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Owner:	*Rae L Baker: PFS Supervisor*
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Uncompensated Care, 8530-401-A

POLICY:

Samaritan Hospital is committed to the provision of Health Care Services to all persons in need of medical attention regardless of ability to pay. This policy defines charity care, as distinguished from bad debts, and establishes policies and procedures to ensure consistent upfront identification and timely recording of such. The Medically indigent patient, those with no or inadequate means of paying for needed care, will be granted uncompensated care regardless of race, color, sex, religion, age or national origin. Accordingly, all persons that have the ability to pay for services shall be expected to do so, unless qualified for uncompensated care.

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DEFINITIONS:

Assets: Any item of economic value owned by an individual or corporation, especially that which could be converted to cash. Examples are cash, securities, real estate, car, boats, life insurance, IRAs trust accounts and other property.

Appropriate Hospital-based Services: Hospital services which are reasonable calculated to diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap or cause physical deformity or malfunction and there is no other equally effective more conservative or substantially less costly course of treatment available or suitable for the person requesting the service. For purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

Bad Debt: Uncollectable amounts, excluding contractual adjustments, arising from failure to pay by patients whose care has not been classified as charity care.

Charity Care: Defined as appropriate hospital-based medical services for which Samaritan Healthcare does not expect to be reimbursed due to the patient's inability to pay.

Family: A group of two or more persons related by birth, marriage, or adoption who live together; all such related persons are considered as member of one family. An unmarried person living alone will be considered a family for purposes of this policy.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention would reasonably be expected in result in:

a. Placing the health of the individual (or with the respect to a pregnant women, the health of the woman or

unborn child) in serious jeopardy

b. Serious impairment of bodily functions
c. Serious dysfunction of any bodily organ or part

With respect to a pregnant woman who is having contractions the term shall mean:

a. That there is inadequate time to effect a safe transfer to another hospital before delivery or
b. That transfer may pose a threat to the health or safety of the woman or the unborn child.

Income: Total cash receipts before taxes derived from wages and salaries, welfare payments, Social Security payments, strike benefits, unemployment or disability benefits, child support, alimony, and net earnings from business and investment activities paid to the individual and/or family members.

Indigent Persons: Patients who have exhausted any third-party sources, including Medicare and Medicaid and whose income is equal to or below 300% of the federal poverty standards adjusted for family size or is otherwise not sufficient to enable them to pay for the care or to pay deductibles or coinsurance amounts required by a third-party payer.

Uninsured: Defined as no third party insurance. Health savings accounts for the purpose of this policy are considered insurance.

POLICY:

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COMPLIANCE-KEY ELEMENTS

Financial options will be given to all patients that have a financial obligation. This will include a financial packet given on admission or a letter sent to the patient after admission highlighting their options which included information about financial assistance.

The determination of charity care generally should be made at admission or shortly thereafter, however, events after admission or at time of service could change the ability of the patient to pay. Accordingly, retrospective determination is possible. Designation as charity care will only be considered after all other resources have been exhausted. It is possible that only a portion of the patient's account would meet the definition to be recognized as charity care. Patient account transactions for charity care must be posted in the month the determination is made.

Appropriate signage will be visible in the facility, specifically in patient intake areas and the business office creating awareness for the charity care program and the assistance available. All public information and/or forms regarding the provision of charity care will use languages that are appropriate for the facility's service area.

ELIGIBILITY CRITERIA:

Uncompensated care is secondary to all other financial resources available to the patient, including group or individual medical plans, workers compensation, Medicare, Medicaid or medical assistance programs, other state, federal, or military programs, third party liability situations (e.g. auto accidents or personal injuries). Health Savings Accounts or any other situation in which another person or entity may have legal responsibility to pay for the costs of medical services.

Financial assistance and charity care shall be limited to "appropriate medical services" as defined in WAC 246-453-010(7).

Any patient communication that occurs after transfer to a bad debt agency identifying a declared inability to pay due to financial reasons should be referred to the Revenue Cycle Director for charity care qualification determination. All standard methods of qualification and validation will be used as outlined above to make this determination.

Charity care determination will be based on the Federal Income Poverty Guidelines as published annually by the Department of Health and Human Services in the Federal Register as well as Samaritan Healthcare's hospital pledge with WSHA.

