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| DEPARTMENT: Vendor Collections Management | POLICY DESCRIPTION: Charity Financial Assistance Policy for Uninsured and Underinsured California Patients |
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**SCOPE:**

All SSC and Facility areas responsible for requesting and evaluating Financial Assistance Applications ("FAA") for the purposes of processing a charity write-off for certain patients receiving services at HCA-affiliated, non-partnership, acute-care hospitals ("Hospitals").

**PURPOSE:**

To define the policy for providing partial or full financial relief to patients who (i) have received emergency services, (ii) meet certain income requirements, (iii) do not qualify for state or federal assistance for the date of service, (iv) are uninsured or underinsured, and (v) are unable to make partial or full payment on outstanding balances. In addition, with respect to the FAA and income validation, to establish protocols and supporting documentation requirements.

**POLICY:**

The following types of patients may qualify for a charity write-off based on the patient's total household income, supporting income verification documentation or processes, as required, and the amount of the patient liability:

1) To be eligible for a charity write-off review, a patient must have incurred emergent, non-elective services and be uninsured or underinsured.

2) For purposes of this policy, an uninsured patient is one (i) with no third party payer coverage for emergent health care services, (ii) who provides documentation that the patient is unable to pay for some or all of the provided non-elective hospital services and (iii) who satisfies the financial eligibility criteria set forth herein.

3) For purposes of this policy, an underinsured patient is one with some form of third party payer coverage for health care services, but such coverage is insufficient to pay the current bill such that the patient retains a patient liability that they are unable to pay.

4) A validation will be completed, as required in this Policy, to ensure that if any portion of the patient's medical services can be paid by any federal or state governmental health care program (e.g., Medicare, Medicaid, Tricare, Medicare secondary payer), private insurance company, or other private, non-governmental third-party payer, that the payment has been received and posted to the account. No charity write-off can be applied to any account with any outstanding payer liability.

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5) Supporting Income Verification Documentation & Review:

A. Medicare Accounts

i. All Medicare patients (i.e., inpatients and/or outpatients) must submit supporting income verification documentation. Electronic validation of patient income, e.g., Experian, alone is not sufficient. Medicare requires independent income and resource verification for a charity care determination with respect to Medicare beneficiaries (PRM-I § 312).

ii. In addition to the FAA, the preferred income documentation will be the most current year's Federal Tax Return. Any patient/responsible party unable to provide his/her most recent Federal Tax Return may provide two pieces of supporting documentation from the following list to meet this income verification requirement:

- State Income Tax Return for the most current year
- Supporting W-2
- Supporting 1099's
- Copies of all bank statements for last 3 months
- Most recent bank and broker statements listed in the Federal Tax Return
- Current credit report
- Qualified Medicare Benefits ("QMB") for inpatients only

iii. Dual-Eligible Beneficiaries: A Medicare beneficiary who also qualifies for Medicaid (dual-eligible beneficiary) may be deemed indigent as long as the "Must Bill" requirements are met. That these requirements are met must be supported by a State Medicaid remittance advice. When claiming an amount as Medicare Bad Debt for a dual-eligible beneficiary, Medicaid must be billed. In addition, the remittance advice showing non-payment must be maintained as supporting documentation for the Medicare Bad Debt adjustment. Charity write-offs for Medicaid Exhausted beneficiaries may be less than $1,500.

B. Non-Medicare Accounts

i. Generally, for all non-Medicare Accounts, the following will be acceptable supporting documentation: (i) the documentation listed in A. above, (ii) or any one of the following:

- Most Recent Employer Pay Stubs

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- Written documentation from income sources
- Proof of Medicaid Eligibility
- Electronic validation of patient income and family size, such as Experian

ii. Supporting income verification documentation through an electronic validation of patient information/income, such as Experian, shall be obtained where no other income verification is obtained.

iii. To the extent required by state law, a complete FAA shall be obtained for any dollars reported as charity to the state.

iv. Review of assets may take place during the application process where required by state law or regulation.

C. Patients/Responsible Party Deemed Eligible.

The patient/responsible party may be deemed to meet the charity guidelines if:

- the patient/responsible party is determined to be eligible by a local clinic under poverty and income guidelines similar to the ones in this policy; or
- the patient/responsible party presents with Medicaid, and Medicaid does not pay.

D. Charity Processing Based on Extenuating Circumstances, i.e., Potential Charity Write-off Absent Full Documentation.

There may be extenuating circumstances where resource testing cannot be completed because the patient/responsible party does not/cannot (i) complete the FAA, or (ii) provide supporting documentation listed in A or B, above. In those circumstances, a manager may waive the required documentation and extend a charity care write-off, consistent with this Policy. The following may be considered by the manager to be extenuating circumstances:

i. *Patients identified as an undocumented residents or homeless through*:

- Medicaid Eligibility screening
- Registration process
- Discharge to a shelter

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- Clinical or Case Management documentation
- Absence of a credit report

ii. *Patients that expire* - if it is determined through family contact and/or courthouse records that an estate does not exist, it may be considered for a charity write-off (even if the patient had a spouse) upon documentation and with the manager's review and approval of a policy exception.

iii. *Medically Indigent* – In addition to the above, if a patient/responsible party meets the medically indigent status based upon state guidelines or requirements, a charity write-off may be applied after the manager completes a resource testing process for the patient/responsible party.

