RAPIDES REGIONAL MEDICAL CENTER

POLICY: DISCOUNT CHARITY POLICY FOR PATIENTS	**POLICY #25 PAGES 1-8**
Department Affected: Hospital-Wide	**Effective: 01/14**
Reviewed by: Policy & Procedure Committee & Community Benefit Committee	**Reviewed Dates: 01/14**
Revisions Approved by: **Randy Rogers** **Chief Financial Officer** **Jason Cobb** **Administration** **Jessie Futrell** **Quality Management** **(SIGNATURES ON FILE)**	**Revision Dates: 01/14**

I. POLICY

Rapides Regional Medical Center (RRMC) is committed to providing charity care to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Consistent with its mission to deliver compassionate, high quality, affordable healthcare services, RRMC strives to ensure that the financial capacity of people who need healthcare services does not prevent them from seeking or receiving care. RRMC will provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility for financial assistance or for government assistance.

Accordingly, this written policy:

- Includes eligibility criteria for free (charity) care
- Describes the method by which patients may apply for charity care
- Describes how the hospital will widely publicize the policy within the community served by the hospital

Charity is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with RRMC's procedures for obtaining charity or other forms of payment and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to healthcare services, for their overall personal health, and for the protection of their individual assets.

In order to manage its resources responsibility and to allow RRMC to provide the appropriate level of assistance to the greatest number of persons in need, the Board of Directors of Rapides Healthcare System LLC establishes the following guidelines for the provisions of patient charity.

II. PROCEDURES

A. Charity discounts may only be provided to patients receiving non-elective, or medically necessary care.

B. The following classes of patients may qualify for a charity discount based on the patient's income through electronic verification and the amount of the patient liability:

1. Under-insured patients (i.e., those patients with some form of third party payer coverage for health care services but such coverage is insufficient to pay the current bill) when 200% of the Federal Poverty Level thresholds are met, and;

2. Uninsured patients (i.e., those patients with no third party payer coverage for health care services whatsoever), who have advised that they are unable to pay their account balances, when 200% of the Federal Poverty Level thresholds are met. The granting of a charity discount shall be based on an individualized determination of financial need and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

C. Patients apply for a charity discount by completing an Application for Financial Assistance and providing all necessary supporting documents to confirm income. All patients shall receive a copy of the Financial Assistance Policy, a Plain Language Summary of the Policy, and an Application upon registration. The also receive a Plain Language Summary of the Policy and an Application with their first three bills.

1. For Medicare beneficiaries, in addition to thorough completion of the Medicare Financial Assistance Application, the preferred income documentation will be the most current year's Federal Tax Return. Any patient/responsible party unable to provide his/her most recent Federal Tax Return may provide two pieces of supporting documentation from the following list to meet this income verification requirement:

    1. State Income Tax Return for the most current year
    2. Supporting W-2
    3. Supporting 1099's
    4. Most recent bank and broker statements listed in the Federal Tax Return
    5. Current credit report
    6. Qualified Medicare Benefits (QMB for inpatients only)

2. Documentation acceptable for Non-Medicare patients:

1. Signed, witnessed Financial Assistance Application
2. W-2 withholding forms
3. Most Recent Employer Pay Stubs
4. Copies of all bank statements for last 3 months
5. Written documentation from income sources such as verification of wages from employer, verification from public welfare agencies or any governmental agency which can attest to the patient's income status for the last twelve (12) months.
6. Income tax returns
7. Forms providing or denying unemployment compensation or worker's compensation
8. A Medicaid remittance voucher which reflects that the patient's Medicaid benefits for that Medicaid fiscal year have been exhausted.