The patient's gross income beginning a or below 300% of the Federal Poverty level, uncompensated care will be made available to all eligible applicants. Applicants with income above 300% of the Federal Poverty level will be responsible for the entire amount owing with the exception as identified in catastrophic uncompensated care. Applicants with income at or below 300% of the Federal Poverty level will qualify for an uncompensated care write-off based on their ability to pay with the following minimum discounts:

100% of poverty level = 100%
101 – 200% of the poverty level = 50%
201 – 300% of the poverty level = 36%

Other factors to be considered in determining eligibility may include, but are not limited to the following:

a. The patient's net worth and liquidity
b. The patient's employment status and capacity for future earnings
c. Other living expenses and financial obligations
d. The previous exhaustion of all other available resources

Catastrophic Uncompensated Care: The hospital may write off as uncompensated care amounts for patients with family income in excess of 300% of the Federal Poverty Standard when circumstances indicate severe financial hardship or personal loss. Catastrophic illnesses are usually where the medical bills exceed the family's gross annual income, and/or net worth and liquidity.

Prima Facie Write-Offs: The hospital may choose to grant uncompensated care based solely on the initial determination. In such cases, the hospital will not complete full verification or documentation of any request. This could include patients that qualify for Medicaid and are not covered for the date of service or patients that are homeless.

ELIGIBILITY DETERMINATION:

Screening Procedure: During the patient registration process, patients without coverage, limited coverage and any patient requesting financial assistance may be screened by the financial counselor and/or registration clerk and provided a summary of all financial options available. If uncompensated care application is requested, the hospital will not initiate collection efforts or requests for deposits, provided the responsible party is cooperative with the hospitals efforts to reach a determination of sponsorship status, including return of applications and documentation within fourteen (14) days of receipt pending final eligibility determination. Patients are responsible for completing the required application forms and cooperating fully with the information gathering and assessment process, in order to determine eligibility for charity care.

The hospital will exercise the following options:

A. The hospital will use an application process for determining initial interest in and qualification for uncompensated care. Should the patient choose not to apply for uncompensated care, they will not be

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considered for uncompensated care unless other circumstances of intent become known to the hospital and the patient/Guarantor complies with application process.

B. Requests to provide uncompensated care will be accepted from sources such as physician, community or religious groups, social services, financial services personnel, or the patient. If the hospital becomes aware of factors which might qualify the patient for uncompensated care under this policy, it will advise the patient or guarantor of this potential and make an initial determination that the account is to be treated as uncompensated care.

All patient's accounts that are pending final determination will have pending charity care financial class assigned. Once the account is approved the final charity care financial class will be assigned as appropriate and the appropriate adjustment code uses.

- No other coverage – Charity financial class is the Primary Payer,
- Any payer coverage – Charity financial class is the Secondary Payer

Application Process: An effort will be made to secure a signed application, but this may not be possible in all cases. Uncompensated care may be granted based solely on the initial determination. In such cases, the hospital will not complete full verification or documentation of any request. This would include but not limited to Patients who qualify for Medicaid with charges for days or services not covered that are patient responsibility, homeless patients and deceased patients with no estate. In these cases, at the discretion of the Revenue Cycle Director, the patient or family member do not need to complete a confidential financial statement. Instead, charity care determination may be made by the financial counselor's completion of the eligibility worksheet.

Patients will be asked to provide verification of ineligibility for Medicaid or Medical Assistance. During the initial request period, the patient shall pursue other sources of funding, including Medicaid if appropriate.

Income Verification: All applications, whether initiated by the patient or the hospital must be accompanied by documentation to verify income amounts stated on the application form. One or more of the following documents may be accepted for verification of income.

A. Pay stubs for all employment during 3 months prior to the date of the request

B. An income tax return from the most recently filed calendar year complete with W-2 withholding statements.

C. Forms approving or denying eligibility for Medicaid and/or state-funded Medical Assistance

D. Forms approving or denying unemployment compensation or social security benefits

E. Written statements from employers or welfare agencies

F. Phone verification form welfare agencies

G. Bank Statements

H. Completed verification of absence of income form

Income shall be annualized from the date of application based upon documentation provided and upon verbal information provided by the patient. The annualization process will be determined by the hospital and will take into consideration seasonal employment and temporary increased and/or decreases of income.

In determining a patient's total income, other financial assets and liabilities of the patient may be considered as well as the patient's family income and the ability to pay. If a determination is made that the patient has the ability to pay the remainder of the bill, such determination does not preclude a reassessment of the patient's

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ability to pay upon presentation of additional documentation. During the verification process, while the hospital is collecting the information necessary to determine a patient's income, the patient should be treated as a pending charity care patient in accordance with the hospital policies.

ASSETS:

- All liquid assets should be considered as a possible source of repayment for services rendered. For patients with no source of regular income (employment, SSI, disability, etc.) other than liquid assets, those assets would be the patient's income source and should be measured against the Federal Poverty Guidelines.
- All other assets, i.e., real estate property, etc. should be considered as a possible source of repayment for services rendered.
- On a case-by-case basis, it may be appropriate to reduce the patient's balance equal to their liquid assets, thereby resulting in partial charity care. In the instance where partial charity is determined the remaining balance will be billed to the patient and normal financial protocols are applicable.
- For those at or below 100% of the poverty assets are excluded, for those above 100% of the poverty level assets may be included.

