



Carnegie Tri-County Municipal Hospital & Carnegie Medical Clinic



TITLE		POLICY	
Financial Assistance (Charity) Policy		CBO400	
MANUAL	EFFECTIVE DATE	REVIEW DATE	
Business Office Manual	11/18		
DEPARTMENT	REFERENCE		
Business Office			

POLICY STATEMENT

In accordance with Carnegie Tri-County Municipal Hospital and Carnegie Medical Clinic, it is the policy of CTCMH and CMC, non-profits, to provide care to patients who are not able to meet the financial obligation (in part or total) due to their income restrictions. Consistent with the mission, CTCMH and CMC strive to ensure that a patient’s financial situation does not prevent them from seeking or receiving care. Financial assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with CCMH & CMC procedures for obtaining financial assistance. Implementation of this policy shall comply with all federal, state and local laws, rules and regulations to comply with IRS 501(r) and the guidelines of CCMH & CMC.

This facility will provide medically necessary care to individuals regardless of their ability to pay. No one who is unable to pay will be denied access to services. This facility does not discriminate due to an individual’s inability to pay or whether payment for those services would be made under Medicare, Medicaid, or CHIP, or the individual’s race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity. Discounts are offered based upon family/household size and annual income. The discount will apply to all services at this facility, excluding those services which are purchased from outside, including reference laboratory testing, drugs, and radiology interpretation by a consulting radiologist, and other such services. The application and review process will be reevaluated every six months, in the hope that an applicant’s financial situation improves. Charity care discounts apply to current medical services.

PURPOSE

This policy is intended to comply with the financial assistance and emergency care policies required by the Internal Revenue Section 501(r) and shall be interpreted to so comply. This policy applies to all medically necessary care and emergency care provided by CTCMH, CMC, and any substantially related entity of CTCMH.

DEFINITIONS

Gross Charges: Total charges of the facilities established rates for the provision of patient care services before revenue deductions are applied

Emergency Medical Conditions: Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 139dd)

Underinsured Patient: A person receiving healthcare services who is not qualified to participate in a

governmental program which provides healthcare benefits to its eligible participants and is not eligible for any type of payer discount and non-discounted payor coverage provides 50% or less reimbursement of total patient charges and/or patient's financial obligation.

Medically necessary: As defined by Medicare (services or items reasonable and necessary for the diagnosis or treatment of illness or injury).

Charity Care: Healthcare services that have been or will be provided but are never expected to result in cash inflows. Charity care results from a provider's policy to provide healthcare services free or at a discount to individuals who meet the established criteria.

Nominal Fee: The amount, not to exceed \$5.00, that this facility will assess and collect as a minimum amount from patients qualifying for financial assistance under this policy.

Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

Family Income: Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

1. Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
2. Noncash benefits (such as food stamps and housing subsidies) do not count;
3. Determined on a before-tax basis;
4. Excludes capital gains or losses; and
5. If a person lives with a family, includes the income of all family members
6. (Non-relatives, such as housemates, do not count).
7. Documents verifying income may include pay stubs, tax returns, bank statements. Alternative sources of verification may include the completed Patient Statement Form.

PROCEDURE

1. Upon registration, and after all EMTALA requirements are met, hospital patients without Medicare, Medicaid, third-party insurance, or other local health care financial assistance or adequate health insurance shall receive financial counseling assistance from hospital and business office staff, including a packet of information that addresses the financial assistance policy and procedures and an application for financial assistance (if requested).
2. Patients requesting financial assistance will be required to complete the Financial Assistance Application Form to establish eligibility. In certain situations, the application process may be initiated by facility staff and/or business office staff. Requests for financial assistance will be honored up to 240 days after the date the

first post-discharge billing statement is sent to the individual either by mail or electronic bill presentment.

