COLLEGE HOSPITAL COSTA MESA **Policy and Procedure BO-2A**	**Page 1 of 5** **Date Adopted: January 2007** **Approval: EXECUTIVE TEAM**
SUBJECT: Charity Care Plan	
DEPARTMENTS: Business Office, Access Services	

PURPOSE
College Hospital Costa Mesa's mission is to develop, manage and promote a continuum of health care services to meet the behavioral and medical needs of its communities.

This charity policy is a means through which College Hospital Costa Mesa will work to meet the behavioral and medical needs of its patients by offering medical services at no charge or at nominal charge for qualified patients. While County government has the responsibility for providing services to the indigent, College Hospital assists in carrying out that responsibility. Helping to meet the needs of the uninsured and underinsured is an important element in our commitment to the community.

WHO MAY PERFORM/RESPONSIBLE
Access Services, Business Office

POLICY/PROCEDURE
The criteria the hospital will follow in qualifying patients or programs for charity purposes are provided in this policy. The hospital has developed these policies in written form and will apply them consistently to all patients.

I. General Process and Responsibilities
   A. Those patients that currently do not pay for their medical bills because of lack of third-party insurance and/or an otherwise inability to pay are covered under this policy. The overall mission of the hospital is expressly demonstrated in this charity policy and through its everyday practices. The Board of Directors, demonstrating through their leadership and affirmation of our mission, has adopted the policy in this document.
   B. All patients unable to pay for their medical bills will be requested to complete a Financial Evaluation Form. This form is available in English and Spanish. It is our goal to have all elective admissions screened for ability to pay. All patients, including those thought to be eligible for Medi-Cal, Victims of Crime, or any other third party coverage, but who are not currently approved for coverage, should still complete the financial screening form if at all possible.
   C. Completion of this form:
      1. Allows the hospital to determine if the patient has declared income and/or assets giving them the ability to pay for the health care services they are about to receive;
      2. Gives the hospital explicit permission to complete a credit check for this individual prior to the billing and collection process;

3. Provides a document to be reviewed by the Business Office staff after the patient is discharged to determine financial class assignment; and
4. Provides an audit trail in documenting the hospital's commitment to providing charity care.

D. All patients whose account are not covered by third party insurance will be asked for a cash deposit from either the patient or the patient's guardian. The deposit will be based on the costs of the estimated services to be received and the ability to pay. Insured patients who indicate that they are unable to pay patient liabilities may be screened at the time of admission, with follow up after insurance billing occurs.

E. Before determining that a patient does not have the ability to pay, the financial screening process requires the hospital staff to make a good faith effort to collect the following information:
   1. Individual or family income.
   2. Individual or family net worth including assets, both liquid and non-liquid, less liabilities and claims against assets. Eligibility for Medi-Cal once some assets are depleted will also be considered.
   3. Employment status. This will be considered in the context of the likelihood future earnings will be sufficient to meet the cost of paying for these health care services within a reasonable period of time. Payment plans will be limited to those which can reasonably be liquidated within 12 months. In unusual circumstances and with permission from the management of the Business Office longer-term plans may be implemented.
   4. Unusual expenses or liabilities.
   5. Family size. This is used to determine the benchmark for 100% charity, if income is at or below the established income levels.

F. This policy indicates that information will be based upon a signed declaration by the patient or patient's family, verification through credit checks and/or other documentation provided by the patient or the patient's family. Additional information may be required only for special circumstances or as determined by management. Non-emergency patients will be asked to provide proof of income during pre-admission screening. It is understood that in some cases this information will not be available and therefore the Patient Access staff will indicate this on the screening forms and place them inside the patient's folder.

G. The attached form is to be used in the financial screening process:
   1. Form 1: Financial Evaluation Form (this form also gives permission to obtain credit information).
   2. The Financial Evaluation Form will be available in the primary languages spoken in the hospital's community area, including English and Spanish.