If the applicant being reviewed was approved as indigent care/charity care patient within the last 3 months prior to the current review, he/she is considered indigent/charity at the time of the current review. New income information is not required. The patient Accounts Representative who is responsible for the account shall complete this information worksheet. Patients who have been denied for indigent/charity care allowance may reapply within 3 months of the original application date.

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Documentation Unavailable: In cases where the patient is unable to provide documentation verifying income, the following procedures should be followed:

- **Obtain Patient's Written Attestation:** Have the patient sign the Financial Assistance Application attesting to the accuracy of the income information provided as well as the Verification of Absence of Income form.
- **Obtain Patient's Verbal Attestation:** The financial counselor who is completing the financial assistance application may provide written attestation that the patient verbally verified the income calculation. In all cases, at least two attempts must be made and documented to attempt to obtain the appropriate income verification.
- **Expired Patients**: Expired patients may be deemed to have no income for purposes of the financial calculation. Although no documentation of income is required for expired patients, an asset verification process should be completed to ensure that a charity care adjustment is appropriate. A copy of the death certificate should be attached to the application and documentation must be recorded on the patient eligibility worksheet that efforts were made to verify estate information through a family member or with the county court house.
- **Balance after Medicaid**: Should the amount being considered for indigent care allowance be a Medicaid Co-Pay amount, a copy of the Spend-down letter must be attached to the charity application. No income information is required if a copy of the authorization is attached. If the spend-down letter is not available, a copy of the RA showing patient responsibility must be attached.

Final Determination: All prepared applications will be presented to the charity committee on a weekly basis or as requested by the Revenue Cycle Director. The committee is comprised of the Revenue Cycle Director and 2 private pay representatives. All write offs less than $10,000 will be approved and signed by the Revenue Cycle Director. All accounts over $10,000 that meet criteria will have final approval by the CFO.

Samaritan Healthcare will provide a final determination within fourteen (14) days of receipt of a completed application and documentation.

Denials will be written and include instructions for appeal or reconsideration as follows:

- The patient/guarantor may appeal the determination of eligibility for uncompensated care by providing additional verification of income, family size or letter explaining circumstances to the financial counselor within thirty (30) days of receipt of notification of denial. All appeals will be reviewed by the Revenue Cycle Director. If this determination affirms the previous denial of uncompensated care, written notification will be sent to the patient/guarantor and the Department of Health, in accordance with state law.If facility has initiated collection activities and discovers an appeal has been filed, we shall cease collection efforts until the appeal is finalized. Initial charity denial can be appealed a maximum of two (2) times.
- If the patient or responsible party has paid some, or all, of the bill for medical services and is later found to have been eligible for financial assistance or charity care at the time services were provided, he/she shall be reimbursed for any amounts in excess of what is determined to be owed. The patient will be reimbursed within thirty (30) days of receiving the financial assistance or charity care designation.

UNCOOPERATIVE PATIENTS:

Uncooperative patients are defined as unwilling to disclose any financial information as requested for4 Medicaid and/or charity care determination during the screening process. In these cases, the account will not be processed as charity care. The patient will be advised that unless they comply and provide information, no further consideration will be given for charity care processing and standard A/R follow-up will begin.

NON-COMPLAINT PATIENTS:

Non-compliance patients are defined as not meeting all required documentation for Medicaid screening, but qualify for charity care. In these cases the Financial Counselor may process the account and may be considered for charity care.

INFORMATION FALSIFICATION:

Deliberate falsification of information will result in denial of the Financial Assistance Application. If, after a patient is granted financial assistance, the hospital finds material provision(s) of the Financial Assistance Application to be untrue, charity care status may be revoked after the Charity Committee review and the patient's account may be forwarded to a collection status.

DOCUMENTATION AND RECORDS:

All information relating to the application will be kept confidential. A complete copy of all documents, which support the application, will be kept with the application form for a minimum of seven (7) years. If the patient is a Medicare patient, and the charity application has proven the patient indigent which qualifies for Medicare Bad Debt, a complete copy of the application and supporting documentation will be kept with the Medicare files for a minimum of ten (10) years.

REFERENCES:

WAC 246-453, WSHA Hospital Pledge, CCMS Reimbursement Manual, Chapter 3

All revision dates:	1/4/2017, 10/20/2015, 9/9/2015, 9/3/2015, 3/2/2012, 6/1/2009

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Attachments:

No Attachments

Approval Signatures

Approver	Date
Lisa McDaniel: Director	1/4/2017
Chandra Rodriguez: Generalist	1/4/2017

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