

RAPIDES REGIONAL MEDICAL CENTER

POLICY: CHARITY DISCOUNT POLICY FOR PATIENTS	POLICY #25	PAGES 1-10
Department Affected: Hospital-Wide and HPL clinic locations	Effective:	12/31/15
Reviewed by: Policy & Procedure Committee & RHS Executive Committee	Reviewed Dates:	12/31/15
Revisions Approved by: <u>Randy Rogers</u> Chief Financial Officer <u>Jason Cobb</u> Administration <u>Sheryl Ireson</u> Quality Management (SIGNATURES ON FILE)	Revision Dates:	12/31/15

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, medically necessary care for individuals regardless of their eligibility for financial assistance or for government assistance.

Accordingly, this written policy:

- Describes what services are eligible for free care and what providers participate in the provision of free care,
- Includes patient eligibility criteria for free (charity) care, and
- Describes the method by which patients may apply for charity care.

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. This includes care received in the hospital, emergency room, and HPLong clinics.

B. This policy is applied to charges for care provided by the hospital, HPLong Clinics and other providers with which RRMC has contracted to provide charity care. Those providers include the companies that provide radiology, laboratory, emergency and hospitalist services, as well as, other independent physicians. The current listing of Charity Care Providers is available from RRMC's business office: First floor, main hospital, Phone 318-769-3225; email: rapidesregional@hcahealthcare.com, or 211 4th St., Alexandria, LA 71301. The office is open from 8:00 am to 5:00 pm, central time, Monday through Friday. The list is also available on RRMC's website at: <http://rapidesregional.com/patients-and-visitors>.

Patients eligible for the RRMC Charity Discount may receive bills for services provided by medical professionals who are not on the Charity Care Providers list.

C. The following classes of patients may qualify for a charity discount based on the patient's verified income 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.

D. Patients apply for a charity discount by completing an Application for Charity Discount and providing all necessary supporting documents to confirm income. All patients shall receive a copy of a Plain Language Summary of the Charity Discount Policy, and an Application upon registration.

E. The Charity Discount Policy, a Plain Language Summary of the Policy and an Application is available on the hospital's website at: www.rapidesregional.com/patients-and-visitors. Spanish language versions of all documents are available at the same site.

The Policy and Application are also available upon request from the hospital's business office: First floor, main hospital, Phone 318-769-3225; email: rapidesregional@hcahealthcare.com, or 211 4th St., Alexandria, LA 71301. The office is open from 8:00 am to 5:00 pm, central time, Monday through Friday. Spanish language versions of all documents are available upon request.

F. Assistance with completing the Charity Discount Application and answers to questions about the application process can be found by contacting the hospital's business office: First floor, main hospital, Phone 318-769-3225; email: rapidesregional@hcahealthcare.com, or in person at the main hospital admitting office, 211 4th St., Alexandria, LA 71301. The office is open from 8:00 am to 5:00 pm, central time, Monday through Friday.

G. For Medicare beneficiaries, in addition to thorough completion of the Medicare Charity Discount 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)

H. Documentation acceptable for Non-Medicare patients:

1. Signed, witnessed Charity Discount 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.

I. Charity Processing based on Extenuating Circumstances:

There may be occurrences of extenuating circumstances where the patient/responsible party is not able to complete the Charity Discount 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:

1. 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 Charity Discount Application was documented and a manager has reviewed and approved a policy exception.

2. 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.

3. Medically Indigent – If 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.

J. Application Review:

Electronic validation of patient information/income is obtained and, together with family size, will be entered into Onbase (the charity web tool) to determine eligibility.

Registrars, Financial Counselors, Support Services and Collectors should utilize all relevant on-line systems (Passport insurance verification, Artiva collection system, the DHH website, and Transunion online) 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.

After thorough review of the Charity Discount 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 law . Under no circumstances will liens be considered on properties less than \$300,000 in value.

If an incomplete Charity Discount Application is received, a patient will be advised in writing of what additional information must be submitted to complete the application process and reminded of where they can receive help completing the application process.