3. It is the patient/guarantor's responsibility to provide, to the best of their knowledge, accurate, honest and complete information regarding their application and billing information. The patient/guarantor shall be required to provide information and verification of ineligibility for benefits available from insurance, Medicare, Medicaid, Workers Compensation, third-party liability (e.g. auto accident or personal injury) and other programs.
4. All available financial resources shall be evaluated before determining financial assistance eligibility. **Carnegie Tri-County Municipal Hospital** and **Carnegie Medical Clinic** will consider financial resources not only of the patient and other members of the household, but also of other persons having legal responsibility to provide for the patient.
5. The financial assistance assessment methodology shall consider income of the patient/guarantor/household and family size, (See Eligibility Criteria/Basis for Calculating Amounts Charged to Patients below).

Presumptive Eligibility:

Individuals who are uninsured may be considered eligible for the most generous financial assistance in the absence of a completed Financial Assistance Application (FAA), and provided 100% charity if:

- Individual is homeless
- Individual is deceased and has no known estate able to pay hospital debts
- Individual is incarcerated for a felony (verified on OSCN.net website)
- Individual has received Medicaid benefits. Service dates for up to one-year, previous accounts with dates of service prior to the Medicaid qualification eligibility date, and six months past the Medicaid eligibility date (accounts will be considered for Financial Assistance).

Financial assistance adjustments will be applied to dates of service for emergency or other non-elective medically necessary services for up to one year prior to the presumptive eligibility and will extend an additional six months into the future.

For any individual presumed to be eligible for financial assistance in accordance with this policy, the same actions described in the section and throughout this policy would apply as if the individual had submitted a completed a Financial Assistance Application.

Approved Financial Assistance:

Patients/Guarantors will be notified by U. S. mail when the financial counselor determines the amount of financial assistance discount eligibility related to emergency or other non-elective medically necessary services provided by the facility.

This eligibility does not extend to services provided by non-facility employees or other independent contractors (physicians, physician practices, anesthesiologists, radiologists,

pathologists, etc.) unless noted in the attached addendum that the provider is participating in this policy.

Financial assistance adjustments will be applied to dates of service for emergency or other non-elective medically necessary services for up to one year prior to the application approval and will extend an additional six months into the future. After that, a new verification of financial status shall be required to continue financial assistance discounts. Accounts will be adjusted at the time the financial assistance is approved.

1. The Application and all supporting documents will be sent securely to the Financial Assistance Clerk for verification and processing.
2. The facility CFO and CEO will each review all completed applications for Financial Assistance. They will individually sign the application to confirm the approval or denial of the application.
3. The patient will be notified of their application status after processing is complete.
 - a. Patients whose family income exceeds eligibility limits for Sliding Fee Scale discounts, or have experienced a catastrophic illness, or are otherwise indigent may be eligible for a discount or Payment Plan Agreement according to the facility medical hardship provisions; however, any discounted rates shall not be greater than the amounts generally billed to and received by Medicare patients.
 - b. Once a patient has been determined to be eligible for financial assistance, that patient shall not receive any future bills covered by the Application based on the NON-discounted gross. Said statements will include a nominal fee where applicable as outlined in this policy.
4. All applicable Patient Confidentiality & HIPAA Guidelines shall be observed in connection with this policy.

Denied Financial Assistance:

Patients/Guarantors will be notified by U. S. mail if financial assistance is denied along with a brief explanation of the reason for the determination and instructions to appeal the decision.

- The appeal process, on denied applications, will be handled by the business office to review and recommend a final decision to the appeal board.
- The appeal board will consist of the facility administrator, business office manager, financial counselor, and revenue cycle manager.

Eligibility Criteria/Basis for Calculating Amounts Charged to Eligible Patients:

Charges for emergency or other non-elective medically necessary care provided to patients eligible for financial assistance under the policy will be limited to not more than the amounts generally billed (AGB), via the Medicare Prospective Method, to those individuals who have insurance.

Charges, as defined in this policy, are considered the amount the patient is personally responsible for paying, after all deductions, discounts and insurance reimbursements have been applied. This facility will use the most current Federal Poverty Guidelines to determine eligibility under its Sliding Fee Scale financial assistance policy. Patients qualifying for

financial assistance may receive fully discounted care or pay a discounted fee under this policy. A medical hardship provision extends financial assistance in the form of a Payment Plan Agreement to patients with incomes above the financial assistance eligibility threshold according to the Federal Poverty Guidelines.

