COLORADO RIVER
Medical Center

POLICY

DEPARTMENT: ADMINISTRATION **POLICY TITLE: Underinsured/Uninsured Patient Discount and Charity Care.** **POLICY NUMBER:** **AUTHOR:**	**PAGE 1 OF 7** **Date of Origin:** 9/3/09 **Revision Date:** 8/28/11

Underinsured/Uninsured Patient Discount and Charity Care Policy is a "resource of last resort" for those who fail to qualify for adequate health insurance, Federal, State or Local medical assistance programs, grants, and other forms of aid.

I. POLICY:

It is the policy of CRMC to provide general acute hospital care and outpatient care through the CRMC hospital for all patients regardless of ability to pay. Financial assistance is extended in accordance with AB774 and the mission and values of the hospital, ensuring a demonstrative benefit to the community.

Consideration is given to any patient based upon financial resources. Screening and processing is conducted without concern for residency, gender, ethnic origin or employment status. Annual income is the primary factor in determining eligibility.

Uninsured patients or their guarantor (responsible party) earning between 201% and 350% of the Federal Poverty Guideline are eligible for a AB774 Discount. The related patient accounts will be written down to the Medicare Allowable Amount. Uninsured patients or their guarantor (responsible party) earning 200% of the Federal Poverty Guideline or less will be granted free care.

Uninsured individuals earning above 350% of the Federal Poverty Guideline whose bill creates an undue financial hardship will be considered for discounts on a case by case basis. See III.5.D.

Any patient dissatisfied with CRMC's decision regarding an AB774 Discount or Charity Grant will be able to appeal that decision by submitting their concerns in writing to CRMC's Compliance Committee.

II. DEFINITIONS

AB774 Discount Rate:	The AB774 Discount Rate will be the average inpatient or Outpatient Medicare Discount for the past fiscal year. Discount Rates will be updated every January first.
Annual Income:	Annual gross income reported on the most recently filed income tax return of all members of the family unit.
Family Unit:	Usually defined by inclusion of the applicant, the applicant's spouse (if any) and the applicant's dependent(s), (if any).
Self Pay:	Patient without insurance coverage or other payer source.
Financial Class-1:	Patient financial status pending review for Underinsured/ Uninsured Patient Discount and Charity Care Policy.
Financial Counselor:	A hospital employee specially trained to assist patients/ guarantors/families to reach an acceptable resolution to identified financial limitations.
Case Management:	A process managed by a licensed nurse or social worker to monitor level of care issues, act as a liaison between patient, physician, other providers of medical and social services, and insurance payers. Further, case managers are instrumental in the process of discharge planning to insure a smooth transition to home or next level of treatment.

III. UNDERINSURED/UNINSURED PATIENT DISCOUNT AND CHARITY CARE POLICY CRITERIA

1. Types of Services Covered

   A. All general acute care hospital service.
   B. Cosmetic surgeries and skilled nursing services are not covered.

2. There is no requirement for residency in order to be considered for assistance.

3. All homeless and/or uninsured patients are automatically screened for consideration for assistance.

4. Insurance Issues
   A. Medi-Cal Share of Cost recipients do not qualify for Underinsured/Uninsured Patient Discount and Charity Care Policy, as their financial responsibility has been predetermined through the Medi-Cal assessment process.

B. Inpatient days denied by Medi-Cal as not medically necessary become eligible for Charity Care write-offs if the denial is upheld following CRMC appeal. The Medi-Cal denied day is adjusted for purposes of stating the "uncollectible" as the charity in preference to inflating the Medi-Cal allowance.

C. Patients with Medicare and commercial HMO/PPO coverage are eligible for Underinsured/Uninsured Patient Discount and Charity Care Policy. If these patients have large out of pocket expenses they will be considered and approved for Charity Assistance if they meet all financial requirements. No discount will be applied to the remaining portion of the patient's claim until after their primary and any secondary insurance payments and contractual adjustments are applied.

5. Financial Status Criteria

A. The Financial Assessment Worksheet (Exhibit C) is used to calculate income and, where appropriate, 50% of monetary assets after the first $10,000.

B. Patients/families whose yearly gross income is less than 200% of the Federal Poverty limit Guidelines (see attached Exhibit A)	100% write off – Charity Care
C. Patients/families whose yearly gross income is between 201% and 350% of the Federal Poverty Limit Guidelines	Patient responsible for the Medicare allowable payment rate (Exhibit B)
D. Patients/families whose yearly gross income is above 350% of the Federal Poverty Limit Guidelines and whose documentation verifies financial hardship.	Charges/balance after all third party payments and discounts have been applied up to a cap equaling 10% of gross annual income plus eligible monetary assets. Monetary assets, Excluding primary residence and Qualified retirement plans, will be Calculated at 50% of the monetary assets after the first $10,000. Qualified retirement plans to be excluded are: • 401K Plans • 403B Plans • IRA's

E. Calculation of annual income includes verification of the prior year's tax return.

1. Income tax documents must be used as indicated to assist in verifying income.

2. If not working, the latest unemployment check or social worker's attesting of homeless can be considered.

III. PROCEDURE

1. Identification

A. Candidates for the Underinsured/Uninsured Patient Discount and Charity Care Policy can be identified at any point along the patient revenue cycle. Every effort shall be made to identify eligibility during the service period.

