-panel, non-emergency care after patient notification and if they reside in an area considered out of our service area.

The Director or Manager of Patient Accounts has the responsibility and authority to grant charity. Exceptions to the Charity Care Plan and total charity adjustments must have the signed approval of the Director of Patient Accounts. Exceptions may include proposed balance reductions to be negotiated on a per-case basis.

PROCEDURE

1. Charity care will be applicable to only those services which represent emergency care or are determined to be medically necessary, using Medicaid/Medicare definitions as a guide. For this policy, emergency care represents immediate care which is necessary to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any organs or body parts. Medically necessary represents both inpatient and outpatient services or care rendered to a patient to diagnose, alleviate, correct, cure or prevent the onset or worsening of conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in overall illness or infirmity.
2. At the time services are scheduled, at the time of presentation for services, and/or at the time coverage determination is made and identified (including pre-screening under ABN requirements and MSP requirements for Medicare), a determination will be made regarding the patient's potential or calculated financial liability. Responsibility: Scheduling, Registration, Financial Counselor.
3. Each patient's availability of insurance will be verified and validated through eligibility software at the point of entry or prior to the point of entry and communicated to the financial counselor's office in a timely, efficient and effective manner for all scheduled admits, same-day surgery and emergency room. Responsibility: Scheduling, Registration
4. The financial counselor will obtain information as to the patient's eligibility for all sources of insurance coverage (either or both through eligibility software and other sources (i.e., attorney, police report). Responsibility: Financial Counselor
5. The financial counselor will screen for:
 - ♦ Ability to meet their obligation
 - ♦ Discuss and finalize payment arrangements
 - ♦ Communicate available options to the patient/family and educate them on program requirements
 - ♦ Finalize payment arrangements in accordance with the individual's financial abilities, or, if they do not possess the means, to confirm eligibility under the Medicaid or Healthcare Assurance Plan (HCAP) programs.
 - ♦ Communicate the charity program to the patient/family, educate them on the options available, assist them in completing the application form and finalize the terms of usage of the charity program as applicable.

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- ♦ Finalize confirmation of the patient’s agreement in writing and scan the confirmation into the imaging system with all other applicable documents to the screening and agreement. Responsibility: Financial Counselor

NOTE: The financial counselor shall maintain exclusive responsibility for this process until such time that arrangements are finalized, or a determination is made that the patient may be non-compliant, to ensure the patient has ONE POINT OF CONTACT. This is to ensure that the patient has a point of reference, and that the patient is provided a level of comfort as well as a sense that the confidentiality of their personal affairs is held in confidence. If the patient is represented by an agency to aid the Medicaid application process, the representative of that agency will be the contact.

NOTE: All determinations for charitable services are valid for one year unless the financial situation changes. Individuals with a change in their financial situation must be re-evaluated by a Financial Counselor by calling 330-489-1145.

- 6. Before instituting extraordinary collection activity (ECA) for non-payment against any patient who is unemployed and without access to health insurance or who is without other significant income or net worth, the Medical Center’s staff will exhaust reasonable efforts made to insure that the patient has been notified of our financial assistance program as well as attempts to determine that the patient is not eligible for any third party program. These efforts will include attempts at verbal and written contact. The Medical Center will notify the individual in writing at least 30 days prior to pursuing ECA. This communication is done through mailed statements or e-mail communications. The Medical Center shall allow external collection agencies to report unpaid accounts to credit agencies as well as file litigation and garnishment orders to obtain judgment liens using only lawful means of collection. Mercy Medical Center’s full collection policy is available upon request.**
7. In order to maintain proper internal control per GAAP, security access to patient accounting transactions that effect AR balances will be restricted to employees who are not directly or indirectly responsible for billing or collection functions. Adjustments or corrections effecting account balances must have proper authorization before posting will be accommodated. The following authorization levels are required for each request:

<u>Authorization Level</u>	<u>Amount</u>
Manager	Required for all transactions
Director	Required for transactions of \$1,200 or more
Chief Financial Officer	Required for transactions of \$10,000 or more

HOSPITAL CARE ASSURANCE PROGRAM (HCAP)

Hospital services are provided without charge to patients who need basic medically necessary hospital services, who are residents of the State of Ohio, who are not recipients of the Medicaid Program, and whose income is at or below the Federal poverty line.

1. All statements notifying the patient of the self-pay balance will include notifications as required by Section 5112.17 of the Revised Code of the State of Ohio.