H. Approval or denial letters will not be provided, as notification of payment obligations, charity assignment in full or in part, and payment plan options will automatically occur with the financial classification assignment. Any billing statements to the patient will indicate the amount written off to charity. Patient account folders will include completed forms, credit check printouts, and Patient Access staff notes.

I. This policy is based upon the most current federal poverty level (FPL) guidelines. Based upon the hospital's demographics and the mission to meet the health care needs of its community, the primary qualifying levels are based upon 350% of the federal poverty guidelines. In subsequent years, this percentage will be evaluated and modified as necessary.

J. To qualify for charity care for either the entire hospital bill or a portion of the hospital bill, the following criteria must be met:
    1. Coverage – The services being provided are not covered/reimbursed by Medi-Cal or any other third party, the patient is self-pay, the patient has medical expenses which exceed 10% of the family income, and/or the patient has family income at or below 350% of the FPL.
    2. Income Level – If the patient's income is 200% or less of the FPL, the entire hospital bill will be written-off, regardless of net worth or size of bill.
    3. Income Level – If the patient's income is between 201% and 350% of the FPL, then a portion of the hospital bill is written-off based upon a sliding scale, regardless of net worth or size of bill, as follows:
        a. 201% - 250% = 80% write-off, with maximum liability of $5,000 (annually in the case of multiple hospital stays).
        b. 251% - 350% = 60% write-off, with maximum liability of $7,500 (annually in the case of multiple hospital stays).

II. Charity Determination, Forms and Recordkeeping

A. The form used for financial screening is attached to the charity care policy. The form requests annual income (plus verification of income) and other relevant information. Family size and special circumstances are also requested. All requested information will be used to determine if a patient is eligible for a write-off of their hospital bill, partially or in total.

B. Hospital financial records will include the recording of health care services at full charges for revenue documentation, adjusting these amounts by payments from individuals or other third parties. Accounts which have been inappropriately recorded as bad debt balances will be reclassified as charity write-offs after the accounts are restored to receivable status or special accounting adjustments are recorded. Documentation concerning the eligibility for charity care status will be maintained in the patient's records.

III. Classification and Determination of Payment Shortfalls

A. Many government programs (Medi-Cal, Healthy Families, and Medicare) and other third party coverage programs have been established to provide for or defray the healthcare costs for individuals who also may be considered needy. In the case where arrangements for payments to the hospital require the hospital to accept the payment amount as payment in full, the balances of these accounts written off due to the difference between hospital charges and payment rates are attributable to contractual adjustments and will not be considered charity care. In cases where these programs require the patients to pay co-payments or deductibles and the patients do not have the ability to pay; these amounts will be considered charity care.

B. Charity determination will be granted on an "all, partial, or nothing" basis. For those who are determined to be ineligible for charity care, they will be notified that they may appeal their decision by sending a written request to the Patient Accounting Department. There is a category of patients who qualify for Medi-Cal, but do not receive payment for their entire stay. Under the charity care policy definition, these patients are eligible for charity care write-offs. In addition, the hospital specifically includes as charity the charges related to denied stays, denied days of care, and non-covered services. These Treatment Authorization Request (TAR) denials, any lack of payment for non-covered services provided to Medi-Cal patients, and other denials are to be classified as charity.

These patients are receiving the service, and they do not have the ability to pay for it. In addition, Medicare patients who have Medi-Cal coverage for their co-insurance/deductibles, for which Medi-Cal does not make payment and Medicare does not ultimately provide bad debt reimbursement will also be included as charity. These indigent patients are receiving a service for which a portion of the resulting bill is not being reimbursed.

C. Administrative adjustments have historically included write-offs for bankruptcy or other special circumstances indicating the patient's inability to pay. These adjustments and write-offs will be reclassified as charity care as they meet the hospital's criteria for charity care. In addition, patients who are seen but have not provided hospital staff with any financial information prior to their departure from the hospital may be written off to charity care, based upon historical experience with this patient population. Patients who are known to be homeless will also be eligible for full charity care.