3. Charity Processing based on Extenuating Circumstances:

There may be occurrences of extenuating circumstances where the patient/responsible party is not able to complete the Financial Assistance Application and/or provide supporting documentation and resource testing cannot be completed or where the medical indigence of the patient is determined by the medical debt outweighing 25% of the patient/responsible party's annual income as outlined by state requirement/policy. In those circumstances, a manager may make the decision to waive the required documentation provided that all attempts to obtain additional information are documented clearly or may perform additional resource testing to validate the need for charity. Some of the following could be considered extenuating circumstances:

A. Undocumented Residents or Homeless - Patients identified as undocumented residents or homeless through:
   a. Medicaid eligibility screening
   b. Registration process
   c. Discharge to a shelter
   d. Clinical or Case Management documentation
   e. Attempt to run a credit report

may be considered for a charity discount if an attempt to complete the Financial Assistance Application was documented and a manager has reviewed and approved a policy exception.

B. Patient Expiration - Patients that expire and research determined through family contact and/or courthouse records that an estate does not exist and was documented, may be considered for a charity discount with the manager's review and approval for a policy exception.

C. Medically Indigent – Based upon state guidelines or requirements the patient/responsible party meets the medically indigent status, a charity discount may be applied after the manager completes a resource testing process for the

patient/responsible party.

D. Application Review:
Electronic validation of patient information/income is obtained and, together with family size, will be entered into the charity web tool to determine eligibility.

After thorough review of the Financial Assistance Application, and documented Medicaid Eligibility attempts or other means, a manager may waive supporting documentation on non- Medicare, non-Tri-Care, non-Medicaid, and non-Medicare Secondary Payor accounts only when it is apparent that the patient/responsible party is unable to meet the supporting documentation requirement but clearly meets the Charity guidelines.

Whenever possible, the hospital will consider an electronic validation of patient information/income, especially for non-Medicare accounts where no income verification is obtained.

Review of assets may take place during the application process, where allowed, by State. Under no circumstances will liens be considered on properties less than $300,000 in value.

Registrars, Financial Counselors, Support Services and Collectors should utilize all relevant on-line systems available to gather correct information. All efforts should be documented in a clear, concise and consistent manner in the Collections/Artiva System. Staff should demonstrate respect and integrity in all internal and external dealings. Confidentiality is considered of utmost importance and should be adhered to by all staff. All guidelines set forth by this policy should be adhered to without exception.

E. Refunds on Charity accounts:
The general expectation is that all patients pay for services rendered if they are not fully covered by a third party. However, if a patient is qualified for charity, no payments are required, and any amount paid by the patient will be refunded.

F. Patient Dispute Process:
In the event a patient wishes to file a dispute and appeal their eligibility for this policy, patient may seek review from the Business Services Director, Hospital Chief Financial Officer or a Hospital Executive.

G. Communication about the Charity Program to Patients and Within the Community:
Notification about charity available from RRMC shall be disseminated by RRMC by various means, which may include, but are not limited to, the publication of notices in patient bills and by posting notices in emergency rooms, at urgent care centers, admitting and registration departments, hospital business offices, and patient financial services offices, and at other public places as RRMC shall elect. RRMC also shall publish and widely publicize a summary of this charity care policy on its websites, in brochures

available in patient access sites and at other places within the community served by the hospital as RRMC may elect.

H. Collection Policies:
RRMC management has developed policies and procedures for internal and external collection practices (including actions the hospital may take in the event of non-payment, including collections action and reporting to credit agencies) that take into account the extent to which the patient qualifies for charity, a patient's good faith effort to apply for a governmental program or for charity from RRMC, and a patient's good faith effort to comply with his or her payment agreements with RRMC. RRMC will not impose extraordinary collections actions such as wage garnishments, liens on primary residences, or other legal actions for any patient without first making reasonable efforts to determine whether that patient is eligible for charity care under this policy. Reasonable efforts shall include:

1. Validating that the patient owes the unpaid bills and that all sources of third-party payment have been identified and billed by the hospital.
2. Documentation that RRMC has or has attempted to offer the patient the opportunity to apply for charity care pursuant to this policy and that the patient has not complied with RRMC's application requirements.
3. Documentation that the patient does not qualify for financial assistance under this policy.