6) Pending Medicaid Effect on Charity Write-off:

The Pending Medicaid and Pending Charity processes should not be concurrent processes. Determination of Pending Medicaid should be resolved prior to evaluating for potential Pending Charity.

7) Health Insurance Marketplace for Qualified Health Plans:

Pending qualification in the Health Insurance Marketplace may take place concurrently with the Pending Charity process. The QHP enrollment is not retroactive. Rather, the coverage becomes effective for future dates of service. Therefore, it is necessary to continue with the Pending Charity process for visits occurring prior to QHP effective dates.

8) Charity Processing based on Federal Poverty Guidelines:

A. Patients with individual or household incomes of between 0-200% of Federal Poverty Guidelines:

Patients that fall within 0-200% of the FPL will have the entire patient balance processed as charity write-off.

Patients with individual or household incomes of between 201- 400% of Federal Poverty Guidelines:

Patients with incomes between 201% and 400% of FPL will have their balances capped at a percentage of their income according to the table below. This percentage will be determined using the patient's FPL.

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- 201% - 300% - balances capped at 3% of annual household income
- 301% - 400% - balances capped at 4% of annual household income

B. Patients Who Are Uninsured:

Notwithstanding 9)A. and B. above, patients who are uninsured and who provide the supporting income verification documentation and otherwise meet the requirements of this Policy, will have their patient balance capped at the lesser of the amount calculated under 9)A. or 9)B. above or the amount calculated pursuant to the uninsured discount model.

Balances from multiple accounts for the same patient may be considered together to determine out-of-pocket responsibility minimums and for calculating the cap.

The write-off will be applied to the entire outstanding patient balance.

9) Refunds on Charity Accounts:

The general expectation is that all patients who qualify for the Charity write-off will apply in a reasonable time so as to have the Charity write-off applied to their bill before the bill comes due, however, if for some reason the patient pays for services rendered and then is later approved for the Charity write-off, the hospital shall reimburse the patient any amount actually paid in excess of the amount due after the Charity write-off is applied plus interest at 10% beginning on the date the payment by the patient was received by the hospital. Hospital is not required to reimburse the patient or pay interest if the amount due is less than five dollars ($5.00). This section is in accordance with Health & Safety Code § 127400 et seq, and all patients applying for the Charity write-off shall do so in accordance with said code, and with all reasonable speed so as to avoid billing mistakes before the Charity write-off is applied.

10) Patient Dispute Process:

In the event a patient wishes to file a dispute and appeal their eligibility for a Charity write-off under this policy, the patient may seek review from the Vendor Collections Management Director, Hospital Chief Financial Officer or an SSC Executive as defined in the Charity Review Appeal Process policy (PARA.PP.VCM.020).

11) Liens:

Under no circumstances will liens be considered on properties less than $300,000 in value.

13) Physician Notice:

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Emergency physicians as defined in Section 127450 of the California Health and Safety Code, who provide emergency medical services in a hospital that provides emergency care are also required by law to provide write-offs to uninsured patients or patients with high medical costs who are at or below 350% of the federal poverty level. Patients with High Medical Costs are patients that incur out-of-pocket costs exceeding 10% of their family income in the prior 12 months excluding Essential Living Expenses and, for purposes of the charity write-off, whose family income is at or below 350% of the Federal Poverty Level. The 10% threshold may be documented in 2 ways: 1) the out-of-pocket costs are incurred at the hospital; or 2) the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

**REFERENCE:**

- **PARA.FT.VCM.606 Federal Charity Guidelines**
- **PARA.FT.VCM.638 Financial Assistance Application**
- **PARA.MF.VCM.804 Collection Charity Letters**
- **PARA.PARS.PP.009 Medicare Bad Debt and Recovery Logs Policy**
- **PARA.PP.VCM.019 Utilizing the Artiva Charity Process**

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**SCOPE:**

An uninsured discount is available to the following California patient accounts:

1) All Self Pay or uninsured patient accounts, excluding elective cosmetic procedures, facility designated self-pay flat rate procedures and scheduled/discounted procedures for International patients;
2) Accounts where insurance benefits have been exhausted or terminated;
3) Medicare outpatient self-administered drugs;
4) All "Insured Patients with High Medical Cost" will be eligible for an Uninsured Discount per the details provided below; and
5) Uninsured Patients whose family income exceeds 350% of the Federal Poverty Level are eligible for a managed-care PPO like Uninsured discount.

NOTE: A client-specific discount policy may need to be developed for Parallon clients with hospitals in California based on the client's charity and discount policies. Use the reference number identifying the client as defined in the Policy and Procedure Development policy PARA.PP.GEN.001. (Example: PARA.PP.VCM.015CAL for LifePoint)

**PURPOSE:**

To define the process, for selecting the appropriate Self Pay IPLAN, providing patients with information regarding available discounts, and processing discounts for patients assigned one of the Uninsured Discount IPLANS. All steps taken will be in compliance with California legislation effective 1/1/2007 – AB 774, Senate Bill No. 350 effective 1/1/08, AB 1503 effective 1/1/11, and Senate Bill No. 1276, effective 1/1/2015.

**POLICY:**

**A. Definitions**

Patients with High Medical Costs – patients that incur out-of-pocket costs exceeding 10% of their family income in the prior 12 months excluding Essential Living Expenses and, for purposes of the uninsured discount, whose family income is between 201% and 350% of the Federal Poverty Level. Patients are eligible for this designation even if they receive a discounted rate as a result of third-party coverage. The 10% threshold may be documented in 2 ways 1) the out-of-pocket costs are incurred at the hospital; or 2) the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

"Essential Living Expenses" – any of the following expenses: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas and repairs, installment payments, laundry and cleaning and other extraordinary expenses."