If a patient submits a complete Charity Discount Application and is deemed ineligible for a Charity Discount, they will be notified in writing concerning the basis for the determination.

J. 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.

K. 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.

L. 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 whether 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 postponement of care, 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 a charity discount 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 a charity discount under this policy.

Patients will receive a written notice 30 days before extraordinary collections actions are initiated notifying them of RRMC's intent to begin such action and of the availability of a charity discount, accompanied by a Charity Discount Policy Plain Language Summary. RRMC will also make all reasonable efforts to notify patients verbally before any actions are taken.

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 a charity discount, 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.

M. 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.

N. Eligibility Expiration:

It is recognized that some patients may have chronic or multiple conditions that may result in frequent visits to RRMC and it may be an undue burden to participate in the full verification process on each visit. For that reason, the charity discount may be applied to any account subsequent to the eligibility date for a period of up to 6 months. It is also recognized that patients may have changes in financial circumstances after the eligibility date and if requested should provide the documentation to support their continued eligibility on each visit to RRMC.

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

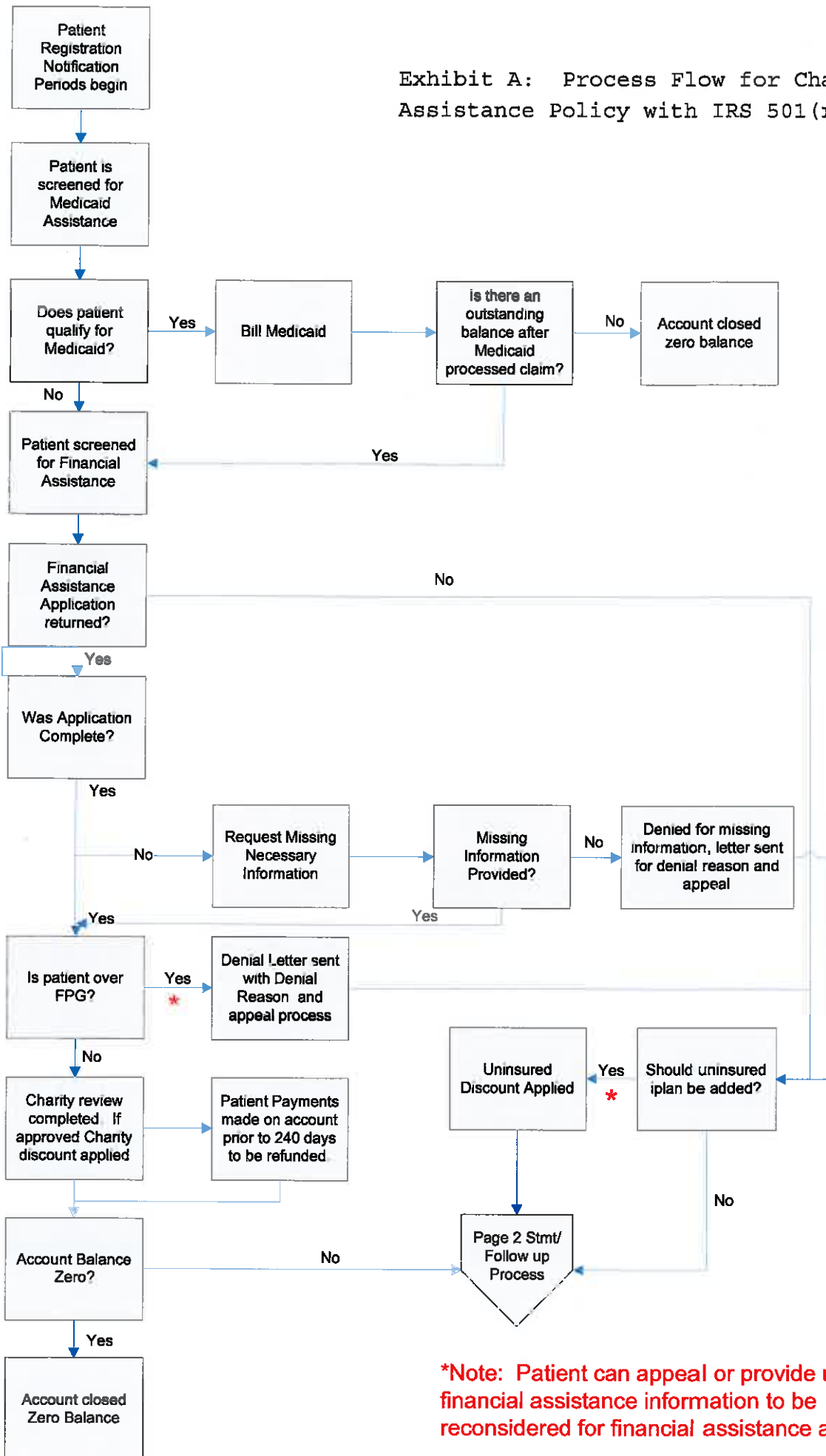
Exhibit C

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%. 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.

Exhibit A: Process Flow for Charity Assistance Policy with IRS 501(r) Revisions



***Note: Patient can appeal or provide updated financial assistance information to be reconsidered for financial assistance at any time.**

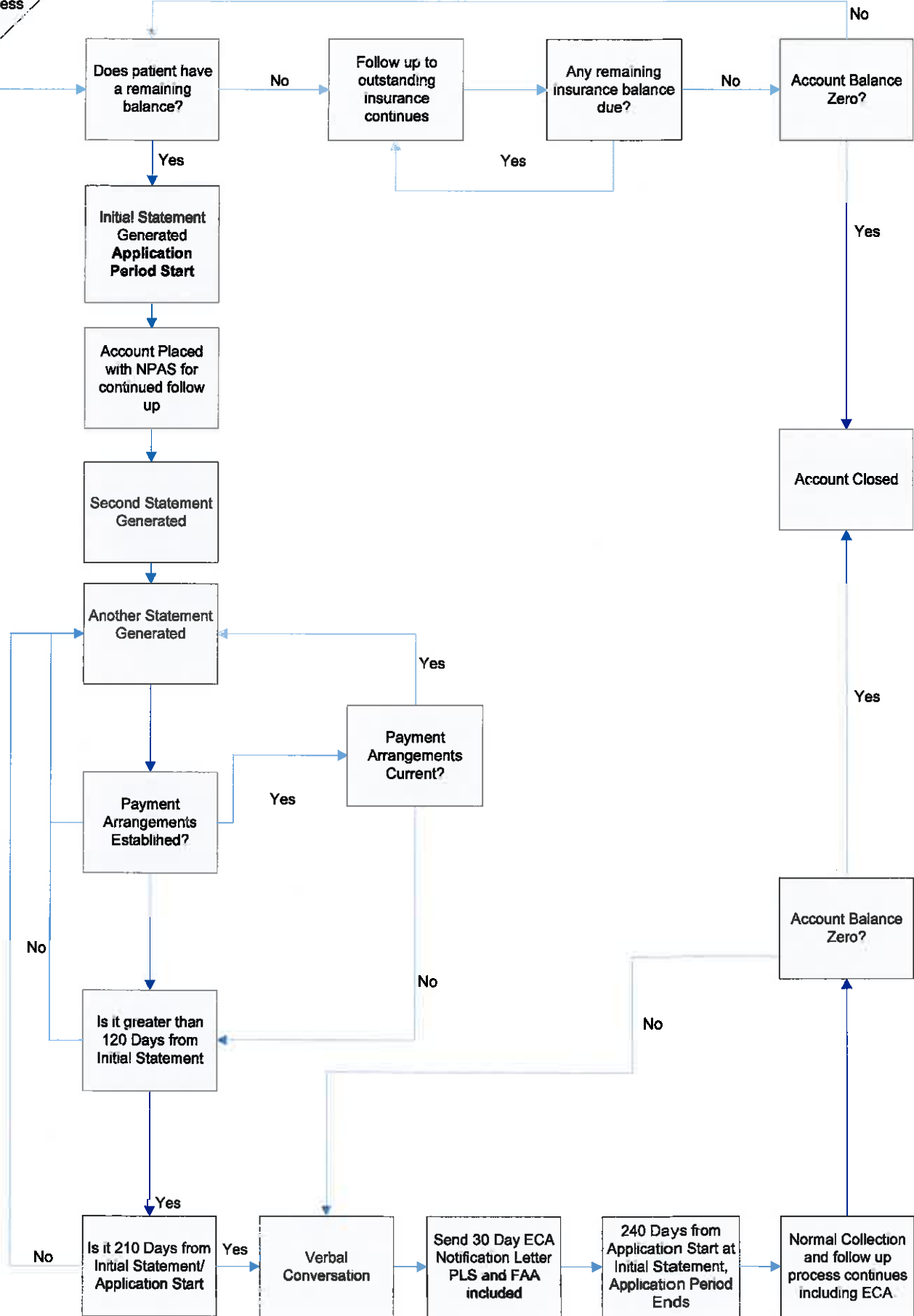
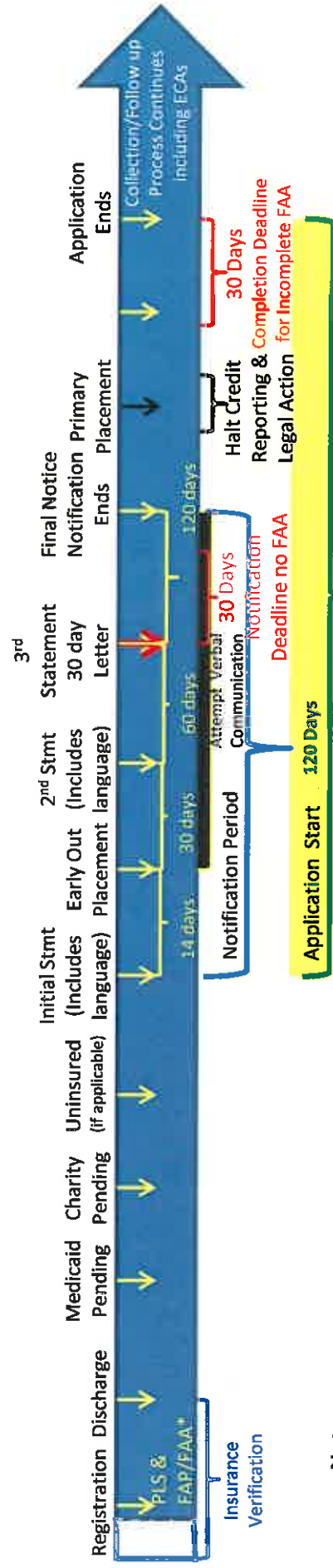