D. Collection agency reports may identify certain patient accounts returned to the hospital after the collection agency has determined that the patient does not have the resources to pay their bill. The Business Office may deem these accounts to be charity care accounts. These reports will be used in lieu of the Financial Evaluation Form. A note referencing the specific collection agency report (by date) will be included in the patient file as well as the central file. The Business Office will make the appropriate transactions to reverse bad debt adjustments and reclassify these accounts to charity care.

IV. Charity Determination Process

A. Access Services Department Role

1. Access Services will establish programs that lead to financially screening 100% of all self-pay inpatients. If there is no income claimed by the patient and no third party insurance, the patient will complete the Financial Evaluation Form with assistance from the hospital's staff. The Financial Evaluation Form provides financial information, along with patient or family approval allowing the hospital to complete a credit check, if necessary, before billing and collection begins. The credit check will be completed as appropriate to confirm financial status.
2. Staff should request a deposit from patients who indicate they have no insurance coverage. However, they should be prepared to give self-pay outpatients who indicate that they are unable to pay their bill the Financial Evaluation Form. Patients will be asked to complete the form prior to discharge. The hospital will continue to attempt to place indigent patients with a county facility.

B. Business Office Role

1. The charity care financial classification code will always be assigned when the income levels based on family size are equal to or less than the established income levels based upon the federal poverty guidelines, along with the add-on for each additional dependent. If a partial write-off of the bill is warranted based upon the initial financial screening, the charity care write-off transaction code will be assigned for that portion of the hospital bill.
2. Verification of income will be through the receipt of paycheck stubs, recent tax returns and/or W-2 forms, as requested by the hospital's staff. If the patient's only income is General Relief, no hard copy verification is requested. A credit report will be obtained based upon the patient's Social Security Number in all situations where necessary to confirm the information provided. After appropriate verification, those patients meeting the hospital's charity care criteria will be assigned a charity financial classification code.

3. Patients who are designated self-pay by Access Services, and are not classified as meeting the charity care criteria, based on the established income levels, will be contacted by the Business Office staff and asked to complete a request for a payment plan, or provide further information that was not obtained during the initial financial screening process. Those patients determined to have the ability to pay part or all of their bill will be requested to make a deposit based upon the expected amount of the bill, and will be offered a payment plan for a term of one year or less. If a discount or payment plan is established, consideration will be made to write off a part of the bill as charity when appropriate circumstances warrant. Staff will approve charity care status, with appropriate management approval, when consistent with the guidelines discussed earlier in this policy

V. Charity Policy Compared to Charity Determination Process

A. Key points to this policy include:

1. The identification of potential charity patients as close to the time of admission as possible.
2. The Financial Evaluation Form will be used and a credit check performed for most self-pay patients, whenever possible.
3. Income will routinely be verified for non-emergency self-pay patients and will be used in all circumstances to determine charity status.
4. The actual charity care determinations will be made based upon the criteria expressed in this charity care policy.
5. Charity determination will be granted on "all, partial, or nothing" basis.

REFERENCES: Clark, Koobajian and /////// report

ATTACHMENTS: Financial Evaluation form

REVIEWS

Date Reviewed	Committee Review (If applicable)	Initials of Reviewer
12/07		ST

Revised:

COLLEGE HOSPITAL COSTA MESA **Policy and Procedure *Assign #***	**Page 1 of 3** **Date Adopted: December 2006** **Approval: EXECUTIVE TEAM**
SUBJECT: Discount Plan & Write-Offs	
DEPARTMENTS: Patient Accounting	

PURPOSE
No accounts shall be adjusted for discounts or ***write-offs*** without written authorization from the Business Office Manager and Chief Financial Officer.