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Patient's Family (for purposes of determining "family income") – For persons 18 years or older, spouse, domestic partner as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not. For persons under 18 years, parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

"Reasonable Payment Plan" – means monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for Essential Living Expenses.

**B.** Eligible Patients[1]

All Self Pay patient accounts and all insured Patients with High Medical Costs accounts will be eligible for an uninsured discount, with the exception of elective cosmetic procedures; facility designated self-pay flat rate procedures, scheduled/discounted procedures for International patients and, accounts eligible for the charity discount. Uninsured discounts will also be applied to accounts where insurance benefits have been exhausted or terminated. Medicare outpatient self-administered drugs will also receive the uninsured discount. Accounts will be assigned one of the following Uninsured Discount IPLANS.

| IPLAN | IPLAN Description | LOG ID | Ins Series | Pat Series | IP Proc Code | OP Proc Code |
|---|---|---|---|---|---|---|
| 099-40 | Uninsured Discount Plan | UINS | 110 | 208 | 920970 | 920980 |
| 099-41 | Uninsured Discount Plan – Burn Unit | UINB | 110 | 208 | 920971 | 920981 |
| 099-42 | Uninsured Discount Plan – Transplant | UINT | 110 | 208 | 920972 | 920982 |
| 099-44 | Uninsured State Specific | UINC | 110 | 208 | 920973 | 920983 |
| 099-45 | Uninsured QMP – Left or Ref | (local) | 110 | 208 | (local) | (local) |
| 099-46 | Uninsured QMP - Treated | (local) | 110 | 208 | (local) | (local) |
| 099-47 | Uninsured Discount Plan – Patient Non-Compliance | UINS | 110 | 208 | 920970 | 920980 |
| 099-49 | Uninsured – Partially Exhausted Benefits | N/A | 110 | 208 | 920970 | 920980 |

[1] An emergency physician who provides emergency medical services is also required by law to provide discounts to uninsured and under insured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level.

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| | | | | | | |
|---|---|---|---|---|---|---|
| N/A | Uninsured – Medicare Self - Administered Drugs | N/A | N/A | N/A | N/A | 957983 |

The discount amounts will be provided to each facility in a formal rate schedule document. The patient will receive the Uninsured Discount unless the patient qualifies for a Charity Discount as outlined in the existing PARA.PP.VCM.016CA Charity Financial Assistance Policy for Uninsured and Underinsured California Patients.

**C. Discount criteria:**

Uninsured Patients, as well as insured Patients with High Medical Costs, whose family income is between 201% and 350% of the Federal Poverty Level are eligible for a discounted payment equal to the amount of payment the hospital would expect, in good faith, to receive for providing services from Medicare, Medi Cal, Healthy Families, or "any other government-sponsored health program of health benefits" in which the hospital participates, whichever is greater. Uninsured patients and insured Patients with High Medical Costs will first be reviewed for Government Program Eligibility and Charity criteria.

Uninsured Patients whose family income exceeds 350% of the Federal Poverty Level are eligible for a managed-care PPO like Uninsured discount.

**D. Documentation of Income:**

To support a patient's income relative to the Federal Poverty Level, documentation in the form of recent pay stubs or income tax returns is required. Patients must make a reasonable effort to provide hospital with documentation of income and health benefits coverage. If the patient fails to complete a Financial Assistance Application, the hospital could consider the patient to be above 350% of the Federal Poverty Level.

No supporting documentation provided by the patient as part of the Financial Assistance Application for the Uninsured Discount shall be used for collections activities.

**E. Patient Notification at the Time of Registration:**

If it is determined the patient is uninsured or an insured Patient with High Medical Costs at the time of registration, the patient/responsible party will be presented with an Uninsured Patient Information document (PARA.FT.VCM.015) that provides information on the Uninsured Discount Policy and other available discounts and payment options. This document will outline the process for uninsured discounts and inform the patient of additional account resolution options (i.e. monthly payments). The patient/responsible party will be asked to sign and date the document. The document will then be scanned into the imaging system and be placed in the imaging Patient Folder document type, as a

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validation that information regarding discounts has been communicated to all uninsured patients and insured Patients with High Medical Costs.

**F. Patient Access Responsibilities at the Time of Registration:**

Patient Access will be responsible for assigning the Uninsured IPLAN using the selections above and for presenting the Uninsured Patient Information Document to the patient/responsible party. However, the Uninsured IPLAN may need to be modified when the supporting documentation evaluation shows the family income falling between 201% and 350% of the Federal Poverty Level. Patient Access will explain the process as documented, answering questions related to the document and obtaining a signature from the patient/responsible party documenting that the information regarding available discounts was provided.

All requests for payment will be based on estimated total charges less the appropriate uninsured discount based on the income criteria listed above.

Patient Access will be responsible for requesting from the patient/responsible party the expected patient liability amount by using a facility specific deposit schedule which has been updated to reflect the Uninsured Discount.

Patient Access will be responsible for asking the patient/responsible party for payment in full or, at the request of the patient with High Medical Costs, shall negotiate monthly payment arrangements on the patient liability amount. If the patient/responsible party and Patient Access employee cannot agree on a payment plan, the Patient Access employee shall establish a "Reasonable Payment Plan" as defined herein, taking into consideration the patient's monthly family income less Essential Living Expenses. Once the payment plan is negotiated, the account will be referred to NPAS, Inc. or other early-out agency for monitoring and collection.