1. Pre-Registration

2. Point of Service

3. Discharge

4. Following discharge

B. Every patient will be presented, at time of service, with notice (in appropriate language) regarding the Underinsured/Uninsured Patient Discount and Charity Care Policy. Every patient will be offered MediCal and/or Health Family applications. Patients will be asked to sign an acknowledgement attesting that notice of program and offer of applications has transpired. (Exhibit D)

C. A follow-up notice regarding the Underinsured/Uninsured Patient Discount and Charity Care Policy will be included with first billing for services.

D. Referral for Consideration

1. Initial referrals may be directed to any business office employee, a Financial Counselor, or the Social Services Department.

2. The Patient/family/guarantor is instructed regarding the application process.

3. Arrangements are made for an in-depth interview.

4. The Patient/family/guarantor is instructed to bring the following documents to the interview:

a) Identification,
b) Last filed income tax return, and
c) Verification of members of the family unit under consideration

E. A summary of the encounter is documented in the appropriate system according to hospital department.

1. Registration personnel document notes pertaining to the situation in the HOSPITAL SYSTEM system.

2. Business office personnel document in the HOSPITAL SYSTEM

3. Social Service personnel document on the patient chart and summaries of their encounters are entered into the HOSPITAL SYSTEM system.

4. Patient attestation regarding receipt of notice and offer of applications filed in patient medical record.

2. Screening

A. The appropriate Financial Counselor reviews the initial referral information and arranges for the initial interview. When possible, this should be completed during the period of service.

B. The Patient/family/guarantor receives clarification of the program and information regarding the documentation required for the review.

3. Financial Assistance Interview by PFS Manager

A. The program is fully described and the Patient/family/guarantor is given opportunity to ask questions and receive clarification about the process and requirements.

B. A review of insurance, lack thereof, and identification of any other potential payer source is conducted.

C. Clarification of and documentation of income and family unit information is verified.

D. Calculation of the annual income is performed.

E. Review of other supportive documentation, as indicated.

F. Other information as indicated on the Disclosure Form is documented/ reviewed; and it is required that the form is signed by the responsible party or assigned representative.

G. Arrangements may be made for subsequent interviews, if necessary, in order to obtain all necessary information.

H. Copies of all documents are retained for hospital record-keeping purposes.

4. Financial Assistance applications are reviewed and approved by PFS Manager.

A. PFS Manager may approve amounts up to $5,000.

B. The Chief Executive Officer approves amounts greater than $5,000.

5. Pending Applications

A. Consideration is given for the fact that the patient and family are in a stressful situation and may not be able to present all necessary information at the first meeting.

B. Financial Counselors follow-up to obtain necessary information by phone, by sending letters asking for needed documents, or by personal visit.

C. After three documented contacts have been attempted and the 150th day is exceeded, the application is documented as denied and closed, and the account transferred to Bad Debt.

D. The collection agent of CRMC will follow all AB774 regulations regarding collection practices.

6. Approved Applications

A. Patient/family/guarantor is notified immediately, in person, if the patient is a hospital in-patient at the time of the approval.

B. A letter explaining the determination and fully describing any necessary arrangements is mailed to the address submitted during the application.

C. The patient/guarantor will be asked to sign a contractual agreement regarding any extended payment arrangements related to the amount determined to be patient responsibility.

7. Denied Applications

A. Patient/family/guarantor is notified immediately, in person, if the patient is a hospital in-patient at the time of decision.

B. A letter explaining the determination and fully describing any necessary arrangements is mailed to the address submitted during the application. included in this letter is a description of the decision appeal process.

C. An individual who is referred to Financial Counseling as a potential recipient of financial assistance who refuses to sign the Disclosure statement or provide required information will be denied automatically.

D. Any impacted party may appeal a denial decision by submitting their concerns in writing to CRMC's Compliance Committee.

E. The patient's financial class reverts to Self Pay and the account is processed as a Self-Pay receivable per protocol.

8. Monthly Reports

A. A monthly report will be prepared giving a total of the charity applications approved with the amounts written off. (Exhibit E)

B. A monthly report will be prepared giving a total of the discount applications approved with the amounts discounted. (Exhibit F)

EXHIBITS:

A. Federal Poverty Guidelines
B. Patient Disclosure Report
C. Patient Charity Care Application