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2. In determining if a patient is HCAP eligible, a financial statement will be completed with proof of income for the past 12 months or past three months times four. Expenses and assets are not used in the HCAP determination. A family shall be defined by the Ohio Regulations.
3. The financial statement will be reviewed by Patient Accounts to determine eligibility. During the review, accounts will be screened for Medicaid through the following programs: Aid to Families with Dependent Children, Aid to Families with Dependent Children-Healthy Start, or Medicaid Disability. If the patient does not meet eligibility criteria for one of these programs, the patient may apply for free care through the Hospital Care Assurance Program.

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4. If the patient is covered by a County Department of Human Resources under the Disability Assistance Program, the patient will receive services without charge as required by Section 5112.17 of the Revised Code. Proof of disability assistance eligibility will be maintained for three years or until 180 days following review. Such proof will consist of the copy of the patient’s card or electronic verification printout.
5. Logs will be kept of all accounts written off under HCAP. This information will be reported yearly on the ODHS 2929 Service Summary Sheet.
6. The determination will be based on the Federal Poverty Guidelines in effect at the time of service.

AMBULATORY CARE CLINIC

All patients of the Ambulatory Care Clinic will complete a financial statement. After all other methods of financing the patient’s care are exhausted, reduced charges will be determined based on the sliding scale or services without charge will be provided.

PROFESSIONAL PHARMACY

All patients qualifying for reduced charges in the Ambulatory Care Clinic will pay only the designated co-payment per prescription. Prescriptions must originate in the Ambulatory Care Clinic or affiliated Medical Center service areas based upon unavailability of the Ambulatory Care Clinic at the time of service.

FINANCIAL COUNSELING

In cases where expenses are deemed to be excessive, Consumer Credit Counseling Services may be utilized. Consumer Credit Counseling is an organization that will provide, at no cost to the consumer, budgeting, counseling and a structured repayment plan to our patients in need of this service.

DOCUMENT RETENTION:

All information related to the Financial Assistance application, proof of income and other related information will be stored electronically by patient name and account number thru the hospital online imaging system.

DEFINITIONS

Uninsured Qualified Patients – Those individuals with income about 100% of the Federal Poverty Guidelines that do not qualify for any third-party payment program.

Under-Insured Qualified Patients – Those individuals with income above 100% of the Federal Poverty Guidelines that do qualify for a third-party payment program but whose medically necessary/emergency services are not covered by their insurer, or whose coverage is limited to such an extent that the patient’s liability exceeds their ability to pay for such services.

Uninsured Non-Qualified Patients – Those individuals with income above 250% of the Federal Poverty Guidelines that do not qualify for any third-party payment program.

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Discount – The percentage reduction from normal billed charges that shall be applied:

Uninsured/Under-Insured Sliding Scale Discount & Payment Table

<u>Federal Poverty Level</u>	<u>% Discount on Charges</u>
At or below 100% of poverty level	100% discount
101% to 200% of poverty level	100% discount
201% to 250% of poverty level	50% discount

Uninsured/Non-Qualified

Self Pay patients will be given a **40%** discount from gross charges on all services including Statcare visits.

Cosmetic Procedures are not included as they are charged a flat fee with a discount already taken.

Addendum

The following providers may be utilized to provide care in an emergency setting. Their financial assistance policies are summarized below.

- Stark County Emergency Physicians
 - Self pay - write off at 40% if paid in full and 30% if paid in 6 months.
- Modern Path
 - Self Pay - accepts hospital charity if the patient has proof from the hospital.
 - They do either 40% or 100% charity. They give the charity discount only.
 - Balance after insurance – will discount up to \$200 with proof of hospital charity.
- Ohio Anesthesia Group
 - Self pay - accepts hospital charity if the patient has proof from the hospital.
 - They do either 40% or 100 % charity. Honors HCAP discount of 100%.
 - If not charity and true self pay, discount up to 20%.
- Radiology Services
 - Self pay - offers 50% discount if paid in a certain time frame.
 - Honors HCAP discount of 100%
- Sound Physicians (Hospitalist Group)
 - Will mirror the hospital policy discounts.
- Dental Services

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- HCAP patients automatically qualify for the Basic Care Plan (Basic Care Plan follows the HCAP guidelines with the exception that patients are responsible for the discounted rate charged for procedures).
- Basic Care fees are \$20 for all diagnostic and minor restorative procedures and between \$50 - \$500 for major restorative and surgical procedures
- Self-Pay – patients will receive a 25% discount off of the UCR rate for all dental services if they are uninsured

Approved by:


Paul C. Hiltz, Interim President & CEO