CMG A DIVISION OF MERCY MEDICAL CENTER

Uninsured/Underinsured Patient Discounts (Charity Care)

Effective Date: March 2020

POLICY

Centennial Medical Group (CMG) is called upon to meet the needs of patients who seek care, regardless of their financial abilities to pay for services provided. Financial Assistance/Charity Care traditionally has been defined as care provided to patients without expectation of partial or full payment for services as a result of a patient's financial inability to pay. Financial Assistance/Charity Care may be provided to patients who are uninsured, underinsured or determined to be medically indigent.

Financial Assistance/Charity Care is secondary to all other financial resources available to the patient, including group or individual medical plans, worker's compensation, Medicare, Medicaid or medical assistance programs, and other state, federal or military programs. Financial Assistance/Charity Care is also secondary to third party liability situations (e.g., auto accident or personal injuries) or any other situation in which another person or entity may have a legal responsibility to pay for the costs of a patient's medical services.

AUTHORIZATION

Authorization for charity care discounts shall be restricted to patient financial services directors and other management resources above the director level. Approval limits for charity care discounts are established by CMG in accordance with policies approved by its Board of Directors.

DETERMINATION

Eligibility for charity care discounts is determined on income at or below 400% of the FPL. Any patient whose income is between 301% of the FPL and at or below 400% of the FPL shall receive discounted care up to 50% from his or her account balance after payment, if any, by any third party(ies) as well as the patient/guarantor's available assets, and any extenuating circumstances. Patients who require non-emergent care must be residents of CMG's service area to be eligible for charity care discounts.

The initial determination shall include an estimate of the need for future services requiring financial assistance. Additionally, separate determinations of eligibility for charity care discounts shall be made for each date of service. *Confirmation of continued eligibility shall be updated every 90 days for patients who require ongoing health care services.* An individual's occupation may be indicative of eligibility for a charity care discount.

Application information may indicate that a patient is eligible for financial assistance or insurance coverage not only for health care services but also for other benefits. Financial counseling staff shall assist patients in applying for available coverage.

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CMG shall make a subjective decision about a patient/guarantor's medically indigent status by reviewing formal documentation for any circumstance in which a patient is considered eligible for a charity care discount on the basis of medical indigence.

PROCEDURE

Financial Assistance Application Process for Current Patients:

1. Patients may request a Financial Assistance application or a CMG representative may offer one to patients who indicate they are unable to pay their balance and/or are unable to make payment arrangements.
2. Financial Assistance applications must be requested and given/sent to the patient within 60 days from the date of the first statement to the guarantor.
    a. Patient bills will include a statement notifying the guarantor that if they believe they would qualify for Financial Assistance, they need to contact the business office to request an application within 60 days of their first statement.
3. The CMG representative giving/sending the Financial Assistance application to the patient will stamp the date that the application was given to the patient in the top right hand corner of the application. The patient has 30 days from that date to complete and return the application with the supporting documentation.
4. The CMG representative shall also write the first eligible date of service under the stamped date.
5. All Financial Assistance Applications (Addendum D) for all CMG clinics will be returned to the Mercy Business Office, ATTN: Financial Assistance, 2700 Stewart Parkway, Roseburg, OR 97471, where they will be processed.
   All Financial Assistance applications will be date stamped by the business office upon arrival.
6. All complete Financial Assistance applications will be processed within 10 working days of their receipt. If an application is incomplete (missing information or attached documentation), the guarantor will be notified by phone or mail that their application is incomplete, and they will have 10 additional working days to submit the needed information. If the requested information is not received within 10 working days, the account will be handled according to the Credit and Collection Policy (LF-06).
7. Once the determination for eligibility for Financial Assistance has been established (25%, 50%, 75% or 100%), that percentage will be applied to the outstanding balance at that time. No refunds will be issued for prior payments made, and any balances that have already been sent to collections will not be cancelled with the collection agency.
8. CMG shall utilize determination on income at or below 400% of the FPL. Any patient whose income is between 301% of the FPL and at or below 400% of the FPL shall receive discounted care up to 50% from his or her account balance after payment, if any, by any third party(ies) as well as the patient/guarantor's available assets, and any extenuating circumstances.
9. Financial Assistance Applications for balances less than $49,999 shall be reviewed and approved by the Director of Business Services or designee. Balances of $50,000 or more shall require approval by Mercy Medical Center's CFO or designee.
10. Patients applying for Financial Assistance will receive an approval or denial letter by mail.
11. Once the determination for eligibility for Financial Assistance/Charity Care has been established, it will remain in place and cover all dates of services included in the approved episode of care for the time period starting 60 days prior to the date the applications is received through 60 days after the date received.
12. A note will be sent to the appropriate CMG billing entity indicating the start and end dates for Financial Assistance, along with the percentage of assistance.
13. The need for future services requiring Financial Assistance/Charity Care shall be assessed. Confirmation of continued eligibility shall be updated every 90 days for patients who require ongoing health care services.