**G. Inpatient and Outpatient self pay patients who are able to make payment in full or monthly payment arrangements.**

- Assign the appropriate Uninsured Discount IPLAN if the family income is known. If the family income is not known, use the 099-40 unless this is a Burn Unit or Transplant patient.
- The Uninsured Discount IPLAN should reflect proration of 100% of the total charges for the patient.
- A facility/SSC specific prompt pay discount may be applied in addition to the Uninsured Discount as set forth in the PARA.PP.SS.035 Discount Policy for Patients.
- The facility and the patient shall negotiate interest free, payment plans if the patient cannot pay for the entire encounter in full, taking into consideration the patient's family income and Essential Living Expenses. If the facility and patient cannot agree on an extended

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payment plan, the payment plan shall meet the requirements of a Reasonable Payment Plan as defined herein.

**H. Inpatient self pay patients or insured Patients with High Medical Costs who are not able to make payment in full or monthly payment arrangements, including a Reasonable Payment Plan, and Outpatient self pay patients will be considered for Medi-Cal eligibility.**

- Assign the facility designated Pending Medi-Cal IPLAN as the primary payor.
  - The Pending Medi-Cal IPLAN should reflect proration of 100% of the total charges for the patient.
- Assign the Pending Charity IPLAN (099-50) as the secondary payor.
  - Present the patient with a Financial Assistance Application for Charity consideration.
- Assign the appropriate Uninsured Discount IPLAN as the tertiary payor if the family income is known. If the family income is not known, use the 099-40 IPLAN unless this is a Burn Unit or Transplant patient.

**I. Outpatient self pay patients or insured Patients with High Medical Costs who are not able to make payment in full or monthly payment arrangements, including a Reasonable Payment Plan and do not meet the Medi-Cal eligibility threshold.**

- Assign the Pending Charity IPLAN (099-50) as the primary payor.
  - The Pending Charity IPLAN should reflect proration of 100% of the total charges for the patient.
  - Present the patient with a Financial Assistance Application for Charity consideration.
- Assign the appropriate Uninsured Discount IPLAN as the secondary payor, if the family income is known. If the family income is not known, use the IPLAN 099-40 unless this is a Burn Unit or Transplant patient.

**J. All Inpatient and Outpatient self pay patients registered for elective cosmetic procedures, facility designated self-pay flat rate procedures and scheduled/discounted procedures for International patients.**

- Assign the facility/SSC designated IPLAN for the discounted/flat rate procedure.

**Emergency Department self pay patients who opt out to a QMP process will be assigned an Uninsured QMP IPLAN.**

- Assign the Uninsured QMP –Left or Referred IPLAN (099-45) as the primary payor if the patient elects to Leave or be Referred during the QMP process.

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- Assign the Uninsured QMP – Treated IPLAN (099-46) as the primary payor if the patient receives treatment via the QMP process.

The default of Self Pay IPLAN 000-00, due to the absence of an IPLAN, should be avoided once this policy is implemented. All accounts that are not assigned an IPLAN and systematically assigned Self Pay 000-00 should be reviewed and moved to the appropriate IPLAN. All accounts excluding Client/Industrial accounts must be registered with an appropriate IPLAN for the third party payor, Medi-Cal Pending, Charity Pending, elective cosmetic/facility designated flat rate plan or an Uninsured Discount Plan. A Business Objects script has been developed to assist in identifying accounts without an IPLAN assignment.

**K. IPLAN Assignment if the Patient has Insurance:**

If at any time it is determined that the patient is covered by a health plan, the Uninsured Discount IPLAN should be removed; except that where the patient meets the definition of an insured Patient with High Medical Costs. The Uninsured Discount IPLAN is limited to patients who have no third party payor source of payment. The IPLAN assignment of the third party payor should be assigned to the account in place of the Uninsured Discount IPLAN.

**L. Retroactive consideration for Medi-Cal eligibility or Charity Discount:**

Uninsured Discount Plan patients that retroactively are considered for Medi-Cal eligibility or Charity discounts will have the appropriate Pending Medi-Cal eligibility and Pending Charity IPLANS assigned as outlined in the Patient Access process above. The Uninsured Discount will be reversed until determination of Medi-Cal eligibility and Charity can be ruled out. If a patient applies, or has a pending application, for Medi-Cal or other health coverage at the same time as he/she applies for a discount payment program, the pending Medi-Cal or other health coverage application shall not prevent the patient from applying for discounted care.

**M. Insurance Denials for Patient Non-Compliance:**

Accounts where a denial is applied due to the patient's lack of cooperation are considered "uninsured".

Based on the liability due from the payor, the following collection guidelines will be followed and approval obtained prior to releasing liability to the patient where the patient failed to provide the requested information timely. Once efforts to obtain required information is exhausted, the 09947 Uninsured Discount Iplan is assigned and remaining liability after the uninsured discount will become the patient's responsibility.