Actions under Billing and Collection Policy in the Event of Non-Payment:

Carnegie Tri-County Municipal Hospital and Carnegie Medical Clinic will not engage in extraordinary collection actions (ECA) for up to 120 days after the date of the patient's first statement. During that time, the

business office staff will make reasonable efforts to determine whether an individual who has an unpaid amount from Carnegie Tri-County Municipal Hospital is eligible for financial assistance.

Reasonable efforts collection actions include:

- 3 Balance Due Statements and 3 Phone Attempts or 2 Contacts
- 1 Final Letter (ECA Notification)
- Reasonable efforts will be monitored by the CBO SELFPAY Representative to confirm statements and calls have been provided before extraordinary collection activity begins

Extraordinary collection actions include:

- Reporting a patient's delinquent debt to a credit bureau
- Selling a patient's debt to a third party
- Placing a lien on a patient's real estate property
- Attaching or seizing a patient's bank account or other personal property
- Commencing a civil action against a patient
- Garnishing a patient's wages

Carnegie Tri-County Municipal Hospital and Carnegie Medical Clinic will publicize the availability of financial assistance. Also, notices will be printed on statements to the patient/guarantor, directing the patient/guarantor to contact the Central Business Office to discuss financial arrangements and the availability of financial assistance.

Also, the patient/guarantor will be sent a written notice 30 days after the initial statement that extraordinary collection efforts (ECA) may be initiated if a complete financial assistance application is not submitted, the bill is not paid, or an arrangement to pay the bill has not been agreed to by both patient and provider within 120 days after the first billing statement. Although the facility may undertake ECAs after this 120-day period, if we have not yet determined whether an individual is FAP-eligible, we will still accept and process an FAP application for an additional 120 days. The total period during which the facility must accept and process FAP applications is 240 days from the date of the first billing statement. If the facility receives an FAP application during the application period, we will suspend any ECAs we have started until we have processed the application and determined eligibility. If the individual is FAP-eligible, we will reverse the ECAs. While debts may be referred to third parties to assist with collection actions at any time, including during the initial 120-day notification period, they will not be sold to third parties during the notification period unless and until an eligibility determination has been made.

Publicizing the Availability of Financial Assistance:

- Health Network facilities will post complete and current versions of the following on the facility website:
- Financial Assistance Policy (FAP)
- Financial Assistance Application Form (FAA)
- Plain Language Summary of the Financial Assistance Policy (PLS)
- Contact information for Cohesive Healthcare Financial Counselors
- Signs will be posted in English to advise patients of the availability of financial assistance. Signage will be displayed in all points of admission and will contain the following:
 - website address where the FAP, FAA, and PLS may be accessed
<http://carnegiehospital.com>
 - Telephone number and physical location that individuals may call or visit to obtain copies of the FAP, FAA and PLS or to obtain more information:
 - Paper copies of this information will be available upon request at all points of admission.
 - Documents by mail: Central Business Office, Cohesive Healthcare Management and Consulting , 2510 E Independence Suite 101 Shawnee, Ok 74804.
 - A notice will be included on billing statements that notifies and informs recipients about the availability of financial assistance for eligible individuals under facility FAP and includes the telephone number of the Financial Counselor department who can provide information about the FAP and application process and the website address where copies of the FAP, FAA and PLS may be obtained.
- Provide FAP and PLS in Spanish version and utilize Other Language phone line to assist Patient/Customers through the application process.

Provider / Entities that are not covered by this Policy:

DIA Diagnostic Imaging Associates, INC
4500 S Garnett, Suite 919 Tulsa, OK 74146 Phone: 918-935-3550—Radiologist Professional fees

Dr W. Gregory Morgan, III M.D. P.C.
PO BOX 5208 Edmond, OK 73038—Professional Fees

ATTACHMENTS

REVISIONS/UPDATES

Date	Brief Description of Revision/Change