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14. Any patient seen by a CMG provider for care having been granted financial aid/charity care from Mercy Medical Center will receive the same level of financial aid/charity care from the CMG provider for those services provided in the hospital for that date of service. Financial Assistance for any follow-up dates of service in the clinic will require a separate CMG Financial Assistance application.
15. All financial assistance applications and their supporting documents will be stored electronically.

Financial Assistance Process for New (never been seen) Patients:

1. New patients with no insurance may apply for Financial Assistance, but will need to pay the lesser of either the self-pay discount price for that service or a $100 minimum at the time of service. This minimum payment shall be due the first time a patient receives services at each individual CMG practice.
2. "Financial Assistance" will be written at the top of the superbill and the account will be flagged to note "Financial Assistance Pending" by the Biller/Financial Account Representative posting the charge.
3. The remainder of the process is the same as for current patients (see above).

Financial Assistance Coverage/Exclusions:

1. Financial Assistance will be granted for patients with out of state Medicaid payers that CMG is not contracted with.
2. Financial Assistance will not be granted for:
   a. Any services related to an MVA or Homeowner's liability, unless the patient's PIP insurance is exhausted and they have no medical insurance.
   b. Any balances (coinsurance, deductible, etc.) that are due to the patient selecting an HMO and being seen out of network.
   c. DME (Durable Medical Equipment)
   d. Cosmetic surgery
   e. All preventative care (Complete Physical Exams, Sports Physicals, immunizations, etc.)

Hospitalist and Pathologist Services

Since Hospitalist and Pathologists services are hospital-based, they will follow the Mercy Financial Assistance policy.

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Providing Financial Assistance to Patients

1. CMG has criteria for determining whether a patient is eligible for a charity care discount, and the amount eligible for write-off or discount, taking into consideration residency within CMG's service area, income, family size, available resources, and the likelihood of future earnings (net of living expenses) sufficient to pay for the health care services provided. CMG evaluates all available financial resources – not only of the patient, but of other persons having legal responsibility to provide for the patient, such as a parent of a minor patient, or the spouse of a patient -- before determining financial assistance eligibility. The patient/guarantor shall be required to provide information and verification of ineligibility for benefits available via insurance (individual and/or group coverage), Medicare, Medicaid, Workers' Compensation, third-party liability (personal injury payments, etc) and other programs. Patients with health spending accounts (HSAs), formerly known as medical spending accounts (MSAs), are considered to have insurance; the amount that the patient has on deposit in the HSA is to be considered insurance and not eligible for any discount.

2. CMG uses the Financial Assistance Application form and the Charity Care Determination Checklist both standardized by CHI.