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| Threshold | Collection Guidelines | Approver |
|---|---|---|
| <$1,500<br><$2000 (Atlanta SSC only) | 1 Letter | 15% audit sample |
| >$1,500 - <$10,000 | 1 Letter and 1 Call | Team Lead |
| >$10,000 - <$50,000 | 1 Letter and 1 Call | Manager |
| >$50,000 - <$100,000 | 2 Letters and 2 Calls | Director |
| >$100,000 | 2 Letters and 2 Calls | COO |

Artiva letters 1100 Request for Additional Information Request and 1153 Additional Insurance Information Request are available to send to the patient for 1st and 2nd letter attempts. The letters contain a dropdown to allow the requester to select the information required or enter free form text if not listed in the dropdown. The next follow-up should occur based on the next follow-up cycle after action is taken based on the standard liability stratification (top, high, etc.).

Once the appropriate collection activity and approval is completed, ensure both the Uninsured IPLAN 099-47 and discount is applied appropriately. No approval is required for insurance liability less than $1,500 ($2,000 ATL only); however; an audit must be performed monthly on 15 percent of the accounts to ensure liabilities are released appropriately. To retain the original insurance plan information, assign Uninsured IPLAN 099-47 as the primary payer and resequence the original insurance IPLAN as the secondary payer.

- Assign the 099-47 Uninsured Discount IPLAN and resequence to the primary payer retaining the original IPLAN as the secondary payer.
    - The Uninsured Discount IPLAN should reflect proration of 100% of the total charges.

Subsequently, if patient complies with the payer request, the uninsured IPLAN can be removed and the original IPLAN information will move to primary intact.

Document actions and approvals with user name and ID in a clear and concise manner in the account notes in Artiva.

**N. Insurance Denials for no coverage including pre-existing:**

Accounts where the insurance remits a denial of coverage including pre-existing conditions and there is no other insurance coverage on file will be considered self-pay accounts. The IPLAN for the insurance denial should be removed and the Pending Medi-Cal IPLAN added as primary (if the account meets local screening guidelines), Pending Charity IPLAN assigned as secondary and the Uninsured

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Discount IPLAN assigned as tertiary. A Financial Assistance Application will need to be forwarded to the patient/responsible party.

**O. Patient Statements:**

Statements should not be sent out until the uninsured discount has been posted. Letters to a Self Pay patient/responsible party should not include the account balance until the Uninsured Discount has been posted. If you use letters in your Medicaid Pending or Charity Pending process, you will need to remove the account balance reflected on them. If the facility bills a patient who has not provided proof of coverage by a third party at the time care is provided or upon discharge, as part of that billing, the facility shall provide the patient with clear and conspicuous notice of: 1) the charges; 2) request that the patient inform the facility if patient has health insurance, including Medicare, Healthy Families, Medi-Cal or other coverage, including coverage under the California Health Benefit Exchange; 3) a statement that, if the patient does not have health insurance coverage, the patient may be eligible for Medicare, Healthy Families Program, Medi-Cal, coverage offered through the California Health Benefit Exchange, California Children's Services program, other state or county-funded health coverage or charity care; 4) a statement indicating how the patient can obtain applications for the above coverage and that the facility will provide these applications; 5) a referral to a local consumer assistance center housed a legal services office

**P. Patient Default on Extended Payment Plans:**

An extended monthly payment plan may be declared inoperative if the patient fails to make three consecutive payments in a 90 day period; provided that, the facility, or its collection agent, shall make a reasonable attempt to contact the patient by telephone and, give notice in writing, that the extended payment plan may become inoperative due to non-payment, and that the patient has an option to renegotiate the extended payment plan. The facility, or its collection agent, shall renegotiate the extended payment plan if the patient so requests. The notice and telephone call may be made to the last know telephone number and address of the patient. No adverse information may be reported to a consumer credit reporting agency and no civil action may be commenced against the patient until the payment plan is declared no longer operative.

**Q. Late Charges:**

Accounts with the Uninsured Discount IPLAN as the primary payor should not have late charges posted. If late credits are posted to the account, the Uninsured Discount should be recalculated to reflect the correct patient liability. The Bill Code master file on Patient Accounting should be modified to reflect no posting of late charges. Late charges after the Late Charge Days have elapsed should be NPST (not posted) from the Late Charge Report.

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**R. Patient Dispute Process:**

In the event a patient wishes to appeal a dispute regarding eligibility for this policy, patient may seek review from the Patient Access Director, Hospital Chief Financial Officer or SSC Executive in accordance with the Charity Review Appeal Process, PARA.PP. VCM. 020.

**S. Patient Overpayments:**

If any amount is paid by the patient and is subsequently determined to be in excess of the patient's liability, the patient will be refunded monies overpaid on the associated account, plus 10% interest beginning on the date the payment by the patient was received by the hospital. Hospital is not required to reimburse the patient or pay interest if the amount due is less than five dollars ($5.00).

**T. Insurance Denials for Partially Exhausted Benefits:**

Accounts where a denial is applied due to partially exhausted benefits, the Uninsured – Partially Exhausted Benefits IPLAN (099-49) should be applied to the secondary position, after the payor with partially exhausted benefits. A manual p-line must be performed to adjust the exhausted benefit portion of the account by the facility Uninsured Discount percentage.

Guidelines to determine if an uninsured discount qualifies based on Partially Exhausted Benefits (All three guidelines must be met):

- The remit indicates a Final Denial, or verbiage used on the remit such as "Exhausted Benefits" or "Maximum Coverage Exceeded" and
- The patient was considered for Charity for the remaining balance and not approved and
- Days being considered for the uninsured discount were not covered by insurer. Also, no insurance payment or contractual adjustment was received or posted for a portion of the day's charges.