No extraordinary collections actions will be taken prior to 120 days following the issuance of the first patient billing. Patients have a total of 240 days following the first billing to submit an application for financial assistance, and should any extraordinary collection action be in process at the time an application is submitted, such actions will be suspended while the application is processed.

I. Compliance with Regulations:
In implementing this policy, RRMC management and staff shall comply with all federal, state, and local laws, rules and regulations that may apply to activities conducted pursuant to the Policy.

IV. PROCEDURE

See Exhibit A (attached) for Charity Procedure Flow Chart
See Exhibit B (attached) for Charity Procedure Timeline
See Exhibit C (attached) for Systems Process Notes

Reference
• FSG.FT.COLL.606 Federal Charity Guidelines • FSG.FT.COLL.638 Financial Assistance Application • FSG.MF.COLL.804 Collection Charity Letters • FSD.PARS.PP.009 PARS Medicare Bad Debt and Recovery Logs • FSG.PP.COLL.034 Utilizing the Charity Review Web Tool • Need to add the Medicare Financial Assistance Application

Exhibit C

SYSTEMS PROCESS NOTES

A. A Medicare beneficiary who also qualifies for Medicaid (dual-eligible beneficiary) may be presumed indigent automatically as long as the "Must Bill" requirements are met which is supported by a State Medicaid remittance advice. Therefore, when claiming an amount as Medicare Bad Debt for a dual-eligible beneficiary, Medicaid must be billed and the remittance advice that shows non-payment be maintained as supporting documentation for the Medicare Bad Debt adjustment. Charity discounts for Medicaid Exhausted beneficiaries may be less than $1000.00.

B. Pending Medicaid Effect on Charity Discount
The Pending Medicaid and Pending Charity processes should not be concurrent processes. Determination of Pending Medicaid should be resolved prior to evaluating for potential Pending Charity.

C. Charity Processing based on Federal Poverty Guidelines

1. Patients that fall within 0-200% of the Federal Poverty Guideline will have a 100% Charity Discount processed. The Charity process will be managed by establishing IPLANS with a Financial Class of 15 for Charity Pending, Charity 0%– 100%, and Charity 101% - 200%. In those instances where state regulations exceed the company policy, additional standard IPLANS will be established. These IPLANS will be attached to standard LOGIDS with the appropriate standard models to calculate the applicable discount and auto post to the account at final bill and should be prorated at 100% of patient charges. These logs will not be worked for discrepancies or any other purposes since self pay underpayments or overpayments would be identified as they are normally identified today through our collection pools/series and credit balance reports. On accounts where the charity IPLAN is placed in the secondary or tertiary position, the applicable manual discount will need to be applied. Standard procedure codes will be established to use in those instances where the discount must be manually applied.

2. In addition, for Legacy Collection system sites, the collection series (4) Charity Pending Patient Liability and (108) Charity Pending Insurance Liability should be attached to the Pending Charity i-plan and collection series (208) Self Pay Liability and (109) Charity Insurance Liability respectively for automated collection tracking for these accounts. Artiva collection sites will need to modify the Artiva I-plan master file by denoting them as Charity i-plans.

3. For uninsured patients, the discount will be applied to total patient liability, (excluding any payments received). For Example: For an account with total charges of $20,000, the

Charity Discount would be applied to the total charges of $20,000. If the patient had paid $50 at time of service, the Charity discount would be $20,000 and the patient would be refunded the $50.

4. For under-insured patients, the discount should be applied to the gross patient due, less any payments received. For example: For an account with total charges of $10,000 and an insurance payment of $6,000 would leave a remaining gross patient due of $4,000. If the patient meets the charity guidelines outlined above, the remaining balance of $4,000 would be written off as a charity discount. If the patient had paid $50 at the time of service, the Charity discount would be $4,000 and the patient would be refunded the $50.

CHARITY CARE PLAIN LANGUAGE POLICY

Rapides Regional Medical Center provides free (charity) care to patients who need healthcare, but are unable to pay. Patients who are able to pay or buy health insurance will be expected to do so. Patients unable to pay need to follow our procedures to apply for charity care or government help. The Board of Directors of Rapides Healthcare System LLC has established these guidelines for providing free patient care.