All information obtained from patients and family members shall be treated as confidential. Assurances about confidentiality of patient information shall be provided to patients in both written and verbal communications. Assessment forms shall provide documentation of all income sources on a monthly and annual basis (taking into consideration seasonal employment and temporary increases and/or decreases in income) for the patient/guarantor, including evidence of:

- Income from wages
- Income from self-employment
- Alimony
- Child support
- Military family allotments
- Public assistance
- Pension
- Social Security
- Strike benefits
- Unemployment compensation
- Workers' Compensation
- Veterans' benefits
- Other sources, such as income from dividends, interest or rental property

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Copies of documents to substantiate income levels shall be obtained (e.g., paycheck stubs, alimony and child-support documents).

For situations in which patients have other assets, liquid assets shall be defined as investments that could be converted into cash within one year; these assets shall be evaluated as cash available to meet living expenses. Assets that shall not be considered as available to meet living expenses include a patient's primary place of residence, adequate transportation, adequate life insurance, and sufficient financial reserves to provide normal living expenses if the wage earners are unemployed or disabled. Listings of other assets shall be provided, including copies of the following documents:

- Savings, certificates of deposit, money-market or credit union accounts
- Descriptions of owned property

The patient/guarantor shall provide demographic information for the patient/guarantor. The patient/guarantor shall provide information about family members and/or dependents residing with the patient/guarantor, including the following information for all:

- Name, address, phone number (both work and home)
- Age
- Relationship

In evaluating the financial ability of a patient/guarantor to pay for health care services, questions may arise as to the patient/guarantor's legal responsibility for purported dependents. While legal responsibility for another person is a question of state law (and may be subject to Medicaid restrictions), the patient/guarantor's most recently-filed federal income tax form shall be relied upon to determine whether an individual should be considered a dependent. The patient/guarantor shall provide employment information for the patient/guarantor, as well as any others to whom the guarantor is legally obligated in regard to the well-being of the patient. Such information shall identify the length of service with the current employer, contact information to verify employment and the individual's job title.

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Assessment forms shall provide for a recap of average monthly expenses including:

- Rental or mortgage payments
- Utilities
- Car payments
- Food
- Medical bills

Copies of rent receipts, utility receipts, or monthly bank statements shall be requested. Determination of eligibility for charity care discounts shall occur as closely as possible to the time of the provision of service to enable CMG to properly record the related revenues, net of charity care.

CMG utilizes a sliding scale to provide up to a full discount of charges for patients with no third-party insurance, and up to a full waiver of co-payments after third-party insurance proceeds, based on indigence. The following points are taken into consideration:

a. The standards of eligibility for the application of charity discounts must consider assets as well as income. Eligibility shall be based on income at or below 400% of the FPL. Any patient whose income is between 301% of the FPL and at or below 400% of the FPL shall receive discounted care up to 50% from his or her account balance after payment, if any, by any third party(ies) as well as the patient/guarantor's available assets, and any extenuating circumstances.

b. When circumstances indicate the presence of severe financial hardship or personal loss, those patients with few resources and a high number of dependents shall receive higher levels of financial assistance. This shall be determined by the use of a sliding scale based on income and family size.

CMG retains a central file, containing financial assistance applications, on each patient/guarantor. To ensure confidentiality, applications for financial assistance shall not be retained with the patient account registration or detailed billing information. A listing of all charity care discounts documenting;

- patient names,
- patient account numbers,
- dates of service,
- brief descriptions of services provided,
- total charges,
- amounts written off to charity,
- dates of write-offs, and
- the names of the authorizing individuals

shall be maintained by the accounting department. Written denials of charity care discounts, including denial reasons, shall be retained in a confidential central file.

C. Medical Indigency

The decision about a patient's medical indigency is fundamentally determined by CMG without giving exclusive consideration to a patient's income level when a patient has significant and/or catastrophic medical bills. Medically indigent patients do not have appropriate insurance coverage that applies to services related to neonatal care, organ transplants, cancer, lengthy and/or intensive care, burn care, etc., within the context of medical necessity. Such patients may have a reasonable level of income but a low level of liquid assets, and the payment of their medical bills would be seriously detrimental to their basic financial well-being and survival.