**U. Medicare Outpatient Accounts containing Self-Administered Drugs:**

Self-Administered drugs (SADs) provided to Medicare outpatients are considered a non-covered service by Medicare. SADs will not be tracked using an IPLAN. A manual p-line using procedure code 957983 must be performed to adjust the SAD portion of the account by the facility specific outpatient Uninsured Discount percentage.

**PROCEDURE:**

| Responsible Party | Action |
|---|---|
| **Self Pay – Inpatient and Outpatient (able to pay)** | |

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|---|---|
| Patient Access | Determines the patient is not seeking services for elective cosmetic, a flat rate procedure or is a scheduled/discounted International Patient. |
| Patient Access | Determines the patient can make payment or establish arrangements for payment. |
| Patient Access | Assigns the Uninsured IPLAN as the primary payor. |
| Patient Access | Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party. |
| Patient Access | Calculates deposit from facility deposit schedule. |
| Patient Access | Collects deposit and documents account. |
| **Self Pay – Inpatient (unable to pay)** | |
| Patient Access | Determines the patient is not seeking services for elective cosmetic, a flat rate procedure or is a scheduled/discounted International Patient. |
| Patient Access | Determines the patient cannot make payment or establish arrangements for payment. |
| Patient Access | Assigns the Medicaid Pending IPLAN as the primary payor. |
| Patient Access | Assigns the Charity Pending IPLAN as the secondary payor. |
| Patient Access | Assigns the Uninsured Discount IPLAN as the tertiary payor. |
| Patient Access | Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party. |
| Patient Access | Presents the Financial Assistance Application to the patient or responsible party. |
| Patient Access | Documents account. |

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|---|---|
| **Self Pay – Inpatient and Outpatients for an Elective Cosmetic Procedure, Facility Flat Rate or a scheduled/discounted International Patients** | |
| Patient Access | Assigns the facility/SSC designated IPLAN for the elective cosmetic procedure, facility flat rate procedure or scheduled/discounted International Patient procedure. |
| Patient Access | Collects payment for elective cosmetic or facility flat rate procedure. |
| Patient Access | Documents account. |
| **Self Pay – Non Inpatient (unable to pay and for services that exceed the facility Medicaid Eligibility threshold)** | |
| Patient Access | Determines the patient is not seeking services for elective cosmetic, a flat rate procedure or is a scheduled/discounted International Patient. |
| Patient Access | Determines the patient cannot make payment or arrangements for payment. |
| Patient Access | Determines the charges will be over the Medicaid eligibility threshold. |
| Patient Access | Assigns the Medicaid Pending IPLAN as the primary payor. |
| Patient Access | Assigns the Charity Pending IPLAN as the secondary payor. |
| Patient Access | Assigns the Uninsured Discount IPLAN as the tertiary payor. |
| Patient Access | Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party. |
| Patient Access | Presents the Financial Assistance Application to the patient or responsible party. |
| Patient Access | Documents account. |

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|---|---|
| **Self Pay – Non Inpatient (unable to pay and charges for services that may not exceed Medicaid eligibility threshold)** | |
| Patient Access | Determines the patient is not seeking services for elective cosmetic, a flat rate procedure or is a scheduled/discounted International Patient. |
| Patient Access | Determines the patient cannot make payment or arrangements for payment. |
| Patient Access | Determines the complete charges for services cannot be made at time of registration or, |
| Patient Access | Determines the charges will not be over the Medicaid eligibility threshold. |
| Patient Access | Assigns the Charity Pending IPLAN as the primary payor. |
| Patient Access | Assigns the Uninsured Discount IPLAN as the secondary payor. |
| Patient Access | Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party. |
| Patient Access | Presents the Financial Assistance Application to the patient or responsible party. |
| Patient Access | Documents account. |
| **Self Pay – Emergency Department Registrations** | |
| Patient Access | EMTALA guidelines must be adhered to for all ED patients. |
| Patient Access | Assign the Charity Pending IPLAN as the primary payor. |
| Patient Access | Assign the Uninsured Discount IPLAN as the secondary payor. |
| Patient Access | Documents account accordingly. |

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|---|---|
| **Self Pay – Emergency Department Departures (able to pay)** | |
| Patient Access | Determines the patient can make payment or arrangements for payment. |
| Patient Access | Removes the Charity Pending IPLAN (if assigned at time of registration) |
| Patient Access | Assigns the Uninsured IPLAN as the primary payor. If the patient opts out for the QMP process, assign the appropriate QMP IPLAN. |
| Patient Access | Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party. |
| Patient Access | Calculates deposit from facility deposit schedule. |
| Patient Access | Collects deposit and documents account. |
| **Self Pay – Emergency Department Departures (unable to pay)** | |
| Patient Access | Determines the patient cannot make payment or arrangements for payment. |
| Patient Access | Ensures the Charity Pending IPLAN is the primary payor |
| Patient Access | Ensures the Uninsured IPLAN is the secondary payor. |
| Patient Access | Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party. |
| Patient Access | Documents account. |
| **Monitoring Inpatient and Outpatient Uninsured Discounts** | |
| Collections and/or Support Services | Reviews Self Pay accounts with the Uninsured Discount Plan as the primary payor for appropriate posted discount. |
| Collections and/or Support Services | Notifies Payment Compliance Department of accounts with Uninsured Discount Plan as the primary payor that are final billed and do not reflect an |