Free care is only given to patients receiving medically necessary care.

Two types of patients can quality for charity care based on their income and debt:
1. Patients with some type of insurance, but where the insurance does not cover the bill; and the patient has income at or below 200% of the Federal Poverty Level.
2. Patients with no insurance and income at or below 200% of the Federal Poverty Level.

Charity care will be based on financial need and will not be based on age, gender, race, social or immigrant status, sexual orientation or religion. Patients apply for charity care by completing an "Application for Financial Assistance" and by providing all necessary documents to confirm their income. If patients have Medicare, we need a completed Medicare Financial Assistance Application and the most current year's Federal Tax Return.
If patients don't have that, they can give us two items from the list below.
1. State Income Tax Return for the most current year
2. SupportingW-2
3. Supporting 1099's
4. Most recent bank and broker statement listed in the Federal Tax Return
5. Current credit report
6. QualifiedMedicare Benefits (for inpatients only)

For non-Medicare patients we need the completed Financial Assistance Application, plus one item from the list below:
1. W-2 withholding forms
2. Most recent employer pay stubs
3. Copies of all bank statements for last three months

4. Written documentation from income sources, such as – verification of wages from employer, verification from public welfare agencies or any government agency that can tell us the patient's income status for the last 12 months
5. Income tax returns
6. Forms providing or denying employment compensation or Worker's Comp
7. A Medicaid voucher that shows the patient's Medicaid benefits for that fiscal year have been used up.

There may be special circumstances, including but not limited to the patient not being able to die. In these or other cases, a manager can make the decision to grant charity care.

If a patient qualifies for charity care, any amount already paid by the patient will be refunded. If a patient wants to appeal their charity care eligibility, they can ask for a review by the Business Services Director, Hospital Chief Financial Officer or a Hospital Executive.

RRMC tells patients and community about their charity care options through notices in patient bills, notices in the Emergency Room, urgent care centers, admitting/registration departments and patient financial services – along with other public places. RRMC will also publicize this policy on its websites and other places in the community. RRMC will NOT use extraordinary collections actions such as reporting patients to credit agencies, taking money from patients' paycheck, liens on patients' home or other legal actions without FIRST making reasonable efforts to determine whether the patient is eligible for charity care.

Patients have 240 days after the first bill to submit an Application for Financial Assistance. If collections are already underway when the application is received, we will stop those collections while a patient's application is processed.

For more information, please visit our website, rapidesregional.com.

Dear Patient/Responsible Party.

We are providing this application, because you may qualify for our ***Financial Assistance Program.***

The attached form only applies to hospital bills, and does not include any other medical bills you may have; such as physician, radiology, ambulance, etc.

In order to be considered for a full or partial assistance, you **must** complete the Financial Assistance Application. The responsible party **must sign** the bottom, and return the completed application within fourteen (14) days of receipt.

Inpatient Visits: If you were admitted into the hospital as an inpatient, it is necessary for you to provide us with **your latest Federal Tax Return** for supporting documentation. If you did not file a tax return, please indicate and attach any two of the documents listed below.

State Income Tax Return
Employer Pay Stubs
Written documentation from income sources
Copies of all bank statements for the past three months

Medicare Patients: If you are covered by Medicare, it is necessary for you to provide us with **your latest Federal Tax Return** for supporting documentation. If you did not file a tax return, please indicate and attach any of the documents listed below.

Supporting W-2
Supporting 1099's
Most recent bank and broker statements
Qualified Medicare Benefits

If, for any reason, you cannot provide us with the requested information, please attach a written statement explaining why you cannot provide the information requested.

Please allow ten (10) business days for our review process. We will notify you of our charity determination by letter. If you have any questions or concerns, please feel free to contact Customer Service at any time.

Remember if you return this form your bill may be included in our Financial Assistance Program

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