1. The patient shall apply for a charity care discount in accordance with the CMG's Administrative policy in effect.
2. CMG shall obtain and/or develop documentation to substantiate the medical indigency of the patient. The following are examples of documentation that shall be reviewed:
    - Copies of all patient/guarantor medical bills.
    - Information related to patient/guarantor drug costs.
    - Multiple instances of high-dollar patient/guarantor co-pays, deductibles, etc.
    - Other evidence of high-dollar amounts related to health care costs, such as the existence of an HSA that has been fully expended.

3. CMG shall grant a charity care discount either through the use of the sliding scale approach or up to 100% if the patient has the following:
   - No material applicable insurance.
   - No material usable liquid assets.
   - Significant and/or catastrophic medical bills.

   In most cases, the patient shall be expected to pay some amount of the medical bill, but CMG shall not determine the amount for which the patient shall be responsible based solely on the income level of the patient.

D. Presumptive Eligibility for Charity Care

There are occasions when a patient may appear eligible for a charity care discount, but there is no financial assistance form on file because documentation was lacking that would support the provision of financial aid. Such instances have resulted in a patient's bill being assigned to a collection agency and ultimately recognized in the accounting records as a bad debt expense, due to a lack of payment. This approach, however, results in neither a fair solution for the patient nor an appropriate accounting of the transaction. Often there is adequate information provided by the patient, or through other sources, that could provide CMG with sufficient evidence to provide the patient with a charity care discount without needing to determine eligibility for medical indigency. This presumptive eligibility, when properly documented internally by CMG's staff, is sufficient to grant a charity care discount to patients who qualify. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted to the patient by CMG is a 100% write-off of the account balance.

Some patients are presumed to be eligible for charity care discounts on the basis of individual life circumstances (e.g., homelessness, patients who have no income, patients who have qualified for other financial assistance programs, etc.). CMG will grant 100% charity care discounts only to patients determined to have presumptive charity care eligibility, and shall document internally any and all recommendations from patients and other sources such as physicians, community or religious groups, internal or external social services, or financial counseling personnel regarding provision of presumptive charity care discounts.

1. To determine whether a qualifying event under presumptive eligibility applies, the patient/guarantor shall provide a copy of the applicable documentation, dated within 30 days from the date of service. The determination of presumptive eligibility for a 100% charity care discount shall be made by Mercy on the basis of patient/guarantor income, not solely based on the income of the affected patient.

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2. For instances in which a patient is not able to complete an application for financial assistance, CMG may grant a 100% charity care discount without a formal request, based on presumptive circumstances, approved by the director of patient financial services, in accordance with CMG policy.

3. CMG utilizes the Patient Discount Application Form – Presumptive Eligibility.

Individuals shall not be required to complete additional forms or provide additional information if they already have qualified for programs that, by their nature, are operated to benefit individuals without sufficient resources to pay for treatment. Rather, services provided to such individuals shall be considered charity care and shall be considered as qualifying such patients on the basis of presumptive eligibility. The following are examples of patient situations that reasonably assist in the determination of presumptive eligibility:

a. Patient has received care from and/or has participated in Women's, Infants and Children's (WIC) programs.

b. Patient is homeless and/or has received care from a clinic for the homeless.

c. Patient is eligible for and is receiving food stamps.

d. Patient's family is eligible for and is participating in subsidized school lunch programs.

e. Patient qualifies for other state or local assistance programs that are unfunded or the patient's eligibility has been dismissed due to a technicality (i.e., Medicaid spend-down).

f. Family or friends of a patient have provided information establishing the patient's inability to pay.

g. The patient's street address is in an affordable or subsidized housing development. In this case:

- Mercy shall contact the individual state agency that oversees HUD Section 8 subsidized housing programs for low-income individuals.
- CMG shall maintain a listing of eligible addresses in Douglas County.

h. Patient's/guarantor's wages are insufficient for garnishment, as defined by state law.

i. Patient is deceased, with no known estate.