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|---|---|
| | Uninsured Discount. |
| Collections and/or Support Services | Ensures that all Statements are held until the Uninsured Discount is posted for patients who have the Uninsured Discount Plan as the primary payor. |
| Collections and/or Support Services | Ensures that all Letters to a Self Pay patient/responsible party do not include the account balance until the Uninsured Discount has been posted. |
| **Self Pay - Medicaid Eligibility Denied** | |
| Collections and/or Support Services | Determines the patient IS NOT eligible for Medicaid Coverage. |
| Collections and/or Support Services | Deletes the Medicaid Pending IPLAN and the system will automatically move the Charity Discount IPLAN to the primary position and the Uninsured Discount IPLAN to the secondary position. |
| Collections and/or Support Services | Considers the patient for a Charity Discount based on PARA.PP.VCM.016CA Charity Financial Assistance Policy for Uninsured and Underinsured California Patients. |
| **Self Pay – Charity Discount Denied** | |
| Collections and/or Support Services | Determines the patient IS NOT eligible for a Charity Discount |
| Collections and/or Support Services | Deletes the Charity Pending IPLAN and the system will automatically move the Uninsured Discount Plan to the primary position. |
| Collections and/or Support Services | Processes an IZ transaction to ensure that the Uninsured Discount IPLAN Log ID performs discount calculation |
| | |
| **Insurance Denials – Patient Non-Compliance** | |
| Collections and/or Support Services | Third Party payor denies coverage due to patient fails to comply with request for information or payment of premium (QHP 8X addendum). |
| Collections and/or Support Services | Sends the patient one or two letters and places one or two phone calls depending on the liability due. |

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| Collections and/or Support Services<br><br>Collections and/or Support Services | Obtains appropriate approval to release liability to the patient.<br><br>Assigns the Uninsured IPLAN – Patient Non-Compliance (099-47) as the primary payor. |
| Collections and/or Support Services | Resequence the original IPLAN to secondary payor. The system will post the uninsured discount. Keeping the original IPLAN on the account retains the insurance information in the event the patient subsequently complies with payor request. |
| Collections and/or Support Services<br><br>Collections and/or Support Services | Documents Account.<br><br>For accounts with liability due <$1000, perform an audit on a 15% sample to confirm one letter was sent and time allowed for the patient to respond before releasing liability to the patient. |
| **Insurance Denials – No Coverage or Pre-existing** | |
| Collections and/or Support Services | Third Party payor denies coverage due to no coverage or pre-existing. |
| Collections and/or Support Services | Remove Third Party IPLAN from account. |
| Collections and/or Support Services | Add Pending Medicaid as primary payor and Charity Pending 099-50 as secondary payor. |
| Collections and/or Support Services | Assigns the appropriate Uninsured IPLAN in the tertiary position if the family income is known. If the family income is not known, use the PLAN 099-40 unless this is a burn or transplant patient. |
| **Insurance Denials – Partially Exhausted Benefits** | |
| Collections and/or Support Services | Third Party Payor denies for partially exhausted benefits. |

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| Collections and/or Support Services | Adds the Uninsured – Partially Exhausted Benefits IPLAN (099-49) into the secondary position following the partially exhausted benefits payor IPLAN. |
| Collections and/or Support Services<br><br>**Medicare - Self Administered Drugs**<br><br>MSC Biller<br><br>Revenue Integrity<br><br>MSC Biller<br><br>MSC Process | Processes a manual p-line for the facility approved Uninsured Discount on the portion of the account partially denied due to exhausted benefits.<br><br>Identifies the potential for Medicare Self-Administered Drugs from the accounts that did not meet the facility SADs translator or SSI Billing Edits and enters the account in eRequest for review by Revenue Integrity<br><br>Reviews account, documents findings in eRequest for review by the MSC Biller.<br><br>Moves the Self-Administrative Drugs to non-covered charges.<br><br>Will identify billed claims from the SSI billing database that require an SAD uninsured discount. This list is matched to the appropriate discount rate based on facility and patient type. The discount is calculated and the p line to adjust the Self-Administered Drugs is posted to eTran using procedure code 957983. The p line follows the standard approval process defined in eTran. Once the uninsured discount is posted to the account; the accounts follow the normal MSC collection process.<br><br>**NOTE: Encounters reaching a zero balance will be moved to zero balance status and will not require an uninsured discount.** |

**REFERENCE:**
PARA.FT.VCM.015 Uninsured Patient Information Document
Facility Specific Uninsured Discount Plan Deposit Schedule
Facility Specific Cosmetic Procedure Plan Policy and Procedure
SSD.PP.SS.035 Discount Policy for Patient
PARA.PP.VCM.016 Charity Financial Assistance Policy for Uninsured and Underinsured California Patients

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QHP- denial code 8X addendum

QHP denial code 8X specific to collectior

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**SCOPE:**

All SSC and Facility areas responsible for requesting and evaluating Financial Assistance Applications ("FAA") for the purposes of processing a Patient Liability Protection write-off for certain patients receiving services at HCA-affiliated, non-partnership, acute-care hospitals ("Hospitals").

**PURPOSE:**

To define the policy for providing partial or full financial relief to patients who have received emergency services, or, are uninsured or underinsured and have received emergent non-elective services and: (i) meet certain income requirements, (ii) do not qualify for state or federal assistance for the date of service, and (iii) are unable to make partial or full payment on outstanding balances. In addition, with respect to the FAA and income validation, to establish protocols and supporting documentation requirements.