Exhibit B: Timeline for Charity Assistance Policy With IRS 501(r) Revisions



Notes:

- Flow should be followed for all patients including uninsured and insured
- Effective date is now, relying on reasonable good faith interpretation of the statute. The final rules apply to taxable years beginning after Dec 29, 2015.
- If a FAA is submitted, complete/incomplete during the application period, hospital will be deemed to have provided reasonable notification.
- If FAA denied, letter indicating reason for denial sent to patient
- Patient statements include phone number and contact for more information and website where FAP/FAA can be obtained
- Patient statement includes message how the patient can get information regarding the AGB for the care.
- Account stays placed with Early Out Vendor for 120 days
- Following 1st 30 day letter, hospital may engage in ECAs as long as notices are provided if no application submitted (must reverse if FAA submitted until determination made)
- If incomplete FAA, have until later of 240 days or completion deadline to submit or ECA's
- If approved for charity, patient payments paid exceeding the patient's financial responsibility must be refunded if within the 240 days/completion deadline
- Facility's Policy considerations:
 - Financial Class that are not sent initial statement
 - Refunds for patient payments

Key:

- PLS-Plain Language Summary
- FAA-Financial Assistance Application
- FAP-Financial Assistance Policy
- ECA-Extraordinary Collection Actions
- AGB-Amount Generally Billed