WHO MAY PERFORM/RESPONSIBLE
Patient Accounting Department

POLICY/PROCEDURE

1. Discounts may be considered in advance of a patient's hospitalization or after discharge. Upon completion of a financial disclosure, a discount may be offered depending on financial needs, and whether the patient is financially eligible.
2. A patient is financially eligible for the discount plan if they meet any or all of the following conditions:
    a.) Self-pay patient without third-party insurance and no Medicaid.
    b.) Patients with family income at or below ***350%*** of the Federal Poverty Level.
    c.) Patients with high medical costs.
3. When establishing the patient's financial eligibility for the discount plan, proof of income is limited to income tax returns or pay stubs. Patients must be notified of their right to submit a written request for appeal if they do not qualify for the discount plan. Appeals will be sent to the Patient Accounting Department.
4. Persons willing to settle an account after payment arrangements have been made may be allowed to do so. However, each case is handled on an individual basis.
5. Interest free, negotiable extended payment plans may be available to the patient.
6. If payment is received within 10 business working days, the Patient Account Representative/Analyst may request a 15% administrative discount on the balance due. No payment agreements can be made on the discounted amount. A prior month must be submitted along with the adjustment request. Pay type 58 must be used.
7. Accounts determined to be uncollectible are written off as bad debt and referred to a collection agency. The Business Office Manager must review all such accounts prior to being written off and approved. The following items must be attached to all accounts before submission (see attachments).
    a.) Letter One (notification letter – Exhibit C)
    b.) Letter Two (final letter – Exhibit D)

c.) Over $200.00, phone call must be made
d.) 2 copies of documentation (printout of Admission Status Inquiry Report)
e.) Cover Sheet (pink collection agency/blue non-collection agency)
f.) Payments made by insurance company/patient (EOB/RA)

Any information obtained from the patient in determining eligibility must not be sent to the collection agency.

8. Prior to referral to a collection agency, the patient must be notified that nonprofit credit counseling may be available to assist the patient. The attached notification must be provided to the patient.
9. The Chief Financial Officer must review all patient files to be referred to a collection agency.
10. The Business Office Manager and Chief Financial Officer must approve all cases before suit is filed against debtors. Suit must not be commenced against a patient for nonpayment prior to 150 days after the initial billing.

REFERENCES:

ATTACHMENTS:

REVIEWS

Date Reviewed	Committee Review (If applicable)	Initials of Reviewer

Revised:

Folder

A 350% of Federal Poverty Levels for 2007. DO NOT USE AFTER FEBRUARY 29, 2008

Patient & Dependents	Annual Income Levels	Monthly Income Levels
1	$34,293	$2,858
2	$46,200	$3,850
3	$58,107	$4,842
4	$69,993	$5,833
5	$81,900	$6,825
6	$93,807	$7,817
7	$105,693	$8,808
8	$117,600	$9,800
Each addl	$11,907	$992

B	Patient's family size (patients and dependents)	2
C	Qualifying Monthy Income amount (A above)	$3,850.00
D	Patient's Monthly Income (from Financial Evaluation Form, Item C.5.)	$2,140.00
E	Patient's income compared to poverty levels (divide D by C) x 100	56%
F	Enter the charity adjustment factor as follows: If E is 100% or less, enter 1.0 If E 101 to 125%, enter 0.8 If E is 126-150%, enter 0.6 If E is 151% or more, enter 0	1
G	Enter amount of hospital bill for which patient is responsible	$630.00
H	Calculate Charity Writeoff (FxG)	$630.00
I	Initial Remaining Balance (G-H)	$0.00
J	Calculate additional charity writeoff, if any: If F - 0.8, remaining balance is limited to $5000. If I exceeds $5000, subtract $5000 from I to calculate addl write-off. If I is less than or equal to $5000, enter zero. If F = 0.6, remaining balance is limited to $7500. If I exceeds $7500, subtract $7500 from I to calculate addl write-off. If I is less than or equal to $7500, enter zero. If F = 1.0 or 0, make no entry in J	
K	Charity write-off based upon income (H+J).	$630.00
L	Remaining balance based upon income-related charity write-offs (G-K).	$0.00

Identify any special circumstances

Patient requests we refund the balance to her ex-husband. He paid her portion of the bill, but then withheld the amount from her monthly child support. She states if we refund to him, he will then add back into the next child support check. See attached credit report and note from patient and Sue Murray (CHCM PHP)

		1/7/2008
Approval Signature	Title	Date

rvsd
01/25/07