**POLICY:**

The following types of patients may qualify for a Patient Liability Protection write-off based on the patient's total household income, supporting income verification documentation or processes, as required, and the amount of the patient liability:

1) To be eligible for a Patient Liability Protection write-off review, a patient who has; a) incurred emergent, OR b) emergent, non-elective services and is uninsured or underinsured, AND c) has a patient liability amount greater than the annual household income thresholds described in Section 8.

2) For purposes of this policy, an uninsured patient is one with no third party payer coverage for emergent health care services, and who satisfies the financial eligibility criteria set forth herein.

3) For purposes of this policy, an underinsured patient is one with some form of third party payer coverage for health care services, but such coverage is insufficient to pay the current bill such that the patient retains a patient liability that they are unable to pay and who satisfies the financial eligibility criteria set forth herein.

4) A validation will be completed, as required in this Policy, to ensure that if any portion of the patient's medical services can be paid by any federal or state governmental health care program (e.g., Medicare, Medicaid, Tricare, Medicare secondary payer), private insurance company, or other private, non-governmental third-party payer, that the payment has been

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received and posted to the account. No Patient Liability Protection write-off can be applied to any account with any outstanding payer liability.

5) Supporting Income Verification Documentation & Review:

A. Medicare Accounts

i. All Medicare patients (i.e., inpatients and/or outpatients) must submit supporting income verification documentation. Electronic validation of patient income, e.g., Experian, alone is not sufficient. Medicare requires independent income and resource verification for a Patient Liability Protection care determination with respect to Medicare beneficiaries (PRM-I § 312).

ii. In addition to the FAA, the preferred income documentation will be the most current year's Federal Tax Return. Any patient/responsible party unable to provide his/her most recent Federal Tax Return may provide two pieces of supporting documentation from the following list to meet this income verification requirement:

- State Income Tax Return for the most current year
- Supporting W-2
- Supporting 1099's
- Copies of all bank statements for last 3 months
- Most recent bank and broker statements listed in the Federal Tax Return
- Current credit report

B. Non-Medicare Accounts

i. Generally, for all non-Medicare Accounts, the following will be acceptable supporting documentation: (i) the documentation listed in A. above, (ii) or any one of the following:

- Most Recent Employer Pay Stubs
- Written documentation from income sources
- Electronic validation of patient income and family size, such as Experian

ii. Supporting income verification documentation through an electronic validation of patient information/income, such as Experian, shall be obtained where no other income verification is obtained.

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iii. To the extent required by state law, a complete FAA shall be obtained for any dollars reported as Patient Liability Protection to the state.

iv. Review of assets may take place during the application process where required by state law or regulation.

6) Pending Medicaid Effect on Patient Liability Protection Write-off:

The Pending Medicaid and Patient Liability Protection processes should not be concurrent processes. Determination of Pending Medicaid should be resolved prior to evaluating for potential Patient Liability Protection.

7) Health Insurance Marketplace for Qualified Health Plans:

Pending qualification in the Health Insurance Marketplace may take place concurrently with the Patient Liability Protection process. The QHP enrollment is not retroactive. Rather, the coverage becomes effective for future dates of service. Therefore, it is necessary to continue with the Patient Liability Protection process for visits occurring prior to QHP effective dates.

8) Patient Liability Protection Processing based on Federal Poverty Guidelines:

A. After all managed care payments, contractuals and uninsured discounts have been applied, patients will have their balance capped depending on their income and corresponding FPL. These caps will be as follows:

Patients with incomes greater than 400% of FPL will have their balances capped at a percentage of their income according to the table below. This percentage will be determined using the patient's FPL.

401%- 500% - balances capped at 10% of annual household income
501% - 600% - balances capped at 10% of annual household income
601% - 700% - balances capped at 12% of annual household income
701% - 800% - balances capped at 12% of annual household income
801% - 900% - balances capped at 15% of annual household income
901% + - balances capped at 15% of annual household income

B. Patients With Multiple Accounts:

Balances from multiple accounts for the same patient may be considered together to determine out-of-pocket responsibility minimums and for calculating the cap.

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The write-off will be applied after the uninsured discount.

9) Refunds on Patient Liability Protection Accounts:

The general expectation is that all patients pay for services rendered if they are not fully covered by a third party. Therefore, any amount paid by the patient (even if the patient subsequently meets the Patient Liability Protection write-off guidelines for their balance due), will be retained. Only amounts paid by the patient that exceed the amount that patient would have paid had they received the uninsured discount, or that exceed their out of pocket responsibility per their insurance, will be refunded. For those patients that do meet the Patient Liability Protection write-off criteria and have made a partial payment, the Patient Liability Protection write-off will be posted on the remaining patient balance.

10) Patient Dispute Process:

In the event a patient wishes to file a dispute and appeal their eligibility for a Patient Liability Protection write-off under this policy, the patient may seek review from the Vendor Collections Management Director, Hospital Chief Financial Officer or an SSC Executive
Compliance with State regulations:

Each SSC should evaluate whether this Policy complies with the applicable state law and regulations regarding hardship care, e.g., California, Florida. If this Policy does not comply with state law and regulations, each SSC must clearly document exceptions to this policy in either a State specific policy or an addendum to this Policy.

11) Liens:

Under no circumstances will liens be considered on properties less than $300,000 in value.

**PROTOCALS:**

PLP Large Balance
Insurance Scenario (